'New Public Management' Reforms in the Catalan Public Health Sector, 1985-1995:

Institutional Choices, Transactions Costs and Policy Change.

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To Jordi, for every single thing.

Abstract

This research uses a transactions costs approach to examine recent developments in the public sector organisational arrangements. It explores the extent to which transactions costs or other factors drive the institutional choices that legislators make about policy implementation. The area of application is the adoption of 'new public management' (NPM) reforms in Catalonia for the governance of the public health care sector in the period from the early 1980s to the mid-1990s.

The methodology used combines qualitative and quantitative approaches in the analysis of data from both primary and secondary sources. The primary sources used here include thirty-eight in-depth and semi-structured interviews with key informants, non-published internal reports from major organisations and an annual survey of all health providers carried out by the Department of Health and Social Security of the Catalan government. The secondary sources include official publications and relevant academic journals and books on the subject.

The study analyses both the policy formulation process leading up to a particular institutional design and the nature of the further implementation process in the Catalan health sector. First, policy precedents are identified and the resources and interests of the policy elites analysed as a basis for understanding the output of the reform formulation in 1990. Second, the analysis shows how transactions costs considerations shaped the stances taken by legislators and influenced the final institutional design. Third, a number of subsequent implementation short-falls are traced to some efforts at minimising transactions costs which turned out to be incompatible with NPM postulates. The analysis shows that the impact of politics, that is, the repeated interactions among policy elites controlling complementary resources, shape the way in which transactions costs and other considerations are approached in both policy formulation and implementation processes.

A central theoretical lesson drawn from this research is that although transactions costs are difficult to measure, they are useful heuristic tools for analysing the rationale driving decision-making processes on institutional design. However, both the theoretical definition of transactions costs and their actual impact on decision-making are mediated by power relations, that is, by politics.

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List of acronyms and glossary

AMIC: Association of Doctors and Nurses of Catalonia, created in 1997 mainly out of CESM-SATSE.

BCU: Basic Care Unit. Output measure of hospital activity defined by the Department of Health and Social Security of the Catalan government in 1986. BCUs are aimed at standardising and rationalising the contracting process with non-Social Security hospitals, by setting prices for each Basic Care Unit.

CATAC: Autonomous Candidature of Workers of the Catalan Administration, created in 1987.

CATSC: Autonomous Collective of Health Workers, created in 1987 and integrated into CATAC in 1990.

CC.OO: Workers' Commissions, class-based trade union with a communist leaning and with a nation-wide militancy basis. After having operated clandestinely from the sixties under the francoist regime, CC.OO. became one of the two most representative trade unions in democratic Spain - together with UGT.

CDS: Social and Democratic Centre, party created in 1982 out of part of UCD.

CESM: Spanish Confederation of Medical Unions, created in the seventies.

CESM-SATSE: Spanish Confederation of Doctors and Union of Technical and Health Auxiliaries, coalition formed in 1987 between the health profession-based unions CESM, representing doctors, and SATSE, representing nurses.

CHC: Hospital Consortium of Catalonia. Association of local administration-dependent hospitals and the corresponding local councils, which was formally created in 1984, but which was largely active over the early eighties. The CHC has had a crucial role in defining the Catalan model of health provision, by acting as a pressure group of political representatives of local governments, as a think-tank, and more recently as a enterprise of services.

CHI: Catalan Health Institute. Management entity of the health services and benefits of the Social Security in Catalonia -namely, the decentralised branch of the corresponding parent entity (INSALUD) at the Spanish central government level. The CHI owns and manages 26 per cent of the hospital beds of the Hospital Network of Public Utilisation and over 90 per cent of the primary care resources in Catalonia.

CHS: Catalan Health Service, the health authority created by the 1990 Law for the Organisation of Health in Catalonia, and endowed with the roles of health planning, financing and contracting/purchasing with health providers.

CiU: Convergence and Union. Coalition of two centre-right Catalan nationalist parties which has been in the Catalan government from the first autonomous elections in 1980. CiU had the support of an absolute parliamentary majority from 1984 to 1995. Its role as a member of a non-formalised minimum winning coalition of the Spanish central government (they did not have any portfolio, but decided support on an issue-per-issue basis) was crucial between 1993 and 1996 with the governing PSOE, and from 1996 to date (mid-1998) with the governing PP.

COMB: Official Medical College of Barcelona, originally created in 1894.

CTSC: Co-ordinating Committee of Health Workers in Catalonia, created in 1994.

DHSS: Department of Health and Social Security of the Catalan government. The Catalan government was provisionally re-established in 1977, after four decades of francoist dictatorship. The Catalan Statute of Autonomy was approved by referendum in Catalonia in 1979 and the first democratic elections to the Catalan Parliament after the transition were held in 1980.

ERC: Republican Left of Catalonia, leading party of the Catalan government under the second Spanish Republic in the first half of the thirties. As an important clandestine organisation under the francoist regime it failed to meet electoral expectations after the first autonomous elections in 1980.

GHL: General Health Law, passed by the Spanish central Parliament in 1986. The GHL created a National Health System characterised by universal coverage, general tax financing and public direct provision of health services.

HBA: Health Basic Area, the smallest territorial demarcation for the organisation of primary health care in Spain and Catalonia. HBAs were defined as part of the reform launched by a 1984 decree of the Spanish central government, by a 1985 decree of the Catalan government, and reinforced by the 1986 General Health Law passed by the Spanish central Parliament. In each HBA a Primary Care Team composed of health and non-health professionals work on a full-time basis in Primary Care Centres, following specified personnel ratios per population, and are responsible for health care, health promotion and illness prevention.

HNPU: Hospital Network of Public Utilisation, created by the DHSS of the Catalan government in 1985. The HNPU represented a policy option which diverted from the publicly-owned, publicly-managed National Health Service model being debated and formulated at the Spanish central government level

between 1983 and 1986. By contrast, this hospital network in Catalonia was heterogeneous in terms of ownership and management forms, and included those accredited hospitals which contracted on a regular basis with the DHSS for the provision of publicly-financed health services. These contracts with the DHSS became the most important and often their only financing source of most HNPU hospitals.

IAC: Alternative Inter-union of Catalonia. Coalition of public sector-based unions created in 1997 mainly out of CATAC-USTEC-CTSC, and integrating several associations of different branches of the public sector - administration, health, education and others.

IC: Initiative for Catalonia, coalition of leftist political parties in Catalonia, with a communist leaning, which was formed in 1987, and federated in 1988 to the Spain-wide coalition United Left (IU), which had been created in 1986.

IC-V: Initiative for Catalonia-The Greens, coalition formed in Catalonia and approved by IU's Federal Congress in 1994. Growing internal disagreements within IC-V have led to break relations with the Spanish United Left in early 1998 and to the schism of the collective Red-Green-Violet from IC-V. This collective will apparently represent the federated branch of United Left in Catalonia in the next elections.

INSALUD: National Health Institute, the management entity of the Social Security health services and one of the four Institutes created in 1978 as a result of a reorganisation of the Social Security administration. Its gradual decentralisation to the Autonomous Communities started in 1981 with the completion of the transfers agreements with Catalonia. To date (mid-1998), seven Autonomous Communities, representing 60 per cent of the population covered by the National Health system, have completed their corresponding transfers agreements.

LOHC: Law for the Organisation of Health in Catalonia, passed by the Catalan Parliament in 1990. This law representing the introduction of NPM postulates in the governance of health care in Catalonia.

NHS (British): National Health Service, largely defined by Beveridge. It was created in 1948 and became one of the centrepieces of the British welfare state.

NHS (Spanish): National Health System, created by the General Health Law passed by the Spanish central Parliament in 1986. It follows a National Health Service model of universal coverage, tax-financed and public provision health care model.

NPM: 'New public management', reform trend affecting the public sector across many OECD countries since the late seventies. Central NPM characteristics are the differentiation of function-based roles (purchaser, provider,

consumer/client), the disaggregation of previously integrated organisational structures on the basis of such differentiation, the introduction of incentives, and the development of market-like competition mechanisms.

PCC: Party of the Catalan Communists.

PNV: Basque Nationalist Party.

PP: Popular Party, created in 1989 out of the previous AP (Popular Alliance). From 1996 to date (mid-1998) the PP is in office in the Spanish central government, with the support of a minority in the Spanish Parliament.

PRH: Plan for the Reorganisation of the Hospital Sector, elaborated in 1986 by the DHSS of the Catalan government. This initiative was aimed, on the one hand, at reorganising the distribution of hospital resources in Catalonia in order to achieve a more balanced network thereby ensuring the population a more equitable access to those resources. On the other hand, the PRH was aimed at rationalising the existing hospital resources and their use.

PSC: Party of the Catalan Socialists, with its organisation and militancy based in Catalonia. From the democratic transition to date (mid-1998), it has been the most voted party in the local elections in Catalonia, the second most voted in the Catalan autonomous elections, and has shared the electoral results of the PSOE in the Spanish general elections. Although the PSC is part of the sovereign party PSC-PSOE, the PSC stands for election in Catalonia thereby receiving the PSOE sympathisers' votes in this Autonomous Community.

PSOE: Spanish Workers' Socialist Party, which was in office in the Spanish central government between 1982 and 1996, with the support of an absolute majority in the Spanish central Parliament between 1982 and 1993.

PSUC: Unified Socialist Party of Catalonia, member of the coalition IC and with its organisation and militancy based in Catalonia. Being an important clandestine organisation under the francoist regime, it failed to meet the electoral expectations after the first Catalan autonomous elections in 1980.

SATSE: Union of Technical and Health Auxiliaries, created in the seventies.

UCD: Union of Democratic Centre, an organisationally weak party which was formed by an ideologically heterogeneous elite. It was in office in the Spanish central government for the first two democratic legislative periods, 1977-79, 1979-82, and collapsed after its defeat in the 1982 general election.

UCH: Catalan Union of Hospitals, an association of private hospital managers created in 1975, which played a central role in the definition of the regulatory measures and policy tools characterising the governance of health in Catalonia. It has acted both as a pressure group and as a think-

tank, and has played the role of the only employers' association within the HNPU until 1994.

UGT: General Union of Workers, class-based union with a socialist leaning, with a nation-wide militancy basis, and with a century-long history. After having operated clandestinely under the francoist regime UGT became one of the two most representative trade unions in Spain - together with CC.OO.

USO: Workers' Trade Unions Association, created in the sixties.

USTEC: Association of Trade Unions of Education Workers' of Catalonia, created in the seventies out of teachers' assembly movements.

Chapter 1

Explaining institutional choice in the health sector.

The politics of institutional choice is the process by which interest groups and public officials (both elected politicians and bureaucrats) make decisions about the structure of government, that is, about the rules governing the relations between different actors in each policy domain. These rules are important because they allocate to different actors decision rights of a public authority nature, together with costs and benefits, which then affects both policy outputs and outcomes (Moe, 1990a, 1990b). In this respect, the end of the 1980s and the beginning of the 1990s saw a widespread reform trend affecting the structure of government across many OECD countries, namely, 'new public management' (NPM). The changes prescribed by NPM involve a shift in the governance structure of different policy domains, that is, in the set of rules governing the relationship between relevant actors. Two main components of a governance structure are the institutional form of the public authority and the policy tools it is entitled to use. The NPM shift is from traditional public administration, where integrated hierarchical structures and command-and-control policy tools are commonplace, to a governance structure inspired on market transactions. In a NPM governance structure functional roles are differentiated (financing, purchasing, provision, regulation, consumption); organisational structures are accordingly disaggregated; and incentive-based contracts are the main instrument for governing the relations between the actors assuming those roles (Dunleavy, 1994).

Most mainstream research on NPM reforms has focused on pioneering experiences in 'Anglo-Saxon' countries such as the United Kingdom, New Zealand, Australia, United States and Canada; or on specific relevant cases elsewhere, such as Sweden, where reforms are taking a relatively comprehensive approach not only to the core public administration but also to policy domains which are central to the

welfare state[1]. This body of NPM research has been mostly concerned with describing the content of the reforms in relation to both the new institutional forms of public authorities and the policy tools being developed. Only recently have some implementation analyses started to assess the impact of those reforms in terms of efficiency, effectiveness and equity[2]. In fewer cases researchers have tried to explain *why* NPM, as a policy reversal, came about. As Hood (1994) concludes, different theories provide insight to this question but they remain incomplete. In fact, Hood classifies them into different sorts of 'complementary' explanations such as: the power and/or packaging of NPM ideas (Aucoin, 1990); a shift of government officials' interests reflected in a 'bureau-shaping' behaviour (Dunleavy, 1991) or the emergence of a new ruling elite within public service bureaucracies (Pusey, 1991; Yeatman, 1987); a change in habitat as a result of the configuration of a 'post-fordist' society (Osborne, Gaebler, 1992; Taylor, Williams, 1991); and a 'natural' process of policy self-destruction in ageing institutions (Painter, 1990).

However, although these theories provide great insight, their very formulation implicitly assumes that NPM is a particular kind of public sector reform which requires a particular, tailor-made explanation. Therefore, the potential application of these theories may appear as limited when trying to explain any other kind of public sector reform. By contrast, if NPM is defined just as one form of governance structure in the public sector (among other possible ones), the question of *why legislators chose this particular governance structure?* requires an explanation based on a more general theory of institutional choice in the public sector. Moreover, this approach would have to be applicable not only to reforms occurring

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[1] As Metcalfe (1993) points out, NPM does not only affect individual organisations at the core of public administration, but it is gradually involving structural reorganisations of the public service delivery system, affecting networks of organisations. In the United Kingdom areas such as local government, the NHS, education, police services are being affected by these reforms. The main elements of this trend are: decentralisation of operational management responsibilities to individual units, creation of a business management ethos, cost consciousness, management by objectives, financial accountability, competition between providers in health and education, the public as consumer rather than client in a purchaser-provider contracting system, centralised financial control over local management discretion, centrally established policy parameters.

[2] See for example: Le Grand, Bartlett, (1993); Robinson, Le Grand (1993); Glennerster *et al.* (1994); Maynard (1994); Ranade (1995); Saltman, Otter (1995); Ferlie *et al.* (1996); Flynn and Williams (1997); Hughes *et al.* (1997); Lane (1997); Mulholland and McAlister (1997); Robinson and Steiner (1998).

in the core public administration but also those found in different policy domains and sectors.

The formulation of such a theory has not proved an easy task. As Moe argues (1990a, 1990b, 1991), the 'sociological' and 'economic' organisational theories developed within new institutionalism in the seventies and eighties, have not integrated politics and organisation into a theory which endogenises the political dimension of public administration into the analysis of its organisational components. Instead, they have consolidated the separation between the study of the political and administrative spheres. Building on this criticism, Horn (1995) elaborated a 'political' organisation theory of institutional choice in the public sector. It tries to integrate the defining features of the political level and the public authority system into the choices legislators make concerning the organisation of the public sector.

In this research Horn's (1995) theory is taken as a first step to answering two questions: 'Why did the Catalan legislators choose a NPM governance structure for the health sector?' and 'why was there a divergence between policy formulation and its implementation, despite the favourable conditions for realising a NPM solution in Catalonia's health sector?' In answering both questions Horn's decision-making theory is extended and complemented in some relevant respects concerning the role of non-institutional policy elites and the implementation process. In the following, some key concepts from advocacy coalition theory are assumed (Sabatier, Jenkins-Smith, 1993), so as to explain the choice of a particular institutional form of the new health authority. In addition, insightful concepts from institutional rational choice (Dunleavy, 1991), transactions costs economics (Williamson, 1975, 1985) and resource dependence theory (Pfeffer, Salancik, 1978) are introduced in order to analyse the actual use made of the policy tools with which that health authority was provided.

This chapter is divided into three sections. The first focuses on the defining features of the NPM reform trend affecting both the public sector in general in many countries, and the health sector in particular. The second section develops the focal theory within which this research has been carried out, drawing on a general theory of institutional choice in the public sector and on specific concepts from different organisational theories. Finally, the third section introduces the theoretical and empirical interest of the Catalan reforms during the 1985-95 period. As an Autonomous Community in quasi-federal Spain, Catalonia does not appear

in the international statistical sources as a country nor has it a relevant presence in international research venues. Therefore, although Catalonia scores high on NPM, it implicitly falls in the same category as Spain, that is, as a 'low-scorer' on NPM[3], together with Germany, Greece, Switzerland, Japan and Turkey (Hood, 1995) - a classification which tends to put off researchers in the field. In this study, the Catalan case is taken as an example of NPM reform.

1.1. 'New public management' reforms.

According to Dunleavy and Hood (1994), NPM involves a shift in the two basic design co-ordinates of public sector organisation, moving it 'down-grid' and 'down-group'. The former means reducing the extent to which discretionary power is limited by rules of procedures, the latter means blurring the distinctiveness of the public sector as a differentiated unit from the private sector. Following this approach, Hood (1994) identifies six main components of NPM. A 'down-grid' shift is achieved through: (1) hands-on top management, requiring a clear assignment of responsibilities so as to allow more 'freedom to manage'; (2) setting explicit standards and measures of performance in order to enhance accountability by reference to stated goals; and (3) designing output or result controls as a basis for linking resources and payment to performance. A 'down-group' movement is pursued through: (4) splitting up purchasing and provision functions to avoid producer bias, and the corresponding disaggregation of previously integrated provider structures into corporatised, product-focused units which hold devolved budgets and do not need to rely on single service employment; (5) the introduction of contract-based competition for the provision of services in order to cut down

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[3] For an overview and analysis of the successive reform proposals (even in the line of NPM) and of the reforms actually implemented in the Spanish central, autonomous and local administrations from the late seventies to date, together with the increasing intertwinning of these administrative reforms with the process of European integration, see Subirats and Gallego-Calderón (1998).

costs through more efficient performance; and (6) the adoption of a private sector management-style.

Table 1.1. 'New public management' components.

'Down-grid' movement	'Down-group' movement
1. Hands-on top management.	1. Disaggregation.
2. Explicit standards and performance measures.	2. Competition.
3. Output/result controls.	3. Private sector management-style.

Source: Adapted from Hood (1994:130).

Pollit's (1993) distinction between the neo-Taylorist administrative reforms in the eighties and the NPM reforms in the nineties may respectively apply to each co-ordinate. Neo-Taylorism, with its emphasis on tight control and supervision, cost reduction, efficiency, economy, performance measurement and related pay, concentrated on the 'grid dimension'. In turn, the NPM of the nineties with its stress on quality, effectiveness and consumer responsiveness, focused on the 'group dimension'. That is, the profound structural reforms derived from NPM have blurred the separation between private and public sector. In Dunleavy's (1994) analysis, neo-Taylorism fits the 'incentivisation' component of the early NPM, while the NPM of the nineties uncovers its 'disaggregation' and 'competition' components.

Drawing on Dunleavy's (1994) concepts, it could be argued that NPM reforms are based on disaggregation as a way to induce competition for public services provision, which in turn could only arise from incentivisation mechanisms. Competition has been sought through mechanisms such as a purchaser/provider split, compulsory competitive tendering, government-to-government contracting and intra-governmental contracting, consumer-tagged financing and vouchers (both involving 'exit' options), user control through the exercise of 'voice', and a

public/private sector polarisation of consumption patterns. In turn, disaggregation has been pursued by several means, such as corporatising large and complex organisations into product-focused units under the figure of a manager-leader, creating quasi-governmental and micro-local agencies, developing independent institutions, creating agencies within central government departments, decoupling related policy systems, corporatising privatised industries, introducing market testing, yardstick competition and league tables, measuring performance, and limiting professional power. As for incentivisation, the main components have included the privatisation of asset ownership, the respecification of property rights, 'light touch' regulation, the involvement of capital markets, the unification of rates of return and discounting criteria across the public and private sectors, the development of charging technology in direct relation to new information technology, the valuation and management of public sector equity, the definition of mandatory 'efficiency dividends', and the development of anti-rent-seeking policies through, for example, deprivileging professions and public sector workers, and linking pay to performance and increasing pay differentiation (Dunleavy, 1994).

According to Aucoin (1990), two major strands of ideas converge upon these NPM developments. First, public choice theory, concerned with re-establishing the primacy of political-representative government and expanding control over bureaucracy through centralisation and close supervision. Second, the 'managerialist' school, which is concerned with re-establishing the primacy of managerial principles over bureaucratic rules and procedures through freedom to manage. Apparently, there is a conflict between these two sets of ideas. In the case of the United Kingdom, this conflict led to three basic inter-locking strategies of control by the mid 1990s (Hogget, 1996): the creation of corporatised operational units was accompanied by an increase in the centralised control over strategy and policy; competition became the main co-ordinating method among those decentralised units; and there was a substantial development of systems for performance management and monitoring, as a new form of power - one concentrated within more remote and less visible centres of corporate and state governance.

In this sense, strengthening the political control over these fragmented, managerially driven scenarios requires a refinement of certain tools of government, particularly those concerned with bridging strategies among organisations. According to Hood (1983), the tools of government may be classified into four

types: organisation, nodality, authority and treasury. Thus, it could be argued that in the current NPM reforms, using organisation as a government's basic tool (in the form of publicly provided services) has declined in favour of the reinforcement of other tools such as nodality (exploiting government's role at the centre of information networks and communication flows). On the one hand, nodality is becoming essential for exerting authority (the capacity to legitimately coerce or regulate or legislate against other social actors). On the other hand, nodality is the basis for using 'treasure' (essentially finance and other requisitioned resources, such as property) in a policy-oriented manner, because policy implementation is increasingly taken over by other organisations. Control over such providers requires these reinforced tools either to support the enforcement of contracts or to build those tools into the contracts themselves.

Both these changes in tools and the idea of a small government controlling a network of contracted arms' length provider units, introduce some features of a divisionalised bureaucracy (Mintzberg, 1983). Here a central agency (the headquarters) manages the strategic portfolio (formulates policy), allocates overall financial resources (makes budgetary allocations), replaces and appoints the managers of the divisions (quasi-autonomous loosely coupled together by that central administration), and designs the performance control system as the base for an *ex-post* co-ordinating mechanism focusing on standardisation of outputs. However, according to Mintzberg (1983), the divisional form of organisation tends to drive its component divisions towards the machine bureaucracy form. An *ex-post* performance control system requires that each division be considered as single, integrated actor with a consistent set of operationalisable goals, easily translated into quantitative measures. The machine bureaucracy is the only configuration that meets both requirements, hence the pressure to centralise and formalise divisions' internal structures. Moreover, at the system level (the whole multidivisional organisation) there is a tendency to centralise power at the level of the headquarters, going beyond its supposedly limited strategic role.

Mintzberg identifies two main obstacles for the divisional form to be successfully introduced in the public sector: the hiring and firing of subordinates should be under middle line managers' control, and artificial performance standards should be devised to measure social goals. These two points are particularly relevant when, as in the health sector, the provider organisations to be 'managed' are professional organisations. Within professional organisations the realisation of

the central activities and the achievement of primary purposes depend on professional employees' competence: they form the organisation's 'operating core' which essentially determines the organisations' success of failure. The NPM shift could result in an erosion of self-management by professionals - a shift from autonomous to heteronomous forms of organisation. In autonomous organisations, administrative officials delegate to the professional employees well-specified responsibilities for the definition and implementation of the organisation's goals, for the setting of performance standards and for their supervision. In heteronomous organisations, the autonomy granted professional employees is relatively small and they are clearly subordinated to the administrative officials (Scott, 1965:66-7).

Following Mintzberg (1983), not only do professionals enjoy a high degree of autonomy in their work, which they carry out relatively independently of their colleagues and in close relation with their clients, but they also normally aim to control the administrative 'middle line' of their organisation, whose decisions can affect their autonomy. This orientation is backed up by making the main co-ordinating mechanism in professional bureaucracies the standardisation of skills and knowledge, which largely originated outside the organisation structure by a broader occupation community organised in self-governing collegial associations. However, professional staffs' autonomy within large employing organisations can be subverted by the drive to introduce a managerial logic of authority with its emphasis on economy and efficiency.

The major change in the health care sector initiated by NPM reforms in a number of OECD countries is a shift from integrated public provision models to competitive contracting and managed markets of divisionalised professional bureaucracies (Abel-Smith, 1995:23-4). However, both the specificities of the health sector (its market failures), and its central role in the welfare state (in the trade off between equity and efficiency) condition the development of these reforms. Originally, the need to counteract private health market failures led to the design of the public health governance structures. Nonetheless, these post-war governance structures gradually developed failures themselves which became the argument for introducing NPM as a way to further counteract them.

The health sector is characterised by a number of market failures such as informational asymmetry; complexity and uncertainty of demand; professional power (supply-led demand, knowledge monopoly); indivisibilities and externalities; difficulty in measuring performance; and equity concerns. Similarly, in health care

insurance, aspects such as the coverage of high-risk groups, the existence of interdependent risks, adverse selection, moral hazard and increasing returns make the health sector market heavily imperfect (Arrow, 1963; Barr, 1993). In this context, the implicit or explicit contractual response (agency relationship) becomes a crucial defining feature structuring the health care market[4]. However, even if all participants in the health market were 'price takers', neither allocative efficiency nor equity would be achievable because the specification of preferences and, consequently, demand are no longer clearly in the domain of choice over which the consumer has fundamental control. Moreover, property rights may not be clearly defined or legally enforced; individuals may not have full information about the nature of those property rights which are defined and legally enforced; and there may not exist a unique, market clearing price for each commodity over which such property rights are defined and legally enforced (McGuire, Fenn, Mayhew, 1991).

A variety of complex governance structures evolved as responses to private health market failures, ranging from the allocation of government subsidies to the appearance of mutual aid societies of private insurance (in Switzerland, and the Netherlands), to the creation of a National Health Insurance (in France), and to the further creation of a National Health Service in some countries (for example, in the United Kingdom, in New Zealand and in Spain). Public provision of insurance (National Health Insurance or NHI) is intended to counteract the adverse selection inherent in an unregulated insurance market. In this model, moral hazard stemming from third-party payment tends to be counteracted through cost-sharing schemes (deductibles, co-payment, and co-insurance). The risk of cream-skimming is diminished in a system of monopsonistic compulsory health insurance, where the

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[4] In the 'agency' literature *asymmetry of information* among self-interested contracting parties is considered the main cause of shirking, namely an inherent problem with hierarchies -which are defined as nexus of contracts themselves. 'The principal-agent model is an analytic expression of the agency relationship, in which one party, the principal, considers entering into a contractual agreement with another, the agent, in the expectation that the agent will subsequently choose actions that produce outcomes desired by the principal' (Moe, 1984:756). Adverse selection and moral hazard are key problems dealt with in principal-agent contractual relations. *Adverse selection* is an *ex-ante* problem to the contract, stemming from the unobservability of the information, benefits and values on which the decisions of the agent are based. *Moral hazard* is an *ex-post* problem to the contract, derived from the unobservability of the actual behaviour of an agent, who, once hired, may change his behaviour to the detriment of the principal. Thus, the essence of the principal's problem is to design a contractual incentive structure that makes it advantageous for the agent to serve the principal's interests. However, the agency theory claim that organisations are not different from nexus of contracts contradicts the claim by other incentive theories that organisational arrangements do matter (Stevens, 1993:281-183).

single purchaser can exert greater leverage over providers' behaviour. The further integration of both public insurance and publicly-owned provision (in a National Health Service or NHS) is an attempt to directly monitor the economic consequences of medical behaviour. This solution provides greater potential for planning and control over costs by bringing together economic and medical information - while self-regulation by the medical profession had overwhelmingly focused on medical behaviour (Immergut, 1992).

Thus, state provision, regulation and taxes/subsidies can be seen as responses to failures of the private health market. Provision is a means of dealing with the problem of monopoly; regulation, with the problem of imperfect consumer information; and subsidies with the problems derived from uncertainty of demand and externalities. Nevertheless, each of these solutions generates its own problems. Provision can create inefficiency as a result of the absence of competition; the regulated can capture the regulator and ensure measures that service their interests; and subsidies can lead to overuse and an unequitable distribution of public resources (Le Grand, Propper, Robinson, 1992). The aggregate measures used in an integrated NHS-type system to constrain behaviour and associated resource allocation do not ensure that such allocation is efficient because basic incentives are absent - for example, those insured have no possibility to exit. If public financing is dependent on macro-economic concerns and there is a lack of detailed information about the demands placed on the sector, resource allocation can hardly be efficient. Moreover, at the micro-level, the medical profession retains a monopoly over information and continues to respond to the uncertainties which dominates the production process through a highly individualistic agency relationship and through the pursuit of medical objectives. Thus, in spite of the move away from fee-for-service to salaried remuneration characterising NHS integration efforts, monitoring problems still remained (Le Grand, Propper, Robinson, 1992).

In either the NHI or in the NHS-type of health systems, the main functions for third-parties (that is, government or other actors) regardless of their organisational and institutional nature are: a) the insurance function, taking over consumers' financial risk of service utilisation; b) the agency function, reducing moral hazard, providing information about the quality of care and being a prudent buyer of care on behalf of the consumer; and c) the access function, guaranteeing universal access to basic health services. Present third-party arrangements adequately fulfil

the first and third functions. However, a common problem is to satisfactorily execute the agency function, that is, to find the adequate incentives for the third party to perform it in an efficient and equitable way on behalf of the consumer (Ven, Schut, Rutten, 1994).

Both NPM and quasi-markets (as a common development of the NPM approach) attempt to introduce incentive structures which seek to counteract some of the failures of either private market provision or government intervention. In quasi-markets the NPM components of incentivisation, disaggregation and competition are comprehensively applied within different policy domains. The shift from integrated models to quasi-markets tries to deal with the tension between more demanding consumers and limited resources. The explicit assumption is that competitive pressures provides incentives for efficiency, the benefits from which outweigh the transaction costs involved in designing and enforcing contracts (Saltman, Otter, 1995). This claim led to two different objectives: delegating more responsibility down the line of management, which requires reducing the burden of control imposed by hierarchies and emphasising local choices; and exerting more control to ensure efficient performance, which emphasises performance assessment and enhanced control over providers' commitment to users' welfare in order to counteract the present producer bias (Harrison, 1993).

Thus, quasi-markets consist of an agency system where relations among purchasers (for example, health authorities, general practise fundholders) and providers (for example, managerially autonomous hospitals, primary care practices) are made explicit and binding through a complex incentive structure founded on contracts. A contract-based model of institutional arrangement is created, where financial risk is moved either to the provider, or to the consumer in the case of voucher systems. It is asserted that separating decision rationality from action rationality would enhance efficiency (Brommels, 1995). Thus, the emphasis is put on entrepreneurial business units, performance related pay, team-based production, decentralised budget management, and clients increasing their satisfaction by exercising a free choice of practitioner and/or hospital.

According to Saltman and Otter (1989, 1992), the health care reforms implemented in the early nineties differed both in the scope for market and competition, and in the lever of change promoted, between supply or demand. The theoretical extremes of the spectrum would be the public competition and the mixed markets models - the former prevailing in Sweden and the latter in Britain.

The public competition model is based on three principles: (1) public ownership and management of providers of health care, and a public insurance system, so there are public purchasers of services; (2) patients are free to periodically choose their general practitioner and health centre; (3) budgetary resource allocations (for capital investment and remuneration incentives) to primary care centres and hospitals are based on their market share (number of patients) and productivity (internal efficiency). In sum, this is a market internal to the public sector.

By contrast, in the mixed market model a budget is allocated to a purchaser authority within a geographical area - with a population between 100,000 and 800,000 people. The margin of manoeuvre for this purchaser includes: (1) negotiating and contracting public or private provision of health services, considering prices and quality; (2) selling and transferring assets; (3) raising financial resources in the capital market. Basically, the difference between the two models is that within public competition the lever of change is the patient, whereas in the mixed market the lever of change is the manager responsible for the health service in the area. In other words, public competition is a demand-led reform, while mixed markets is a supply-led reform.

There has been an awareness, though, that for quasi-markets to succeed certain conditions should be fulfilled. Following Le Grand and Bartlett (1993), key conditions are:

a) Market structure: the structure on both sides of the market should be competitive. Nevertheless, when a monopoly exists on one side, a monopoly on the other side may be needed as a countervailing power.

b) Information: both providers and purchasers need to have access to accurate, independent information, the former primarily about costs, the latter about quality.

c) Transaction costs associated with uncertainty should be kept to a minimum.

d) Motivation: providers should be motivated to some extent by financial considerations, and purchasers by the welfare of users.

e) Cream-skimming: no incentives should exist for purchasers or providers to discriminate between users in favour of the least expensive ones[5].

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[5] The difficulty to meet such conditions for quasi-markets to succeed is the reason for different kinds of implementation 'shortfalls' in the new health care model. Evidence of the British experience, where this reform process has been taken furthest, is available for the early nineties. There was a lack of relevant and accurate information on costs, outputs and

Moreover, contracts are incomplete by definition. They cannot cover the contingencies involved in the sequential nature of the production process of health care. The formalisation of the agency relationship between purchasers, providers and patients does not overcome the fundamental problem of uncertainty and the complexity of diagnostic and prognostic processes. For example, cash-limited budgets might increase rather than reduce allocation problems, because budget-holders should attempt to reconcile unpredicted resource commitments with their budget constraints. Also, the change in the financial incentives towards prospective payments or relating fees to service provision seems likely to foster costs escalation, as providers attempt to minimise financial losses. Therefore, crucial questions about quasi-markets are their potential impact on the structure of organisational power and accountability in health institutions (managers, clinicians, patients), shaping the best task-focused units from hierarchically integrated local centres and hospitals, developing forms of internal and external competition, designing contracts suitable to achieve health policy objectives, consequences for health personnel (flexibility in labour regulation), and equity considerations (Saltman; Otter, 1995).

Such rediscovered prospective quasi-market failures led to a shift from 'quasi-market' to 'managed market' (Ranade, 1994:156-8). The purchasing function

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outcomes for monitoring and evaluating health services on both sides of the market . In fact, in a competitive market there are advantages to be gained from retaining rather than sharing information (Maynard, 1994). At a district level, the market structure seemed to stabilise with a single purchaser and a few large providers, and mergers are being encouraged (Robinson, Le Grand, 1993). There was also evidence of greater transactions costs -namely, administrative and management costs derived from contracting-, in the form of new accounting and information systems and staff. District Health Authorities had, in principle, an advantage over GP fundholders as purchasers in terms of *ex-ante* costs, as health authorities tended to use block or cost-and-volume contracts. General Practise (GP) fundholders negotiated contracts on a case-per-case basis, which, given their increasing number, was likely to prove expensive in terms of *ex-ante* transactions costs also for providers. Nonetheless, fundholders had an advantage in terms of *ex-post* costs, since they were in closer touch with the patient and, consequently, in better place to monitor contract compliance as well (Appleby *et al.* 1993:24-53). Interestingly enough, some GP fundholders set up private companies so as to contract with themselves and profit thereby -a practice which was stopped by the government in 1993 for contradicting the purchaser/provider split . On the purchaser side, strong motivation to keep within budget, that is, remaining financially viable, was documented. Admittedly GPs' preferences counted for more as a determinant of health authorities' decisions to purchase than other factors such as competitive prices or quality assurance (Le Grand, 1993:258-9). According to some researchers, fundholding GPs were, in principle, able to distort priorities by requesting preferential admission for their patients, fostering accusations of a two-tier system and demands for more regulation (Mohan, 1995:226). However, some evidence showed no clear cream-skimming trends, partly as a result of the historical cost base applied to the calculation of GPs' funds (Glennerster *et al.* 1994).

has evolved from an initial preoccupation with contracts and information systems design, to a determination to make providers adapt to purchasers' demands and criteria. This attitude asserted a disengagement with providers' financial difficulties and consequent crises. Later on purchasing was understood as 'commissioning', that is, working closely with providers in order to jointly plan contracts and future service developments, although incentives for efficient management continued to be crucial. However, in the United Kingdom such collusive tendencies were not approved of by the Major government. Region Health Authorities (with a regulatory role) were abolished in 1993 and replaced by eight regional offices of the NHS Management Executive (Mohan, 1995:213). Some reasons for such a decision pointed to Region Health Authorities having excessive sympathy towards 'their' trusts and undertaking too much interference with providers' affairs: separation of purchasers and providers was a principle to be safeguarded.

Despite the varying emphasis on different NPM components across the countries leading these reforms, their respective policies have a common objective: to redesign the governance structure of both public administration and several substantive policy domains. In order to identify explanatory variables of public sector institutional reforms and their outputs, I now turn to explore relevant existing theories and elaborate the framework guiding this research.

1.2. Governance structures in the public sector.

According to Moe, public administration is the natural domain for a theory of political organisation to have developed, but this has not happened. Organisation theory has remained the domain of economists, sociologists and psychologists. Political scientists still have to build a theory of political organisation which integrates the defining features of the political process in order to understand the politics of structural choice, that is, the process by which public officials and interest groups make decisions about the structure of government (Moe, 1990a; 1990b; 1991). Nonetheless, the structure of government does not only involve the

institutional form of public authority, but also the policy tools with which it is endowed for governing the relationships between the relevant actors of a policy domain. Therefore, the theoretical framework proposed for this research (about why Catalan legislators chose a particular governance structure) not only has to account for the design of a particular institutional form, but also for the accommodation between this institutional design and the policy tools which actors in the governance structure are entitled to use.

a) Choosing institutional forms.

Deciding on the structure of government, that is, on the structure of political organisations, means setting the rules governing the relationship between different actors and allocating them decision rights of a public authority nature as well as costs and benefits. In this respect, political organisations serve two objectives. First they help mitigate the problem of collective action (particularly the *commitment* and *enforcement* problems which hinder political exchange), by allowing actors to cooperate in the political arena and benefit from political exchange. Second, they are tools of coercion and distribution because they are the means by which political winners pursue their interests often to the detriment of losers (Moe, 1990a:213). Therefore, a theory of political/public organisation (that is, of political institutions and public administration) has to build on essential features of politics, such as public authority, political uncertainty, political compromise, fear of the state and problems in effective organisation (Moe, 1990a; 1990b).

Politics is about the exercise of public authority and about the struggle to gain control over it. In a principal-agent relationship where the exercise of public authority is involved, the agent (public officials) controls the principal (interest groups and citizens) in a relationship which, moreover, is not based on voluntary exchange but on coercion. In addition, politics is characterised by uncertainty, because 'property rights' are not guaranteed. The right to exercise public authority does not belong to specific individuals but to offices whose conduct and effects depend on who gains the office according to the selection rules established. This uncertainty makes it difficult to ensure legislators reach a political compromise

(their commitment problem) assumed in relation to specific policy options, on which their constituents supposedly base their support for legislators.

Both public officials and interest groups are aware that the structure of government influence policy outputs and outcomes. Thus, when making decisions on the structure of government, interest groups and legislators are both driven by fear of the state. Interest groups seek protection through structural design features (such as, participation rights, appealing rights, oversight) so that other rival groups cannot capture public agencies and thereby influence policy. In turn, public officials seek to ensure through their decisions on structures that reversing or modifying their policy commitments is difficult for a new legislative majority or a new incumbent in government to accomplish. Thus, both of them are ultimately concerned with designing an effective organisation to ensure the implementation of their policies, while opponents are interested in jeopardising the structural design which may lead to effectiveness in those policies which they do not support.

None of the theoretical frameworks developed in organisational theory in the seventies and eighties endogenises these characteristics of political/public organisations into an explanation of the process of institutional choice. In those decades new institutionalism 'rediscovered' institutions as a central subject of political research and shifted away from the study of behaviour as the main unit of analysis. Despite the high fragmentation of schools within new institutionalism, a distinction may be drawn between a sociological and an economic approach. The 'sociological' version of new institutionalism rejects two prevailing approaches to the explanation of organisational phenomena - the contextual (systems perspective) and the individual actor (rational choice) frameworks. According to new institutionalism, these two perspectives take politics and political phenomena (like public institutions) as a by-product of non-political factors such as social structure or individual self-interest (March, Olsen, 1989:8-19). Instead, this new approach argues that institutional change processes are of an inherently political nature, by which they mean that the ideas of purposeful organisational design is not defensible. 'Organisations can never be restructured according to formulas by means of policy fiat' and 'the notion of effective organisational adaptability to environmental needs is an illusion'. Instead, 'organisational change is a contested process involving accidental outcomes and random activity ... results cannot be predicted and change cannot be controlled by fiat' (Lane, 1993:172-3).

According to March and Olsen (1984, 1989), the main exponents of this strand of thought, interests cannot be separated from institutions. Rather institutions are normative, cognitive and symbolic orders that pre-exist and shape, or even determine, the definition of interests and preferences. In fact, in their garbage can theory (Cohen, March, Olsen, 1972) there is no causal link between individual choices and organisational features, because the former are left endogenous to the choice process, which is itself determined by organisational features. There is no room for the pursuit of strategies, because outputs are largely random. Similarly, in the institutional school of organisation theory organisational structure is not the result of either individual or group strategies, but of symbolic processes of social and cultural adaptation for survival (Meyer, Rowan, 1977; DiMaggio, Powell, 1983). The central argument of these schools down-plays the action components of institutional change, thus sharing the risk of its predecessor (the old institutionalism) of over-emphasising the formal aspects of organised collective action. This argument is particularly relevant for the decision-making model prevailing in the present 'segmented negotiation state', because formal institutions will determine the outcome of the interactions between organised interests. However, as Lane (1993:175) points out, this premise does not imply the conclusion that institutions and interests cannot be logically separated. Rather, such a premise shows the importance of purposeful institutional design as a vital political concern and the need to distinguish conceptually between individual or group preferences and institutions.

In other words, this approach's argument that institutions are to be treated as political actors for the sake of institutional coherence and autonomy (March, Olsen 1989:17) does not follow on to incorporate the decisive role of interests - be they of an individual or of a group nature. As Dowding (1994) points out, there is a flaw in the new institutionalists causality argument which defines institutions as autonomous decision-makers themselves - holding a deterministic view of policy outcomes affected by structural and procedural features. Instead, 'institutional rational choice' (part of the 'economic' version of new institutionalism) takes individual and collective actions as the cause of social change. It conceives of organisational structures and rules as a framework which both induces and constrains the strategies and behaviour pursued by such actors. In this respect, the 'economic' version of new institutionalism conceives of political institutions as being not just a *policy outcome*, but a *policy option* in the first place. That is, political

institutions may be the result of a purposeful deliberation by which patterns of interaction in society are defined. Underlying this statement is the conception of decision-making as a rational (though *boundedly* rational) process through which appropriate means (organisational designs) are chosen in the pursuit of ends. In sum, 'instead of treating institutions as given, the institutionalist approach in economics attempts to endogenise what has traditionally been regarded as exogenous' (Lane, 1993:176).

However, as Moe (1990a, 1990b) argues, within this 'economic' version of new institutionalism, neither the positive theory of institutions nor the new economics of organisation (transactions costs economics, agency theory, repeated games theory) have integrated the political and organisational dimensions into their theories. Instead, they have mostly applied to the public sector theories which have been developed in another discipline - namely, economics. On the one side, the positive theory of institutions focuses on the paradoxes explored by social choice theory (Arrow, 1971), mainly concerning theoretical instabilities inherent to voting processes. This school interprets political institutions as sources of induced stability and concentrates its application on the role of committee structures, agenda-setting processes and majority rule in the United States Congress (Shepsle, 1979; Shepsle, Weingast, 1981; Weingast, Marshall, 1988; Weingast, Moran, 1983). The connection of these political institutions with organisation theory has been limited to issues of political control over bureaucracy.

On the other side, the new economics of organisation (Williamson, 1975, 1985) represented a shift from theoretical classical market equilibrium models to a 'greater respect for *organizational* (as opposed to technological) features and for *efficiency* (as opposed to monopoly) purposes' in explaining the development of modern economic organisations (Williamson, 1985:17). Its central claim is that the organisations which support contracts matter, and so does their evolution. Positive theorists of institutions drew on the conceptual apparatus of new organisational economics for the study of legislatures - not bureaucracy. The underlying assumptions of this school referred to voluntary exchange in the pursuit of efficiency, which does not belong to the political but to the economic sphere.

Therefore, the theoretical problem remains that neither the sociological nor the economic perspective integrate politics and organisation. An attempt to overcome this dissociation in order to build a 'political' theory of organisation is Horn's (1995) theory of the main variables affecting legislators' decisions on the

structure of government and the public sector. According to Horn, an enacting coalition (the political party in power) faces the *commitment problem* of how to ensure that its policy objectives are difficult to influence by the next incumbent coalition. This author argues that this commitment problem drives the institutional choice which the enacting coalition has to make concerning the design of the public sector, and that this choice is made on transactions costs criteria. That is, legislators choose those administrative arrangements that best address the following transactions costs:

1. *Decision costs* involve a choice between vagueness and a detailed refinement of legislation, and in turn impact on participation costs: Conflict between private interests and uncertainty about the contingencies that may derive from legislation increase the decision costs of refining a law and encourage the enacting coalition to leave it vague. This, in turn, has an impact on the need for constituents to participate in the implementation process. Beneficiaries (with a concentrated benefit or intense preferences) face lesser collective action problems and less participation costs than taxpayers. However, those bearing the costs of participating may have differing preferences on the balance between legislative vagueness and participation costs, because it implies different degrees of influence and different kinds of influence channels.

2. In a parliamentary regime *the commitment problem* facing the enacting coalition is particularly acute, even more when situations in which the party controlling the executive has an overall majority in parliament are frequent. The incumbent coalition has the power not to meet the previous enacting coalitions' commitments. This model assumes that forward-looking constituents (both supporters and opponents) capitalise the long-term impact of legislation (costs and benefits) into its present 'value'. Therefore, the amount of net electoral support legislators receive depends on the flow of benefits and costs that private interests expect it to generate over time. The shorter the time which the legislation is likely to endure the less present value it has.

3. The enacting coalition faces the *agency costs* of ensuring a successful implementation of legislation. These costs derive from the principal-agent relationships between legislators and the implementing agent, characterised by moral hazard, adverse selection and information asymmetry.

4. *Uncertainty* about the private benefits and costs associated with legislation implies costs for the enacting coalition. It makes it difficult for them to derive

support from strategically assigning risks to the social groups and interests that are best able to control or insure against these risks.

Horn argues that these four transactions costs facing the enacting coalition are the independent variables in a theoretical model which tries to explain the apparent regularity between organisational forms in the public sector and the function they perform. Resorting to different institutional forms (bureaux, state-owned enterprises, regulatory agencies, private providers) implies the design of distinctive governance, financing and employment characteristics[6]. In this respect, the choice variables are: the degree of legislative vagueness (extent to which decisions are delegated to the administrative level rather than taken by the legislature); the rules for administrative decision-making (including the rights that constituents have to participate directly in them); the nature and extent of legislative monitoring of administrative decision-making (such as the ability to use ex-post rewards and sanctions); and the rules governing the allocation and use of capital and labour (such as, the extent to which agencies are financed by sales revenues or by taxes, and administrative employment conditions).

Different functions assigned to the public sector involve different mixes of objectives, such as commercial or non-commercial objectives. In the latter case, for example, legislators would prefer implementation to be undertaken by less independent agents (such as a government bureau) which is more responsive to beneficiaries' interests. In this respect, 'form follows function'. And form also follows transactions costs, because particular functions are characterised by particular transactions costs. However, the choice of a particular institutional form in the public sector is influenced, according to Horn's model, by *exogenous* variables such as: the historical and institutional framework; the distribution of the costs and benefits of legislation among supportive and non-supportive private or civil society interests; the difficulty in defining goals and the way to achieve them; and the

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[6] An example of the regularities in choosing between different forms in modern bureaucracies is that bureaux are tax-financed and tend to have non-commercial objectives, pose high monitoring costs, and participation by beneficiaries in administrative decision-making makes bureaus less independent implementing agents. By contrast state-owned enterprises (SOE) sell public sector output and are funded by sales, are governed by a board which enjoys some independence from the legislature and are less contrained by civil service rules. Moreover, SOE's self-financing contraint helps legislators address the commitment problems linked to commercial objectives and reduce political uncertainty for tax-payers and bondholders, as well as beneficiaries. Lastly, production for sale enables better monitoring of management and so helps reduce agency costs without the need of civil service contraints (Horn, 1995).

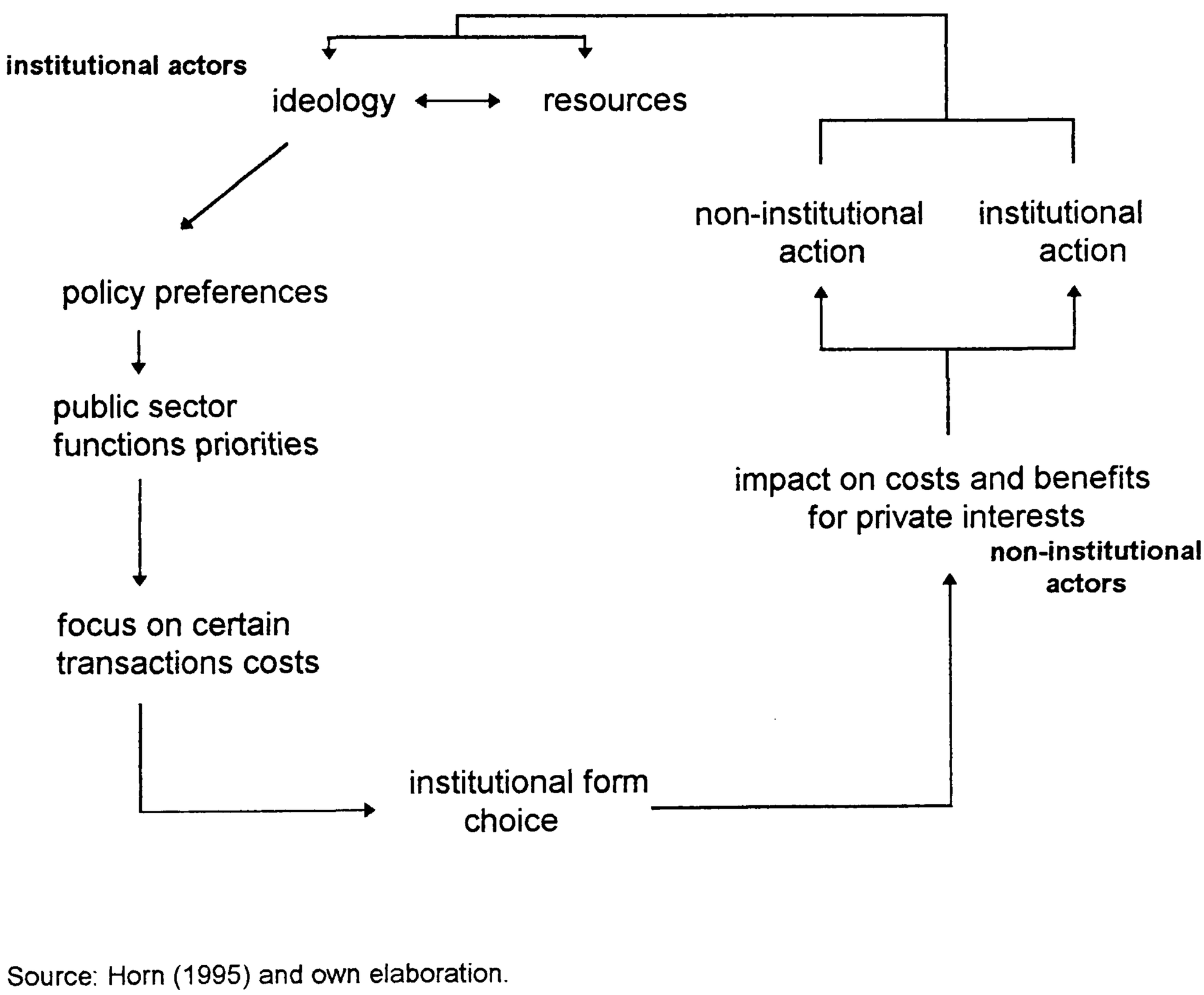
ability to rely on output and factor markets to decrease transactions problems. These variables constrain the range of institutional arrangements among which legislators may choose, as well as the perception they have of the relative importance of the transactions costs they face. In principle, these constraints affect all legislators alike (the enacting coalition and prospective incumbent coalitions).

Nonetheless, if rational legislators in the opposition are capable of foreseeing that they may be in government in the future, which may often happen in a democratic system, then they should not assess transactions costs in a very different way from the enacting coalition. However, the policy preferences of legislators or political parties may have a great impact on the kinds of transaction costs that legislators care about. Therefore, Horn's model could be complemented as shown in Figure 1.1. Different *policy preferences* lead politicians to care about different functions to be performed by the public sector, and in turn, to care about different transactions costs. As a result, they will support different institutional choices. In this respect, the model endogenises the formation of policy preferences in the process of institutional choice - because once an institution has been created, legislators, beneficiaries and other interest groups have a stake either in its maintenance unchanged or in its reform or even abolition. Preferences are also influenced by both the ideology of actors and the resources on which these actors count - such as reputation, information, legitimate authority, and conditional and/or unconditional incentives to alter other actors' incentive structures. Preferences may also be influenced by the way that actors use (or do not) use their resources (Dowding, 1995, 1996). These resources enable the development of specific choice situations and patterns of interaction among both institutional and non-institutional actors, which also become key variables explaining policy outputs (in this case, an institutional form).

In political decision contexts, both access to decision-makers and argumentation by those affected (that is, non-institutional actors) influence outcomes. These 'outside' actors also count on a wide range of resources and have their own preferences concerning the design of public institutions. In this respect, the 'power of ideas' within policy-making is associated with the diffusion processes of belief systems. Along with the standardising effects of political control across the public sector, these diffusion processes help account for mostly the same policy option being adopted across domains or environments which are very different in terms of institutions, resources and interests groups. In this respect,

advocacy coalition theory defines an 'advocacy coalition' as a policy community which 'brings together actors from a variety of governmental and private organisations at different levels of government who share a set of policy beliefs and seeks to realise them by influencing the behaviour of multiple governmental institutions over time' (Sabatier, 1988; Sabatier, Jenkins-Smith, 1993:212).

Figure 1.1. The politics of institutional choice.



Source: Horn (1995) and own elaboration.

The belief system these actors share consists of a set of value priorities, causal assumptions about how to realise them and problem perceptions. The structure of belief systems in an advocacy coalition normally consists of a deep

(normative) core of axioms, a near (policy) core concerning basic strategies for achieving the normative axioms, and secondary aspects concerning instrumental decisions and information searches necessary to implement the policy core. It is asserted that, actors within one advocacy coalition will show substantial consensus on issues pertaining to the policy core, although less so on the secondary aspects. This is why an actor (or a coalition) will give up secondary aspects of her belief system before acknowledging weaknesses in the policy core.

Such considerations imply that new policy options stem from a process of policy-oriented learning. This process involves relatively enduring alterations of thought or behavioural intentions which result from experience and which are concerned with the attainment or revision of the precepts of one's belief system. This learning process can result from factors external or internal to the policy community/subsystem. Among the *exogenous* factors affecting the constraints and opportunities of subsystem actors, a distinction is made between:

a) relatively stable parameters: the basic structures of the problem area (or 'good'), the basic distribution of natural resources, fundamental cultural values and social structure, and the basic legal framework, and

b) dynamic (system) events: changes in socio-economic conditions and technology, changes in systemic governing coalitions, policy decisions and impacts from other subsystems.

Among the factors *endogenous* to the policy sub-system, the following are stressed: the delimitation of sub-system boundaries (the range of actual and potential actors involved); the origins of the subsystem; the number of subsystem actors (advocacy coalitions and policy brokers); guidance instruments and resources used to translate beliefs into policies; policy-oriented belief systems; policy change within subsystems and policy-oriented learning across belief systems.

The model summarised in Figure 1.1 brings together Horn's (1995) theory on the transactions costs driving legislators' decisions on the organisation of the public sector, and Sabatier's and Jenkin's (1993) theory on the role of non-institutional advocacy coalitions. Both models are complemented with Dowding's (1995, 1996) argument on the need to look into the use all these actors make of the resources on which they count. This theoretical framework is then applied to the questions set out above about the shift to a NPM solution in Catalonia's health care system, and

the appearance of implementation gaps or deficits despite favourable conditions for the reform.

In Chapter 2, the stable and dynamic environmental parameters affecting policy elites' resources and belief systems are analysed, looking at the policy options that led Catalonia to follow a diverging path from the rest of Spain in the design of a governance structure for the health system during the 1980s. In Chapter 3, the gradual consolidation of the non-institutional policy elites and the role they played in the policy options made in Catalonia is examined, taking into account both their resources and their belief systems. This consolidation process is taken as an antecedent variable in understanding the 1990 legislative debates about Catalan health care reform, analysed in Chapter 4. The aim is to examine the extent to which legislators cared about Horn's main types of transactions costs, and whether their ideology and resources influenced their commitment problems and the transactions costs about which they cared most.

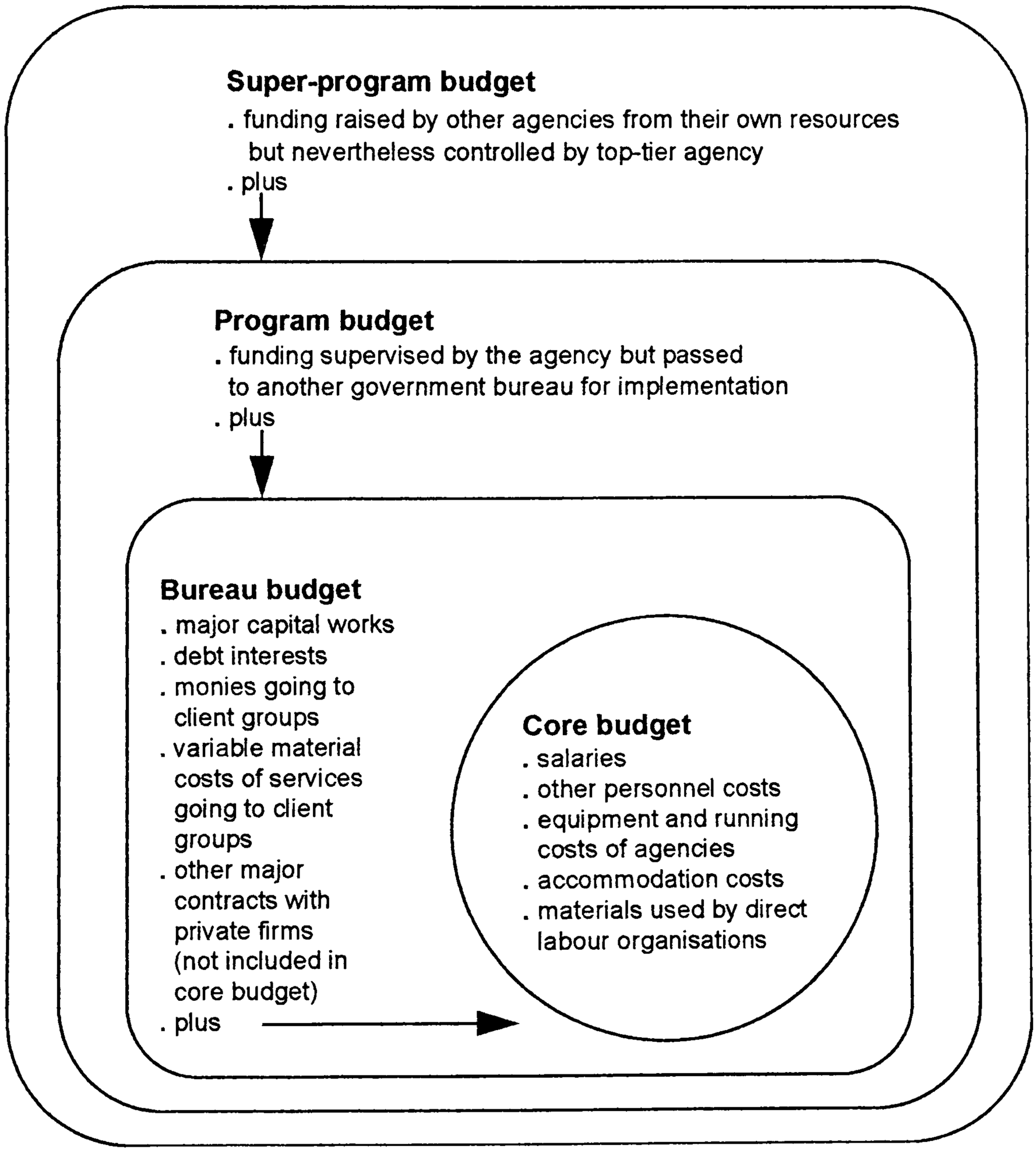
b) Choosing policy tools.

The actual 1990 formulation of the institutional form of the Catalan health authority was apparently ambiguous, partly because of the negotiation process between the enacting coalition and the political parties in the opposition. However, the law passed by parliament was shortly afterwards reinterpreted in new public management terms with a wide consensus among all the policy elite, who took a NPM view as *the* defining formulation of the Catalan health reforms. The main NPM tenet for the design of a governance structure is to reconfigure the public authority into a separate purchasing/contracting agent and providers organised as delivery agencies. Therefore, in order to answer the question of 'to what extent was the actual or the discursive formulation of the reform implemented?', it is necessary to define indicators of such function-based roles. In Chapter 5 this question is answered by applying the bureau-shaping model's function-based typology of agencies (Dunleavy 1991:181-190).

Dunleavy argues that by analysing the different components of the budget structure of public agencies it is possible to infer the functions they carry out, and

their role in their relationships with other agencies. He identifies four different budget elements: core, bureau, programme and super-programme budgets (see figure 1.2). The relative weight of each of these elements within an agency's global budget reflects its budget structure, which, in turn, indicates the function-based role it performs.

Figure 1.2. Components of core, bureau, program and super-program budgets.



Source: Dunleavy (1991:182).

Building on these concepts, Dunleavy defines the following types of agencies which are particularly relevant for NPM reforms[7]:

a) Delivery agency. It directly produces outputs or delivers services using its own personnel to implement policy, so that they are labour-intensive. This role is reflected in its core budget absorbing a large part of the bureau and programme budgets, with a high proportion spent on staff costs. As it tends not to have important relations with subordinate public agencies, the super-programme budget is very small or non-existent.

b) Regulatory agency. It limits or controls the behaviour of private and public agents through, for example, accreditation or licensing systems, or performance standards controls. Its budget structure resembles that of a delivery agency, but because it actually externalises the costs of compliance, the size of its budget is typically very much smaller.

b) Contracts agency. It develops services, outputs or capital projects specifications, as the basis for letting contracts with providers, which may be either private firms or commercially-run public agencies, for the implementation of policy. Consequently, its bureau budget absorbs most of its global budget, and its core budget (running and administration costs) appears to be only medium-sized.

c) Control agency. It channels funding to other public agencies or levels of government and is responsible for supervising the management of that funding and the implementation of policy. Its budget structure shows a small core budget, with low running and administration costs and a relatively small bureau budget. As it transfers money to sub-national levels of government or to other public agencies its programme budget represents the largest part of its global budget. And its super-programme budget's size depends on the amount of self-raised money spent by those agencies and levels of government which the control agency supervises.

d) Transfer agency. It shifts government payments to private firms or individuals. Even if it has a large staff, the running and administration costs, included in the core budget, represent a small share of the global budget of the agency, in relation to the share represented by the transfers it handles ('monies going to client groups'). Thus, the bureau budget absorbs most of the agency's global budget.

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[7] Dunleavy (1991:186-190) also defines other types of agency which are not so relevant as indicators of NPM function-based roles. For example: taxing agencies, trading agencies and servicing agencies.

In Chapter 5 of this study, the analysis of the budget structure of the different public health bodies comprised in the Catalan health authority is taken as an indicator of the type of agencies they actually were. Thus changes in budget structures can show the extent to which either the 1990 reform formulation or its NPM reinterpretation concerning their institutional design were finally implemented.

Apart from the institutional design of the new health authority, the other main component of a governance structure is the policy tools which public agencies exercising authority are entitled to use for the fulfilment of its policy objectives. In a NPM model such as the Catalan health system contracts are defined as the main policy tool to govern the relationship between the health authority and a network of arms' length providers. The actual operation of these tools by the health authority is the object of Chapter 6. The incentive-based contract system characterising NPM governance structures theoretically involves an increase in transactions costs, that is, in the costs derived from 'writing and monitoring long-term contracts that are complex because of all the contingencies introduced by uncertainty and by the disposition, in what [Williamson] calls "human nature as we know it", to lie, cheat and steal' (Perrow, 1986:239). In this sense, transactions costs economics examines 'the comparative costs of planning, adapting, and monitoring task completion under alternative governance structures [that is, hierarchies and markets]' (Williamson, 1985:2)[8]. And it argues that the choice between them will be based on efficiency criteria - a common and very explicit argument among supporters of NPM reforms.

Williamson (1975:9) argues that the circumstances under which complex contingent contracts will pose overwhelming transaction costs for the parties arise from the combination of two sets of factors. On the one hand, environmental factors may lead to prospective market failures - especially, uncertainty, information impactedness, and small-numbers exchange relations. On the other hand, there

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[8] By contrast to other incentive approaches, such as agency theory, transactions costs economics appears to be more comprehensive. It concentrates both on *ex-ante* and on *ex-post* sides of contracts, as, it argues, support organisations of contracts matter and thus their evolution. Its explanation of the forces driving this process -namely, economising on transaction costs- is more insightful than other institutional economics approaches. As Perrow (1986:239) points out, Williamson's major departure from agency theory is his admission of authority relations, as they replace contractual disputes with fiat. Agency theorists, by contrast, not only deny authority relations and insist there are only contracts even within organisations, but also concentrates on the accountability conspiracy sustained by the agent, thus, under-emphasising the principal's resources to constraint such conspiracy, through the overall control of incentive systems.

are human factors such as bounded rationality (the limited human capability to acquire, process and communicate information) and opportunism ('rent-seeking with guile' or the pursuit of self-interest at the expense of others). In such cases, the decision may be to resort to hierarchical or vertical modes of organisation (forward or backward integration) to economise on these costs, by assigning them to an internal governance structure.

Hierarchy or unified governance (see Table 1.2) permits interdependent organisations or units to adapt to unforeseen contingencies in a co-ordinated way, and to absorb uncertainty. The information gap between agents is narrowed by extending central units' powers to perform an audit. Small-numbers bargaining indeterminacies are resolved by fiat. Unified governance also extends the bounds on rationality by permitting the specialisation of decision-making and economising on communication expenses. Additional incentive and control techniques would serve to curb opportunism. Finally, a less calculative exchange atmosphere than in a market context is provided[9]. Thus, forbearance - as bilateral adaptation effected through fiat - has its origins in the employment contract and is the implicit contract law supporting internal organisation (Williamson, 1975:257-8).

Most importantly, hierarchy or unified governance would institutionalise the 'disequilibrium' (in terms of the neo-classical market model) derived from an 'asset specificity' relationship - namely, small-numbers exchange relations. This situation develops when parties engaged in a trade that is supported by non-trivial investments in transaction-specific (idiosyncratic) assets are effectively operating in a bilateral trading relation with one another. Internalising this relationship allows for harmonising the contractual interface, thereby affecting adaptability and promoting continuity, turning it into a source of real economic value. Thus, both the frequency of such transactions and the uncertainty inherent to the environment will provide an efficiency criterion to organise contractual relationships. It becomes possible to economise on bounded rationality, while at the same time safeguarding the parties against the hazards of opportunism. Yet, markets will continue to exist when spot

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[9] However, although integration may have been fostered by asset specificity, the latter is in fact intensified after integration. In this respect, Perrow (1981:373-375, 1986:241-247) argues that vertical integration may increase costs of coordination, of surveillance and accounting systems, without necessarily eradicating opportunism -internal pricing systems are unreliable and expensive, while the market provides comparatively cheap information. Eventually, bureaucratic proclivities inherent to hierarchy may hinder flexibility to adapt to changes and to recover from shocks *because of* increased transaction costs.

(that is, occasional) transactions are needed; when investments are non-specific but oriented to the production of standard goods which are not subject to uncertainty in price, volume, production costs, or labour relations; and when the costs of entry to the market are low.

Table 1.2. Types of transactions and governance structures.

	Investment characteristics		
Frequency	Non-specific	Mixed	Idiosyncratic
Occasional	Market governance (classical contracting)	Trilateral governance (neo-classical contracting)	
Recurrent		Bilateral governance (relational contracting)	Unified governance

Source: Williamson (1985:79).

According to Williamson (1991:271-77) each generic form of governance - market, hybrid, and hierarchy - needs to be supported by a different contract law. The efficiency of each governance structure will vary according to the joint effect of the investment characteristics (non-specific, mixed, idiosyncratic), and with the frequency of transactions (recurrent or occasional). Classical contract law applies to the ideal autonomous market structure, where non-specific investments and occasional transactions dominate. However, between markets and hierarchies theoretical possibilities exist of *hybrid* forms of governance: trilateral and bilateral governance (see Table 1.2). Trilateral governance is needed where investment is mixed (with some degree of asset specificity) or idiosyncratic (highly asset-specific) but when transactions are only occasional. Neo-classical contract law supports hybrid modes of contracting, where the parties to the transaction are bilaterally dependent to a relevant extent and are therefore interested in promoting continuity for an efficient adaptation by resorting to the involvement of a third party in the

governance of a contractual relation, instead of going to litigation. When transactions are recurrent but investment is asset-specific only to some degree, bilateral governance will be preferred. Here adaptation through the contractual relation itself prevails over resorting to a third party.

Markets, hybrids and hierarchies also differ in the mechanisms on which they rely for adapting to disturbances (autonomous adaptation, co-ordination), and in the trade off between the intensity of incentives and the strength of administrative controls which they enforce. For example, by preserving ownership autonomy, the hybrid mode of governance fosters strong incentives and encourages autonomous adaptation to disturbances - without having to consult the other parties. At the same time, though, administrative controls are provided for by the long-term contract supporting the bilateral dependency, which elicits adaptation through co-ordination (see Table 1.3).

Table 1.3. Distinguishing attributes of market, hybrid and hierarchy governance structures.

	Governance structure		
Attributes	Market	Hybrid	Hierarchy
Instruments			
Incentive intensity	+ +	+	0
Administrative controls	0	+	+ +
Performance attributes			
Autonomous adaptation	+ +	+	0
Co-ordination	0	+	+ +
Contract law	+ +	+	0

+ + = strong; + = semi-strong; 0 = weak

Source: Williamson (1991:281).

In this sense, Stinchcombe's (1985) definition of 'hierarchical' contracts could apparently be taken as the contractual form supported by Williamson's (1991) 'hybrid' governance structure. Stinchcombe argues that solving hierarchical

problems by contractual means requires building hierarchical elements into contracts. First, a command structure and authority system are needed whereby communication flows are certified as legitimate or authoritative. Second, incentive systems are designed supporting the authority system and establishing performance measures, according to which differential rewards can be allocated without recourse to the market. Third, standard operating procedures are included which describe routines to be followed by both clients and contractors in their actions. Fourth, dispute resolution procedures are provided which are isolated to a certain extent from the court system and the market. Finally, non-market pricing (usually based on contractor costs) is the basis for valuing variations in performance. Their aim is to serve as substitute for the regulations a formal organisation would have written in its constituent documents, by incorporating elements of the client and the contractor organisations into a new unity under circumstances where theory would predict vertical integration. When uncertainty involves too many contingencies to be predicted in advance, 'hierarchical contracts' provide that contractual stipulations may be changed by specific methods. This provision is intended to better deal with uncertainties derived from: (1) performances not being easily or separately measured and observed; (2) costs not being accurately predictable because of contractor technical uncertainty or cost uncertainty, or client ignorance, or of commercial or legal uncertainty in the client-contractor relation; or (3) client or contractors wanting to change specifications. Ultimately, 'what usually has to be binding under such circumstances is the overall control of the incentive system by one of the parties' (Stinchcombe, 1985:169).

The overall shift from soft to hard contracting that NPM entails - that is, from command-and-control supervision to incentive-based contractual systems - has deep consequences at an organisation level as much as at a systemic level:

> 'While soft contracting presumes much closer identity of interests between the parties, and formal contracts are much less complete, under hard contracting, the parties remain relatively autonomous; each is expected to press for his or her interests vigorously, and contracting is relatively complete' (Williamson, Ouchi, 1981:361).

In this respect, shifts in bridging strategies affecting organisational structures are being developed. Organisations depend on continuous exchanges of personnel, resources, and information with the environment for their survival - hence

contingency theory's claim that successful organisational forms are designed according to the nature of the environment in which they are embedded. According to resource dependence theory, a system of external control of semi-autonomous organisations is based on a boundary-setting strategy. An organisation's boundary is determined by its relative influence and control over activities critical for its survival compared to the influence and control of other social actors over the same activities (Pfeffer, Salancik's, 1978:23-32).

Within this framework, the two major components of inter-organisational power relations are an organisation's dependence on crucial resource exchanges and the control other organisations exert over such exchanges. Thus, resource importance, discretion over resource allocation and use, concentration of resource control, and asymmetric dependence appear as features essential to effectively designing a system of external control of organisations. From a resource dependence perspective, bridging strategies involve designing mechanisms for co-ordinating mutual interdependence and are aimed at stabilising the resulting transactions in order to reduce uncertainty. By establishing linkages - of varying formalisation, flexibility and scope - with interdependent others, and by negotiating and standardising power/dependence relationships, organisations develop channels of communication, of persuasion and of negotiation.

In Chapter 6 the effective use of contracts as the main tools of the new Catalan health authority for governing its relationship with providers is analysed. The aim is to assess, first, the extent to which the frequency and kinds of transactions occurring fit with the typology of contracts discussed above; and second, the extent to which contracts are in fact being used for the development of bridging strategies based on resource-dependence relations. As Ferlie *et al.* (1996) conclude, public sector quasi-markets are socially, relationally and institutionally embedded, and their distinctiveness derives from the fact that it is the government that sets their boundaries through its financing and regulation powers. As a result, hybrid forms of organisations (public and private, tax-financed and sales-financed), and relational markets based on trust and long-term dependence relations, tend to prevail over NPM discourse.

1.3. The Catalan case.

Although Horn points to the historical and institutional frameworks as exogenous variables influencing legislators' decisions on the institutional design of the public sector, he does not develop their role much in his model, and so leaves little room for institutions and 'path dependence' to play a role in institutional choices[10]. The commitment problem of an incumbent coalition as defined by Horn is most suitable for a parliamentary regime of a Westminster system, in which the executive supported by parliament has the power to overhaul previous policies. However, in a parliamentary regime dominated by proportional representation, such as the case of Catalonia, direct confrontation between government and opposition is more blurred than in a Westminster system. In turn this difference affects the way in which an incumbent coalition seeks to manage its decision costs and tries to overcome its commitment problem. In a proportional representation system the executive may often not have an absolute majority in parliament on which to rely. Even if it does have such a majority, its commitment problem will much less commonly centre on fears of a complete policy overhaul by the next incumbent party. The opposition may be fragmented into several forces which may or may not coalesce against the government, and any new government may well find itself in a minority position. So the commitment problem is more about maximising present support for the government's legislation so as to prevent any later coalition effecting radical changes or operating discretionary elements of the legislation in ways inimical to the enacting government's or enacting coalition's interests.

In addition, the structure of the state also affects the way in which an incumbent coalition may deal with its commitment problem. While in a unitary state there is one main formal decision-making venue at the central level of government (apart from the informal venues existing in all political systems) in a decentralised

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[10] According to North (1990:3-7), organisations are created or restructured both to take advantage of institutions and to alter them, because institutions are the rules of the game: they create an incentive structure for organisational strategies by affecting the costs of exchange and production.

state such as quasi-federal Spain[11], inter-governmental relations between municipalities, Autonomous Communities and the central government appear as parallel decision-making venues. Each may affect the policy commitments of the enacting coalition operating at any of the component levels of government. Moreover, if these inter-governmental relations are affected by citizens splitting their support across parties differently at local, autonomous and general elections, issues about possible 'divided government' come to the fore. The commitment problem may not be perceived as a mere question of insuring against policy shifts by the next incumbent coalition, but as a question of consensus-building at different government levels[12].

This complex system of political power-sharing forces both incumbent parties and the opposition to repeatedly interact with each other and amongst themselves, even when they may be holding different power positions at different government levels. As a result, co-operation emerges as a rational strategy[13]. However, co-operation may not only come under several forms of formal and informal coalition building. It may also develop into a *de facto* different strategy, such as co-optation of part of the opposition. As Moe (1990) suggests, a way to promote durable deals when negotiating about the structure of government (namely, the design of the public sector) is to co-opt part of the opposition and of interest groups and give them offices in the structure of public authority being defined. In this way, their 'fear

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11 For a discussion and analysis of empirical data on the actual federal model being developed in Spain, see Grau (1998). For a comprehensive analysis of the modern Spanish political system and its immediate origines in the democratic transition of the late seventies, see Heywood (1995). For a description of the institutional framework of the Spanish state organisation see Newton and Donaghy (1997).

12 According to Ostrom (1991), the configurational interaction of rules in the decision-making process provides opportunities and constraints for those actors to shape their respective 'action situation' and the interrelation between different 'action arenas'. Thus, a distinction should be made between the impact of formal institutions and the impact of the actual decision-making process, in which the location and nature of veto points are crucial to condition policy outcomes and their relation to active interests (Immergut, 1992). This entails the need to take into account not only the policy stances of participants -including interest groups, but also the use they make of the resources they count on to shape others' preferences.

13 Liphart (1984) identifies several dimensions along which majoritarian (Westminster) and consensus models of democracy differ. In contrast to the majoritarian model, the consensus model aims at counteracting the effects of majoritarian rule by establishing power-sharing mechanisms (coalition governments), the dispersal of power (among more than one legislative chamber, among the executive and the legislature and among different levels of government), 'fair' distribution of power (proportional representation), and formal limitation of power (minority veto).

of the state' is reduced, and the commitment problem solved, because these actors no longer have an interest in overhauling a government structure in which they have a stake.

This is the context in which the NPM policy options in health care administration have been adopted by the Autonomous Community of Catalonia between 1985 and 1995. The Catalan political system is a parliamentary regime of proportional representation. Although the enacting coalition (Convergència i Unió or CiU) had an absolute majority in parliament from 1984 to 1995, it has tended to adopt co-operation and co-optation strategies to overcome its commitment problem concerning its preferred model of governance structure for the health sector. However, the strategies of co-operation and co-optation have been influenced by the split voting affecting the main parties in Catalonia. The nationalist centre-right coalition CiU performs more strongly in the Autonomous elections and the Party of the Catalan Socialists (PSC) is favoured in the general and local elections. Moreover, the dynamics of inter-governmental relations require simultaneous coalition-building processes at different levels of government. Thus, apart from the role of ideology itself, these different power positions influenced CiU's commitment problems and, therefore, the governance structures they advocated.

The strategies of co-operation, co-optation and consensus building have led to the emergence of a wide consensus among the Catalan health policy elites which refers both to policy instruments and political discourse, and which involves not only legislators but also the main social actors which are the object of the reforms. Nonetheless, this dynamics has been facilitated and induced by the initial distribution of resources among the most relevant policy elites. While the autonomous government had the normative and economic resources (legislative competencies and budget) the provision of hospital services was to a large extent in the hands of non-Social Security providers - namely profit and non-profit providers, many of the latter under the patronage of local governments. And the main policy elites involved agreed on preserving this distribution of resources as the basis for gradually consolidating the health system.

In sum, the existing distribution of power and resources among relatively stable policy elites is at the origin of the wide consensus achieved on NPM ideas in Catalonia. In Spain, by contrast, such considerations were ignored at the central government level when a 1991 report suggested the reform of the National Health

System on NPM lines[14]. However, despite the apparently favourable scenario for the introduction of NPM in the Catalan health sector, a paradox arises. There is not only a gap between the initial and ambiguous formulation of the Catalan reforms in 1990 and its clear NPM interpretation shortly afterwards. There is also a gap between this clear NPM formulation and the actual implementation of the new governance structure between 1990 and 1995. In this respect, the object of this research is to find out why the Catalan policy elite designed this particular NPM governance structure for the health sector, and why its implementation encountered short-falls.

Conclusions

This research uses a transactions costs approach to examine recent developments in the public sector organisational arrangements. It explores the extent to which transactions costs or other factors drive the institutional choices that legislators make about the organisation of the public sector, including both the institutional design of public authority and the policy tools it is entitled to use for the governance of particular policy domains. This approach is applied to the analysis of the 'new public management' (NPM) reforms introduced in Catalonia between the mid-1980s and the mid-1990s for the governance of health care. The questions explored in this case are 'why did the Catalan legislators choose a NPM governance structure for the health sector?' And 'why was there a divergence between policy formulation and its implementation, despite the favourable conditions for realising a NPM solution in Catalonia's health sector?'

Horn's (1995) theory of the political transactions costs that legislators have to address when designing public sector organisations is taken as a core focal theory. I assume that the organisational design of the public sector influences both policy

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[14] The proposals of this report were never the object of a public debate. Instead it was put aside as a result of the opposition to some of its proposals by the main political parties both to the right and to the left of the PSOE government, and by class-based, health professions-based and civil service unions, as well as by consumers and retired people associations (Rico, 1997; WHO, 1996).

outputs and outcomes, and that both legislators and interest groups are aware of their political stake on such design. Legislators have to overcome their commitment problem concerning the persistence of their policy options and the conditional support of their constituents by designing public sector organisations that best help them minimise their political transactions costs. These political transactions costs include decision or legislative costs and participation costs, implementation costs, as well as costs associated with the uncertainty about assigning risk to those agents best able to control or insure against it.

This theory tries to overcome the critique made of the two main approaches of new institutionalism: first, that the 'sociological' approach does not allow either theoretical or empirical differentiation between interests (individual's and collective's) and organisational structures, because the latter are not conceived of as the result of purposeful strategies but are taken as given exogenous determinants of action; and second, that the 'economic' approach does not integrate the power components inherent in political processes of formulation and implementation of new governance structures. Moreover neither the 'sociological' nor the 'economic' approaches have elaborated a theory in which both the organisational and political dimensions of the public sector as a political organisation are integrated as independent variables.

In the theoretical framework presented here interests are clearly differentiated from organisational structures. However, Horn's (1995) theory is modified by not conceiving of the elites' preferences and interests as exogenously fixed, but as endogenous to the decision-making process, though not determined by it. Rather, the preferences and interests of the policy elites (public officials and interest groups) concerning the design of the public sector are conditioned both by their ideology (their belief systems) and the resources on which they count. The distribution of these resources and the way actors use them to facilitate certain patterns of interaction will in turn influence the formulation and implementation of new governance structures.

This study analyses both the policy formulation process leading up to a NPM governance structure in the Catalan health sector in 1990 and the nature of the further implementation process between 1990 and 1995. In order to understand the output of this formulation Chapter 2 explores the policy changes made at the Spanish central government level over the 1980s in relation to the governance of health care. The contrast with the policy options taken over the same period in

Catalonia is made apparent. Innovation and incrementalism in the introduction of policy tools characterised the gradual configuration of the Catalan health system and paved the way for the NPM reforms of the early 1990s. Chapter 3 focuses on the resources, interests and patterns of interaction among the Catalan health policy elites and on their gradual consolidation throughout the eighties. This process is analysed in the light of central concepts of Sabatier's and Jenkin's (1993) advocacy coalition theory.

Chapter 4 analyses how political transactions costs considerations shaped the stances taken by legislators and influenced the final institutional design of the new health authority in the 1990 reform. Regarding the implementation process, Chapter 5 uses Dunleavy's (1991) function-based typology of agencies and budget structures to assess the extent to which the implementation of the new institutional design of the Catalan health authority fitted either the legislative formulation of the reforms or its further NPM interpretation. Finally, Williamson's (1985) typology of governance structures is applied to assess the extent to which the policy tools and contract law on which this new health authority relied fitted the governance structure designed. In both Chapter 5 and Chapter 6 a number of divergences between the NPM discourse (that was taken as the interpretation of the 1990 reform) and the actual implementation are traced to some efforts at minimising transactions costs which turned out to be incompatible with NPM postulates. The analysis shows that the impact of politics, that is, the repeated interactions among policy elites controlling complementary resources, shaped the way in which transactions costs and other considerations were approached in both policy formulation and implementation processes.

The concluding Chapter 7 draws, first, some conclusions concerning the characterisation of NPM in the Catalan case, the extent of change that the reforms brought about, and both the institutional design and the policy tools which configured the new health governance structure. Second, it focuses on some recent developments of NPM in health care and in the public sector in general. Finally, two central theoretical lessons are drawn from this research: that although transactions costs are difficult to measure, they are useful heuristic tools for analysing the rationale driving decision-making processes on institutional design, and that both the theoretical definition of transactions costs and their actual impact on decision-making are mediated by power relations, that is, by politics.

Chapter 2

The governance of health care in Spain and Catalonia.

The role of political transactions costs as defined by Horn (1995) was explicitly circumscribed both to the decision-making stage of the policy process and to the specific institutional design which is the object of legislation. However, the way political transactions costs are perceived and dealt with at a particular point in time reflects also the impact of decisions made about other institutions and within other policy domains. In order to complement Horn's model, it is necessary to examine how other external policy processes have a cross-influence on the decisions made on the policy subsystem which is the focus of this research. In this sense, advocacy coalition theory identifies two sets of factors -exogenous and endogenous to the policy subsystem - which create both constraints and opportunities for the policy elite to elaborate and redefine their preferences and arguments (Sabatier; Jenkins-Smith, 1993). Thus, the introduction of 'new public public management' policy tools in the Catalan health sector was gradual and conditioned by two main exogenous variables: the creation of a National Health System and the democratisation and decentralisation processes affecting the Spanish state. The focus of this chapter is on the way these variables influenced and conditioned the early development of a differentiated health system in Catalonia. This is the context in which the factors endogenous to the Catalan health policy subsystem developed, which is the object of the following chapter.

Until recently the Spanish health system was based on a Beveridgean direct public provision of services, and a Bismarkian system of financing, that is compulsory Social Security contributions. The National Health System (NHS) created by the 1986 General Health Law (GHL) was intended to gradually shift from professionalist Social Security foundations to a model similar in concept and objectives to the British National Health Service (Bohigas, 1992:9). Ideals of achieving equity, solidarity and universal coverage fostered not only the extension

of Social Security coverage, but also general tax finance - the latter introduced in 1989. Central to the GHL were also the priorities set by the World Health Organisation (1978) - reinforcing the role of primary care, health promotion and illness prevention. Moreover, citizens' participation and control were introduced as additional legitimising elements.

This 'substantive dimension' of health policy was gradually consolidated under the mandate of the Spanish Workers' Socialist Party (PSOE) throughout the 1980s without relevant controversies. It was a constitutional mandate formulating a collective aspiration. In addition, the gradual increase of health coverage had achieved a rate of 82 per cent of the population by 1978, when the Spanish Constitution was approved, and, thus, the effective universalisation of coverage had to be more of a qualitative than a quantitative nature. By contrast, the 'operational dimension' - namely, the governance structure of the NHS - was at the forefront of the political debate surrounding the GHL and has continued to be a matter of disagreement and critique until the present day (mid 1998). The controversy during the 1980s arose mainly from the impact of the GHL (and of the specific regulations derived from it) on the actual practice of the medical profession, that is, on both the structure of the health care market and the governance structure at a micro-management level of individual health centres. In turn, the beginning of the 1990s saw the debate shift to focusing on the macro- and meso-management levels of the whole health care system.

Both the gradual decentralisation of the management of health services to the Autonomous Communities since the early 1980s, and the international reform trend towards introducing 'new public management' (NPM) in the health sector, contributed to the re-opening of the debate about the NHS's governance structure at the beginning of the 1990s. However, those who took the lead in questioning the integrated public provision model characterising the NHS were some Autonomous Communities with full competencies over health. In this respect, in the early nineties innovation was sought through new institutional forms for the health authority which allowed the use of new management forms - in line with NPM reforms - to reorganise the health services within their territory under new governance structures.

While at the time of writing (mid 1998) these reforms are at a very initial stage both in those Communities and in the Spanish non-decentralised health authority, in Catalonia a contract-based governance structure for the health sector was

designed over the first half of the eighties and consolidated through the decade. The policy tools characterising this governance structure happen to fit the NPM discourse of the nineties, and are being taken as a reference point by reformers in the rest of Spain. In this chapter, the governance structure of the Spanish health care system is first described, focusing on the evolution of the provision and financing models during the eighties and early nineties. Within this framework the different governance structure developed in Catalonia over the eighties is then analysed, and interpreted as the policy precedents leading up to the NPM reform which this Community launched in 1990.

2.1. Creating the Spanish National Health System, 1978-95.

The creation of a National Health System (NHS) in Spain in the mid-1980s basically involved a compromise to achieve universal coverage, to gradually finance the health system through taxes - that is, through the budget instead of through Social Security contributions. It also aimed to consolidate and improve the existing public provision model of Social Security-owned and directly managed providers where other public providers were integrated to conform a single NHS network, and where private providers might only have a complementary role. The governance structure of this system was characterised by the integration of providers in the health administration and their lack of managerial autonomy or differentiated legal personality. These aspects were the target of reforms in the early nineties as a result of the direct pressure from international forums.

a) The provision model.

The present governance structure of health care in Spain is closely identified with the Social Security administration, as designed during the democratic transition in the second half of the 1970s. The Ministry of Health was created in 1977 assuming together for the first time the responsibilities for both Social Security health care and public health[15]. In 1978 the National Health Institute (INSALUD) was created as an autonomous organism of an 'administrative nature' for the management of Social Security health services[16]. Social Security health providers were integrated into it as budgetary and expenditure units without autonomous legal personality. The INSALUD's direction and supervision was assigned to the Ministry of Health in 1981, which formulated health policy and managed the budget. However, the INSALUD finance and expenditure control remained with the Ministry of Labour and Social Security until 1988: this section formulated the budget project, approved its modifications, and controlled expenditure process.

In administrative law terms the INSALUD is an 'institutional' or 'autonomous' organism of an 'administrative' nature, that is, a body created by law and subjected to public/administrative law both in its internal and external operations[17] (Parada, 1997:251-4). Within this framework, Social Security providers of health services are

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[15] During the francoist regime public health was a competency of the Home Ministry, under whose authority were the psychiatric and charity hospitals of the provincial administrations (*Diputaciones*). In turn, the Social Security administration and its health care services were managed by the National Institute of Prevision, an autonomous body which was first under the tutelage of the Home Ministry and then of the Ministry of Labour. Over the years, this duality resulted in networks differing in their staff regime, in the services offered, and in their organisation and territorial distribution. The state owned a heterogeneous network related to infectious diseases, to charity, and to medical staff training, the latter carried out in university hospitals dependent on the Ministry of Education (Lobo, 1993).

[16] Three other institutes were created in 1978: the Social Security General Treasury, for the financing and economic management of social security benefits; the Social Security National Institute, for the management of pensions; and the National Institute of Social Services, for the management of social services. These three institutes, together with the INSALUD, form the 'institutional' administration of the Social Security (Guillén, Cabiedes, 1998:177).

[17] Autonomous organisms are defined by the present legal framework as those which operate within administrative law regulations and which perform functions of promotion, provision or management of public services which have been functionally decentralised to them by the parent Ministry for the implementation of specific programmes (Parada, 1997:251).

budgetary and expenditure units of the INSALUD but have no autonomous legal personality. The structure and subjection to administrative law characterising the INSALUD have been repeatedly criticised for some aspects which were considered as dysfunctional for an efficient management. First, the political level, instead of providers, was held responsible for service management. Second, health services were organised following public administration principles - centralisation, hierarchy, uniformity and an emphasis on procedural controls. Third, effective supervision of health services was biased because of public administration's responsibility for their provision management. Fourth, managers were trapped into bureaucracy. Fifth, it became extremely difficult to 'incentivise' managers to achieve the system objectives, so that meeting citizens' demands became extremely difficult (Elola, 1993:150-1).

Within this hierarchical and integrated public provision model, the civil service-like status of the personnel working for the Social Security health services is a most controversial point of criticism. Within the Social Security 'statutory personnel', different groups have their own statute (regulatory framework) - the medical profession, non-medical health professionals, and non-health personnel (López, 1993). The main argument against the maintenance of this personnel regime is that the rigidities derived from selection, promotion and personnel management tools not only hinder an efficient personnel policy definition and management, but also reinforce the corporatist tendencies of the medical profession, as opposed to a more managerial approach to health care. The regulation of this personnel regime was given a basic character by the 1986 GHL, that is, this area of competency is exclusive to the Spanish government. The GHL established that a framework statute for this personnel had to be elaborated by the central government. The fact that it has not been done by mid 1998 is a consequence of the disagreement between the Autonomous Communities themselves, and between them and the Spanish central government, on the labour relations model to be defined. There has also been resistance from the unions to accepting the different proposals.

The need to reform the governance structure of the health care system has been stressed as the decentralisation of the INSALUD's health management competencies to the Autonomous Communities has developed. This process started in 1981 with the transfer of Social Security health services and related budgetary resources to Catalonia. Later on, decentralisation affected those

Autonomous Communities which the 1978 Spanish Constitution defined as having a higher level of competencies (Catalonia, Andalusia, Basque Country, Galicia), and those assimilated (Valencian Community, Navarra and Canary Islands)[18]. These Communities have gradually created their respective 'Health Institutes' for the assumption of responsibilities over the services transferred to them from the INSALUD[19]. While they have the 'INSALUD decentralised', the remaining Communities have their health services managed by the 'INSALUD-direct management'.

This decentralised management model was reinforced by the 1986 GHL. As Vicens (1991:16-7) stresses, this Law did not provide the NHS with a legal personality, but defined it as composed of the health services of all the Autonomous Communities (article 44.2). Within the distribution of competencies jointly established by the Constitution and the Statutes of Autonomy[20], the GHL provided the obligation for every Autonomous Community to create a Health Service, by reorganising and managing under their authority all the public health providers within their territory, regardless of whether they were attached to provincial, local or other sub-autonomous levels of administration (article 51). Autonomous Communities were made responsible for health services

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[18] So far, the decentralisation of the INSALUD has affected Catalonia (1981), Andalusia (1984), Basque Country (1987), Valencian Community (1987), Galicia (1990), Navarra (1990), and Canary Islands (1997). These Communities represent 61 per cent of the population covered by the NHS (Guillén, Cabiedes, 1998:180; Rico, 1997:232-236).

[19] As a rule, departmental structures of the Autonomous Communities' governments reproduce the bureaucratic model of the Spanish central government. However, there is a generalised trend to build the Communities' own public sector on what in an Administrative Law system is named 'institutional' or 'autonomous' organisms. They have been created for the gradual assumption of responsibility over the services transferred to the Communities, and embody the trend of 'escaping Administrative Law' (Aja, 1985:300-1; Martín-Retortillo, 1988:14; Ariño, 1994).

[20] The 1986 GHL completed the basic legal framework for the creation of a NHS, but it did not establish either the timing of the decentralisation process or a detailed specification of the distribution of competencies between the State and the Autonomous Communities. The reason is that for each an every policy area, such a basic legal framework is jointly laid by the 1978 Constitution and the Statutes of Autonomy of each of the 17 Communities. This legal framework establishes the distribution of competencies over policy areas between central and autonomous governments, and to be effective it needs to be followed by the corresponding transfer agreements and decrees concerning the actual services and resources involved in each area.

management, public health and health planning. The health plans of all the Autonomous Communities had to conform to the National Integrated Health Plan[21].

According to some scholars, a completely decentralised scenario could result in the emergence of 'seventeen health systems'[22]. First, the process of transferring the services previously managed by the INSALUD to each Community has not been completed yet. Second, Communities differ in their administrative traditions and thus, in their readiness and potential to assume the responsibilities mentioned above. Third, factors such as the structure of the services inherited, socio-economic conditions, morbidity and coverage, posed a major challenge for a financing system to be equitable across Autonomous Communities, a question which has not yet been solved (Gallo, 1994:863). In any case, at the time of writing (mid 1998) the central government still keeps full powers over economic and budgetary matters concerning the INSALUD - which is financed through the Social Security budget and the state general budget.

The decentralisation of the NHS as defined by the 1986 GHL was crucially shaped by the main Catalan nationalist force (Convergence and Union or CiU) and the main Basque nationalist party (PNV) in the Spanish central Parliament. According to Rico's (1997:134-6) findings, they achieved, first, their objective that most of the articles concerning the territorial organisation and organisational structure of primary care were not classified as 'basic' for those Autonomous Communities which had already regulated those matters. Second, any mention of

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[21] This plan has to establish basic evaluation criteria for needs and services, include an inventory of physical and human resources, and set common basic objectives about illness prevention, health care, health promotion and protection. The first state health plan as part of the Integrated Plan was issued in 1995 (WHO, 1996:44). However, 12 years after the 1986 GHL was passed there are still two Communities (Extremadura and Balearic Islands) which have not elaborated their respective Health Plans. This means that the Ministry of Health and Consumption cannot as yet elaborate the Integrated Health Plan required by the GHL (*Diario Médico*, 25 April 97). Taking into account that for health plans to have any usefulness - as guidelines for the organisation of provision of health care according to needs-assessment - they have to be revised every two or three years, the viability of an Integrated Health Plan in this bottom-up process has so far been questioned.

[22] An integration mechanism designed by the 1986 GHL was the NHS Inter-territorial Council, which was composed of one representative of each Community and an equal number (17) of members of the Spanish central administration. However, according to a non-published report elaborated in 1997 by consultants external to the Ministry of Health and Consumption, this Council had not played the expected role of central venue of co-ordination, direction and planning of the system - particularly in controversial areas common to all Communities where tough decisions had to be made. Instead, it had turned out to be a consultative and consensus-building forum where no binding decisions were made (Koldo *et al.*, 1997).

the General Health Co-ordination as an exclusive competence of the (central) State was eliminated, together with its capacity to modify the Communities' Health Plans. Similarly, the High Inspection was no longer defined as ordinary inspection, and mention of the capacity of the State to evaluate the quality and results of the health services in the Communities was suppressed. Third, numerous functions were re-defined from being the exclusive competence of the State to being a shared competence with the Communities - among which the accreditation of non-public hospitals, the design of contracts with the private sector and the legal nature of the autonomous Health Services were particularly relevant for the Catalan case. Fourth, the principle of subsidiarity which in the 1978 Constitution favoured the State, was defined in the opposite direction by the GHL, favouring the Autonomous Communities. Moreover, the Catalan minority got both a legal recognition that non-profit providers may be part of the NHS, and that the intervention of the Spanish central government should not be a requirement. Finally, it achieved its demand that the Communities with health transfers had a proportional share in the annual budgetary deviations of the INSALUD.

However, the reforms of the 1980s fostered by the GHL had a 'basic' legal character and therefore affected the whole NHS, although those Autonomous Communities with a higher level of competencies could legislate without contradicting the GHL. The formulation of these health care reforms in the 1986 GHL was the result of a long process[23] which was characterised not only by the

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[23] In December 1983 the socialist Minister of Health publicly presented the final draft bill of the General Health Law elaborated by a parliamentary commission - one year after the first draft bill had been elaborated by the Ministry. Even before the bill was sent to parliament for debate, amendments and voting (a process which lasted for eight months until the law was passed in April 1986) a controversial public debate took place in which several professional groups asserted their opposition (Rodríguez, de Miguel, 1990:238-43). However, health reform had also been the object of two previous failed attempts to legislate under the Union of Democratic Centre (UCD) government (in 1978 and in 1981). Both the definition of different models of health systems and the initiation of the decentralisation process (affecting not only health but also the rest of competencies concerned) were at the origin of a long and deep controversy among political forces and between the Spanish central government and autonomous governments. In 1981 the UCD government approved a decree, with the support of an agreement with the PSOE (the Autonomic Pacts) by which the authority of the Spanish central government over health was reinforced to the detriment of the Autonomous Communities. This measure led the Catalan and the Basque autonomous governments to present several appeals before the Constitutional Court on the grounds that the decree was unconstitutional. The resolution by the Constitutional Court was not approved until May 1983. Meanwhile, in 1983 the Catalan and the Basque autonomous governments passed their respective health laws after receiving their competencies transfers and unconstrained by a basic health legislation of the Spanish central Parliament (Rico, 1997:117-20).

negotiation with Communities of a high ceiling of competencies, but also by the political confrontation between the medical profession and the PSOE's government. The limits and structure of the health care market on the one hand, and the structure and organisation of the health care centres on the other hand, were both at stake. The socialising stance of the government openly questioned the power and authority which the medical profession had enjoyed over the francoist regime and until the early eighties over these two areas[24] (Rodríguez, 1996:152).

The main thrust of the reforms of the GHL focused on the development and restructuring of the primary care sector as the gatekeeper of the system, and as a means to ensure equity of access to health care. Thus, reinforcing the 1984 decree of primary care reform passed by the Socialist government, this 1986 law organised health provision in Health Areas defined on demographic and socio-economic criteria where primary care is the main reference point. There, Primary Care Teams of salaried medical professionals (primary and non-hospital specialists) and non-medical professionals were responsible for health care, health promotion and illness prevention. The reform required these professionals to co-ordinate their activities within Primary Care Centres, and to raise their working timetable from the previous two hours a day to a full-time schedule.

This reinforcement of the primary care role within the health system was relevant in Spain, where the weight of the hospital sector has developed to the detriment of new conceptions of health based on illness prevention and health promotion through an equitable and accessible primary network. As Figure 2.1 shows, expenditure on the hospital sector represented nearly 63 per cent of total health expenditure in 1990 - eight points above the percentage it represented in 1982[25] -, while the percentage of total health expenditure corresponding to primary care decreased six points over the same period. From the late 1940s to the early 1990s, some developments can be traced within specialised care. Despite the creation of a hospital network, the ratio of beds remained unchanged (4.4 per

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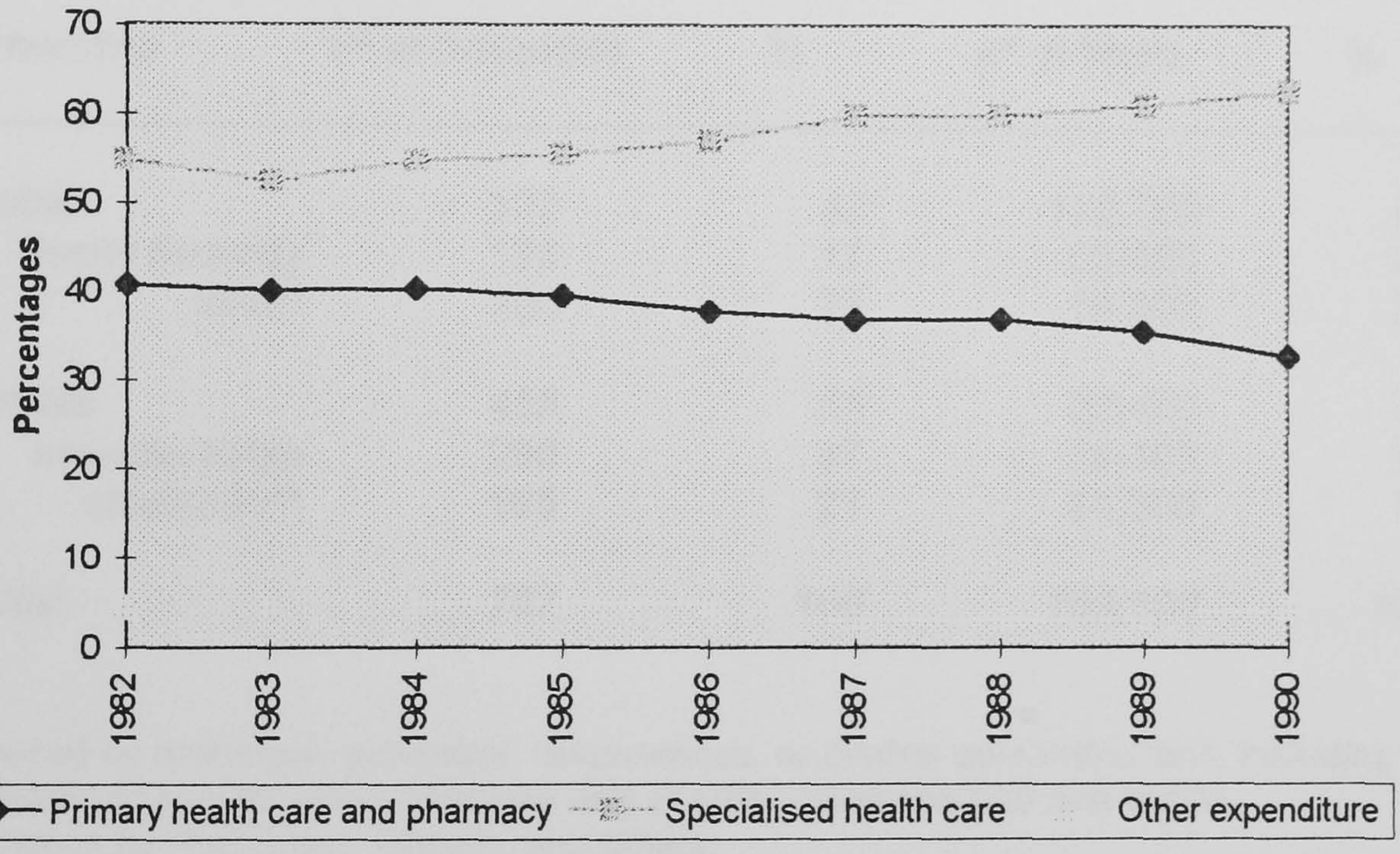
[24] Three main strikes by health care professionals made opposition to these reforms apparent: in 1985 - against the implementation of the Work Incompatibility Law -, in 1987 - against the internal reorganisation of hospitals and labour conditions and remuneration of the professional work all derived from the GHL -, and in 1990 - against the remuneration system of hospital doctors (Rodríguez, 1996).

[25] For a detailed disaggregation of these data see Table A.1 in Appendix 1.

1,000 inhabitants) as well as the weight of the public sector (70 per cent of beds). There was a concentration in a lesser number of hospitals and a centralisation of the public sector while many small private hospitals disappeared. Still, by OECD standards, even by the mid 1990s there were not enough hospital beds in Spain, too many physicians, scarce and inadequate resources, utilisation rates were low, and the territorial distribution of resources was unbalanced (Caïs, Castilla, 1995:246). Therefore, despite the pre-eminence of the public sector, the INSALUD's own specialised resources were insufficient to cover the demand of a growing coverage (see Table 2.1).

Figure 2.1. Structure of public health expenditure in Spain, 1982-90 (in percentages).



Source: CAESNS, 1991:18.

For this reason, the Social Security resorted since its creation to the establishment of agreements with other public and private centres. However, as Espadas and Largo (1933:186-7) point out, these agreements were not specifically regulated until 1981, when providers were classified into seven groups and twenty-one levels according to which tariffs were calculated, but priority was given to public and charitable centres. Moreover, such 'agreements' were defined as an *ad hoc* complement to the Social Security's own specialised resources, mainly used for diagnostic and treatment services, while being almost irrelevant in the primary

care sector. In this respect, the 1986 GHL provided two formulae for establishing service 'agreements' between the Social Security, that is, INSALUD, and private providers. On the one hand, *convenios* (articles 66-67) implied the full integration of the private provider into the public hospital network, being subject to the same legal regime. On the other hand, *conciertos* (article 90) defined a specific service to be provided which cannot be offered by the public sector - the duration of the agreement is not explicit, though. As for agreements between the INSALUD and other public providers, *conciertos* were also established for the provision of health care.

Table 2.1. Hospitals and available beds in Spain classified by private or public ownership, 1995.

Ownership	nº of hospitals	%	nº of beds	%
Public	*332*	*42*	*115,700*	*69*
Social Security	132	17	56,400	34
other*	200	25	59,300	35
Private	*455*	*58*	*52,400*	*31*
non-charitable	290	37	28,100	17
charitable**	165	21	24,300	14
Total	*787*	*100*	*168,100*	*100*

* Owned by municipal, provincial, autonomous, or central administrations, including consortia of several administrations and of administrations and non-profits.
** Owned by Red Cross, Church, and others.

Source: Based on MSC (1995).

The payment method for such services was designed on a *per diem* basis, adjusting rate levels to the foresaid functional classification of the centres. As Espadas and Largo (1993:188-9) stress, the situation resulting from both the implicit incentives to lengthen stays and the pervasive revision of rates below the inflation level, led to designing different payment formulae. Thus, since 1988 'administrative' hospitals have been defined on an experimental basis, affecting seven specialised care centres in Spain, where rates are calculated according to functional costs. In these cases, the INSALUD signed 'special concerts' (*conciertos singulares*) with *public* providers (owned by provincial or municipal administrations)

or charitable private centres for the co-ordination and programmeming of their activities within the corresponding sectoral plan of the public sector. In contrast to the foresaid *conciertos* (article 90), *private* providers were thus made subject to the legal regime of the public sector by these *conciertos singulares* (Martín, 1996:201).

In sum, the weight of the Social Security health care sector in terms of budget, personnel, structure and functioning did not change in a relevant way during the seventies and eighties. The meso- and micro-management levels were still conditioned by the hierarchical organisation of medical specialities and by the lack of management autonomy of such hospitals, which were expenditure and budgetary units of the INSALUD. These issues were central to the reform affecting hospitals in the 1980s, and were also the focus of the contestation of the GHL by the medical profession and the unions. It was these two management levels in the hospital sector, and the macro-management level of the whole NHS, that were still the focus of discourse and reforms of the 1990s.

b) The financing model.

The compromise made to reach universal coverage as a defining feature of the NHS was virtually achieved by the end of the nineties, being no longer linked to the Social Security contributions. Thus the direct public provision model established by the GHL covered 99.8 per cent of the population by 1991. However, the coverage rate had already reached 82 per cent in 1978 and 96 per cent in 1986[26]. Therefore, the universalisation of coverage was more related to small groups than to the core of the system. The relevance of public coverage is apparent from Table 2.2, as the overlapping between the population covered by the public system and the population covered by private systems in 1993 implies that only seven per cent of the population had double coverage[27]. The total health expenditure rose from 5.7 per cent of the GDP in 1980 to 6.9 per cent in 1990 and 7.7 in 1994. In 1980, 80

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[26] For a detailed disaggregation of these data see Table A.2 in Appendix 1.

[27] For a detailed disaggregation of these data see Table A.3 in Appendix 1.

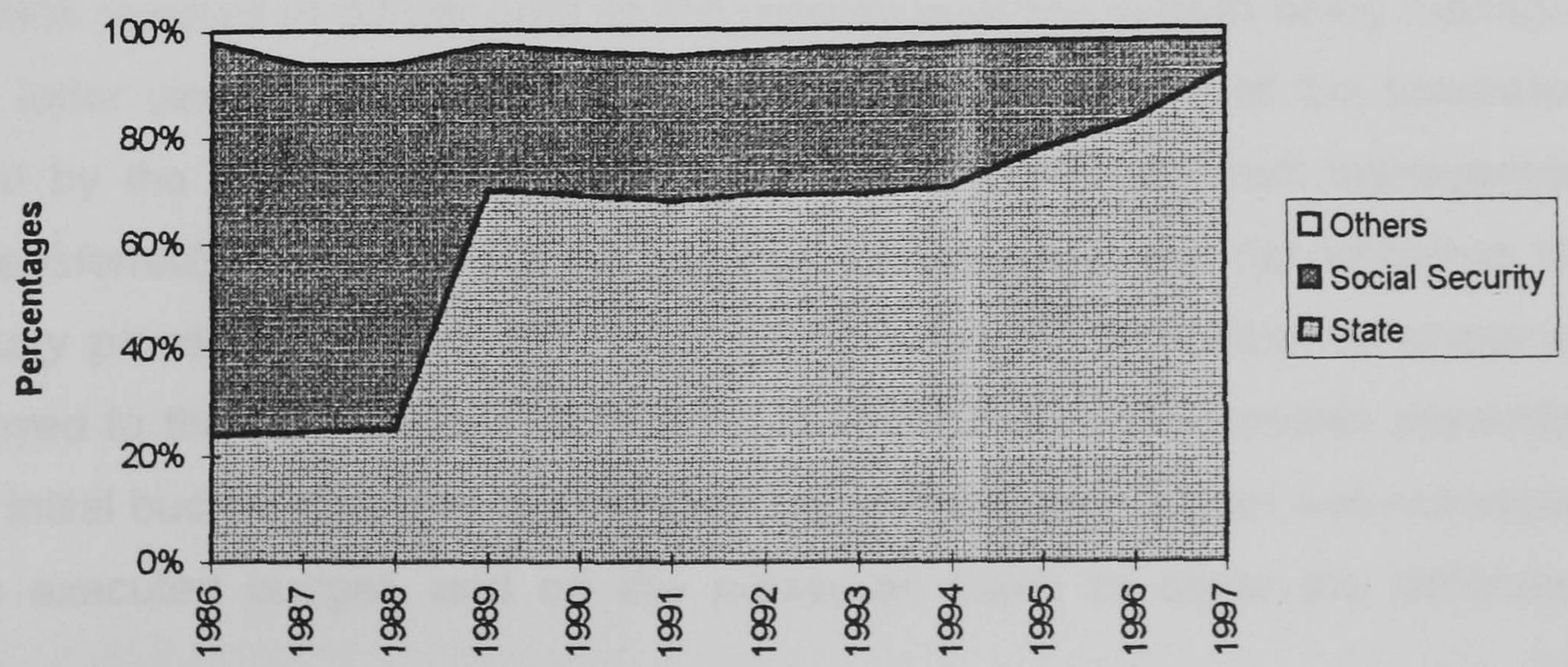
per cent of this total health expenditure was public (4.5 per cent of GDP), in 1990 public expenditure reached 79 of the total health expenditure (5.5 per cent of GDP), and 1994 it amounted to 77 per cent of the total health expenditure (5.9 per cent of GDP) (Bengoechea, del Llano, 1995:188).

Table 2.2. Public and private health coverage in Spain, 1993.

Public coverage	
Social Security Health care coverage	91.7%
(Charity and others without resources)	0.4-1.0%
Civil servants' mutualities	7.5%
Public total	**99.6%**
Private coverage	
Individual private insurance	4.4%
Individual employers insur.	2.0%
Private fee for service	0.4%
Iguala	0.8%
Private total	**7.6%**

Source: Freire (1993:89) .

Figure 2.2. Financing sources of the INSALUD's budget: State contributions, and Social Security contributions, 1986-97.



Source: C.Gest (1997:26).

In 1988 the Ministry of Health and Consumption reinforced its budgetary autonomy by having the INSALUD's budget share of the state general budget directly transferred to its own budget instead of to the Ministry of Labour and Social Security's. From Figure 2.2 it appears that the evolution of the financing sources of the INSALUD's budget had a clear turning point in 1989, when the share of State contributions (general tax financing) rose from 25 to 70 per cent. After remaining stable for five years, the State contributions to the INSALUD's budget were raised again and reached 92 per cent in 1997, following the NHS financing model defined by the GHL[28].

The transfer from the State general budget was formally integrated into the INSALUD's budget and had to be spent on the NHS health services. These were either directly managed by the INSALUD (INSALUD-direct management covering those Autonomous Communities without these services transferred) or by those Communities with health competencies which had already had the services to be managed transferred. In principle, the Social Security general financing was clarified: general taxes for health care as a provision of a redistributive nature, and Social Security contributions for the financing of pensions as transfers within the life cycle (Lobo, 1993:122). However, the INSALUD-direct management and the decentralised INSALUD under the authority of Autonomous governments continued to be regulated as 'autonomous organisms' for the management of Social Security health services.

In turn, the decentralisation process of health care management to the Autonomous Communities initiated in 1981 was bringing crucial structural problems of the financing model to the fore of the political debate. The decentralisation of the INSALUD's management competencies to seven Autonomous Communities by the mid 1990s resulted in 60 per cent of the resources of the system being managed by the latter (as these Communities represented 60 per cent of the population covered by the NHS). However, the fact that the INSALUD-direct management (non-transferred) managed only 40 per cent of resources did not influence the budgetary process. As Sanfrutos (1993:105-7) explains, the economic resources transferred to the Autonomous Communities with health competencies depended on the initial budget allocated to the INSALUD, on how that budget was managed, on the executed budget, and on the measures taken to cover the difference

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[28] For a detailed disaggregation of these data see Table A.4 in Appendix 1.

between the executed budget and the initial budget appropriation. Such measures affected the delay in receiving the corresponding transfer which, for example, took one year in the case of credits covering the INSALUD's direct management - and these credits covered 85 per cent of budgetary deviations.

The relevance of this process stemmed from the increasing deviation of the INSALUD's budget over the years - the difference between the initial appropriation and the budget executed -, which reached 14.4 per cent of the initially appropriated budget in 1992. Referring to these dynamics, Argenté (1993:114) stresses that the fact that the initial INSALUD's budget was insufficient as a rule not only hindered management itself, but also cast doubts on the credibility of the budgetary system as a tool to incentivise more efficient management. The financial crisis of the health system derived from the difficulty with adjusting the level of services covered and results of health management to the budget, and from the delays in the adoption of structural measures to contain expenditure. This situation led to increasing debt being incurred by the INSALUD with providers and with the Communities which had health competencies transferred for insufficient budget estimates. In order to pay for these debts, four major additional budget allocations for compensation were approved between 1982 and 1997. The last three of them approved between 1989 and 1993 amounted to over one billion pesetas (CGest, 1997:27-9).

The distribution of the INSALUD's budget among the Autonomous Communities - whether having health services and resources transferred or still being under the INSALUD-direct management - remained a controversial matter for some other reasons. As Rico (1997:342-3) explains, the transfers were calculated on three different criteria: the cost of services in the year before the transfers; the population covered according to the census - which is updated every ten years -; and the bilateral agreements reached between the Spanish central government and each Community which were made at different points in time, as the decentralisation process developed. Only Catalonia and Galicia followed the first criteria, while Andalusia and the Valencian Community followed the criteria of service cost in the previous year, and the Basque Country and Navarra followed a different system related to their special financial status within the constitutional framework[29]. Rico highlights that the gradual adjustment to the population criteria

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[29] The Communities of the Basque Country and Navarra have a financing system different from the rest of Communities which concerns not only health care but all policy areas. Basically, instead of relying on the budgetary allocation to be transferred by the Spanish central government, these Communities transfer to it a share of their own budget. In the

favoured Galicia, whose historical service costs are well below what would correspond to them for the population covered. Andalusia would also be better off if it received its budgetary share on the basis of the population criteria instead of service cost. By contrast, the population criteria has made Catalonia worse off as the cost of services in this Community are well above its population share. This would have also been the case of the Basque Country and Navarra if they had been part of the main financing system, and of Madrid if it had accepted the transfer of the health competencies - which in fact this Community rejected in 1992.

However, these aspects of the financing model not only concerned territorial equity, but also the margin of manoeuvre available to those Autonomous Communities which, by virtue of their competencies, strove to develop a differentiated health policy. The uncertainty about the budget which would finally be transferred to them after the initial under-estimated budget project had been exceeded affected policy definition and implementation. In this respect, the September 1994 Council of Fiscal and Financing Policy addressed these problems and proposed measures for a new financing model for the period 1994-97 concerning aspects such as: (1) replacing the mixed capitation/historical costs calculation base by the criterion of the protected population registered in the 1991 census; (2) designing compensation mechanisms for patients' displacements among Autonomous Communities; and (3) designing a more realistic health budget in keeping with GDP growth in order to reduce deviations between appropriated and executed budgets (Montero, 1994:128-9).

However, some dysfunctions of that new financing model were apparent. First, as in the previous model, the criterion of protected population as registered in the 1991 census did not incorporate socio-economic factors (for example, urbanisation level, age pyramid), or provision network characteristics specific to each Community (for example high-technology hospitals treating patients from other Communities). Second, a mechanism of compensation for patients' displacements was not approved. Third, although since 1994 the annual health budget increment was adjusted to the GDP growth rate, no structural measures were taken to ensure that those budgets were reliable (CGest, 1997:32). Moreover,

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case of health these two Communities managed to negotiate participation shares in the INSALUD's budget larger than it would correspond to them on the population criteria. Moreover, they receive the compensations for the INSALUD's annual budgetary deviations the year after (Rico, 1997:345).

in July 1995 the Ministry of Economy and Treasury of the central government revised the agreed level of resources to be transferred and reduced their amount according to new measures of expenditure rationalisation, thereby affecting the above agreements, whose budgetary valuation was again insufficient for the whole NHS (DSSS, 1995a:17).

c) From the Abril Report to the Convergence Plan.

The Abril Report was elaborated in 1991 by a Parliamentary Commission following a mandate from the Spanish central Parliament. Citizens' dissatisfaction with health services quality and the need to control expenditure and reduce deficits were the main arguments for analysing NHS structures, as well as management and financing techniques, so as to formulate adequate reform proposals. Two principles were central to the Report: devolving decision-making authority and fostering entrepreneurial management. Some of the proposals formulated in the Report included: clarifying and separating purchaser/financing and provider responsibilities, redefining district purchasers' coverage, converting hospitals into autonomous bodies subject to private law, enhancing managerial freedom at health centre level (particularly for staff policy), increasing contracting out with private providers, introducing invoicing and revising pricing techniques, defining budgetary allocations at the centre's disposal, defining basic and complementary services coverage as a basis for charging, weighed per capita and territorial financing criteria; and maintaining social security contributions to health services (CAESNS, 1991:49-66). This Report raised such a controversial debate between political and social actors that it was finally side-lined in the public arena. The most controversial proposals of the Report were not implemented - the co-payment of pharmaceuticals by pensioners, the managerial autonomy of hospitals, the definition of basic and complementary health care services, and a clear separation between purchasing a provision functions.

After the 1991 Abril Report, the need to reform the health sector came directly from international forums. In this context, the 1992 Spanish Convergence Plan for meeting the Maastricht criteria established several measures. As Montero

(1993:33-4) points out, the most relevant ones undertaken include organisational, budgetary and management measures. Concerning organisational measures, a 1992 decree assigned to the INSALUD-direct management (non-transferred) the functions of insurance coverage and health promotion, differentiating them from the provision role. For the first time, contract-like agreements with public or private centres could have a substitute rather than a complementary nature. By the late 1990s five hospitals had their 'special agreements' accordingly transformed. As for budgetary measures, steps were taken to gradually cancel the INSALUD's debt. Finally, management measures included a catalogue of services to be provided by the NHS (1995); the creation in 1992 of a National Commission for the Rational Use of Pharmaceuticals; the project to create a National Agency for the Evaluation of Technology[30]; the co-ordination of health and social services for the care of the elderly; and the reduction of personnel costs through not offering new public employment posts and freezing civil servants' wages in 1993.

The most relevant management measure established in the 1992 decree was the introduction in 1994 of the 'programme-contract'. This tool was projected to be extended to the 88 hospitals managed by the non-transferred INSALUD, and primary care centres, on an experimental basis. Following an explicit drive for efficiency, several measures were designed to link management objectives to budget allocation mechanisms. First, prospective budgets were negotiated on a per centre basis according to health care objectives. Second, activity measures were defined for primary and specialised care (Activity Weighted Units)[31] (Sevilla *et al.*, 1993:144-6). Third, information systems on activity and costs were developed across the 88 hospitals directly managed by the INSALUD (Elola *et al.*, 1993:150-4). The main objectives pursued by these measures included: a more accurate payment system (as by process), the possibility of introducing economic incentives to efficiency at the centre level, a more transparent definition of objectives and

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[30] According to Abel-Smith *et al.* (1995:62-3), only Catalonia (1991) and the Basque Country (1994) had set up health technology assessment agencies dependent on their respective autonomous governments by 1995. At the Spanish central government level the Drugs Directorate exerts regulatory powers particularly towards industry.

[31] These measures developed by the INSALUD-direct management were very similar to those introduced by the Basque, Andalusian, Valencian and Galician Health Services during that same period. In Catalonia activity measure units have been used for prospective contracting with providers since 1986 (see Section 2.2).

responsibilities on each part, a more decentralised and autonomous management, and to make managed internal competition possible (González *et al.*, 1995:10-6).

However, the programme-contract remained a *legal fiction*, as it was constrained by the unchanged public administration organisational and contractual framework, where *ex-ante* controls and centralised decision-making is the rule. The budgetary process was in practice subject to the legal framework of the annual public administration budgetary process. In this process, prospective budgeting was confined to an exercise without direct economic consequences, as risks were not born by managers. Personnel and payment policies remained centralised and ruled by statutory and civil service legislation. However, the very instrument of programme-contract was criticised for the following shortcomings: first, these contracts agreed on a per centre basis hindered an effective planning and co-ordination between primary and secondary health care levels; second, the planning agent interfered with management by setting objectives which were in fact management indicators (for example length of stay per service); third, health objectives concerning the population were not included in these agreements (González *et al.*, 1995:10).

Moreover, the regulation of prices and activity measures as the base of prospective budgeting was not being implemented as it had been defined. Instead, the incrementalist dynamics in the definition of budgetary objectives persisted. In turn, subsidies covered the difference between budgetary and activity objectives agreed and the actual performance, as a rule. The decentralisation of decision and control rights to health care managers referred to the objectives established in the programme-contract with that particular centre. But the effectiveness of the process was impeded because risks were not simultaneously transferred. In addition, health centre managers did not have decision-making power over personnel - who were centrally managed under statutory and civil service regulations. They also had a budgetary ceiling for contracting out goods and services, and were not allowed to decide on investments once projects affecting the centre have been centrally approved. They did not even have market-price valuations of their capital assets. And finally, the General Social Security Treasury centralised payment fluxes derived from payrolls, contracts and purchases (Martín, 1996:198-200).

2.2. The origins of the 'Catalan model', 1981-89.

The relevance of the 'governance issue' in health care was explicitly claimed by the party coalition in the Catalan government (Convergence and Union or CiU) during the negotiation process of the GHL, which was eventually passed by the Spanish Parliament in 1986 after a long and controversial negotiation process. The fact that this law had a 'basic' character meant that it established the principles concerning health care which were applicable to the whole country. However, while those Communities with a higher level of competencies had the health and social services actually transferred to them in terms of resources and regulatory powers between 1984 and 1997, Catalonia had received the transfers in 1981[32]. By the time the GHL started to be debated in 1983 as a forthcoming major health care reorganisation at the state level, the Catalan government had already formulated and implemented policy options which departed from the model that law projected. They criticised the GHL as 'statist' because of its overwhelming focus on direct provision and bureaucratic management.

a) Allocating health competencies and resources.

The Catalan government elected in 1980 - the first after the democratic transition - was aware of the political importance of health policy not only in terms of resources (the health budget amounted to a third of the Catalan government's total budget) but also in terms of its impact on other sectoral policies which could be affected by the development of a health care network. The corresponding negotiations and actual decentralisation of health competencies from the Spanish central government to the Catalan government took place between 1980 and 1982 within

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32 In 1977 the provisional Catalan government was re-established, in 1979 the Catalan Statute of Autonomy was approved by referendum, and in 1980 the first Catalan democratic government was elected within the new constitutional framework of 1978. For a political and historical analysis of the origins and evolution of Catalan nationalism see Balcells (1996).

the legal framework jointly established by the 1978 Spanish Constitution and the 1979 Catalan Statute of Autonomy. In this respect, the bulk of the resources transferred included the health services owned and directly managed by the Social Security administration as well as their corresponding budget. These health services basically comprised the network of large, high technology and research hospitals built up by the Social Security mostly since the sixties and concentrated in the largest cities, and a weaker primary care network.

According to a former top official of the Department of Health and Social Security (DHSS) of the Catalan government, in the very initial stages of political autonomy within the new democratic state, the Catalan government's priority was to assume the competencies established in the Statute of Autonomy as soon as possible in order to assert their political power. Thus, having exclusive competencies over health care, the negotiations to reach the transfers agreements with the Spanish central government for the management of the health services became a matter of political opportunity. However, what they did not expect, was to face an 'inexplicably receptive INSALUD' towards the transfer of competencies. Convergence and Union (CiU), the coalition in office in the Catalan government[33] wanted the transfers and accepted them at any price - and as a result, the price was too low. In this interviwee's view, this is still considered as one of the key reasons for the historical under-funding of health care in Catalonia:

> 'These transfers were not well calculated in terms of financing. I think that it was not because of anybody's bad faith, but ... because the transfer was done on a criterion of political opportunity. In a relatively inexplicable way, the central government said: "If you want the INSALUD I pass it to you". And the political directive was that everything which could be brought here and which strengthened autonomy was essential, and thus, let the INSALUD come here'.

The main policy options made over this initial period were formulated within the Direction General of Health Care. This DG was created within the Department of Health and Health Care of the provisional Catalan government (1977-80) and undertook the task of 'receiving' the health resources which were going to be transferred to the Catalan government. Although the small staff of experts of this DG had diverse political allegiances, they were not replaced by the new democratic

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[33] CiU obtained 27.6 per cent of votes and 43 of the 135 seats of the Catalan Parliament.

autonomous government elected in 1980. As a former prominent political figure in the DHSS explained:

> 'It has been a joint effort. The [provisional] Department of Health, before CiU won the elections, was under the area of influence of Dr. Espasa of the PSUC[34]. When the *Conseller*[35] changed [for one of CiU, after the elections], half the people in the DHSS could have been replaced. But we did not do it - instead we chose to collaborate ... We have had many advantages. We started this policy in 1981, the year of the transfers, and we have remained in government. And I would say that the same team has remained in the DHSS over sixteen consecutive years, and this has given a great coherence to what we have been doing. Dr. Espasa began [as *Conseller*], but I was already working with him, and the present one had been working with me, that is, we have been a team. We have had a very good collaboration at the level of local administrations, a very close collaboration, and also with the private, charitable foundations, which were usually presided over by the mayor'.

During the first year of the first legislature the new Department of Health and Social Security (DHSS) of the Catalan government was structured into three Direction Generals (DG of Health Promotion, DG of Social Services, and the foresaid DG of Health Care), and three staff organs (the Cabinet of the *Conseller*, the Technical General Office, and the Institute for Health Studies) directly attached to the *Conseller*. Within the DHSS, the weight of this DG of Health Care in formulating policy was related, in part, to the competencies it held among its four Services: first, health care analysis and programmeming (accreditation, regulation and control of providers, care reorganisation, private insurance sector); second, non-hospital services and equipment; third, the hospital care sector (hospitals and contract-like agreements with private and public providers); and fourth, organisation of the pharmaceutical sector. In part, too, the think-tank role of this politically heterogeneous staff was reinforced by their strong collaborative links with relevant figures in the academic and managerial communities in Catalonia - particularly, with the Catalan Union of Hospitals, an association of managers which until the early

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[34] The communist Unified Socialist Party of Catalonia.

[35] The *Conseller* is the political head of the Department and a member of the Catalan core executive, and is the counterpart of a Minister of the Spanish central government.

nineties had the role of the main employers' association in the hospital sector (see Chapter 3). According to a former top political appointee of this DG:

> 'The 'Catalan model' was promoted from within the DG from the very beginning. What we promoted was further transformed into a political tool named 'Catalan model'. What we promoted from that moment was, first, the creation of the Hospital Network of Public Utilisation. This concept, and this name, I wrote it down on a working document for the first time the day after the 23-F[36] - as we all were dependent on whether they would get us out or not, we had time to think. Second, the accreditation order of 1981 - the first in Europe - together with contracts orders ..., to make possible that the network of hospitals which were contracted - which until that moment had had to go to Madrid, half-begging, ... because for the INSALUD contracts were totally subsidiary. We said "with the transfers it is made clear that all centres which are used to give a public service have to be considered equal to those which are public, with reasonable tariffs, etc". We gave the contracted sector the strength and the extension we thought it needed. And third, I ... made the decision - of course further supported by the *Conseller* and the President -, of appointing a professional manager at the top of each public [Social Security] hospital.'

Thus, the DG's staff continued under the new CiU government doing their 'fieldwork' in order to gather the information which was not only necessary for managing this policy area, but also for calculating, first of all, the budget required for its financing. Civil servants working until then for the INSALUD had suddenly to cope with a different political and administrative authority - the DHSS of the Catalan government. Therefore, in these first stages, collaboration and exchange of necessary information was very dependent on personal relations and networking. As this former top official of this DG recalled, they almost started from scratch. To begin with, a task of 'inventory' had to be carried out to find out the resources which the DHSS could count on, and what the budgetary and economic situation was for both the Social Security providers and other providers (public and private) in Catalonia. The INSALUD had a very poor knowledge of its own administration and the real situation of health services in Catalonia - for example, it did not have reliable data on human resources (either in its own administration or in health centres), and expenditure was not updated because many documents had

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[36] February 23, 1981, when a *coup d'état* was attempted and failed.

not been inspected or fiscalised over the previous years, and therefore, that expenditure was not registered as having been incurred.

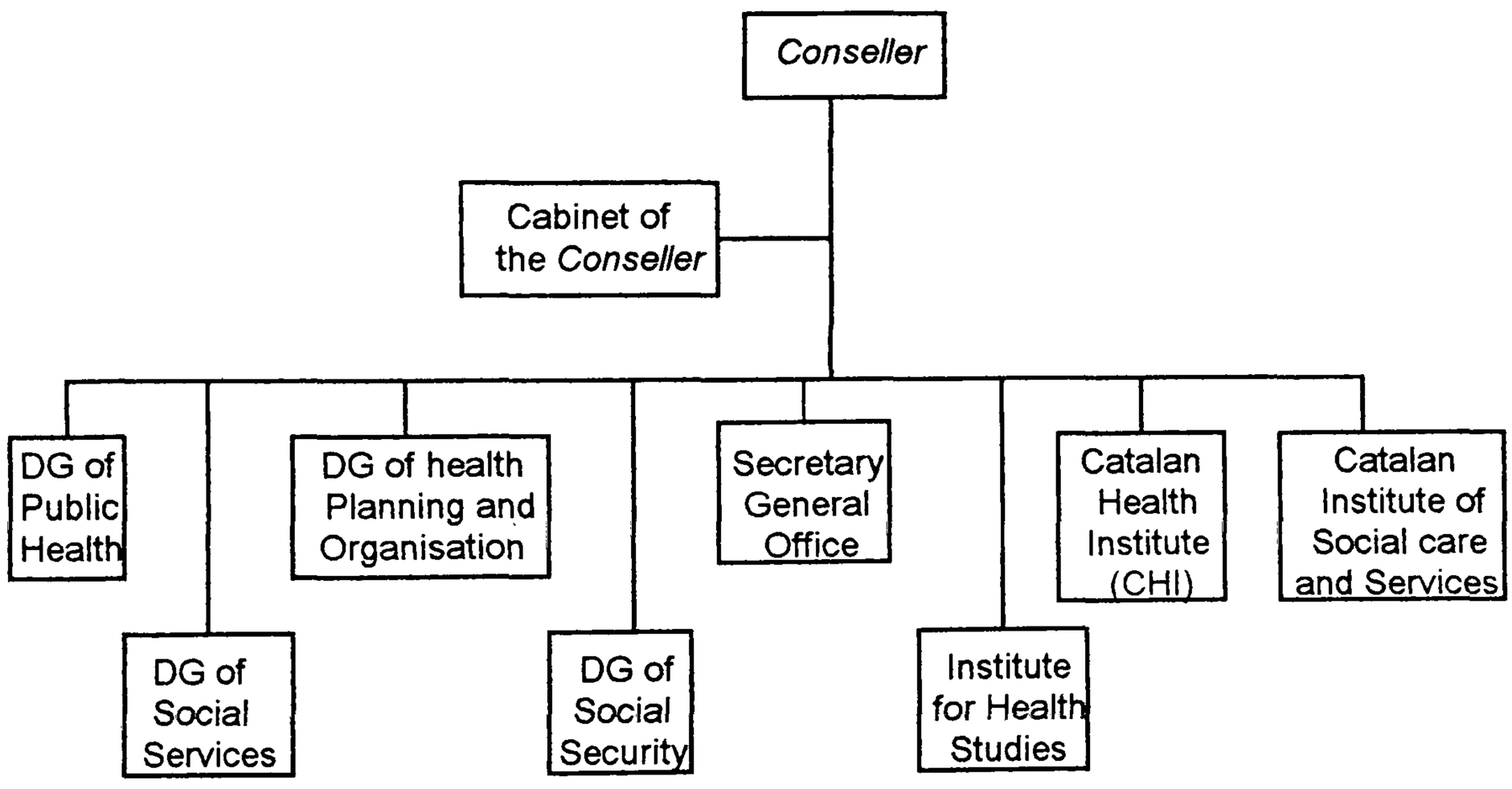
Moreover, the Social Security administration preceding the INSALUD had been contracting with non-Social Security providers - which in Catalonia represented over 75 per cent of available hospital beds - at a price well under the real production cost, because they were considered as 'complementary' providers to the Social Security-owned and managed services. This situation was maintained even though those providers were in fact 'substituting' for the lack of Social Security-owned services in Catalonia: the Social Security-owned services in Catalonia had a per capita bed ratio well under the average in the rest of Spain (Vallribera, 1994). Within these constraints, the calculation of the health budget to be transferred on a annual basis by the INSALUD to the Catalan government was under-estimated. This was not only because it did not include a population criterion, but also because it took as a point of reference the expenditure at the time of the transfers, which was not reliable. As a result of these factors, the transfer agreements became the origin of a cumulative public debt. When other Communities received their transfers from 1984 onwards, the calculation base was changed to introduce the criteria of population covered, although the under-funding and the accumulation of historical debts continued to grow.

During the second year of the first legislature, a new DG of Social Security was added to the organisational structure of the DHSS. This new DG held the competencies over the health care Social Security budget, the Social Security legal regime, the Social Security personnel, and the provision of health services and Social Security benefits (pensions, related mutualities, own health care providers). In turn, the pre-existing DG of Health Care saw its role as a regulatory agency reinforced. Its structure was enlarged and made more complex with the creation of four territorial delegations, an Under-DG including the techno-structure Services, and a new Service of Planning and Organisation. Moreover two new Services were created to assume the Social Security Health Services and Social Security Social Services respectively - as they were eventually transferred from the Spanish central government. In 1983 the latter of this Services became the Catalan Institute of Social Care and Services, and the former became the Catalan Health Institute (see Figure 2.3).

By 1983, when the stage of receiving the transfers of health competencies over budgetary, human and physical resources was finally accomplished, the DG

of Health Care was dismantled, and a new DG of Health Organisation and Planning was created within the DHSS. Its competencies covered regulation (accreditation, inspection and evaluation of services), resource organisation and planning, health programmes, organisation of the pharmaceutical sector, relations with private insurance entities and mutualities, and health promotion. In other words, all the former DG of Health Care's competencies plus health promotion and a stronger role for planning, organisation and health programmes now organised under an Under-DG (Vallribera, 1994).

Figure 2.3. Organisational chart of the Department of Health and Social Security, 1985.



Source: DSSS (1987:11).

In 1983 the Catalan Health Institute (CHI)[37] was created by law as the Social Security management entity in Catalonia - that is, the decentralised Catalan branch of INSALUD[38]. The weight of the CHI was apparent as it managed 88 per cent of

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[37] Law 12/1983, 14 July, passed by the Catalan Parliament.

[38] The parliamentary debate leading to the passage of this law reflected disagreement between political parties on the legal nature of this new entity - whether the CHI should be defined as a management entity of the Social Security (as the Spanish central government

the DHSS's total budget, for the financing of the services it owned and directly managed - that is, over 90 per cent of primary care and a seventh of hospital beds available in the early 1980s - and for contracting any complementary providers needed. The CHI was created mirroring the INSALUD's governance structure, as an autonomous organism of an administrative nature. That is, the CHI was (and by mid 1998 still is) defined as an organism with a single legal personality, within which hospitals and primary care services were cost centres without management autonomy or any independent legal personality of their own. The corporate centre of the CHI centralised the budgetary processes and the personnel policy - which was conditioned by the quasi-civil service status of health professionals. In addition, contracting and procurement policies were subjected to the Law of Public Administrations' Contracts - that is, previous inspection of most administrative acts involving expenditure. The lack of flexibility and therefore the difficulties in introducing managerial practices in this structure were later on to be the target of reforms. The main competencies of the CHI were assigned to its three under-DGs (General Administration, Health Services, and Personnel). Moreover, the CHI managed the budget for and negotiated the contractual agreements with those non-Social Security public and private health providers whose services were necessary for ensuring Catalans' health. In 1984 this contractual agreements with non-Social Security providers represented 34 per cent of the CHI's budget and 30 per cent of the DHSS's budget.

Within the INSALUD and, therefore, within the CHI there had been no managerial tradition beyond the 'administration' of the budgetary allocation. In the early 1980s, at the head of each hospital there was an administrator, while the medical director and the 'board of doctors' embodied the formal and informal power within each hospital, and in any external relations with the CHI or with the DHSS. In the primary care centres, the figure of the medical co-ordinator was the visible head but with no decision power. In this respect, before being dismantled, the DG of Health Care had taken two initiatives to change this lack of managerial culture. First, a system of correspondence between the budgetary public accounting and

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had done since the Social Security creation) or as an autonomous organism. This was relevant because in the latter case, the CHI resources could not be prevented from being used for financing non-Social Security expenditures. Keeping the Social Security budget separate from the general budget was a guarantee that when the state incurred debt it could not resort to the Social Security resources, but only to the Public Treasure (DSPC-P, 139:4327-8, 4332,4343-4, 4346, 4353).

management accounting was set up. Second, in 1982, this DG formulated the definite will of the DHSS to 'managerialise' Social Security hospitals by appointing a manager to each of them. These managers were further health area managers when the CHI was territorially organised into nine management areas (initially ten) in 1983, within which they had to co-ordinate a pattern of integrated health care provision and to administer and control the budget allocated to it. As a former official of the DG and former hospital manager put it:

> 'We started from scratch. The [hospital] administrators purchased, paid, transferred the payroll to the personnel and controlled them, carried out the required investments decided on somewhere else, contracted-out, were responsible for the up-keeping, and for accountancy. In contrast to managers, administrators did not have responsibility over health care tasks. The medical director, the nurses' head, and the administrator, it was like a triumvirate: different spheres of power. One or another could have more power in practice. ... There was something basic: in hospitals nobody was in charge. And we launched this programme for training managers, together with these ... business schools in Barcelona and the Catalan Union of Hospitals. This policy affected mainly the Social Security hospitals because the others usually had managers'.

The first generation of health area and hospital managers was hired following the advice of 'head-hunters' from sectors other than health care. Of the ten initial managers, five were industrial engineers, three were economists, one was a navy engineer, and one was a merchant navy captain (Roma, 1994a). The introduction of managers at the head of the Social Security hospitals raised opposition partly because at that time their wages were considered too high within the health sector standards. Most importantly, as the same former hospital manager argued:

> 'Appointing a manager meant that the medical director and the general administrator had to be under his/her authority. Managers gradually created close support staff for the management of resources, legal matters ... In this way the managerial and command structure was consolidated in this first period with the creation of three directors below the managerial structure (medical, nurse and administrative directors). ... The manager figure was gradually accepted partly because in a period of expansive investments the power of he [*sic*] who allocates resources is consolidated, and partly because of the generalisation of this figure in the rest of economic and organisational environments. ... In the second generation of managers the number of doctors re-trained

> as managers was very important ... When it comes to relationships and credibility there is more understanding ... and management is very well paid'.

The first director general of the CHI in 1983 (who had previously been manager of infrastructures of the INSALUD) developed an administrative and civil service-like style. He had sought the advice of a close staff who had previously been members of the INSALUD and whose 'bureaucratising' drive led some of those first managers to resign in 1984. That same year Mr. Xavier Trias, member of the Catalan DHSS and clearly committed to the 'managerial drive' of the initial DG of Health Care, was appointed as the new director general of the CHI. It was not until 1986, though, that the figure of manager for the whole CHI was created, with the function of co-ordinating the territorial structure of management areas and the central services (Roma, 1994a:95, 101, 110). At the same time, Xavier Trias, the director general of the CHI, was also appointed director general of the DG of Health Organisation and Planning created in 1983, thus holding both offices. In 1988 Xavier Trias (until then Director of the CHI and of the DG of Health Organisation and Planning) was appointed *Conseller* of the DHSS. He held this office for the two legislative periods over which the 1990 Law for the Organisation of Health in Catalonia was debated and passed (1989-90) and further reinterpreted and modified (1991-95)[39]. The debate concerning this law was at the centre of a consensus-building process whose results sharply contrasted with the controversy which the 1991 Abril Report faced at the Spanish central government level.

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[39] In November 1995 CiU won the autonomous elections for the fifth consecutive legislative period since 1980, but this time without the absolute majority in parliament it had had since 1984. The CiU President of the Catalan government appointed Xavier Trias as Head of the Presidency Department of the Catalan government. In May 1996, he announced a four-year programme to *reorganise the Catalan government's administrative apparatus along private sector management criteria*. This was to be achieved through the introduction of incentives to foster competitiveness, the definition of citizens as clients who have to be served effectively, and the pursuit of flexible and quick responsiveness through the *creation of autonomous agencies, public or mixed companies, and consortia which could by-pass administrative law* (*La Vanguardia*, 13/5/96, my emphasis).

Figure 2.4. Reorganisations of the Department of Health and Social Security, 1980-89.

1980 Health competencies transfers to the Catalan government

DG of Health Care

.regulatory agency role

1983

Creation of the Catalan Health Institute (CHI)

.management of the Social Security health providers and benefits,
.management of the Catalan government's health providers and benefits,
.contracting with non-CHI providers.

Creation of the DG of Organisation and Planning

.organisation, control and evaluation of health programmes,
.control, inspection, evaluation and planning of health services.

reallocation of competencies

1989

CHI restructuring

.managerialisation

DG of Organisation and Planning reorganisation

.planning, organisation, evaluation and control,
.general objectives of the health system.

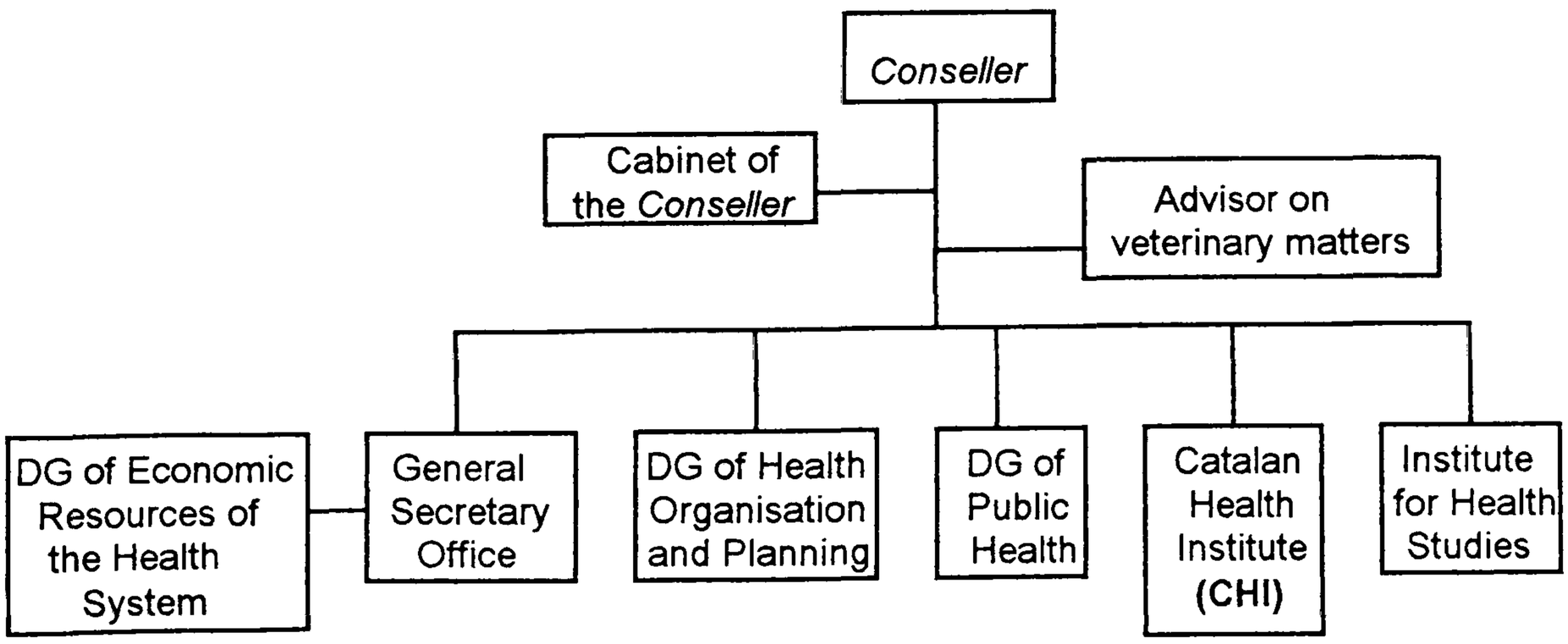
Creation of the DG of Economic Resources of the Health System

.allocation and distribution of economic resources,
.compatibilisation of budgetary systems,
.organisation of physical resources.

Source: Vallribera (1994:39).

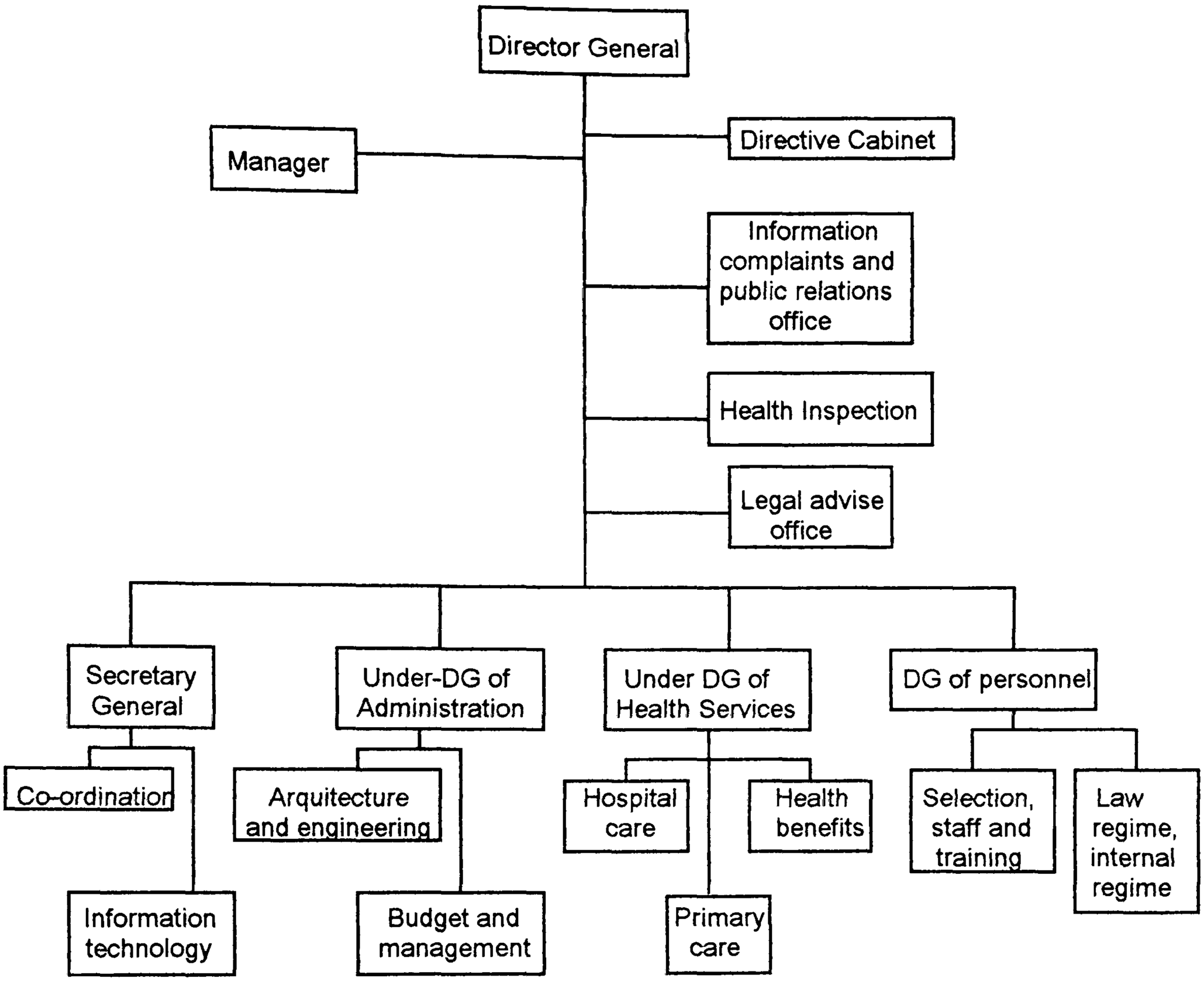
Two changes in the macro-institutional framework appear to be a prelude to the reforms further introduced by 1990 Law for the Organisation of Health in Catalonia and its 'new public management' (NPM) interpretation: the split between financing and provision. The first of these two changes was the creation of the Direction General of Economic Resources of the Health System in 1989 by decree within the DHSS. It assumed the functions of allocation and evaluation of economic resources within the health sector, organisation and projects of physical resources, and economic and financing control of the CHI and of the rest of public and private providers holding contracts with the CHI. With the benefit of hindsight, this new DG of Economic Resources of the Health System is now defined as the precursor of the Catalan Health Service created by the 1990 LOHC (see Chapter 4). The regulatory role (definition and evaluation of the accreditation system) still remained with the DG of Health Organisation and Planning created in 1983, but this DG was dismantled with the creation of the Catalan Health Service in 1991, and this regulatory role was assigned to the DG of Economic Resources of the Health System, which changed its name into DG of Health Resources (see Figure 2.4 and Figure 2.5).

Figure 2.5. Organisational chart of the Department of Health and Social Security, 1989.



Source: DSSS (1990b:15).

Figure 2.6. Organisational chart of the Catalan Health Institute, 1987-88.

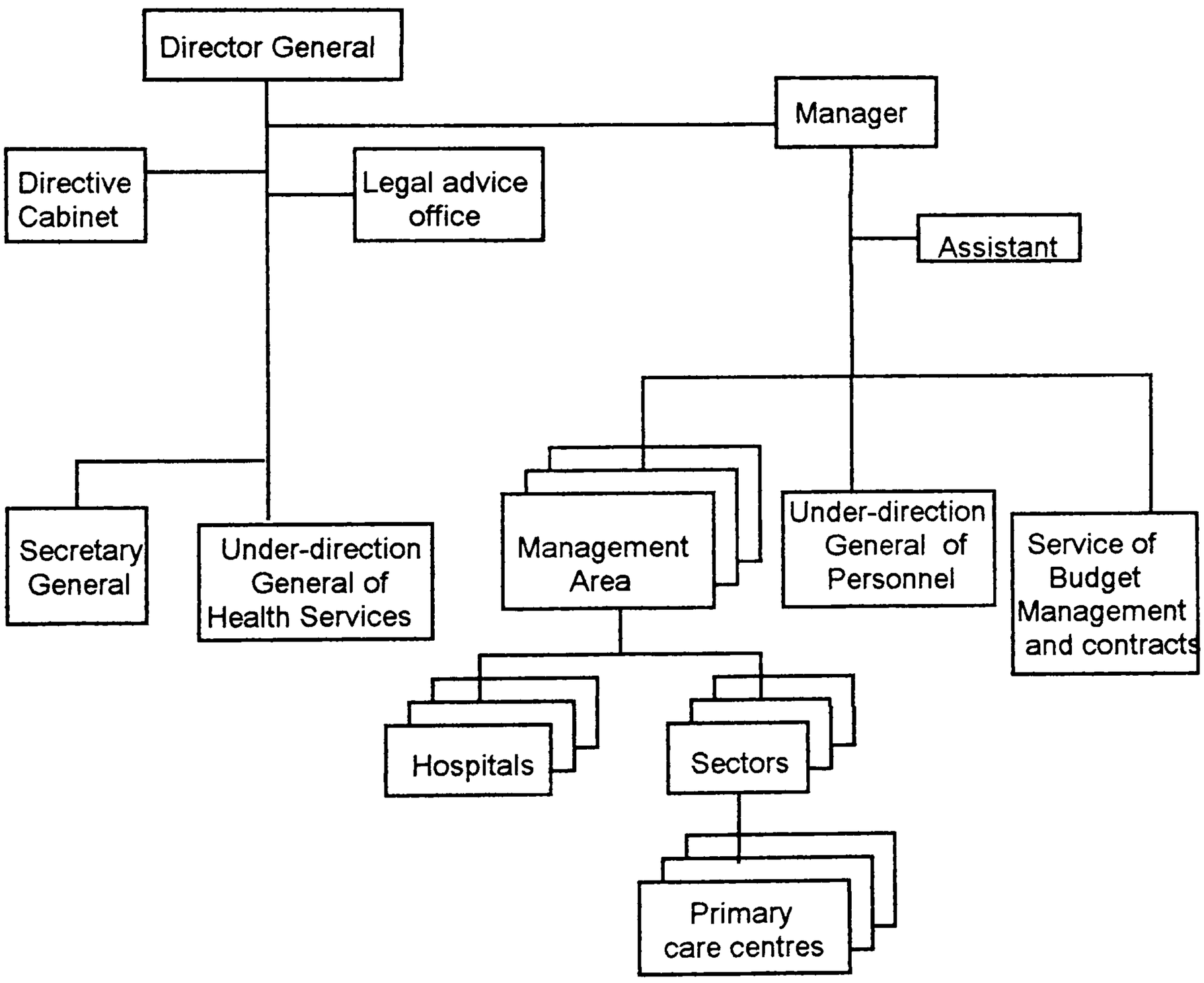


Source: DSSS (1988:23, 1990b:19).

The second main institutional change in 1989 affected the CHI. By virtue of the same decree, the CHI had an internal restructuring mandated by which the units holding managerial tasks were directly attached to the CHI's manager - a figure created in 1986 which broke some hierarchical features of its organisation. As Figure 2.6 shows, the figure of manager introduced in 1986 did not have clear areas of responsibility under its line of hierarchy. By contrast, the 1989 reorganisation of the CHI gave the manager an explicit area of competence - namely the management of the CHI hospitals and primary care providers (see Figure 2.7). In this reorganisation the Under-DG of Administration of the CHI disappeared and the role of health area managers was reasserted - beyond their

turnover, which was said to be concomitant to changes in organisational culture (Roma, 1994a:127). Most importantly, within the Under-DG of Health Services of the CHI, the Sections responsible for the contracted services with non-CHI providers disappeared, so that the Services of Hospital, Primary Care and Pharmacy, kept only the Section of 'activity' and 'control' concerning CHI providers only. This institutional redefinition of the CHI is also considered to be a prelude to the split between financing and provision which the LOHC developed one year later.

Figure 2.7. Organisational chart of the Catalan Health Institute, 1989-93.



Source: DSSS (1990b:20), ICS (1994b).

b) Regulating health care provision.

The diversity of providers in Catalonia has traditionally contrasted with the homogeneity of public provision in the rest of Spain. Taking into account all hospital beds available, that is, those accredited as part of the acute Hospital Network of Public Utilisation (HNPU) created in 1985 and those which were not accredited and were therefore non-HNPU members, their distribution by ownership in Catalonia differs substantially from that in the rest of Spain (see Table 2.3). The weight of public providers is higher in the rest of Spain both for Social Security-owned hospitals (39 as against 12 per cent) and for hospitals owned by local and provincial administrations (37 as against 29 per cent). Also, the weight of private providers in Catalonia is twice as much as in the rest of Spain in the case of the non-charitable, and nearly three times in the case of the charitable.

Table 2.3. Hospitals and available beds in Catalonia and the rest of Spain, classified by private or public ownership, 1995.

Ownership	nº of hospitals		% over total		nº of beds		% over total	
	Catalonia	rest of Spain	Catalonia	rest of Spain	Catalonia	rest of Spain	Catalonia	rest of Spain
Public total	*48*	*284*	*27.1*	*46.5*	*12,900*	*102,800*	***41.0***	***75.3***
Soc.Security	8+	124	4.5	20.3	3,800	52,600	**12.2**	**38.5**
Other*	40	160	22.6	26.2	9,100	50,200	28.8	36.8
Private total	*129*	*326*	*72.9*	*53.5*	*18,600*	*33,800*	*59.0*	*24.7*
non-charit.	68	222	38.4	36.4	9,400	18,700	29.7	13.7
charitable++	61	104	34.5	17.1	9,200	15,100	29.3	11.0
TOTAL	**177	610	100	100	31,500	136,600	100	100

+ Counting the three hospitals of Vall d'Hebró as one.
++ Owned by the Red Cross, the Church, and others.
* Provincial and municipal hospitals, in the case of Catalonia including the newly created consortia (4,752 beds) in most of which the Catalan government takes part.
** Of which only 69 hospitals (17,878 beds) are part of the Catalan Hospital Network of Public Utilisation.

Source: Own elaboration based on MSC (1995).

This scenario has given the Catalan government a wider margin of manoeuvre in the field of health management concerning the 'contracted sector' than in the rest of Spain. The Catalan government had a choice to make: either expanding the organisational and direct management model of the CHI (Social Security-owned health services), or revitalising the existing non-CHI contracted providers and transforming them into a network for the coverage of public health care, that is, 'substituting' instead of 'complementing' the Social Security/INSALUD direct provision. The Catalan government chose the latter option. In fact, the driving idea throughout the eighties was the need to integrate the existing resources in a single health care network, the Hospital Network of Public Utilisation (HNPU), which was internally diverse in terms of both management and ownership.

The Department of Health and Health Care of the pre-autonomous, provisional Catalan government elaborated a Health Map of Catalonia under the co-ordination of its *Conseller*, Mr. Ramon Espasa, who was a leading member of the communist Unified Socialist Party of Catalonia (PSUC). This Health Map was a consequential contribution to further developments in the Catalan health policy. It was presented in 1980 before the first autonomous elections gave the largest minority to CiU and confined the PSUC to the opposition. The leftist forces represented in parliament were not able to reach any post electoral agreement and CiU governed as a minority. The Health Map was conceived of by its authors as an expression of the main strategies to follow for the implementation of the model of National Health Service defended by the Catalan socialists and communists during the transition. In the second half of the seventies, they were the first to directly tackle the issue of defining a model of health policy and system as a centrepiece of a democracy[40], and explicitely focused on the 'Catalan Countries'[41] even before

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[40] The theoretical health system models and proposals elaborated by the leftist opposition during the Spanish democratic transition in the second half of the seventies (for example, by Espasa, Arcarín, Reventós, Artigas, Brunet and Soler, among others) and the contributions of the 1976 *Congress of Catalan-speaking Physicians and Biologists*, were all discussed and brought together in the *Congress of Catalan Culture* in May 1977. The main conclusions of this congress pointed to the need to create a public health system financed through the general budget and aimed at universal coverage. Universal coverage was not defined as equity of access but equity in the actual opportunities to achieve the same minimum level of health across the territory (regionalisation of the network) and across social classes (selective interventions) (GoI, 1978: 93-6). The proposals in this congress were also the first among the opposition's models in which the creation of a fund for regional redistribution for counteracting territorial inequities was suggested not only for the Catalan Countries but also for the rest of the Spanish state (GoI, 1978:91; de Miguel, 1979:214-222).

the political system and territorial organisation of the state was defined. The core of their proposals were universal coverage, equity in the access to resources through the regionalisation of the health network, planning, and an integral concept of both health (prevention, public health and education) and of health provision (co-ordinating different levels and areas of services). These ideas became the core of the Health Map.

The central idea of regionalisation of a health care network based on the existing resources - though without integrating them in the health administration - and the principle of equity of access were central contributions of the Health Map which characterised the policy developments throughout eighties. To this end, Catalonia introduced an accreditation system for the hospital sector in 1981, immediately after the Spanish government transferred the management of its health services to the Catalan government. It was the first accreditation programme in Europe[42]. In contrast to other countries' accreditation systems, the Catalan accreditation body was not a professional agency or commission but the health administration itself - which was also responsible for setting the prices system which applied to contract-like agreements (Bohigas, 1991a:139). According to López *et al.* (1988:15-6), the need for the Catalan government to design an accreditation programme, after the assumption of competencies over health, came about because of three main factors: first, the lack of data about the centres for which it had become responsible; second, the fact that the hospital network of public coverage consisted (via economic contract-like agreements held by the INSALUD in Catalonia) of hospitals belonging to private and public proprietors other than the INSALUD; and third, the urgent need to contain health care costs without decreasing quality.

The process of accrediting a health care provider was based on the analysis of its physical, organisational and operating structures and its comparison with

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[41] The term 'Catalan Countries' defines a geographical area with common socio-cultural features - at present with a clear reference to where the Catalan language is spoken. This area includes Catalonia, the Valencian Community (called Valencian Country in this terminology), the Balearic Islands, a narrow strip of the east of the Autonomous Community of Aragon (called the 'west strip' in this terminology), a southern strip of the Rosselló in France (called the northern Catalonia in this terminology), and l'Alguer (in Sardinia).

[42] And in Spain, where the 1991 Abril Report still recommended the creation of an accreditation programme for the INSALUD's own providers and for those with which it has contractual agreements. For an analysis of different health sector accreditation systems in the different countries see Scrivens (1995).

standard indicators. In the case of Catalonia, this regulatory role was played by the DG of Health Care from 1981 to 1983 and from 1983 to 1990 by the DG of Health Organisation and Planning. The aim of this process was to guarantee adequate structure levels and detect problems which can affect the quality of care, as a first step to project improvements. Furthermore, being accredited (that is, meeting the standards), was a necessary condition for holding a contractual agreement with the DHSS for the provision of health services. The first accreditation order (November 1981, and revised in 1986 and 1992), together with the contractual agreements orders (1981, and revised in 1983 and 1991) modified the existing Social Security contractual system by reducing the hospital levels established by the INSALUD from twenty-one to three. Those centres which were not given accreditation did not renew their contractual agreement and either disappeared or, as in the second accreditation order, were redefined as hospitals for chronic illnesses and mental care. In turn, the Development of the Health Map of Catalonia was presented in 1983. This Development was a strategic document which formulated the criteria and proposals to guide the planning of hospital resources for the following ten years. The basic idea was the need to rationalise the health care supply and to ensure its quality. To this end, the projected public hospital network had to include the non-Social Security hospitals holding contractual agreements as stable and regular providers of Social Security-financed services (Vallribera, 1994:28).

c) Policy tools in health care.

The accreditation process as a selection mechanism had a major impact on the hospital sector as it informed the creation of the Hospital Network of Public Utilisation (HNPU) in 1985. This network included only accredited centres, regardless of their ownership and legal nature, which provided health care for the Social Security beneficiaries - and since 1986 for all the population covered by the NHS. The Spanish Social Security had started building some hospitals of its own at the end of the forties and intensified investments from the sixties. However, in Catalonia such investment was lower on a *per capita* basis than in the rest of Spain, because Social Security relied on contractual agreements with long-existing

public and private hospitals, the latter being mostly charitable and often involving the church, local governments, and mutuality members in their directive boards. By the beginning of the 1980s the number of Social Security beds in Catalonia was 0.74 per 1,000 inhabitants, compared to a ratio of 1.56 beds in the rest of Spain, where, for this reason, the role of contractual agreements was much less important (Pomés, Ahicart, 1988:55),.

The existing diversity of providers in Catalonia originated from a differentiated Catalan health policy. This policy was intended to reverse the prevailing preference for Social Security providers and, consequently, the consideration of public and private non-Social Security providers as 'complementary' resources. Instead, the latter became a priority for the Catalan government in an attempt to redress their under-funding, while all public hospitals were considered to be most in need of better management (Bohigas, 1991b:6). The creation of the HNPU as a central measure in the development of the Catalan 'model' was the consolidation of a policy option formulated back in 1981 within the DG of Health Care. As a representative of the managers association Catalan Union of Hospitals expressed:

> 'The 'Catalan model' [was not 'formulated' but] already existed. What we have done is to organise, up-date, and modernise it. The Catalan model is based on the historical fact that a number of hospitals existed which were the initiative of the civil society's - not of the administration's. It did not make sense to invest in new hospitals because then those would have closed down. And we did not have the money [to built new hospitals].'

However, whether these developments were the re-assertion of an existing model or a deliberate policy option among other possible options is a matter of debate. In this respect, a top official of the Catalan Health Service (the new health authority created in 1991) argued that:

> 'The 'Catalan model' was the freest by the time the transfers of the Social Security health services were agreed. The case of Catalonia had the most open options. If the whole territory is covered by the health services of the Social Security it is more difficult to change than if you have a structure which, to begin with, is more diverse ... There were options: everything which has been done from anew could have been done according to the INSALUD's model. With the transfer agreements two unfinished hospitals of the Social Security were also transferred

> (Vic and Terrassa), which [once finished] could have been managed by the Social Security [that is, the CHI], having statutory personnel ... The decision of the Catalan government not to do it was political. They negotiated with close entities (foundations, the church, local councils...) and the first consortia were created'.

In any case, this proliferation of private hospitals as civil society initiatives included both non-charitable (including mutualities)[43] and charitable (of a larger size) centres. The private hospital sector in the rest of Spain is characterised by open institutions, such as private clinics, which do not have structural costs comparable to closed institutions. For these open institutions the client is not the patient but the doctor, who treats her/his own patients in those clinics and receives fee-for-service payment. In this system, doctors remain liberal professionals. By contrast, a crucial feature of the management tradition of charitable private hospitals in Catalonia was that they were not open but closed institutions. That is, they had an integrated, permanent medical staff, paid for by the hospital (fee-for-service was not permitted), and patients were treated there as clients of the institution rather than of a particular doctor - in a similar way as in a public hospital. Some of the largest of these hospitals belonged to the Church and had the highest reputation as centres of excellence for treatment, research and medical training. In some cases their reputations dated back to the middle ages (for example the Sant Pau's Hospital in Barcelona). Their reputation attracted prestigious professionals to work as staff members - who also worked as liberal professionals in private practices - and students, in spite of the poor remuneration involved (Reventós *et al.*, 1991:69-82).

Many of these private hospitals had reached a critical economic and financial situation of bankruptcy and de-capitalisation, due to a lack of investment as well as to an improvement of Social Security health services. They depended on contributions from the Church, from their municipal councils, from private donations given by mutualities' clients, and from the contractual agreements they had been signing with the Social Security. These contracts were based on the negotiation of a block grant, which was similar to a budgetary allocation as it did not specify the

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[43] In contrast to the rest of Spain, where double public and private health coverage reached seven per cent of the population in 1993 (see Table 2.2), in Catalonia 21 per cent of the population has double coverage - Social Security contributions and private insurance.

units or the kinds of services to be provided. However, it was not until the late 1970s that this situation began to be considered as non-sustainable. The local authorities had often been represented as honorary members in those hospital's directive boards. Following the first muncipal elections of 1979, the democratic local authorities undertook financial and political commitment towards these hospitals - a policy area of greatest importance to the local people. When a new health authority with exclusive competencies was created (the DHSS of the Catalan government), these local governments and hospitals demanded that this new authority undertook the responsibility for the survival of these centres.

The creation of the HNPU in 1985 had two main objectives. On the one hand, to give those hospitals stability in the provision of services and, consequently, ensure their economic viability. On the other hand, to require from such hospitals the adoption of efficiency, quality and cost-control measures[44]. Thus, the HNPU integrated all the accredited acute hospital resources regardless of their ownership and legal nature. Some hospitals outside of this network would be financed (contracted) to undertake care of patients with chronic illnesses - a service not covered by the Social Security (Vallribera, 1994:30-5). Thus, from 1985, being a HNPU-member required hospitals to be a more closed institution and to redefine the role of the hospital as a publicly financed provider. Something which was not required but which has been a dominant development is that mostly all HNPU-members ended up having a single main client: the DHSS, which contracted with them for the health coverage of nearly the whole population.

However, the criterion for being included in the HNPU was not only because of having a contract-like agreement with the CHI - since contracts can be used with non-accredited providers in time-limited, exceptional situations. Rather, the criterion for including a hospital in the HNPU was the health care role that particular provider was supposed to play in a particular geographical area. The consolidation of the HNPU as a territorially balanced network required an expansive trend of investment aimed at rebuilding, enlarging or modernising existing old private and public non-

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[44] In addition to being accredited as a necessary condition to hold a contract with the CHI, the HNPU-member hospitals were required to: adapt their accounting systems to a standard plan designed by the DHSS; supply management indicators and adapt their management to the DHSS guidelines; facilitate discharges reports following standardised models; ensure quality control mechanisms; to facilitate annual audits undertaken by the Department of Economy and Finance of the Catalan government; and submit a three-year plan for resources and investment (Pomés, Ahicart, 1988:57).

CHI public centres, or even buildings which had not been completed or equipped, in order to transform them into A-level facilities, namely basic hospitals with a view to cover the territory equitably (DSSS, 1995b:10). This investment programme was halted by a deep economic crisis in 1984-85 affecting the hospital sector, which created difficulties for the accreditation process. As a result the prices used in contractual agreements were frozen following the budget control policy decided by the Spanish central government. Social Security hospitals also had wages and investments almost frozen. This crisis situation led to an agreement between the DHSS and the Spanish central government (the Cullell-Guerra Agreement), which provided a temporary solution through an additional budget allocation.

Two main causes were argued to be the origin of this situation of near-bankruptcy amongst hospitals. On the one hand, there was the argument that the accreditation programme had been too strict in its requirements, inducing hospitals to live up to them by increasing their expenditures. On the other hand, as a top representative of a HNPU member hospital consortium (created in 1986 by several private and non-CHI public hospitals) put it:

> 'The Social Security had been paying contract-agreements much below the real costs of services ... This led to an endemic under-financing of the [contracted] sector over time ... The tariff paid for contracts had been frozen, while the inflation of health costs is higher than in other economic sectors ... This generated a deficit in the operating costs of these hospitals, and the only way to solve the tension created was to stop paying the Social Security contributions, thus generating a huge debt ... Many hospitals still resort to this solution when they have financial problems'.

It was in this context of financial and economic crisis that the 1986 Plan for the Reorganisation of the Hospital Sector (PRH) was formulated. Its main drive was to reorganise the hospital sector by consolidating an accessible hospital network based on basic level hospitals evenly distributed across Catalonia. This required expanding resources in some places and reducing them in others. The former was achieved, but the second was not. As Pomés and Ahicart (1988:58) point out, the ratio of beds per 1,000 inhabitants ranged from 3.66 in the then CHI's management area of Barcelona to 1.9 in those of Lleida and Girona, and 1.46 in that of Maresme. In order to achieve a more even distribution of beds, the PRH was

presented as a planning exercise of the public supply of hospital health care services to be implemented between 1987 and 1991, and was intended to develop the Development of the Health Map. The expansive measures continued while the projected rationalisations (that is, reductions) of hospital resources mostly in the metropolitan area of Barcelona were not carried out.

The problems the PRH was supposed to address were: the rising costs of hospital services, the excessive weight of the hospital sector in the health care network, the territorial and technological imbalance in the hospital network, and the low productivity of the health sector in general (Bohigas, Oriol, 1987:7). Therefore, the PRH provided several supply-side measures to influence both the HNPU-member hospitals (for acute patients) and those non-HNPU hospitals (for chronic patients), the latter being a first step for the elaboration in 1986 of the socio-health programme for the elderly 'Life to Years'. A first group of measures was intended to help the economic survival of providers by postponing the payments of the Social Security contributions to the Treasury for a period of 20-30 years, giving credits in special conditions, as well as non-recovery subsidies. In addition, financial measures were taken to increase the global health budget in real terms, regardless of the transfers from the central INSALUD - which had decreased as a percentage of the GDP in the previous two years. Given that by 1987 the debts of hospitals contracted by the CHI amounted to 75 per cent of their annual income, and many of them were bankrupt, these measures were justified as vital.

A second group of measures was intended to modify the contractual system by defining levels of hospitals and calculating the price of units of activity measures for each level. In this respect, planning measures intended to give more weight to the basic of the three levels of hospital (A) to the detriment of the reference[45] general level (B) and the high technology level (C). Thus, the bed distribution projected was 25 per cent for level C - one hospital per 1,5 million people-, and 35 per cent for level B - one hospital per 400,000 people. A-level hospitals were projected to be equitably distributed within Catalonia - one hospital per *comarca* (a supra-municipal territorial demarcation). As for the chronic network, the objective was to achieve a ratio of 0.5 beds per 1,000 inhabitants. Within this classification, prices paid for Basic Care Units (BCU) of activity measure were adjusted to costs

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[45] A reference hospital is that to which patients are referred by other hospitals of lower technological level, so that they can be provided with more complex treatment.

according to the different level of treatment complexity dealt with by these levels of hospitals, and the financing system was left to be negotiated with providers.

These measures were formalised in four contractual orders in April 1986 regulating the bases of the corresponding administrative process, including levels of hospitals defined, the procedures for the integration into and exclusion from the HNPU, health care services regulations, and BCUs of activity and payment. Thus, the contract model included clauses on the services to be provided, the length and method of renewal or non-renewal, patients' access regime, the statistical documents required, the incompatibility regulations applying to their personnel, and the maximum percentage of primary care emergencies to be billed (Artal *et al.*, 1987:36). In 1992 and in 1997 these contractual orders were again revised.

Among the central supply-side measures of the PRH, the reduction of beds in the metropolitan area confronted a strong opposition from the collectives affected and was actually not implemented[46]. By contrast, the objectives of expansion and consolidation of a territorially balanced hospital network of basic-level hospitals was achieved to a large extent. This process relied on the proliferation of new management forms such as the creation of consortia with the participation of the DHSS, and the contracting out of the management of public providers. In this context, the DHSS took an active role in fostering the creation of consortia in order to reorganise the provision structure of health care. This process involved the integration of individual hospitals of specific areas into public-private consortia in order to rationalise the existing resources and their utilisation. Also, the DHSS invested in infrastructure and equipment of non-CHI hospitals and became in several cases a member of the directive board of some of the consortia it had encouraged to form. These negotiations were aimed at finding locally based solutions by involving local councils, mutualities and other private owners. In this period four consortia were created - two hospital consortia (in Vic and in Sabadell), and two health consortia which included both hospital and primary care (in Terrassa and in Barcelona)[47]. The aim was to reorganise services, raise the quality

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[46] Several key informants stressed this point: a leader figure of the HNPU member Health Consortium of Barcelona, a manager of the HNPU member Hospital Consortium of Parc Taulí in Sabadell and a top figure of the Foundation of this Consortium, and a a leader of the hospital association UCH.

[47] Several cases of negotiation processes leading up to the creation of consortia are explained in (SCS, 1995c).

standards of care, optimise resources and engage institutions in a co-responsible health care management. In this respect the indirect management form of consortia was preferred (as opposed to direct management by the CHI) because there was no general regulation of it as a legal figure: it was therefore a flexible mechanism of governance. This change was intended to facilitate the further introduction of private sector management practices and the avoidance of bureaucratic models of organisation, together with public sector features such as personnel regime and budgetary processes (Lafarga, 1994:142-3).

These tactics of local-based negotiations in the development of the Catalan 'model' of hospital network are interpreted differently by other informants. They find a parallelism between these tactics and those being applied in the implementation of the contractual system characterising the relationship between the health authority and non-CHI providers - even after the introduction in 1986 of the calculation system of BCU per tariffs. In the view of a former senior official of the DHSS and top directive of the Hospital Consortium of Catalonia, an association which mostly represents non-CHI public hospitals in which local governments are involved:

> 'The tactics of the DHSS has been to segment, forcing very individualised negotiations - and this finished with blocks. For example, the DHSS negotiates hospital contracts on a per centre basis, it has never accepted to negotiate them with associations. With them the DHSS only discusses big issues (tariff increments...), but the translation into concrete stay length, activity... is made in the clauses of each contract and is discussed with each hospital. This is a transaction in which many contingent factors are at play - if there are municipal elections or of another kind that year, the relationship between the mayor of that locality with I do not know whom, that a leader of the [Official] Medical College works there...'

The primary care sector, virtually all of it owned and managed by the CHI, was also the object of reform from 1985. From 1982 to 1985, the DHSS of the Catalan government built 26 primary care centres in Catalonia (DSSS, 1995b:38-9). A 1985 decree[48] initiated the reform following the pattern of the 1984 primary care decree of the Spanish central government. Thus, Basic Health Areas were defined, in each of which a Primary Care Team comprising medical and non-

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[48] Decree 84/1985, 21 March, of the Catalan government.

medical staff developed activities of health care, health promotion and illness prevention. The implementation of this reform further reinforced by the 1986 GHL at the state level, and again by the 1990 Law for the Organisation of Health in Catalonia (LOHC), confronted apparent difficulties (see Chapter 6). From the early nineties to date (mid 1998), this model of primary care provision has been openly questioned and contrasted with new management forms. These new forms involved the integration of primary care into health consortia comprising also specialised/hospital care, the creation of new providers acting within private law management mechanisms and the diversification of providers in terms of organisation, ownership and management form. These processes were formalised into 'management by contract' forms and were also introduced in the early nineties in the primary care providers which were owned and managed by the Social Security administration - the CHI.

Conclusions

According to a former senior official of the former DG of Health Care in the DHSS:

> 'The [1990] Law for the Organisation of Health in Catalonia (LOHC) is what really creates the Catalan health model, but the LOHC creates the model when it was ripe. That is, the LOHC is born because all the pieces are already there and in one way or another you cover them with an umbrella and bind them up.'

As this observer implied, the policy options taken in Catalonia about a differentiated health provision model stretched throughout a decade and were adopted on an incremental bases without an explicit and binding legal framework which might have shaped them from a top-down perspective. With the benefit of hindsight, the decade of the eighties in Catalonia was characterised by a permanent state of health care reform in which both maintaining continuity and making innovations played a relevant role. However, both the sequence and

content of these political decisions were conditioned not only by stimuli endogenous to the Catalan political and health systems, but also by factors exogenous to them. For example, the almost full financial dependence of the DHSS of the Catalan government on the central INSALUD's transfers and the negotiation and formulation process of the 1986 GHL both conditioned the strategies of the Catalan government. Thus, although the Catalan government and its DHSS did follow a purposeful and differentiated line of reform which was based on their exclusive competencies to organise health care, their autonomy was not clear-cut. Nor did they have a health provision model which was clear enough for them to pass an explicit legislation right after the basic GHL provided this mandate.

Initially, the innovative drive of the Catalan reforms emerged from the 1981 accreditation system and subsequent contracting orders, which implied the will to regulate non-Social Security providers with a view to giving them a role in the provision of public health services. This accreditation system was at the origin of the most consequential of the policy options taken in Catalonia - the creation of the HNPU in 1985, which became the basic piece of the 'Catalan model'. The HNPU expressed the definite political commitment to follow a divergent path from the main Spanish health system by promoting the diversification of health care management and provision forms away from the model inherited by the health authority. From then on, the management model of the Social Security services transferred was not to be expanded but confined to those providers integrated in the Catalan Health Institute (CHI) - the decentralised INSALUD. In turn, the existing public and private non-Social Security providers were to be regulated and consolidated into a network which would remain at an arms-length relationship with the health authority (the CHI) *on the basis of a contractual system.* The several updatings of the accreditation system and contracting orders, together with the definition of the BCU as an activity measure for setting contractual prices, configured the main elements of that contractual system. In the early nineties the HNPU and the development of contracting processes were viewed as the origin of the NPM governance structure which became the focus of the reforms from 1990.

While innovation was remarkable concerning the policy tools used in the hospital sector, the organisation and management of primary care closely followed the NHS model defined for the rest of Spain in the mid-eighties. In contrast to the hospital sector where the CHI owned and managed less than a fourth of resources, in primary care the CHI owned and managed virtually all services. This situation left

little margin for divergence from the model being implemented in the rest of Spain, based on the creation of Health Basic Areas and the full-time, multidisciplinary team configuration of Primary Care Centres.

The institutional design of the health authority was also characterised by continuity and inertia. The CHI mimicked the INSALUD's structure and management form. Hospitals and primary care services were cost units of a CHI which had a single legal personality and which allowed little managerial freedom to its provider units. The introduction of Health Area and hospital managers in the early eighties and of the CHI manager in 1986 did not involve consequential changes in the basic features of the model. However, the fact that the CHI was both a provider of health services and the contracting health authority did not seem to hinder the gradual consolidation of the HNPU and the contracting system as the main features of the Catalan hospital sector.

This differentiated governance structure of the health sector developed within a wider state health system which was also undergoing reforms but leading to a different provision model. While the Catalan government was committed to preserve and expand a privately managed hospital network, the PSOE in the Spanish central government was committed to a direct, public provision model of health care. Aware as the Catalan government was of these diverging paths, it turned out to be particularly active in influencing the formulation of the GHL. This law was passed in 1986 after a long and controversial process of negotiations and was endowed with a basic legal character - that is, it affected all Autonomous Communities. As a result of the negotiations, though, the provisions concerning the organisation and management of the health services were classified as non-basic for those Communities with full competencies over health.

In the Spanish case, the creation of a NHS was a continuity option which built on the existing model of Social Security services, and above all, on the hospital network which the Social Security had built from the sixties. The reinforcement of primary care as the main gatekeeper of the system did involve innovation in relation to the weak network of services available until the mid-eighties. By the early nineties, when the NHS created by the 1986 GHL had almost achieved universal coverage and almost full tax-based financing - to the gradual detriment of Social Security contributions - a 1991 report recommended NPM-like reforms for the NHS but was rejected by relevant political and social actors. Shortly afterwards the pressures for reform came from international events, such as the Maastricht

Treaty (1991) and the subsequent 1992 Convergence Plan, focusing on the need to reorganise the direct public provision system. As a result, the main aspects of reform involved the management autonomy of Social Security providers. They were supposed to eventually opt out of the health administration structure and contract with the health authority, thereby separating purchaser and provider. There was also to be a gradual shift from the 'statutory', civil-service like regime of health professionals to a labour market-like contractual system. Thus, it is not until the early nineties that both the Spanish central government and some Autonomous Communities considered undertaking reforms on the lines that Catalonia has followed since 1981.

However, although the creation of the HNPU is an innovative policy option in the Spanish context, it is arguably a feature of structural influences and incrementalism in the Catalan context, since the HNPU involves reinforcing and consolidating a network of providers which already existed. Even so, in order to explain why the Catalan government managed to develop a governance structure for the health sector which was different from the rest of Spain is it not enough to just point out the existence of a heterogeneous hospital network - because in the early 1980s most of these hospitals were in an non-sustainable economic situation and did not even meet the standards of the Social Security providers. Clear decisions had to be made about policy options which affected different policy coalitions. For this reason, an analysis of the role played by non-institutional actors involved in the health policy arena is necessary to understand the developments which occurred in the Catalan health policy over the eighties. The policy preferences of these actors, their resources and the patterns of interaction among them are strong explanatory variables for the policy outcomes which followed.

Chapter 3

Policy elites and the consolidation of the Catalan model, 1980-90.

Two important factors that influence the decisions legislators make about the design of public sector institutions are policy precedents and the interaction between public officials (legislators and bureaucrats) and non-institutional actors (interests groups). In this sense, political transactions costs derive, to a large extent, from the way in which risk is assigned to different groups who have varying capabilities to insure against it (Horn, 1995; Moe, 1990). The formulation in 1990 of a new governance structure for the Catalan health system was dependent, to a relevant degree, on a decade-long policy incubation period in which both the development of key policy tools and the participation of interest groups in their formulation and implementation played a strong role. As advocacy coalition states, two kinds of exogenous elements influenced the Catalan health policy subsystem throughout this period. First, those stemming from the Spanish political system (democratisation, decentralisation and creation of a National Health System), and second, those derived from the Catalan political system (institution-building and territorial distribution of power within Catalonia). This chapter analyses the latter exogenous elements, as well as those elements endogenous to the Catalan health policy subsystem -namely, the role that interest groups and governmental actors of different administration levels played in the incremental development of a health system differentiated from the rest of Spain.

One of the characteristic features of the reform process of the Catalan health sector since the late 1980s has been the high degree of consensus achieved on a wide policy core of ideas among a relatively stable policy elite. There are four reasons why this consensus should be seen as remarkable and made a matter of inquiry. First, in the Catalan case this agreement concerns the introduction of policy tools and of a political discourse clearly in line with 'new public management' (NPM) reforms which in other countries and even in the rest of Spain have been a

matter of strong disagreement. Second, in Catalonia this consensus encompasses not only political parties whose ideological counterparts in other countries have strongly criticised NPM reforms, but also the actors who were most fundamentally affected by the reforms. Third, the distribution of political power in Catalonia among different levels of government (the Autonomous Community and local governments) reflects both a particular distribution of resources and the persistence of split voting between the two largest parties, each facing different commitment problems and having different reasons for co-operating. And finally, despite this wide consensus there has been a gap between actual formulation and discourse, and between discourse and implementation, which, according to an even wider policy elite (including the minority opposing the reform), amounts to a fundamental distortion of the model and of the spirit of the reforms.

In order to explain - at least to a relevant extent - this unusual consensus it is necessary, firstly, to analyse the role of the non-institutional elite in the policy-making process - namely, the consequences of their interactions with public officials. In this sense, advocacy coalitions are defined as comprising actors 'from a variety of governmental and private organisations at different levels of government who share a set of policy beliefs and seeks to realise them by influencing the behaviour of multiple governmental institutions over time' (Sabatier, 1988; Sabatier, Jenkins-Smith, 1993:212). On the one hand, the analysis of the role of advocacy coalitions requires identifying the resources the different actors rely on, the way they use (or do not use) them, the choice situations they face and the pattern of interactions among them. These factors help explain the gradual consolidation of the policy elite, their interests and their expressed preference orderings concerning the policy in question. On the other hand, the analysis of the role of this elite in the consensus achieved requires defining the areas on which their belief systems offer a common bases for agreement. The belief system they share consists of a set of value priorities, causal assumptions about how to realise them and problem perceptions. In this respect, their explicit arguments and preferences on specific policy choices expressed in publications and in-depth interviews provide evidence about the extent to which their belief systems overlapped - which in turn reveals the potential bases for agreement or disagreement in the case of the Catalan institutional reform process.

Table 3.1. Changes in factors exogenous and endogenous to the Catalan health policy elite over the 1980s.

Exogenous factors

Relatively stable parameters:	*Dynamic system events:*
1.assumption of health competencies by the autonomous government, 2.regulation of the health sector (provision side) 3.consolidation of asset ownership on the provision side 4.revival of cultural values enhancing the role of civil society.	1.stability in the systemic governing coalition (territorial distribution of power), 2.impact from another subsystem (financing from the Spanish central government, negotiation of the General Health Law), 3.change in socio-economic conditions and technology (demand, resources management techniques).

↑

Endogenous factors

1.shared and stable leadership of central actors (policy brokers and advocacy coalition leaders),
2.clear definition of subsystem boundaries (actual and potential actors),
3.policy oriented learning across belief systems in the late eighties and nineties.

Source: Own elaboration based on Sabatier and Jenkins-Smith (1993).

The learning process by which actors redefine their convictions and arguments can result from changes in factors which may be exogenous or endogenous to the policy elite or subsystem. Advocacy coalition theory identifies two sets of factors which affect the constraints and opportunities of subsystem actors (or policy elite) - exogenous and endogenous factors to the subsystem - and which have a two-directional impact between one another. This theory

distinguishes between two kinds of exogenous factors: stable and dynamic parameters. Concerning the *exogenous-stable factors*, the most relevant in the Catalan case appear to be the following (see Table 3.1). First, there have been gradually induced changes in the basic structures of the problem area through both the assumption of health competencies at the autonomous government level and the purposeful consolidation of a heterogeneous health care provision network. Second, these structural changes have been supported by modifications of the basic legal framework through the regulation of the sector. Finally, an induced revival of fundamental cultural values, namely the countervailing roles of the civil society and of government, has been fostered by the policy elite.

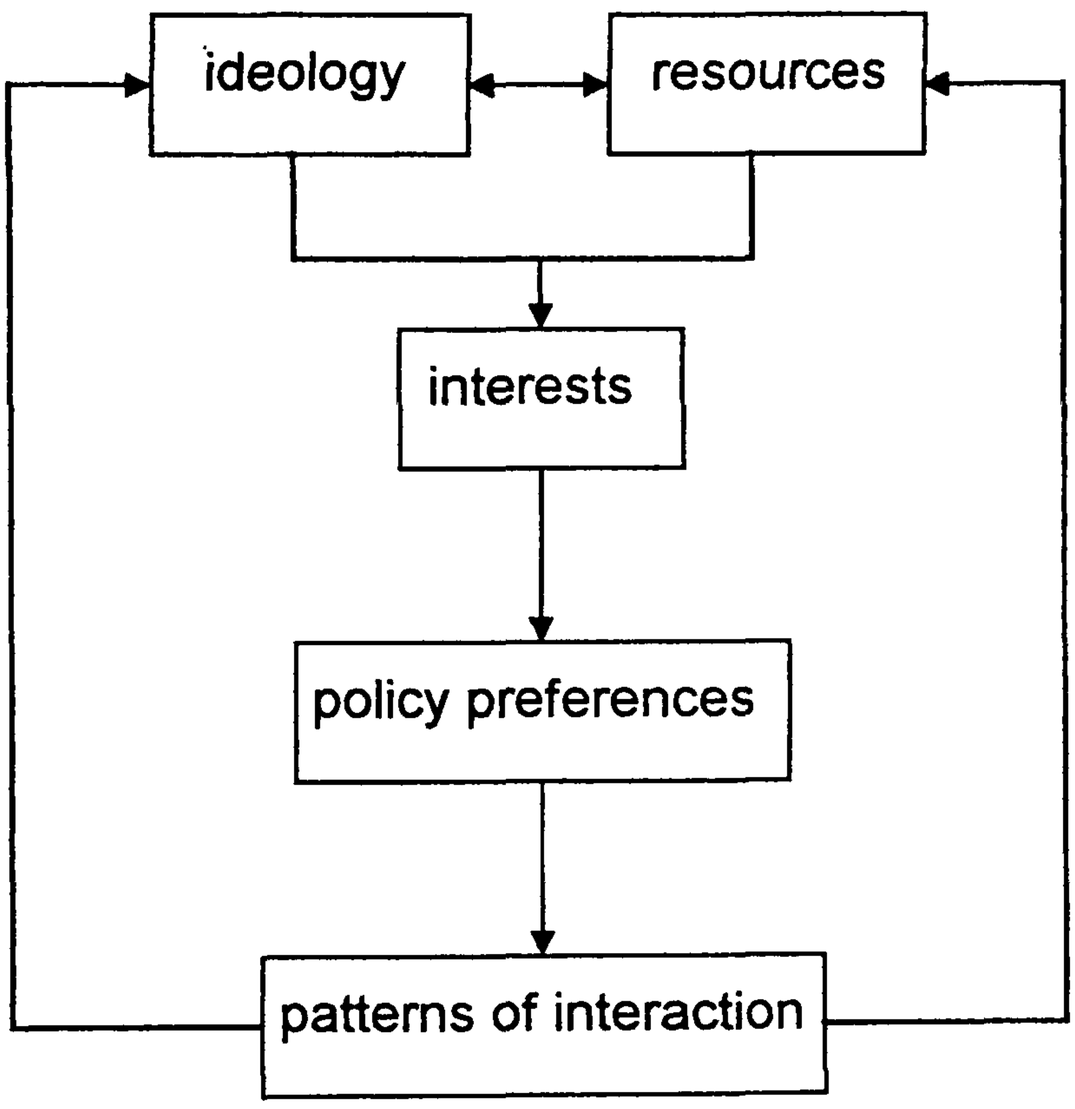
At the same time, the *dynamic factors exogenous* to the policy subsystem appear to be relevant for the consensus achieved in the late eighties and early nineties reform in Catalonia. First, there has been relative stability in the Catalan political system. The two largest forces, the coalition Convergence and Union (CiU) and the Party of the Catalan Socialists (PSC), have to a great extent accommodated to a territorial distribution of their respective power. The impacts from other policy subsystems have mainly concerned the financing of the whole reform process - because this financing has been subjected to negotiations with the Spanish central government - and the negotiation of the 1986 General Health Law at the Spanish central government level. Finally, there have been remarkable changes in socio-economic conditions and technology such as the introduction of private management techniques in the health sector, investments in infrastructure and technology and an overall increase in the resources of the system.

Among the *factors endogenous* to the policy subsystem identified by advocacy coalition theory, the most relevant in the Catalan case is the shared and stable leadership of central policy elite actors (policy brokers) over the eighties and early nineties, combined with a clear delimitation of subsystem boundaries (actual and potential actors). In addition, policy-oriented learning across belief systems was purposely intensified throughout that same period by the different advocacy coalitions.

However, although advocacy coalition theory explores the role of values of coalition members and of exogenous factors in fostering policy change, it does not stretch its analysis to find out how ideas are actually used by decision-makers. This theory could be even more insightful if it attempted to link properties of the structure under which decision-making takes place with the properties (resources)

of individuals - such as information, legitimate authority, conditional and/or unconditional incentives to alter others' incentive structure and reputation (Dowding, 1995, 1996). Both resources and ideology have an influence on how actors' perceive their interests and form their preferences. These preferences and the use actors make of their resources enable the development of specific patterns of interaction which become explanatory variables of policy outputs. In turn, these patterns of interaction influence both actors' ideology and the distribution of resources among them (see Figure 3.1).

Figure 3.1. Policy preferences formation.



Source: Own elaboration.

Following this framework, this chapter focuses on the pattern of interactions (bilateral and multilateral) between the main actors of the most relevant actors, that is, among the non-institutional policy elite and between each set of actors and the health administration as a central actor. These interactions help explain not only the result of the policy formulation process, but also the result of the implementation process. The analysis of these relationships will be based on the use these actors make of the resources on which they depend. At the same time, the gradual consolidation of the belief systems of this policy elite will be analysed on the bases of the arguments they have developed. This analysis identifies a

common ground for agreement and for the consensus which further characterised the 1990 reform process that is analysed in Chapter 4.

The non-institutional policy elite which has played a relevant role in the decision-making process of the Catalan health care reforms throughout the eighties and nineties conforms to a policy subsystem in which four different interest groupings may be identified. Each grouping - or rather, their leader and most prominent figures - depend on different resources, develops a different pattern of relations with the health administration and focuses their broker activities on different aspects of the policy area. Two organised groupings have maintained the closest relations with the health administration - the DHSS of the Catalan government - and played a central role in the definition and implementation of the reforms: the Catalan Union of Hospitals (UCH), formed by hospital managers, and the Hospital Consortium of Catalonia (CHC), initially formed by 'public/political' owners. A third interest grouping is formed by a particularly relevant professional association of compulsory membership for the medical profession, the Official Medical College of Barcelona (COMB). The COMB represents the interests of the medical profession in the province of Barcelona[49] but its informal, issue-led pattern of interaction with the health administration (DHSS) and the large membership it represents has led it to become the most relevant of its kind in Catalonia[50].The fourth grouping shows a more heterogeneous composition, formed by class-based and profession-based unions. The class-based unions are nation-wide and the

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[49] Catalonia is divided in four provinces (Barcelona, Girona, Lleida and Tarragona) which are supra- municipal, local administrations. In 1987 the Catalan Parliament passed four laws for the territorial organisation of Catalonia. Two of them were relevant for provinces. One established the provisional nature of the competencies of the provincial administration organ (*Diputació*) with a clear aim to gradually reduce their functions and eventually abolish this administrative level. The other law created a different supra-municipal, local demarcation (*comarca*) which further led to the organisation of the Catalan territory in 41 supra-municipal units. Similarly to the *Diputacions*, the *comarca's* administration organ (*Consell comarcal*) is formed out of a mixed system of direct and indirect representation out of the municipal electoral results. The competencies assigned to the *Consells comarcals* overlapped those of local governments (municipalities) and those of *Diputacions*. However, as at 1998, provinces have not been abolished yet. These laws were driven by the anti-provincialist stance which has traditionally characterised the political Catalanism from the second half of the XIX century. After the francoist dictatorship and into the new democratic regime the provincial administration was still viewed as an imposed structure which bore no relation with the economic, social and idiosyncratic configuration of the Catalan territory (Bagó, 1991:17- 45).

[50] The territorial organisation of the Official Medical Colleges have a provincial basis - that is, there is one Official Association in each province.

most representative of them are the communist-leaning Workers' Commissions (CC.OO), and the socialist-leaning General Union of Workers (UGT). Among the profession-based unions CESM-SATSE is the most representative one, being a coalition formed by the Catalan branch of the Spanish Confederation of Medical Unions (CESM) and the main union of nurses (SATSE). Several other profession-based unions have been emerging in the late eighties through a bottom-up process originated in different health providers across the Catalan Health Institute, the rest of the Hospital Network of Public Utilisation and the private providers, making the interests representation more complex. The influence of trade unions has been more relevant in specific issues such as labour relations, than in the definition of the 'Catalan health model'.

3.1. Hospital interest groups.

The non-institutional policy elite groups which most closely collaborated with the DHSS of the Catalan Government in the decision-making processes leading to the 'Catalan model' of health care were the UCH and the CHC. To some extent, these two organisations had a common origin which was soon followed by a diversion in their interests and arguments. But they converged again in the mid-nineties both organically and in argumentation terms. Their roles are further analysed.

a) Managerial interests.

The UCH is an association of hospital managers initially created in 1974-75. In this period the objectives of the hospital managers involved were to co-ordinate actions and efforts to confront an administration - namely, the Spanish central

administration until the early 1980s. They argued that it treated non-Social Security hospitals arbitrarily both in the allocation and remuneration of contracts. At first, the UCH assumed the functions of an employers' organisation looking after negotiations with trade unions, plus the health administration and with other associations. Later on, the UCH widened its objectives to cover the preservation of the health provision heritage and of their experience, with an aim to improve the organisation and operation of hospitals. Thus, the UCH gradually developed into a forum of debate, training and research, and into an instrument of opinion building and pressure (UCH, 1995a).

The relevance of the UCH's role as a collective actor in the policy formulation process concerning health policy in Catalonia stems to a great extent from the contribution of a small number of its leaders. These people were highly qualified and well reputed health managers with an economic education and, in some cases, they were also members of the academic staff of private specialised undergraduate and postgraduate programmes of well reputed institutions. Key members of the directive board of the UCH were in fact in-house staff of the DHSS of the Catalan government, actively participating in expert committees during the early and mid-eighties. They played a central role in the formulation of key policy options throughout the eighties, such as the organisation of the health services and resources transferred by the central government, the accreditation and contracting orders, the creation of the Hospital Network of Public Utilisation (HNPU), the formulation of the Plan for Hospital Reorganisation (PRH), and the definition of the Basic Care Unit (BCU, a contracting method for measuring activity and calculating the tariffs to be paid for the services contracted by the administration on the bases of a fix part and a variable part) (Martínez, 1995; Trullà, 1995). As a highly involved actor in the UCH put it:

> 'The relations between the Department of Health, the Direction General of Health Care and the UCH were fruitful for the country and for the hospitals ... The existing mutual acquaintance and friendship links with some members of the board of the UCH, were key elements for achieving the climate of trust which was established between the Catalan Health Administration and the UCH. Thanks, on the one hand, to the knowledge and experience accumulated by the members of the board and, on the other hand, to the technical quality of the studies it had been elaborating, the UCH was, in those years, the *privileged interlocutor* of the Department of Health and the Direction General of Health Care.' (Martí, 1995:11, emphasis in the original).

In addition to this central role of influential UCH members as in-house experts in the DHSS throughout the eighties, the UCH configured itself as a polyvalent think-tank. This role involved, first, undertaking the responsibility for co-ordinating mutual collaboration between its members; second, providing services for helping smaller members and reaching agreements with enterprises for improving the operating of those members; and third the development of research, consulting and professional training activities. The UCH was not only personally and ideologically close to the party in government, but it was also persistently committed to the managerialisation of the health sector amongst both public and private health providers. In this respect, the UCH has carried out numerous studies on the improvement of hospital management and on the regulation, organisation and management of the whole system according to its explicit normative convictions and its policy strategies. These studies covered areas such as the sectoral adaptation of the General Plan of Accountability in 1978 and 1990, the management and training of human resources in health services, and handbooks of recommendations for the design and operationalisation of the health information system. These studies have been disseminated in courses, conferences and seminars for professionals of the sector, as well as in documents for the health administration which have represented a direct influence on policy formulation (UCH, 1995b).

The UCH considers as one of its main achievements the creation and spreading of a common language across the administration and the health sector and among most of present managers. In fact, many of the UCH's arguments - that is, their policy strategies or near core arguments - have impregnated the vocabulary and thinking of the professionals within the health sector and outside it. In this respect, Martí (1991a) and Salazar (1995) point out the following arguments originally brought to the fore by the UCH, and now widely accepted: the defence of the hospital heritage built up by the civil society; the separation between planning, financing and provision; an equitable distribution of resources, autonomy of management for providers; the need to foster organisational changes for the improvement of efficiency and quality; and the emphasis on personnel training and a homogeneous information system. In a working session of conferences on the HNPU held in 1991, Martí (1991b) insisted on the success of this process. He argued that two sub-networks (public and private) of non-Social Security contracted

providers became acquainted in order to harmonise their objectives and language, and ended up becoming more similar and homogeneous as a result of the exchange of experiences and knowledge.

However, from the passing of the 1990 Law for the Organisation of Health in Catalonia and the creation of the Catalan Health Service, the UCH's leaders stood to be amongst the most critical towards the distortion of the model they had so closely collaborated to create for over a decade. Thus, from the beginning of the nineties:

> '... the relations with some members of the super-structure which has been created in the CHS [the Catalan Health Service] and its regions have not always been totally cordial and fluent. Over the past years, the UCH has observed with concern the temptation to create oligopolies of providers and strategies of vertical control over population areas. For this reason [the UCH] reinforces the position it has always defended, in favour of organising *hospitals as enterprises of services*. At the same time [the UCH] highlights the negative 'politicisation' of many hospital directive councils and the inconsistency embodied in having separated the functions of financing (purchase of services) and provision (sale of services), and still having representatives of the purchaser in the councils of providers. [The UCH] also reports against the excessive bureaucratisation of the CHS and the lack of homogeneity of criteria and actions in the different regions. The UCH thinks that the intermediation which is taking place in the Catalan public health system contributes little to efficiency and does not add value to the care process, and that, on the contrary, it makes it more expensive and deteriorates its functioning. Finally, [the UCH] sees with disappointment how some 'actors' are helped to position themselves strategically in order to 'live on the system' instead of 'working for the system'.' (Martí, 1995:13, original quotes and emphasis).

The creation and evolution of consortia, which has been a central feature of the health reforms throughout the eighties, has been viewed by the UCH's leaders as a way of making providers which were the expression of a dynamic civil society become *de facto* public[51]. The financial and organic dependency of these providers

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[51] A leader of the UCH regretted the increasing dependency of civil society on the administration. She asserted that the latter hindered the dynamism the former had shown in the case of the Catalan health sector, with the creation of hospitals and prestigious schools of medicine which are documented even for the middle age (Martí, 1995). On this latter point see also Gol *et al.* (1978). This same argument was also stressed by a top official of the Institute of Health Studies of the DHSS of the Catalan government interviewed for this study. Trullà (1995) gives evidence on the 'associative spirit' of the Catalan civil society by citing the guide of entities in Catalonia, which is edited by the Department of Justice of the Catalan government. In this guide, the legal associations are classified into ten categories.

on the administration and the interventionism derived from this situation was defined as the antithesis of the management autonomy which the UCH had defended. This autonomy of management and its identification with private business management techniques were the policy core of the reforms throughout the eighties and were even intensified from the early 1990 as one of the main arguments of the NPM discourse and reform. The UCH and CHC shared views on this policy core of ideas, (leaving aside the theme of the 'public/municipal ownership' of providers), and as a result their respective positions got closer by the mid-nineties.

Among both the institutional and the non-institutional policy elite there is a widespread consensus on the need to preserve the active role of the civil society. The argument is that in Catalonia there is a culturally different approach to the private/public debate partly because the presence of the private (profit and non-profit) initiative has always been very relevant and also very dynamic - particularly in those sectors where the administration has not had a strong presence or has not covered the existing demand. In the case of the health sector, the evolution of highly reputable and prestigious institutions which are rooted in consolidated social networks has helped develop this differentiated mind-set.

However, a former top political head of the DHSS of the Catalan government insisted that despite this dynamism - which he recognises as a valuable heritage - 'civil society' as a concept has been used to support policy choices which purposely 'resuscitated' the private sector to the detriment of the public sector expansion. This is also the view of the leftist coalition Initiative for Catalonia (IC), created in 1988, and of its largest member - the communist leaning Unified Socialist Party of Catalonia (PSUC)[52]. As a minority, IC has strongly opposed the actual development of the Catalan model of health care:

> 'In the hospital sector, the Catalan government has financed the re-conversion of non-Social Security providers which were bankrupt, has promoted the creation of private providers for the management of Health Basic Areas in primary care always avoiding any direct

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In 1995 there were over 25,000 such associations in Catalonia, from which 500 belonged to the health sector. The latter were distributed among three categories of the existing ten - health associations, economic and professional interests and co-operatives.

[52] From 1987-88 the PSUC was a member of the coalition Initiative for Catalonia (IC), which in 1994 was enlarged and became IC-V, including The Greens.

management involvement ... The critique *ad absurdum* would be: 'If they are so liberal, why is the government directly promoting and financing the appearance of new economic agents? Let them appear by themselves'. It has been the government, with the help of the Official Medical College of Barcelona, which has revived mutualities and helped private providers of intermediate products to emerge in order to contract with them. The supposedly spontaneous creation of the civil society has instead been actively promoted by the DHSS.'

Table 3.2. Overlapping membership between hospital associations in 1994.

	HNPU members				Non-HNPU members				Total	
	beds		hospitals		beds		hospitals		beds	hospitals
	n.	%	n.	%	n.	%	n.	%		
only UCH membership	4,540	25	22	32	3,979	30	19	16	8,519	41
only CHC membership	3,562	20	17	24	1,438	11	9	8	5,000	26
UCH and CHC double membership	2,448	14	15	22	530	4	4	4	2,978	26
non-associated	7,348	41	15	22	7,253	55	84	72	14,601	92
Total	17,898	100	69	100	13,200	100	116	100	31,098	185

Source: Own elaboration based on data from UCH, 1995a; CHC, 1996; and DSSS, 1994a.

In 1994, 25 per cent of the HNPU beds belonged to hospitals which were only members of the UCH, while 20 per cent belonged to hospitals which were only members of the CHC. In addition, 14 per cent of the HNPU beds belonged to hospitals with simultaneous double membership to both the UCH and the CHC (see Table 3.2). Bearing in mind that 26 per cent of HNPU beds belong to the CHI (Social Security administration) and, therefore, are not members of any of these organisations, this means that around 60 per cent of bed hospitals - namely almost

all non-CHI beds - were represented by either one or the two of these very relevant organisations. This double membership affected 37 per cent of the CHC's total bed number and 26 per cent of the UCH's total. That is, the CHC had a higher ratio of double membership of its associates and, moreover, 74 per cent of the CHC beds belonged to the HNPU, which involves a much greater dependency of this organisation on the HNPU regulations and financing (UCH, 1995a; CHC, 1996; DHSS, 1994a). The CHC had no private clinics members but had 15 Basic Health Areas associated - primary care teams -, and socio-health centres.

By contrast, the UCH had a smaller ratio of double membership of its associates, was less dependent on the HNPU, but also had a more heterogeneous composition, with a higher potential for internal interest conflicts. On the one hand the UCH is interested in defending the HNPU, but on the other hand, above half the UCH bed total, that is nearly 5,000 beds, belonged to non-HNPU member hospitals including private clinics, psychiatric hospitals, and medium and long stay centres, apart from private diagnostic and intermediate product providers. Moreover, 1,000 beds (ten providers) of the UCH are also members of an association of private, profit-making health centres which was created in 1977 - the Catalan Association of Health Centres -, and which was ideologically close to the UCH.

The centres associated to this Catalan Association of Health Centres are all external to the HNPU. This association includes acute clinics - one of which contracts with the Catalan Health Service (CHS) -, socio-health centres - 12 of which have contracts with the CHS -, psychiatric centres - two of which have contracts with the CHS -, and several providers of intermediate products. In income terms, the relevance of this private sector stems from the fact that its total income amounts to seven percent of the Catalan Health Service's budget (see Table 3.3). This association has not have, though, any relevant role in the formulation of the Catalan health policy nor in the policy developments of the eighties and nineties. For example, they did not organise their first public cycle of conferences until November 1997, twenty years after their creation. The title of the conference spoke for itself: 'Private health: new horizons, new perspectives'. According to a top manager of this association, their main role so far has been that of an employers' association for the collective bargaining with unions. In the late nineties, though, they are developing several lines of action: institutional relations with the DHSS and with the CHS, with the Official Medical College of Barcelona, with mutualities,

insurance companies and individual professionals (which represent almost 90 per cent of their businesses), and with other providers. In this top manager's view, the basic difference between non-Social Security providers inside and outside the HNPU is that in the former owners do not risk their own capital, while in the latter they do. And the UCH tries to represent both these incompatible interests.

Table 3.3. Activity and resources of the hospital members of the Catalan Association of Health Centres*, 1996.

	Acute care	Chronic care	Psychiatric	Mixed	Total
Beds	2,351	1,070	1,511	355	5,287
Personnel	6,357	832	738	362	8,289
Average stay	4.25	163.65	157.39	20.38	11.47
Occupancy index	60.18	96.75	90.01	67.49	76.61
Rotation/bed	51.65	2.16	2.09	12.08	24.81
Income**	28,039,186	3,546,701	3,541,454	1,132,488	36,259,829

**Agrupació Catalana d'Establiments Sanitaris* (ACES).

Source: ACES (1997) *ACES informatiu*, nº2:6.

The UCH, the CHC and the Catalan Association of Health Centres act as employers' associations and conduct the collective bargaining affecting their members with the most representative unions of the sector (the UCH and the Catalan Association of Health Centres from their creation and the CHC since 1993-94). Nevertheless, the signing of regular contracts between the Catalan health authority and providers is bilaterally agreed between the authority (the Catalan Health Institute until 1990 and the Catalan Health Service from 1991) and each individual hospital. The DHSS has not accepted suggestions to do it otherwise, and the CHC and the UCH only participate in the definition of the model of contract and the financing model, leaving the negotiation of the individual contracts to the health authority and the individual providers themselves.

The explanation of this overlapping membership of hospitals between two organisations, the UCH and the CHC, which followed divergent policy orientations over the eighties requires analysing the origin and role of the latter, an equally relevant group, as well as the different set of costs and benefits facing it when defining a health system model.

b) Local governments and inter-governmental relations.

Whereas the UCH was and is an association of managers, the CHC is an association of political representatives of public providers (and semi-public providers) attached to local governments which, in the mid-nineties, started to include managers too. During the second half the 1970s, and after the first municipal democratic elections in 1979, some local governments assumed political commitments to improve local health services. This issue was a major demand by active and numerous neighbourhood associations and municipal movements during the Spanish democratic transition and the municipal electoral campaigns. Citizens' expectations about local democracy were high, and they viewed it as a key channel for facilitating the badly needed investments in infrastructure and management. Mayors, as political representatives, often presided in the governing boards of non-profit and charitable health trusts[53] and foundations which had a municipal or even supra-municipal area of influence for their services (see Table 3.4). By contrast, the large and high-technology Social Security-owned hospitals were concentrated in the provincial capitals and their area of influence.

In this context, the Department of Health and Health Care[54] of the pre-autonomous, provisional Catalan government (1977-80) actively promoted

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[53] A trust is 'money or property vested with an individual to administer in the interest of others. Trusts of this kind are usually set up to continue interests in accordance with the general instructions of the initiator and to protect them from outside interference and for tax reasons. Thus, people set up trusts or appoint trustees to administer their states after their death.' (Bannok *et al.* ,1992:429). In the case of Catalonia a number rich people left their heritage to the Church or to local authorities for the provision of hospital health care, from the middle age.

[54] The political head (*Conseller*) of the Department of Health and Health Care of the provisional Catalan government was a member of the communist PSUC, which, since the

meetings of managers and presidents (mayors) of these non-profit charitable hospitals to exchange information and to approach the situation of these hospitals. The political and institutional movement led by the concerned municipal governments elected in the 1979 municipal elections aimed to decentralise the health network model developed by the Social Security, and to achieve an equitable access to health resources by better distribution across the territory. This policy option involved the transformation of the existing local non-Social Security network into a publicly financed acute network, instead of enlarging the centralised Social Security model of health provision.

Table 3.4. Ownership distribution of hospital beds and centres in Catalonia, 1975.

	Hospitals		Hospital beds		Average hospital size
Ownership	**nº**	**%**	**nº**	**%**	**nº of beds**
Public total	*52*	*22.2*	*13,679*	*40.6*	*373*
Social Security	10	4.3	4,705	14.0	470
Municipal admin.	27	11.5	2,187	6.5	81
Provincial admin.	9	3.8	3,447	10.2	383
Other	6	2.6	3,340	9.9	557
Private total	*183*	*77.8*	*19,995*	*59.4*	*120*
Charitable found.	32	13.6	3,282	9.7	103
Red Cross	4	1.7	594	1.8	145
Other	147	62.5	16,119	47.9	110
Total	*235*	*100*	*33,674*	*100*	*247*

Source: DSAS (1980:118).

One of the first steps taken by local governments was to appoint managers and widen the representation of the different sectors of civil society in those hospitals' governing boards. These measures reflected the political will to modernise the management of health services by appointing professionals from

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first democratic autonomous elections in 1980, has been part of the opposition in the Catalan Parliament.

the private business sector (such as banking and industry) who could develop, for example, accounting systems, human resource management or information systems. In contrast to the case of the CHI, though, the introduction of private management techniques was facilitated by the fact that these providers had no organic or hierarchical dependence on the public administration and therefore had full autonomy of operations. This autonomy was purposefully reinforced as an alternative model to that of the CHI.

Between 1982 and 1984 these local government representatives had an acknowledged PSC-leaning according to all expert interviewees and to the municipal electoral map of the early eighties in terms of votes. But in this same period they decided to create the CHC, together with the hospitals involved, as presidents and hospital owners representatives of citizens. A top representative of the CHC recalled that:

> 'When we were about to create the CHC we analysed the possibility of being born inside the Federation of Municipalities of Catalonia and we decided not to do so, but to get organised autonomously and separately because by that time the municipal movement was undergoing a division between two associations: the socialists [PSC] and communists [PSUC] consolidated the Federation of Municipalities of Catalonia, while those of CiU created the Catalan Association of Municipalities, promoted by this party in the autonomous government. Therefore, in order to avoid this division we created the CHC autonomously because one of the features of our entity has been the unity of different political parties, or rather different mayors of different political parties for the defence of a decentralised, high quality hospital network.'

However, another top representative of the CHC and of the local council of Barcelona emphasised that the CHC was partly a tool for co-ordinating and giving technical and professional support to health care-member providers, but that it was also an interest group facing a new and closer administrative and political power - the Catalan government. Moreover, not only was the CHC an initiative of the local council of Barcelona (led by the PSC, in opposition in the Catalan Parliament), but also most of the initial local councils who became members of the CHC were PSC-governed, and in some cases PSUC-governed:

'The local council of Barcelona and the Municipal Institute of Health Care[55] created the CHC, which others then joined. The objective of the Consortium was to provide a networking field between local councils and the hospitals linked to them, through an organ which at that time was basically a mechanism of co-ordination and representation before the health authority. Moreover, it was done in a moment in which the health map of Barcelona had just been elaborated, in which there was the former health map of Catalonia, but in which also the Plan for the Reorganisation of the Hospital Sector was being discussed. That is, we wanted to have a voice, which was not the voice of the hospitals' employers' association - the UCH.'

Until that moment, the UCH had led the representation of the interests of both profit and non-profit non-Social Security hospitals in Catalonia, even from within the DHSS as internal staff. However, the prospective members of the CHC felt that the UCH could no longer adequately represent their interests as public owner and politicians, because the UCH were managers - and some of them from the municipalities' own hospitals:

'One of the conceptual differences between the UCH and the CHC is that we are owners that are moreover public, institutional owners and who are in these institutions as a result of municipal elections and are therefore endorsed by political parties. The UCH is an association of hospital managers, not owners, and thus, throughout their history, they have defended biased interpretations about the role of ownership and the role of the politician-owner and the role of the manager ... These were the differences which made us create a separate organisation. Because from 1979 to 1982-83 we see that the discourse, the role, and the concepts [which the UCH] defends do not represent our interests as owners of municipal public [health] resources in Catalonia ... At that time, the model of the UCH was an open clinic and ours was a closed, hierarchical hospital'.

Although the mayors in the CHC were the 'patrons' or 'bosses', the CHC did not undertake the role of an employers' association and let the UCH do the collective bargaining with professionals and unions until the early nineties, when the CHC decided that this role should be part of their responsibility. The reason for

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[55] This autonomous organism of the local Council of Barcelona was created in 1983 for the management of the municipal health services run by this local council. In its organisation and management it tried to avoid the CHI model, particularly the statutory, civil service- like regime of its personnel.

delaying the adoption of this responsibility was the political consequences and difficult situations which might derive from the exercise of this function.

The gradual implementation of the Autonomous Communities involved the assignment of exclusive competencies over the organisation of health to the Catalan autonomous government, which received the transfers of the Social Security health services in the early eighties (Manté, 1993). However, local governments continued to experience direct pressure from the population's demand to improve public health services. But the budgetary constraints of these municipal administrations and the unsustainable economic situation of those providers brought the improvement process into a *cul-de-sac*. Mayors did not want to lose control over those hospitals but they also wanted the Catalan government to assume financial responsibilities for remedying their economic, infrastructural and technological deficiencies.

Therefore, the actual distribution of resources among the relevant policy elite led to a *de facto* situation in which a co-operative strategy was a rational choice to make. That is, the autonomous government had the legitimate authority over health in terms of legislative and executive competencies, and the associated budget, which could be used either as conditional or unconditional incentives to shape municipal governments' policies. However, municipal governments had information concerning the existing health network derived from their direct involvement in those hospitals, and a reputation derived from their explicit commitment to the health issue and from the close - though very recent - relation with their municipality. And most importantly, the first democratic electoral map in Catalonia showed a split pattern of voting which gave the autonomous government level to the CiU and municipal governments and provincial administrations to the PSC. As a former top official of the DHSS put it:

'The distribution of political power in Catalonia between local government and autonomous government, the fact that the health resources, their ownership and management, were distributed between these spheres of political power, and the *savoir faire* of key leaders on each part (who in some cases have followed parallel political careers from lower to higher posts), are all factors which partly explain the development of a consensus and the culture of negotiation. They have similar problems - both have responsibilities over the health sector, [so] co-operation was the best strategy. The diversification of management forms and the introduction of private law has also been carried out by

> the PSC in the municipal government of Barcelona ... Therefore, in actual fact, they are not that different.'

Between 1982 and 1984 the constraints on health expenditure by the central government had a corresponding impact on the investments and hospital contract tariffs in the health sector in Catalonia, leading to a crisis situation. The CHC suggested the possibility that the Catalan government should assume the management responsibilities that local governments had been exercising without having either the legal competencies to do so or sufficient financing. The conflict of interests derived ended up in a debate in the Catalan Parliament which represented a turning point. The Catalan government asked local governments to continue exercising such managerial responsibilities under a commitment not only to finance the reform of the network but also to get directly involved in the creation of consortia with local governments for the governance of the system. With the improvement of the economic situation in 1985-86, the Catalan government committed itself to the creation and consolidation of these network of supra-municipal medium and small size hospitals. Key steps were the creation of the HNPU, the Plan for Hospital Reorganisation, the creation of consortia, and new investments and contracting and payment systems. All these steps attracted the active collaboration of both the UCH and the CHC.

Therefore, throughout the eighties there was the definite will - both on the part of the municipal and autonomous governments - not to enlarge the centralised public sector structure characterising the Catalan Health Institute (CHI), nor its form of (direct) management and organisation. Instead, the option was to reinforce the existing network of non-Social Security (non-CHI) providers, particularly those which were non-profit organisations, and which had private forms of management. Thus, in the mid-eighties an expansive process of investments was initiated in order to rehabilitate those hospitals and create a network of acute care. Until that moment, those hospitals had held contracts with the Social Security for covering the provision of health services where the Social Security administration had not built providers of its own. These contracts were not meant to substitute but to complement Social Security provision. But in fact, these providers were substituting the Social Security provision as in most areas of Catalonia such services were scarce or non-existent. This led to an insufficient financing and led many of those non-Social Security providers either to disappear or to become centres for chronic

patients or for elderly people. Both this insufficient financing of contracts and also the gradual improvement of the Social Security health services had led those providers into de-capitalisation. The investment programmes subsequently developed were accompanied by a gradual movement of health professionals from the large and complex Social Security hospitals concentrated in Barcelona, and province capitals, to those smaller local hospitals which were being rehabilitated and transformed into basic reference centres of a territorially expanded network. These professionals brought with them expertise, qualifications and the will to develop professional practices learnt in the Social Security centres.

The re-conversion and consolidation of this network of basic or general medium and small size hospitals, as opposed to a capital city-based, large complex organisations of the Social Security administration, was based on an intense process of reorganisation of resources through collaboration mechanisms. Different forms of collaboration between the DHSS and these existing providers involved, in some cases, the contribution by the DHSS of the infrastructure and the assignment of its autonomous management and organisation to the existing provider/s in the area. This strategy was a way to co-ordinate and unite tangible and intangible resources (infrastructure, budget, managerial know-how, knowledge of local conditions), and to create a sense of identification of the population with a hospital - which was not built from new but from the re-organisation and re- enforcement of the existing centres.

In this context, consortia were conceived of as a tool for achieving consensus. In the mid-eighties the Catalan government and some local hospitals together with their respective local governments launched several initiatives for rationalising, co-ordinating and integrating health care resources which were in deep economic difficulties, or in bad need of investments. They had originally developed at the margin of any health sector planning, leading in some cases to destructive competition in overcrowded areas. The fact that there is a lack of a general regulation of consortia as a legal form has facilitated the introduction of private management instruments in the public health services and the consolidation of a model of management alternative to that of the Social Security health services, which characterises the CHI and most of the Spanish health sector. The flexibility of this legal form stems from the present legal framework defining it as a formal coverage for a wide variety of activities, allowing in each case the most suitable organisation and legal operating regime (Lafarga, 1994). Significant innovations

derived from this flexibility were the introduction of administration boards with representation of the plurality of owners rather than relying on a single manager head of a hierarchy, and a more participative definition of operational programmes by professionals. As for personnel policy, the contractual relation developed was that of a general labour market regulation instead of the civil service employment regime. Finally the creation of consortia facilitated the economic and financial recovery of those providers (SCS, 1995a).

Following the objective of promoting the diversification of management and organisational forms in the provision of health care, in the late eighties and the early nineties there was a proliferation of forms other than consortia which do not require the consensus of different administrative levels and institutions. Instead these new forms - namely anonymous societies and autonomous institutes - involve either the creation of new organisations or the subdivision of parts of an existing organisation into product-oriented smaller units, whose operations are then subjected to private law and private management techniques. These forms were developed in both the CHI and non-CHI providers.

From the early nineties the CHC also consolidated itself as an association providing technical services to its members, as a think-tank for the diffusion and training in new management techniques, and as an interlocutor of the autonomous administration. The CHC also diversified its structure creating a group of service enterprises (consulting, supply of health intermediate products) in order to professionalise the services offered to its members and to improve the quality of final (care) services to patients. This new role was also accompanied by a closer collaboration with the Catalan autonomous administration, which was at the base of the consensus achieved in the whole reform process of the late eighties and nineties. Nevertheless, according to this same informant (who has himself been a leading interlocutor of the DHSS from the late seventies), collaboration was facilitated by a relatively unusual political stability:

'As for this existing consensus in Catalonia, there is an important fact which is the people who have been at the front of the organisations. There has been leadership, there has been continuity, there has been intelligence for accepting negotiation instead of confrontation. First we have something unusual and it is not me who defends it, but we have continuity in the autonomous government since 1980 - the same party, same president, and basically the same people in health. Mr. Xavier

> Trias[56] was already there [in the DHSS] during Mr. Laporte's[57] period, though in lower posts, and then he was *Conseller* until 1995. But even now [two years later], in the background, there is this same person. Thus, knowing who your interlocutor is year after year ... is very important because eventually there is friendship and you get to know one another. I do not know if this is good for the democratic system that there is so much continuity, but this is a fact which moreover has created leadership. Second, we have promoted consensus by creating the CHC separately from both the Federation of Municipalities of Catalonia and the Catalan Association of Municipalities, thus avoiding the division between political parties over health issues[58]. Here [in the CHC] the presidency is renewed every four years, thus changing political colour so that everybody feels comfortable.'

In this respect, the composition of the directive board of the CHC reflected both the continuity of leadership figures and changes in the municipal political map represented through its mayors, as did the CHC permanent commission which was formed by hospital managers. Thus, by the late 1990s the CHC no longer only represented owners. Moreover, the owners and managers representatives in the CHC did not usually belong to the same hospitals and some managers were UCH members. All this reflected not only the constant undergoing negotiation processes, but also, the increasing links with the UCH, from which they had distanced themselves throughout the eighties. These renewed links with the UCH involved, first, that the owner and the manager of a hospital might belong to the CHC and to the UCH respectively and even the manager might belong to both of them. Second, this link pattern was reproduced at the top of the directive board of both organisations from 1995. Third, top members of the new directive board of the UCH had been trained within the CHC and shared their core views on the hospital model and on the role of the public owner and the managers and their relationships. As a leader of the CHC put it:

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[56] Mr. Xavier Trias was *Conseller* of the Department of Health and Social Security of the Catalan Government from 1988 to 1995, and from 1995 is *Conseller* of the Department of the Presidency of the Catalan Government.

[57] Mr. Josep Laporte was *Conseller* of the Department of Health and Social Security of the Catalan Government from 1980 to 1988.

[58] The Federation of Municipalities of Catalonia is considered to be socialist-leaning, while the Catalan Association of Municipalities is considered to be CiU-leaning.

'Until the mid-nineties the discourse on the public ownership *versus* the civil society reflected our discrepancies. When the historical leadership of the UCH gave way to this new directive board the discourse on ownership is left aside and the discourse on management becomes the main core of the reforms. And it is here that we all agree. Even more when in the consortia directive boards there are representatives of that civil society [that is, private actors].'

According to a former high official of the DHSS, the development of a common frame of mind was a key feature of both the institutional and the non-institutional policy elite. Thus, the consensus which has characterised the Catalan health policy throughout the eighties and in the definition of the Catalan 'model' of health care after the passage of the 1990 LOHC, may be partly explained by the disposition, frame of mind, political ability, and the long leadership incumbency of the core of the policy elite. This elite included the Catalan government, the DHSS, politically relevant local governments of large and medium size municipalities, and the leaders of the UCH, and of the CHC. A former official of the DHSS expressed that:

'The political ability of the *Conseller* has led him to give relevant offices to sympathisers or even members of the socialists, as hospital managers, or within the Department. Or, if he did not give them posts, he, the Department, has been wise to give the local council of Barcelona and its political representatives enough leading role and enough weight for them to feel that they were also collaborating or participating in the design of a model ... [Mr. Xavier Trias] is a very clever politician and he has been wise to get health out of the everyday political battleground. And he has been wise to give a role to the different groups, not only political, but also corporatist - I am thinking of the Official Medical College of Barcelona - and within CiU itself [the Catalan nationalists] to people of CDC and of UDC[59] of different branches. He has known how to keep everybody a bit happy, and how to give everybody a share of leadership role and participation.'

However, a different view was taken by a representative of the minority communist-leaning PSUC (member of the coalition Initiative for Catalonia or IC) which has not shared the consensus:

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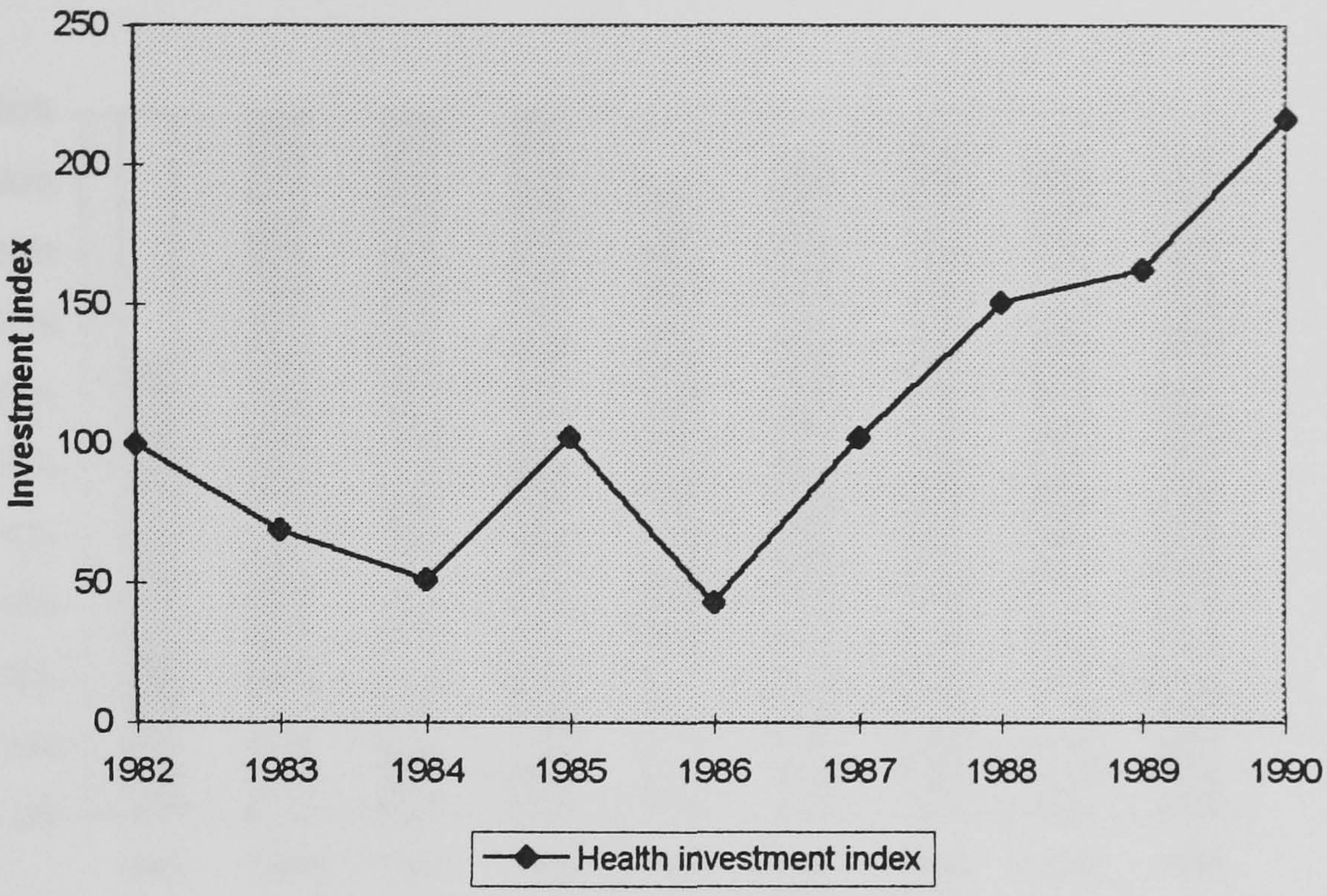
[59] CiU is a coalition formed by two political parties: CDC (Democratic Covergence of Catalonia) is the largest member in terms of parliamentary members and votes of the CiU coalition. The other member is UDC (Democratic Union of Catalonia).

'This model of creation of consortia and of appearance of new health provision agents generates the emergence of a managerial elite which can be shared by two large political organisations. And depending on where one is, and in order to preserve one another, they end up frustrating the progressive thinking of one's or the other's. I think this is what has happened ... Also, the managers of the contracted hospitals of the HNPU which are in progressive administrations - socialists, communists before and IC now, or of leftist alliances - to the extent that the contracts with the CHS through the HNPU are absolutely vital for their survival, they cannot even think about critique ... They depend on one another ... As everybody depends on the contract nobody dares criticise the system this is the benevolent explanation. The malevolent explanation would be: they have created a managerial elite who, regardless of the political colour each one has, is interested in ensuring that everything remains the same, and the more new agents there are the more managerial posts there will be ... And it is much more pleasant to have a managerial post and get paid a lot of money than to have a clinical post and get paid what a doctor gets paid - which is relatively little in the public sector.'

c) Distribution of resources and activity.

The public investment effort made in the Catalan health sector over the eighties is reflected in its indexed representation in Figure 3.2. Setting the public investment made in the health sector at 100 in 1982 (the base year), it appears that by 1990 the budget share spent on this sector had more than doubled. The first half of the eighties showed a declining investment trend in the sector reflecting the general economic crisis which affected Spain and which by extension had also a negative impact on the financing of health. The increasing investment effort of the second half of the decade was only halted and reversed in 1986, when the level fell even below the lowest rate, registered in 1984.

Figure 3.2. Evolution of total investment in health care in Catalonia by the corresponding health authority*, 1982-90 (indexed 100 in 1982).



*Between 1982 and 1983 the financing health authority was the Direction General of Social Security Health Services, from 1984 to 1990 the Catalan Health Institute, and from 1991 to date the Catalan Health Service.

Source: Own elaboration based on DEF (1982, 1983, 1984, 1985, 1986, 1987, 1988, 1989, 1990).

As Figure 3.3 shows, the largest part of these public investments were made in the hospital sector, including both CHI and non-CHI providers[60]. Reform of primary care started in the mid-1980s, following the same model of the rest of the Spanish NHS and allegedly required important investments in infrastructure. Primary care did receive increasing investments in the early 1980s, but its share stabilised in the second half of the decade. This distribution of resources, which allocated an average of 63 per cent of investments between 1983 and 1990 to the hospital sector, not only indicates the higher costs involved in hospital infrastructure and technology in comparison to that of primary care, but also the clear commitment of the relevant health policy elites to revitalise the existing hospital resources and to create a hospital network which was territorially balanced and close to citizens[61].

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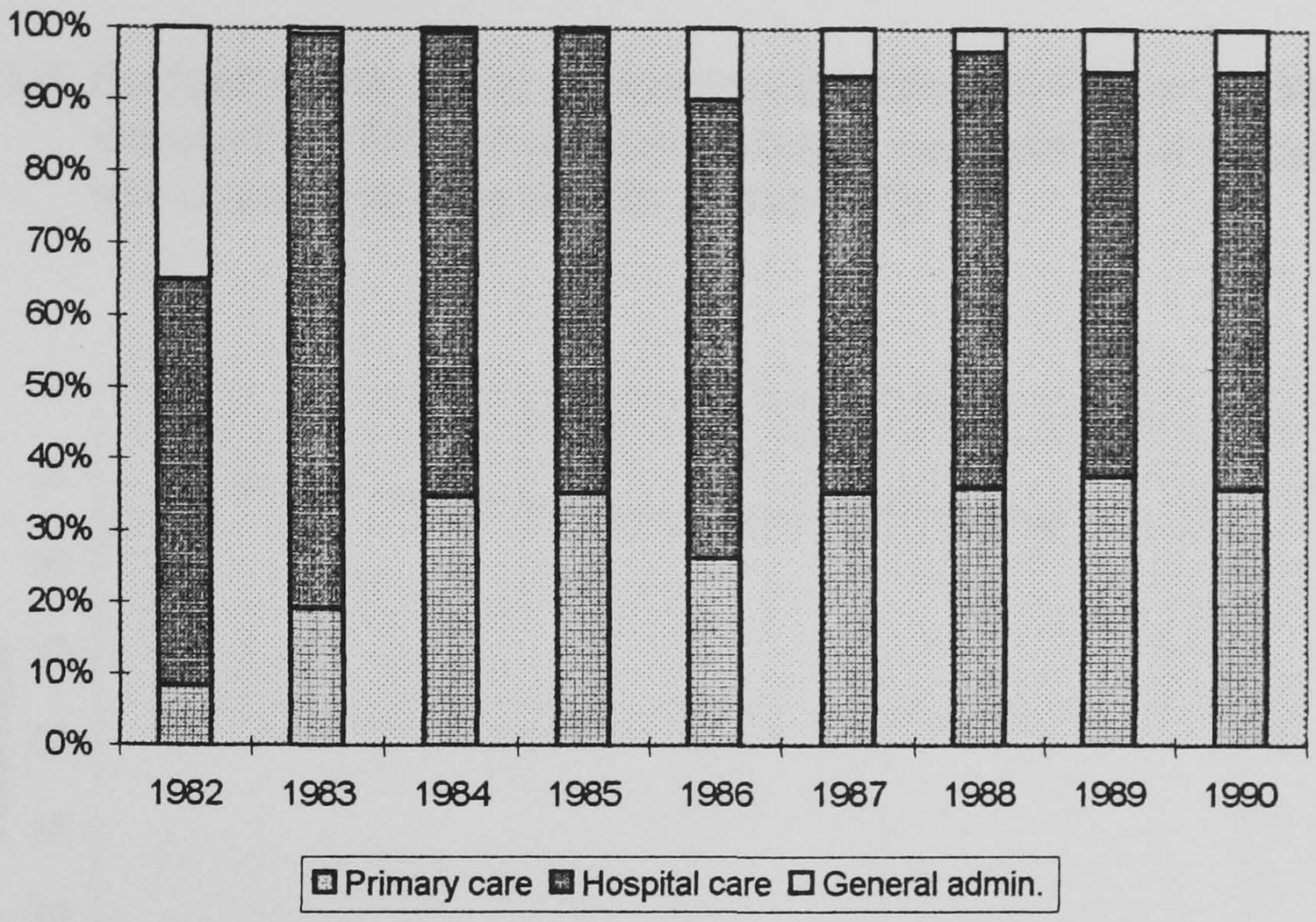
[60] The data published by the DEF do not reflect the disaggregation of recipients of investments into CHI and non-CHI providers.

[61] For a more detailed disaggregation of these data see Table A.5 in Appendix 1.

Figure 3.3. Distribution of investments* in the Catalan health sector, 1982-90 (in percentages over total investment by the corresponding health authority).



*Investments include real investments in and capital transfers to both CHI and non-CHI providers.
NB: From 1982 to 1984 there is no item classified as 'investment in general administration', but as 'other', and it included urgent investment programmes for infrastructure and equipment, prices review and other (the first of them being very important in 1982).

Source: Own elaboration based on DEF (1982, 1983, 1984, 1985, 1986, 1987, 1988, 1989, 1990).

The evolution of the total health budget share spent on contracts with non-CHI hospitals and primary care centres for the provision of public health services remained relatively stable throughout the 1980s - representing an average of 33.4 per cent of the budget of the corresponding health authority[62]. Only in 1989 did a clear increase start. This change of trend, though, reflected the increase in the budget share spent on contracting with non-CHI hospitals: the budget share spent on contracting with non-CHI primary care providers sharply diminished in 1989 (see Figure 3.4). While this change in the late eighties represented an increase of nearly ten points in the budget share spent on contracts with non-CHI hospitals, in the

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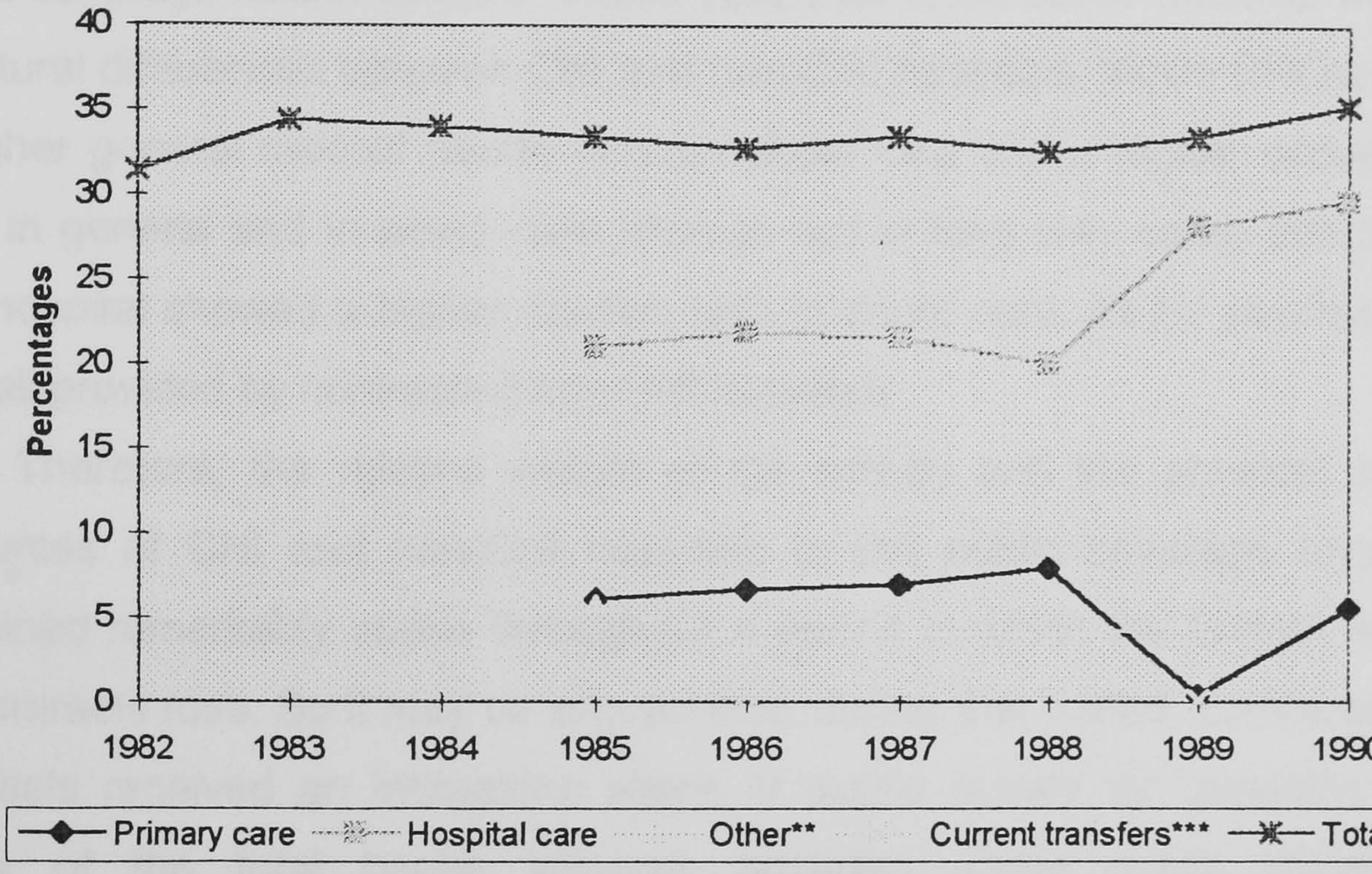
[62] If this calculations are made over the total budget of the DHSS of the Catalan government the share spent on contracting with non-CHI providers is higher and shows a more steep increased. For a more detailed disaggregation of these data see Table A.6 in Appendix 1.

case of primary care it represented a decrease of nearly eight points from 1988 to 1989 followed by an increase of nearly six points by 1990.

Figure 3.4. Budget share spent on contracts with non-CHI providers in Catalonia, 1982-90 (in percentages over the total budget of the corresponding health authority*).



*Between 1982 and 1983 the financing health authority was the Direction General of Social Security Health Services, from 1984 to 1990 the Catalan Health Institute, and from 1991 to date the Catalan Health Service.
**Specialists services and other, in 1989 it also included haemodialysis.
***To families and non-profit organisations (one-off regulatory payments, prostheses, vehicles for handicapped patients and other).

Source: Own elaboration based on DEF (1982, 1983, 1984, 1985, 1986, 1987, 1988, 1989, 1990).

Although the evolution of the budget share spent on contracts with non-CHI providers shows a clear increase in 1989 and 1990 for the hospital sector, the relative weight of the physical and human resources and activity of CHI and of contracted non-CHI hospitals within the health system of public coverage remained remarkably stable between 1987 and 1990, when the increasing trend in the budget share spent on contracts was reinforced. As Tables 3.5 and 3.6 show, the indicators of the general resources and activity of CHI and of contracted non-CHI

hospitals and the indicators concerning acute and psychiatric care reflect little variation throughout the period. For example, activity indicators such as discharges and stays remained around 27 per cent for the CHI and 63 per cent for contracted non-CHI hospitals throughout all the period. Only in the cases of emergencies, discharges paid by the Social Security and outpatients visits did the variation involve more than one percentage point (2.9, 2.8 and 2.5 points respectively). By contrast, in the case of long stay care a clear general decrease was apparent in the relative weight of the CHI physical and human resources and activity within the public coverage health system. These data also show some features which reflect structural differences between CHI and non-CHI hospitals. While CHI hospitals had a higher general ratio of health personnel per bed and a higher occupation ratio both in general and in acute care (though not in long stay care),. contracted non-CHI hospital showed a higher rotation ratio in acute care. As for psychiatric care, it was all provided by contracted non-CHI hospitals.

Therefore, the relative weight of the activity and the physical and human resources of CHI and non-CHI hospitals in the public coverage health system remained remarkably stable throughout a period in which the budget share spent on contracts rose. So it may be argued that, during that period, contracted non-CHI hospitals received an increasing share of public money for providing the same share of the total health services provided under public coverage. This interpretation may support key informants' argument that the policy option to create a heterogeneous hospital network based on the existing resources required not only large investments, but above all that the contractual system redressed the historical underfunding of the contracts which the Social Security administration signed with non-Social Security (non-CHI) providers. Considering non-CHI hospitals as substitute rather than complementary providers of publicly financed services necessarily involved reducing the comparative disadvantage of non-CHI providers in the financing of the public services which they provided.

Table 3.5. CHI hospital resources and activity, in percentages over total CHI and contracted non-CHI hospital resources and activity for acute care in Catalonia, 1987-90.

	1987	1988	1989	1990
General				
Hospitals	18.9	17.6	16.7	15.2
Beds*	27.2	27.1	26.4	26.4
Total personnel	36.1	36.9	36.4	35.9
Health personnel	35.0	35.5	35.0	34.4
40 h. health personnel**	37.0	38.0	37.0	36.3
Discharges	27.5	28.9	27.3	26.8
Stays	26.9	27.0	27.9	27.1
Outpatient visits	19.1	22.9	22.1	21.5
Emergencies	26.0	24.9	24.5	23.8
Discharges paid by Soc. Sec.	29.0	30.3	28.6	28.7
Running costs	36.9	37.3	36.9	36.5
Income	38.5	38.6	38.6	38.0
Health personnel/bed	*2.0*	*2.2*	*2.2*	*2.3*
Occupation ratio	*79.0*	*81.7*	*86.2*	*82.5*
Soc. Sec. dischar./Total disch.	*93.9*	*94.0*	*93.2*	*93.2*
Acute care				
Beds	28.5	28.2	27.9	27.7
Discharges	27.5	28.8	27.5	26.9
Stays	28.4	28.6	29.7	28.6
Occupation ratio (%)	*79.1*	*81.6*	*86.2*	*82.6*
Rotation ratio	*28.7*	*31.6*	*30.8*	*31.1*
Average stay	*10.1*	*9.4*	*10.2*	*9.7*
% over total stays	*97.4*	*96.9*	*99.3*	*99.2*
Long stay care				
Beds	11.2	12.5	3.3	5.0
Discharges	33.1	52.8	9.0	10.1
Stays	9.4	11.4	3.2	4.1
Occupation ratio	*75.7*	*84.6*	*89.6*	*73.4*
Psychiatric care				
Beds	0	0	0	0
Discharges	0	0	0	0
Stays	0	0	0	0

*Includes incubators.
**Personnel weighted at a timetable of 40 hours a week.

Source: DSSS (1994c): 112, 113.

Table 3.6. Hospital resources and activity of contracted non-CHI hospitals for acute care services, in percentages over total CHI and contracted non-CHI acute hospital resources and activity in Catalonia, 1987-90.

	1987	1988	1989	1990
General				
Hospitals	81.1	82.4	83.3	84.8
Beds*	72.8	72.9	73.6	73.6
Total personnel	63.9	63.1	63.6	64.1
Health personnel	65.0	64.5	65.0	65.6
40 h. health personnel**	63.0	62.0	63.0	63.7
Discharges	72.5	71.1	72.7	73.2
Stays	73.1	73.0	72.1	72.9
Outpatient visits	80.9	77.1	77.9	78.5
Emergencies	74.0	75.1	75.5	76.2
Discharges paid by Soc. Sec.	71.0	69.7	71.4	71.3
Running costs	63.1	62.7	63.1	63.5
Income	61.5	61.4	61.4	62.0
Health personnel/bed	*1.2*	*1.3*	*1.4*	*1.5*
Occupation ratio	*80.4*	*81.3*	*79.9*	*79.8*
Soc. Sec. dischar./Total disch.	*87.1*	*87.9*	*87.9*	*84.9*
Acute care				
Beds	71.5	71.8	72.1	72.3
Discharges	72.5	71.2	72.5	73.1
Stays	71.6	71.4	70.3	71.4
Occupation ratio (%)	*79.3*	*80.1*	*78.9*	*79.0*
Rotation ratio	*30.1*	*30.7*	*31.5*	*32.3*
Average stay	*9.6*	*9.5*	*9.2*	*8.9*
% over total stays	*90.2*	*90.2*	*90.7*	*92.1*
Long stay care				
Beds	88.8	87.5	96.7	95.0
Discharges	66.9	47.2	91.0	89.9
Stays	90.6	88.6	96.8	95.9
Occupation ratio	*92.1*	*94.4*	*93.3*	*92.0*
Psychiatric care				
Beds	100	100	100	100
Discharges	100	100	100	100
Stays	100	100	100	100
Occupation ratio	*82.0*	*86.7*	*76.0*	*84.4*

*Includes incubators.
**Personnel weighted at a timetable of 40 hours a week.

Source: DSSS (1994c): 112, 114.

3.2. The power of the medical profession.

The Official Medical College of Barcelona (COMB) is the main medical professional body in Catalonia. Its leading figures stressed that its relationship with the health administration in the late 1990s followed two different channels - formal and informal. The COMB formally participated together with other organisations in the directive and participation organs of the new health authority - the Catalan Health Service -, as provided by the 1990 Law for the Organisation of Health in Catalonia (LOHC). In these meetings, the administration presented projects and listened to the view of the rest of members. The COMB's view was that the administration did not have the will to make a forum of debate and discussion out of these formal meetings, but instead used them as a place to cover formalities and avoid conflict. However, the COMB did not try to change this dynamics of relationship at this level even though they thought it was not very constructive. The reason was that another channel of bilateral and informal interrelation with the administration was available and had proved more effective and flexible. The COMB resorted to direct contacts with top officials of the health administration for dealing with specific problems affecting the different sectors of the medical profession whom they represented. The COMB found in the administration a satisfactory predisposition to discussion and a will to find agreed solutions, so they did not consider it necessary to try and change the rules of the game.

The COMB leadership feel that their organisation has not been an actor consulted on a regular and relevant basis concerning the policy options taken throughout the eighties in the Catalan health policy. Only after professional organisations built up their legitimacy long after the democratic transition did they gain a role as interlocutors of the different administrations with health competencies - though not on a regular basis. The professional organisations' difficulties in re-gaining legitimacy after the democratic transition of the late seventies in Spain may by illustrated by the case of the Spanish body of official medical associations - the Collegial Medical Organisation. The creation of this organisation during the Franco regime was conceived as a mechanism for the political control of the profession. By imposing compulsory affiliation and endowing it with a high degree of control over the design and operation of the Social Security

health system which was being created, the Collegial Medical Organisation became a tool for suppressing potentially divergent ideologies within the profession or any conflict with the state, for which the Collegial Medical Organisation actually worked (Rodríguez, 1994, 1995:153). Thus, after the democratic transition the public corporative status of this organisation was openly questioned, as much by the government as by the profession. As Rodríguez (1995:154-5) explains, while the Collegial Medical Organisation struggled to re-define its role as the representation of medical interests, other organisations emerged as alternative articulation mechanisms. Thus, on the conservative side, the Spanish Confederation of Medical Unions was founded as a profession-based union, for the defence of work-related interests. With a leaning towards the Collegial Medical Organisation, it defended the reinforcement of the liberal profile of the profession and the extension of the private market. On the leftist side there emerged the Federation of Associations for the Defence of Public Health. Sharing arguments with the class-based unions CC.OO and UGT (communist and socialist leaning respectively), it defended a socialised, public health system.

While this political fragmentation of the representation channels of the medical profession at the Spanish central government level aggravated the problems of interest articulation and the profession's relationship with the government, parallel and different legitimisation processes developed in Catalonia. Contrary to the assertion that the COMB has not been a relevant actor in the health policy in Catalonia, a former senior official of the DHSS contended that:

> 'There might be the impression that the *Conselleria* has never consulted them for any relevant decision and that therefore they have not been a relevant actor. But what I can say, having been inside, is that what the COMB might or might not say was very much taken into account. Second, many of the appointments within the *Conselleria* over the past years have been people of their liking or well linked to them [to the COMB]. In a way, when somebody is appointed to a directive post in the *Conselleria* they do not only look for somebody who can do a good job, but someone who also has good relations with the COMB, or with the personnel of the local council of Barcelona if the job so requires ... The COMB has always had within the *Conselleria* someone with whom they had a good relation or whom they had in good consideration, or who had been a member of the COMB's directive board ... And there has been some exchange of people going from the *Conselleria* to the COMB and from the COMB to the *Conselleria*.[63]'

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[63] All the *Consellers* of the DHSS of the Catalan government so far have been doctors, as well as the President of the Catalan government, who has been the same person since its

A long-standing issue in contention between the COMB and the General Council of Medical Colleges (representing all province-based official medical colleges in Spain) stemmed from the transfers of health competencies to Catalonia and was not settled until 1994 (COMB, 1994a). The COMB claimed that the new distribution of health competencies required a more relevant role for the province-based official medical colleges of Catalonia and for the corresponding Medical Council of Catalonia. This more relevant role implied keeping a higher proportion of the membership fees from those collected by the General Council of Medical Colleges. The settlement of this dispute involved an agreement between the COMB and the General Council to jointly decide on the share to be kept by the official associations in Catalonia.

Formally, the COMB has no political affiliation. Its main objectives concern the defence of professional ethics, of the quality of the health services provided by its members, and of the rights of professionals[64]. In the celebration of its centenary in 1994, the COMB president insisted on its role as an example of the dynamic civil society of Catalonia and its commitment to the defence of the Catalan identity[65] (COMB, 1994a; *La Vanguardia*, 1/10/94; *Avui*, 2/10/94). However, this claim is ubiquitous among almost all the Catalan political forces, so, in principle, it shows no explicit party-leaning. However, according to a survey conducted in 1997 a third of the member doctors of the COMB declared not to have any political ideology or affiliation. Among the rest, the majority felt closer to CiU[66]. In the view of a COMB leader:

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first incumbency in 1980.

[64] The foundational objective of the COMB was to clearly define the boundaries of the profession and to fight intrusiveness from other sectors. In the third decade of this century the COMB impulsed the creation of a medical union in Catalonia for the defence of the labour rights of the medical profession. In the late francoism and the democratic transition the COMB took part in charitable activities. Presently, the defence of the rights of the medical profession focus on the development of a professional ethics, the definition of the civil responsibilities of professionals before the judicial system , and the negotiation with mutualities about the remuneration of professionals (COMB, 1994a).

[65] An indicator of the perception of this defence role is that the Catalan government awarded the Saint George's Cross to the COMB in 1994 (COMB, 1994a).

[66] This information was given by a top representative of the COMB. The results of this survey were published but the questions concerning the political ideology of the COMB members were not published (EIPO, 1997).

> 'This leads to the directive board [of the COMB] being a bit of a reflection of this. The board comes out of an election and it is logical that the doctors who do have a specific political leaning vote for people who are, let's say, closer to this same political position - even though this is never used in the electoral campaign for gaining access to the directive board. For example, I am affiliated to CDC from 1977 - this is public and everybody knows it. Therefore, if they vote for me it is because this does not bother them and there is not any critical opposition. I do not think they vote for me because of this - they may vote for me for other things, but as a matter of fact, this gives the directive board of the COMB a leaning towards the orbit of CDC - though unintentionally. But I do not exercise as an affiliated member here and therefore I would say this does not introduce any distortion. There is good personal understanding with the [Catalan] government and the *Conseller* of health of CDC, which facilitates rather than hinder things.'

The COMB has also established collaboration links with other professional organisations in the health sector, with mutualities, unions, public and private health providers, and with insurance companies. These links involve the organisation of conference cycles, seminars and training courses, as well as financing and other purpose-led collaboration. Thus, it is not only the official medical college of compulsory membership for the profession but also a forum of debate, a think-tank, and a provider of services for the health sector.

In contrast to other interest organisations which undertake the representation of relatively homogeneous collectives - such as class-based unions or sectoral organisations - the COMB has the formal monopoly of interest representation of the whole medical profession in Barcelona, which is heterogeneous in terms of labour market prospects, working conditions, and which, accordingly, shows mixed preferences over health system and organisation. However, the COMB's directive board showed a clear preference for introducing management reforms on the line of facilitating the involvement of professionals in management, and bringing in forms of organisation and service provision closer to that of a liberal profession.

The interests of the medical profession condition their support for the COMB and are to a great extent dependent on their labour situation. The data available on this variable come from two surveys conducted in 1994 and 1997, which showed a divergence which appears too remarkable to have developed within a three-year period - which is why they should be taken as indicative. According to the 1994

survey[67], 30 per cent of the medical profession had more than one professional activity, while according to the survey conducted in 1997[68] nearly half the medical profession (48 per cent) has more than one professional activity. Both surveys found that those who tended to have only one activity as a salaried employee were predominantly women, non-specialists and the youngest sections of the profession. Those who tended to combine more than one activity were predominantly men, specialists and over 40 years old - who are the elite of the profession. Finally, the 1994 survey found that nearly three quarters of professionals were employees and the rest practised as liberal professionals, whereas the 1997 survey found that only half the professionals exercised their profession as employees, while the rest were either liberal professionals in private practice (19 per cent) or combined both situations (31 per cent).

The analysis of the 1997 survey focused more on trends. It showed that the youngest members of the profession tended to gradually depend more on organisations for the exercise of their profession - and to be characterised by greater job insecurity or relative precariousness in comparison with previous decades, whereas the private practice sphere tended to diminish. Those who were only employees are so in the public sector. However, this gradual dependence of professionals on organisations involved mainly dependence on non-Social Security providers. These doctors consequently hold labour-market contracts instead of working in statutory, civil service-like regimes (EIPO, 1997). These trends were interpreted by the authors of the survey as a reflection of the mechanisms used by the profession to adjust to the historical process of building an organised public health system based on an employer-employee contractual relation, while trying to preserve the organisational forms of the liberal exercise of the profession.

In the survey responses the medical professionals said that they received most satisfaction from the service they provided (helping the others) and from the exercise of the whole content of the profession itself. By contrast, dissatisfaction

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[67]This survey was carried out by EMB-Yankelovich and by the COMB, which also sponsored it. It was published in COMB (1994b). The sample surveyed had 600 individuals of a population of 21,000 individuals. The sample was stratified and randomised.

[68] This survey was conducted by the Research Team on Professions and Organisations of the Department of Sociology of the University of Barcelona, directed by J. Rodríguez, and sponsored the COMB. The sample surveyed had 500 individuals, who were selected through a stratified and random process. This sample was representative of a population of 21, 549 individuals (doctors members of the COMB).

derived from factors over which they had no control: the saturation of the medical labour market (leading to high unemployment and job insecurity), low wages, unsatisfactory career development, lack of incentives, bureaucratisation and impersonal professional-patient relations. Thus gradual 'proletarianisation' was seen as the source of their discontents as the progressive loss of autonomy in decision-making. Lack of control over organisational, technical and ideological aspects of their job situation were the main problems, rather than the mere fact of being employees.

Nevertheless, despite the high percentage of the profession dependent on the public sector, only 30 per cent thought that the solution to this problem should come from the public authorities. Instead they should come from the profession itself, with possible solutions involving recovering the organisational, value system and technical control over their organisations - 81 per cent thought that hospitals should be managed by doctors who are adequately qualified to do so. Moreover, 78 per cent would prefer to work in smaller and more simple organisations (small professional teams) - instead of large complex ones or individual practice. Public institutions were the preferred context for exercising their profession for 51 per cent of respondents, institutions of professional ownership for 27 per cent, and private institutions for 22 per cent. Accordingly the preferred model for organising the health system was universal public coverage with complementary private health for 50 per cent of the profession, followed by a mixed model for 40 per cent. Only seven per cent defended an exclusively public provision and under four per cent defended an all-private health system. The high technical and clinical quality and the social and the re-distribute goals of the public sector were the base for this preference, because they enabled professionals to meet patients' needs better.

The demand for a new organisation and management setting expressed by the medical profession was part and parcel of a legislative initiative fostered in the mid-nineties by the COMB. Leaders of the organisation asserted that while the role of this professional organisation was not at all relevant in the formulation process of the 1990 LOHC, it was decisive in its modification in 1995 (see Chapters 5 and 6). The reason was that while the LOHC was mainly concerned with separating the functions of financing and provision as a basic organisation principle for the whole system, the 1995 modification directly focused on management forms which could give a more relevant managerial role to doctors within their own organisations. It established the possibility for professionals to create enterprises and anonymous

societies and contract with the new health authority created in 1991 - the Catalan Health Service or CHS - for the provision of primary care. The COMB was so committed to this project that it even created a foundation for financially collaborating with these private associative teams[69] (*El País*, 15/2/95, 21/9/95, Barcelona edition).

Thus, the initiative in 1995 to modify the LOHC and introduce the possibility of self-managed primary care teams opting out of the CHI was first put forward by the COMB. In fact, a top representative of the COMB declared to *El País* (14/2/95; 15/2/95, Barcelona edition) that they had been working on the project for the previous three years. According to this report, the project was conceived of as a by-pass to the primary care reform launched in 1985, which in Barcelona had only reached 25 per cent of the population. The main reason was that this reform was made dependent on doctors being willing to be integrated in Primary Care Teams, where, among other aspects, their working hours would rise from two to six a day. In Barcelona, where the combination of public and private practice of the profession is most relevant, the reform had come to a standstill. Thus, it seemed an attractive possibility to create enterprises or anonymous societies where doctors have managerial responsibility and freedom - within the economic allocation set in the contract signed with the CHS - as well as the potential to keep any surplus.

However, while one such pilot experience was started in 1996, no other of its kind has been tried (see Chapter 6). The COMB believes that the fact that this line of reform seems to have been halted stems from the administration not being willing to expand it. A leader of the COMB asserted, though, that the COMB has not received any explanation from the administration which could show they have any conceptual or ideological disagreement at all with the basic principles of this form of management apart from 'it is too complicate, it costs a lot'. In the COMB's view the administration has not facilitated the expansion of this model because it involves losing control over management decisions and over professionals, who thus escape the administration's authority by getting closer to the private practice model of the liberal profession. Some people in the COMB argued that the

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[69] The president of the UCH strongly criticised the initiative of the COMB to give financial support to these new providers that might emerge, as well as the privileged treatment the DHSS provided for them in the 1995 bill - reservation of the statutory place for three years. According to the UCH this was unfair competition for those providers which did undertake risks (*El País*, 1/2/95, Barcelona edition).

involvement of health professionals in the management of health centres should not only apply to primary care in the form of self-management, but also within hospitals, by giving professionals more autonomy to manage resources and a consequent direct responsibility for the use they make of them. A suitable organisation for the development of integrated services processes could be the support for such distribution of responsibilities - which should involve some sort of financial incentivisation.

3.3. The role of trade unions.

Several of the most representative trade unions had formed clandestinely under the francoist regime and had gathered strength towards the end of the dictatorship as part of the opposition movement against the regime. In 1977 a law passed by the Spanish Parliament established associative freedom. It was then that the existing unions - and many other organisations - were legalised, and that other most representative health professionals unions were also created. However, while the employers' associations UCH and CHC had consolidated their central role in the gradual definition of the 'Catalan health model' during the early eighties, the unions did not start to assert their relevance among the health policy elite until the late eighties and early nineties. Although their organisations did operate and had informal contacts with the employers' organisations, they were not central actors in the formulation of policies leading up to the 'Catalan model'[70]. Therefore, their interests and preferences - and those of the people they represented - did not have an impact comparable to that of the UCH and the CHC on the policy precedents of the 1990 Catalan reform (see Chapter 4). A top representative of the class-based union CC.OO recalled that:

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[70] The information presented in this section comes basically from two sorts of sources: from the non-published internal reports cited, which were provided by the corresponding unions, and from four interviews held with one representative of CC.OO, one representative from CESM, one representative from CATAC and one representative from CTS.

'When the HNPU was defined, we gave an important answer against it from the union. In that moment we thought that the option to be made was to expand a publicly owned network. This was not done this way, and the HNPU was developed, and the stance of the union from that moment was to accept this situation and try that those resources were managed through consortia with the direct participation of the DHSS ... We were in favour of this management form given that almost 100 per cent (between 80 and 96 per cent) of the HNPU resources come from purchases made by the Catalan Health Service[71]. It is obvious that the Catalan Health Service has to be represented in the governing boards of these providers.'

The relevance of unions as collective actors in the health policy arena in Catalonia was linked to the celebration of unions elections. The first elections were held in 1987 and only in the CHI providers, and from 1990 they affected the rest of the HNPU. These elections are held every four years and the electoral district is the 'working centre' (each provider) - an enterprise or a provider may have more than one working centre. The elections follow a regulated process covering, for example, the duration and timetable of the whole process, the updating of census, the number of representatives eligible in each centre, and the formal presentation of candidatures. Closed and blocked lists of unions apply in the case of working centres with more than 50 workers, and open lists of candidates in the case of working centres of less than 50 workers (CC.OO, 1998a). The results of the elections were the legitimising basis for the collective bargaining process. This was not a single global process for the whole sector, but was separately organised: one for the whole CHI, another for a number of HNPU members which negotiate and sign a common collective agreement, and a series of different bargaining processes for each HNPU provider which decided to have their own individual enterprise collective agreement[72]. For each of these bargaining processes a permanent negotiation table was set up which was composed of representatives of the employers' associations[73] and of different unions according to the results of the elections. The importance of being among the most representative unions in each

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[71] The Catalan Health Service was created in 1991 and took the role of the health authority which the Catalan Health Institute had performed until then.

[72] This latter option is predominant among private non-HNPU providers.

[73] In the HNPU the main employers' associations are the UCH and the CHC, and in the private sector the Catalan Association of Health Centres.

of these sectors - namely, those with more than ten per cent of representatives - depends chiefly on the number of workers affected by the collective negotiation. In 1990 there were 30,000 workers in the CHI[74], 7,000 in the members of the HNPU with the same collective agreement, and 11,000 in the members of the HNPU which had individual enterprise collective agreements[75] (CC.OO, 1991).

Table 3.7. Unions electoral results in the health sector, 1987-90.

	1987	1990		1990		1990	
	CHI	Catalan Health Institute (CHI)		HNPU non-CHI providers (common collective agreement)		HNPU non-CHI providers (individual enterprise agreements)	
Unions	%	representatives elected	%	representatives elected	%	representatives elected	%
CESM-SATSE	38	84	37.7	17	6.6	28	14.0
CC.OO	34	70	31.4	138	53.7	100	50.0
UGT	8	26	11.7	24	9.3	31	15.5
USTECATAC		22	9.9	0	0.0	16	8.0
USO	2	7	3.1	46	17.9	19	9.5
Other**	1	14	6.9	3	1.2	6	3.0
Non-affiliated	15			29	11.3	0	
Total	100	223	100	257	100	200	100

**The unions included in this category are not specified in this internal report, which does point out that none of them reached the level of ten per cent of the elected representatives and, therefore, cannot be considered as being among the most representative unions in the health sector - namely, those obtaining at least ten per cent of representatives.

Source: CC.OO. (1991) based on the certificates of elections of the Department of Labour of the Catalan government.

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[74] At that time, in the CHI only those having a statutory, civil service-like contract -namely 93 per cent of its workers- were entitled to vote.

[75] In the private sector there are 5,900 workers, in the psychiatric sector 500, and 540 in the providers for elderly people care. In the HNPU and in the private sector the electoral results are the aggregation of the results of two different electoral colleges: on the one hand, medical staff, nurses and administrative personnel, and on the other hand, nurse assistants and non-health personnel. The number of representatives each electoral college may elect is proportional to the number of workers in each college (CC.OO, 1998b).

As Table 3.7 shows, the electoral results of the 1987 elections in the CHI made apparent, first, the strong position of a coalition formed that same year by two sectoral, profession-based unions - CESM (Spanish Convergence of Medical Unions)[76] and SATSE (Union of Technical and Health Auxiliaries) - representing the interests of doctors and nurses respectively, which obtained 38 per cent of the delegates elected. Second, the classed-based, communist-leaning union CC.OO (Workers' Commissions) obtained a very relevant 34 per cent of the delegates elected. However, the non-affiliated reached 15 per cent of delegates, which put them among the most representative forces - namely, those obtaining over ten per cent of delegates. They obtained twice as many representatives in the HNPU - providers with a common collective bargaining process in 1990 but lost their representativeness in the CHI[77].

The HNPU was not created until 1985 and its gradual consolidation took place during the second half of the eighties. Thus, it was not until 1990 that the unions election were held not only in the CHI, but also, and for the first time, across the HNPU and the private providers outside this network. In the elections of 1990 CESM-SATSE maintained its share of delegates in the CHI, while CC.OO lost three percentage points in its share of delegates. Also, the class-based, socialist-leaning UGT (General Union of Workers) joined the most representative unions gaining almost three percentage points in representation. Moreover, a new coalition of public sector unions - USTEC from education and CATAC from the administration - almost joined the group of the most representative by obtaining ten per cent of delegates. By contrast, in the rest of the HNPU CC.OO was by far the majoritarian union, obtaining over half of the elected representatives. Among the private providers UGT obtained an important representation share - 35 per cent.

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[76] The Catalan branch of CESM is also referred to as Medical Union of Catalonia.

[77] For a detailed disaggregation of electoral results among private providers, psychiatric hospitals and elderly residences see Table A.8 and Table A.9 in Appendix 1.

Table 3.8. Unions electoral results in the health sector, 1994-97*.

Unions	1994-1997 Catalan Health Institute(CHI) representatives elected	%	1994-1997 HNPU non-CHI providers (common collective agreement) representatives elected	%	1994-1998 HNPU*** non-CHI providers (individual enterprise agreements) representatives elected	%
CESM-SATSE	134	42.8				
CEMSAT			3	0.7		
SATSE			55	12.1		
AMIC			8	1.7		
APF			8	1.7		
CC.OO	75	24	171	37.5	87	46.8
UGT	37	11.8	79	17.3	39	21.0
USTECATAC	31	9.9				
CTSC			48	10.5		
SAE	9	2.9	3	0.7		
CGT	8	2.6	4	0.9		
CSIF	8	2.6				
USO	4	1.3	44	9.6		
CTC	3	1.0				
SAC	2	0.6				
APAIL	2	0.6				
SPAS	0	0.0				
INDEP			12	2.6		
SMC			12	2.6		
API			9	2.0		
Non-Affiliated					7	3.7
Other**					***53	28.5
Total	313	100	456	100	186	100

*The union elections follow a dynamic time pattern as they are not held at the same point in time in all providers. The data shown in this table represent the results obtained by the different unions in the health sector as accumulated between 1994 and 1997.
**The unions included in this category are not specified in this internal report.
***Those included in this result involve some associations standing for election within AMIC and others, though they have not been classified as such in this report[78].

NB: The membership of the HNPU varies over the years as new providers sign contracts with the Catalan Health Service on a regular basis and are included in the HNPU by decree.

Source: CC.OO. (1998b) based on the certificates of elections of the Department of Labour of the Catalan government.

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[78] I want to thank Javier Sánchez, head of the electoral office of CC.OO., for providing me with these unpublished data directly from CC.OO's database, which was updated to May 1998.

The accumulated results of the unions elections between 1994 and 1997 - as they were gradually held in the different providers -, showed a reinforcement of CESM-SATSE and a decrease in CC.OO's representation in the CHI. On the other hand, a complex process of coalition building and alliances pushed by CESM-SATSE among profession-based unions had an impact on the electoral results across the HNPU. First, CC.OO's proportion of delegates declined by 16 points in the HNPU with a common collective bargaining process and also that of USO declined eight points. By contrast, the representation share of UGT in these providers increased seven points, and CTS appeared as a new union obtaining over ten per cent of delegates. CESM-SATSE's strategy also led to a sensible increase in its representation in the HNPU (see Table 3.8). In the HNPU sector where collective bargaining is carried out on a centre-per-centre basis CC.OO lost three points in its percentage of representatives while UGT increased by more than four points. Among these providers, recent coalition-building initiatives promoted by CESM-SATSE in 1997, such as AMIC, were still classified within the group 'other', thereby making it difficult to assess the extent to which the increase in their representatives stems for this strategy. Finally, in the private sector, CC.OO continued to be the strongest union, followed by a slightly weakened UGT and slightly reinforced smaller unions.

The objective of the unions has been that there should eventually be a single collective bargaining process for the whole HNPU - namely CHI and the rest of the HNPU (both those with a common collective agreement and those with individual enterprise agreeements) - as a first step to homogenise the labour conditions of all health professionals and workers. Thus, while the class-based CC.OO and UGT were already represented in all three sectors, the strongest union in the CHI - the profession-based CESM-SATSE - was gradually spreading across the rest of the HNPU in the mid-nineties. However, the articulation of interests among unions was far from fluent, but rather characterised by conflict of interests, as class-based and professional-based unions wanted to assert their respective sphere of influence, which, in fact, overlapped. Moreover, class-based unions' approach was that professions were not a differentiating feature when defining a union's strategy for the defence of workers, while corporatist approaches focused on the representation of specific professions such as doctors, nurses. However, they did have some common arguments. The interests defended by the unions CESM-SATSE, CC.OO and UGT in the second half of the eighties were mostly identified

with those of health professionals on the statutory, civil service-like contracts working in Social Security health providers, the CHI. Their actions focused on labour relations, working conditions and the professional careers of these health professionals. In this respect, one of the clearest points of consensus among the central policy elites - the CHC, the UCH and the COMB -, as well as among the autonomous and local administrations and the directive personnel of the CHI itself, was that the statutory personnel regime together with the lack of managerial autonomy to develop a personnel policy (including retributive incentivisation) were the most important factors leading to inefficiency in the Social Security health services. They argued, that this situation was further aggravated by other factors, such as the administrative constraints on procurement expenditure and procedures and the consequent transactions costs involved.

By contrast, the most representative unions in the CHI were against the gradual transformation of the statutory regime for the CHI's employees into a contractual labour market-like employment relation. First of all they acknowledged that, as unions, they were stronger in large organisations whose employees had the kind of civil service-like contractual arrangement which gave them employment security and independence to defend their rights through collective action. By contrast, a CC.OO's leader acknowledged that they had encountered great difficulties in gaining support among employees of the contracted sub-sector of the HNPU, where providers had a contractual relation with their employees based on the labour market regulations. These labour contracts covered a wide range of different working conditions and different degrees of labour insecurity which made it difficult for employees to develop solidaristic common goals for collective claims. Thus, there were very low levels of awareness of the unions as a tool for collective bargain or for the defence of their rights. Instead, these employees believed that any improvement in their condition would be better dealt with directly and individually with their employer.

However, these unions also pointed out principle-based arguments as the main reasons for defending this contractual arrangement. The leadership of both CC.OO and CESM-SATSE argued, first, that there was no evidence (comparing providers with similar levels of complexity and cost structures) that the civil service regime imposed an inefficient burden on the management of public health providers. Second, they claimed that being a civil servant involved an ethical commitment not only of a professional kind but also to the public service. This

commitment was safeguarded by the civil service status, which enabled employees to develop their profession free of political and managerial influences and uncertainties - which they viewed as often related. Finally, the unions viewed the civil service system as a guarantee of quality of service and economy in management. Both aspects they saw as difficult to guarantee in the ongoing process of diversification of management arrangements in the Catalan health system.

Table 3.9. Personnel ratio in HNPU acute hospitals classified by ownership in Catalonia, 1993.

Ownership	Beds	Doctors /bed	Nurses /bed	Auxiliaries /bed
Social Security (CHI)	4,495	0.7	1.1	0.7
Other public	2,839	0.5	0.8	0.6
Municipal	1,074	0.4	0.7	0.6
Foundations	3,287	0.4	0.7	0.6
Diputació*	468	0.4	0.7	1.1
Red Cross	547	0.4	0.7	0.4
Mutualities	2,361	0.3	0.5	0.5
Church	1,598	0.3	0.5	0.8
Other private	2,900	0.3	1.6	0.7
Total	19,569	0.5	0.9	0.7
Social Security (CHI)	4,495	0.7	1.1	0.7
Non-CHI	11,765	0.4	0.6	0.5
The rest	3,309	0.4	1.6	1.1

*Provincial administration's governing organ (high number of psychiatric hospitals outside the HNPU).

Source: Ramis *et al.* (1997:103) based on the *Estadístiques d'Establiments Sanitaris en Règim d'Internat* of the DHSS of the Catalan government.

The unions argued that the Catalan reforms of the eighties took the statutory employment regime of the health professionals of the Social Security health services (hospitals and primary care) as the scapegoat on which to pin the blame for the inefficient management of the system. One of the reasons why the

organisational and management forms of the CHI had not been taken as a pattern for the rest of the HNPU was the aim of reducing personnel expenditure and staffing levels. As table 3.9 and table 3.10 show, the CHI hospitals have a higher ratio of personnel per bed and spend a higher percentage of their income on personnel. On this line, a former official of the DHSS and member of IC (the only political force opposing the reforms) argued that:

> 'Limiting or reducing the personnel who directly depends on the public administration [the CHI] is a way to reduce the risks of negotiation, of strikes impacting on politicians ... And who may be the progressive agents most likely to support a public model of health [system]? ... The workers of the public sector themselves, and not only for corporatist interests, but also for scientific interest - health as a collective problem, planning, selective interventions.'

Table 3.10. Personnel expenditure as a percentage of total income and expenditure of hospitals in Catalonia, classified by ownership, 1993.

	Personnel expenditure	
Ownership	% over total expenditure of the hospital	% over total income of the hospital
HNPU	65	69
Non-HNPU	54	54
CHI	67	71
Non-CHI	64	67
The rest	52	52
Other public	66	71
Municipal	63	69
Priv. foundation	65	68
Diputació	64	64
Mutualities	56	58
Church	58	59
Other private	53	54
Total	63	66

Source: Ramis et al. (1997:93) based on the *Estadístiques d'Establiments Sanitaris en Règim d'Internat* of the DHSS of the Catalan government.

From the perspective of the private sector, a top manager of the Catalan Association of Health Centres pointed out that the wage level agreed through collective bargaining in the CHI was higher than that of the HNPU (which he considered to be para-public), and the latter was higher than that of the private sector, having a corresponding impact reflected on the personnel expenditure of their respective providers. From the private sector perspective the reason was that in the private sector personnel relations were between labour and capital, and therefore followed an economic (and more balanced) rationale, while labour relations in the public sector were based on political struggle mediated through the vested interests of civil servants.

In the late 1980s, while CESM-SATSE, CC.OO and UGT were the most important unions and the CHI was the only sector where elections of unions had been held, other associations started to emerge both in some CHI's centres and across the rest of the HNPU. The new groupings did not see their interests represented by these existing and largely consolidated unions. On the one hand, their members did not identified with the organisation and decision-making procedures of the class-based unions, and on the other hand they regretted what they saw as the corporatist view taken by the main profession-based union, representing doctors and nurses. Instead, they first aimed at representing all workers in the publicly financed health sector (the CHI and rest of the HNPU), and later on widened their aspirations to the whole public sector. Concerning the health sector, their main objective was the homogenisation of labour conditions for all workers of the HNPU at the same standards as the CHI's workers.

These associations originated from a bottom-up process in which committees elected from assemblies followed relatively *ad hoc* networking patterns. In 1987 some of these assemblies created, through their committees, the Autonomous Collective of Health Workers of Catalonia (CATSC). In 1990, CATSC agreed to be integrated into the public sector union Autonomous Candidature of Workers of the Catalan Administration (CATAC), which had been created in 1987, and to stand together for elections with the Union of Education Workers of Catalonia (USTEC), which had been created in the late seventies. In a parallel process other assemblies created the Co-ordinating Committee of the HNPU. This Co-ordinating Committee of the HNPU negotiated the first agreement in which the gradual homogenisation of labour conditions across the HNPU was defined, and which was the basis for the first collective negotiation with the employers' association - that is,

the UCH because the CHC did not assume this particular function until 1993. However, although the first agreement was signed by the Co-ordinating Committee, the collective negotiation was formally signed by the best represented unions of the sectors, as the Co-ordinating Committee had not stood for elections and therefore did not have any formal legitimacy from the ballot box. In order to obtain such a legitimacy for future negotiations, they created in 1994 the Co-ordinating Committee of Health Workers of Catalonia (CTSC) out of the existing committees. The CATAC-USTEC coalition did not welcome the parallel process that CESM-SATSE was pushing to spread its influence across the HNPU, creating the Association of Doctors and Nurses of Catalonia (AMIC) in 1997 together with other smaller unions (see Table 3.7). This coalition saw CESM-SATSE as too corporatist, focusing on doctors and nurses, while the coalition aimed at different sectors within the public sector from a more global approach. At the end of 1997 CATAC-USTEC formed a coalition with CTSC in order to increase their representativeness in the following elections. And shortly afterwards they created the Alternative Inter-Union of Catalonia (IAC), by associating with other unions from health and other public sectors.

CATAC-USTEC-CTS not only demanded the homogenisation of labour conditions across the HNPU at the same level as the CHI, but also supported the predominance of the public sector ownership and direct management responsibility over what they view as an increasing predominance of the private sector. In their view those HNPU's providers which had received public money for their survival - namely investments and subsidies - should have been transferred into the ownership of the autonomous administration, an argument in line with that of the leftist coalition Initiative for Catalonia (IC) in the Catalan Parliament. In the 'Catalan model', the radicals argued, the opposite has been done: public investments in those providers have in fact been a transfer of public resources to private interests which have seen their capital increased and their initial debt frozen.

The issue of reforming the statutory regime applying to CHI personnel, or even changing the legal nature of the CHI, has not been at the centre of the debate so far. Since the Social Security health services represent only a fourth of acute hospital beds in Catalonia, the unions see the Catalan government as trying to avoid the political risk of being the first in Spain to have a direct confrontation with those sectors. Some senior figures in the DHSS and the CHI assumed that a consensus is emerging in the late nineties on the need to reform the non-

transferred INSALUD, the Social Security health services still managed by the central government in ten Autonomous Communities. Their view was based on extrapolating from Catalonia's experience, so that any reform needed in the CHI (the INSALUD transferred to Catalonia) must also be needed to a greater extent where the full public sector is the largest part of the health system.

The difficulties this reform is bound to encounter are not only confined to the reaction of the statutory personnel, but also that of the Autonomous Communities, because any reform process is integrally bound up with decentralisation of the INSALUD to the Autonomous Communities, and with disagreements over the distribution of financing resources among the latter (see Chapter 2). Conflict of interests which may derive from this process partly explain why some Communities have made less progress in acquiring these competencies. For example, the Autonomous Community of Madrid refused in 1992 to have the INSALUD and the health competencies transferred (although it would have given this autonomous government enhanced influence since the capital's health budget is huge). One of the reasons for this was that the concentration of Social Security high technology centres in Madrid have high costs, and hence the city would not be able to run them if funding was allocated to this Community on a per capita basis.

Conclusions

The Catalan health care reforms of the eighties were influenced by both exogenous and endogenous factors. The most relevant of these endogenous factors included, first, the shared and stable leadership of both the main coalitions as collective actors and their leaders (policy brokers). Second, there is a clear definition of the subsystem boundaries between actual and potential actors; and third, a process of policy-oriented learning resulting from the interaction and collaboration between interest groups and advocacy coalitions which controlled key complementary resources in the health policy domain.

While the new autonomous health authority had the legal competencies and the financial resources for the governance of health care, non-institutional policy elites had been emerging and consolidating in the late seventies and early eighties. The resources these elites controlled were essential for the development of the Catalan government's policy preferences. Thus, while the autonomous health administration owned and had management responsibility over the transferred Social Security health services, most hospital resources were in private and semi-public local hands. Among private providers, a relatively small managerial elite had accumulated the knowledge and experience which were most needed for the organisation and rationalisation of a hospital network which had developed without planning and hospitals which in many cases were in dire financial straits. Among semi-public providers dependent on the local administrations, the role of municipal representatives involved both managerial and political commitment to a decentralised hospital network model, in which the resources under their influence could play a central role.

The policy preferences of these elites were, in principle, compatible with those of the health administration - namely, the consolidation of a mixed health provision model. Therefore, the existing distribution of key resources concerning this policy area involved an internally heterogeneous policy elite who found themselves forced to develop a collaborative pattern of relations in order to co-ordinate the use of those resources in the pursuit of common policy preferences and objectives. In this context, the incremental and consensus-building strategy pursued by the DHSS of the Catalan government was facilitated by the compatibility of the policy elites' preferences and belief systems, which were themselves conditioned to a large extent by that distribution of resources. As shown in Chapter 2, the DHSS of the autonomous government had a clear policy preference for not enlarging the Social Security provision and management model, but rather for regulating the provision of health care in such a way that the existing heterogeneous network of non-Social Security providers was reinforced and consolidated as a stable contracted network. This option involved first, the detachment of the health authority from public direct management and ownership in relation to those providers, and second, the expansion of private management techniques in the health sector.

On this same line, the main policy preferences of the managers' association UCH focused, on the one hand, on the managerialisation of the health care

network, including the Social Security providers (CHI) as well, by introducing private management techniques. The UCH was also determined to avoid public sector features such as the civil service-like personnel status of the CHI's workers or the lack of managerial freedom, which they considered to be the most important obstacle to the improvement of efficiency. On the other hand, they demanded from the Catalan government the political and economic commitment to the existing heterogeneous provision network as an example of a dynamic civil society. Similarly, the main policy preference of the local governments associated in the CHC was to ensure the Catalan government's financial commitment to the consolidation of the existing non-Social Security network - in which the CHC had a large stake - while maintaining the managerial and political relevance of the municipal providers.

Thus, the distribution of resources and dependencies among different groupings of actors explains to a great extent their interest and patterns of interaction. The contribution of the UCH to the development of the Catalan 'model' was channelled by some of its leading members being appointed as internal collaborators of the DHSS, from which they had a most relevant role in the design of regulatory and contractual policy tools. The collaboration between the DHSS and the CHC as representative of providers dependent on local administrations was also crucial for the rationalisation and consolidation of the HNPU. Both the UCH and the CHC played mixed roles as pressure groups, think-tanks and, more recently, consulting and services enterprises of the hospital sector.

The policy learning process involved in their constant and developing collaboration was to a large extent the origin of the consensus achieved by the main groups of actors. However, another crucial strategy which helped the development of this consensus was the purposeful focus the Catalan reforms on aspects of the elites' belief systems dealing with applied policy issues. Other aspects touching on different groupings' deeper values (their normative core beliefs) were consistently left to be dealt with in the formulation processes at the Spanish central government level. For example throughout the formulation of the 1986 General Health Law the coalition in the Catalan government actively participated to help its preferences prevail. And these preferences were not only shared by the UCH and the CHC to a large extent, but also by the Party of the Catalan Socialists (PSC). Although the PSC-PSOE was in office in the Spanish central government, it was the largest party in the opposition in the Catalan

Parliament and the most important party in terms of local councillors in the Catalan municipal governments - which led the PSC to identify with their corresponding mayors' interests.

The applied beliefs on which this heterogeneous and stable elite agreed included the policy tools they developed throughout the eighties - namely, the managerialisation of the health care network. However, a deep (normative) core argument that set the UCH and the CHC apart was the role that public authorities - and in this case including local governments - should have in relation to the ownership and management of the non-Social Security providers. While the UCH argued for managerial autonomy and depoliticisation, the mayors represented in the CHC re-asserted their involvement as elected politicians representing public ownership, and argued that management efficiency was not necessarily at odds with public authorities' responsibility. By gradually leaving this argument aside, consensus was relatively achievable. Building on both the policy precedents of the eighties and the consolidation of a highly interdependent policy elite of clearly defined collective actors, the formulation process of the 1990 Law for the Organisation of Health in Catalonia was widely interpreted as giving consistency and legal status to the existing model, which made consensus appear achievable.

Nevertheless, the early nineties were characterised by a challenge to those clearly defined boundaries of the policy subsystem as other advocacy coalitions demanded a more relevant role in the decision-making processes within the health policy domain, in the face of the increasing heterogeneity of labour situations and conditions. These collective actors who had been at the outskirts of the core-decision making until the late eighties were both class-based and profession-based unions. The importance of these unions was originally linked to the gradual introduction of elections for unions in the health sector. Thus, in the late eighties the profession-based CESM-SATSE and the class-based CC.OO shared the highest representation levels in the CHI providers, focusing on the labour relations concerning the statutory civil service-like personnel. But in the early nineties, new unions, emerging from a centre-based, bottom-up process gained some relevant representation both in centres of the CHI and across the rest of the HNPU, where, previously, CC.OO had been the most important negotiator with the employers.

But interest representation in the health sector was not straightforward. The fragmentation of the unions' forces reflected conflicts of interests between corporatist approaches (focusing on the representation of specific professions such

as doctors, nurses, etc.), class-based approaches (where professions were not a differentiating feature when defining a union's strategy for the defence of workers), and public sector-wide approaches (pursuing the homogenisation of labour rights across the public sector). Moreover, some of the key workers in the health sector, the medical profession, were also represented via their most influential official professional association, the COMB. Through this channel the medical profession's influence was not only reflected in the exchange of relevant figures between the DHSS and the COMB but also in an explicit common political leaning. In the early nineties, the COMB took a more relevant role in supporting a line of reform of the Catalan model which most unions opposed: the possibility that primary care doctors could assume financial risks by running team-based primary care centres as a private business contracting with the new health authority created in 1991 - the Catalan Health Service.

In 1990, after the passage of the Law for the Organisation of Health in Catalonia gave legal status to the previous reforms and provided their further development, the policy elites realised that the 'new public management' (NPM) discourse which was spreading across many OECD countries actually fitted the main features of the Catalan reform. Thus, they imported it and gave the ongoing policies a discursive consistency with what the international academic and political elite defined as a new paradigm to be pursued for the management of the public sector. However, during the first half of the nineties this elite complained that there were divergences between this discourse and the implementation of the reforms furthered from 1990, divergences which involved the need to further clarify the 'Catalan model'.

Chapter 4

Institutional design issues in the 1990 reform of health administration.

Institutional choice is about specifying and allocating decision rights to different actors and determining the rules that govern the way that these actors are selected and the way they use their discretion. The formulation process of the 1990 Law for the Organisation of Health in Catalonia (LOHC) was a case of institutional choice concerning the design of the governance structure for the health sector - that is, the rules governing the relations between the different actors who may play a role in a particular policy domain. More specifically, this institutional choice concerned the design of the administrative agent which, within the Department of Health and Social Security of the Catalan government, embodied the public health authority, and which would be responsible for organising and co-ordinating the health system and for implementing health policy.

According to Horn, an enacting coalition (or the political party in power if it enjoys an overall majority) faces the commitment problem of how to ensure that its policy objectives will remain untouched or unchanged by the next incumbent coalition. In Horn's account this commitment problem drives the institutional choice the enacting coalition has to make concerning the design of the public sector, and this choice is made mainly on transactions costs criteria. That is, legislators choose those administrative arrangements that best address the following transactions costs:

1. Decision costs (vagueness *versus* refinement of legislation) and its impact on participation costs. It will be shown that the LOHC was extremely vague concerning the institutional form of the new health authority and its relations with administration-owned providers and with the rest of providers. In turn, the participation issue concerning social actors became the main point involved in open negotiation.

2. The commitment problem to ensure the flows of costs and benefits derived from the new governance structure. In the Catalan case, the solution to the commitment problem was not influenced by the majoritarian dynamics of the Westminster-type of democracy - even though the enacting coalition had an absolute majority in the Catalan Parliament. Instead, co-operation, negotiation and co-optation of different interests into the very structures of the health administration were the preferred strategies *to solve the 'prospective side' of the enacting coalition's commitment problem.*

3. The enacting coalition faces the costs of ensuring a successful implementation of legislation - namely, the costs derived from an agency relationship. As it will be shown, CiU designed an implementing agent which was highly dependent on the executive (the incumbent coalition), and which at the same time had a high degree of discretion in terms of management. By contrast, opposing projects by the Party of the Catalan Socialists (PSC) and by the leftist coalition Inititative for Catalonia (IC) advocated a more politically independent agent but with a lower degree of management autonomy. Moreover, CiU and the PSC advocated an arms-length relationship with non-administration providers, while IC supported the integration of the latter into the structures of the health administration.

4. The enacting coalition faced the costs derived from uncertainty about the private benefits and costs associated with the legislation, which made it difficult for them to derive support from strategically assigning risks to the group that was best able to control or insure against it. In the formulation of the LOHC these groups were not only citizens, but mainly numerous public and private providers which were not part of the public administration structure with which they had contractual relationships. These non-institutional actors had consolidated a strong role for themselves throughout the eighties in the health policy domain, and had developed implicit and explicit identification links with the different political parties in parliament.

The enacting coalition Convergence and Union (CiU, the main Catalan nationalist party) claimed that the passage of the LOHC confirmed the Catalan government's capability to set and maintain their own distinctive policy priorities for the organisation and administration of health. Having been in power since 1980, the enacting coalition argued that their policy priorities were reflected in the policy options they had developed throughout the eighties, which had consolidated into

their own 'model of health system'. The 1990 LOHC gave legal status to those policy precedents and clarified the governance structure of their 'model' by designing a more adequate institutional form for the health authority. In Mintzberg's (1987) terms, decision-makers recognised an *emerging strategy* as a result of a repeated feedback between formulation and implementation by which a strategy (option) is re-defined, reinterpreted and legitimised[79].

In Horn's terms, CiU had a commitment problem (Horn, 1995) in safeguarding the persistence of the 'Catalan model of health system'. However, it could be argued that this commitment problem had two time dimensions: one retrospective and another prospective. In *retrospective* terms this commitment problem had arguably been solved: CiU in the Catalan government had been capable of setting and maintaining its priorities for a health care governance 'model' *without* formally changing the institutional features of the health authority (CHI). This point is relevant because such institutional features of the Catalan health administration had been inherited from the Social Security administration transferred from the Spanish central government in the early eighties and these features were claimed to be an obstacle by both central and autonomous governments to developing a different governance structure for health care. However, although the Social Security management entity (CHI) had represented the health authority from 1983, some policy options considered central to the 'Catalan model' had been developed, such as the introduction of an accreditation system for health providers in 1981, the creation of the HNPU in 1985, and in 1986 the reform of the contracting system with non-CHI providers.

In order to achieve a balanced mixed provision system CiU's policies had required priority investments in the non-Social Security sector which, despite its relevance in Catalonia, had persistently been under-funded through its contracts with the Social Security administration. As explained in Chapter 3, these policy options had been intertwined with intense consensus building and policy learning processes amongst the main policy elite in the health sector. The consolidation of this consensus by the late 1980s ensured that the enacting coalition's (CiU's) *commitment problem had actually been solved*. That is, the main policy elite and

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[79] For a case study which shows a similar process of 'recognition of an emergent strategy' by the Catalan government see Gallego-Calderón and Grau (1996). This case study analyses the territorial policy developed by the Catalan government concerning the location of protected green areas and the development of urbanisation.

the largest party in the opposition (the PSC) fully supported the defining features of the 'Catalan model'.

A variable that intervened in this piecemeal reform process that stretched throughout the eighties was the negotiation of the General Health Law (GHL) passed by the Spanish Parliament in 1986, and the policy preferences and power position of the Ministry of Health of the Spanish central government. The General Health Law created a National Health System (NHS) and defined it as comprising and integrating the Health Service of each of the seventeen Autonomous Communities. In turn, the implementation of this NHS was made dependent on the gradual passage of corresponding laws by the autonomous Parliaments organising their respective health services. This mandate, though, had to follow a defining feature common for the whole NHS: the health service of each Community had to integrate and co-ordinate all public providers (owned by the autonomous, local, and any other public administrations) in their territory, as well as establishing the required complementary relationships with private providers necessary for ensuring universal public coverage of health care.

CiU's capability can be analysed resorting to Weaver's and Rockman's (1993) theoretical framework. These authors argue that the set of institutional rules characterising the political system in general and the decision-making process in particular determine a series of government policy-making capabilities[80]. Three of them have a clear relevance for the this case study: setting and maintaining priorities, ensuring policy stability, and innovating. Although the relevance of the first capability was most emphasised by CiU when referring to the policy precedents of the 1990 LOHC, the second capability - to ensure policy stability - has also been pointed out by this enacting coalition in relation to a particular aspect of their 'model', the consolidation of the public-private network of health providers in Catalonia. The capability of 'innovating' has been directly linked to the 1990

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[80] Weaver and Rockman (1993:6) identify ten capabilities which, according to them, all governments need to master: 'to *set and maintain priorities* among the many conflicting demands made upon them so that they are not overwhelmed and bankrupted; to *target resources* where they are most effective; to *innovate* when old policies have failed; to *co-ordinate conflicting objectives* into a coherent whole; to *impose losses* on powerful groups; to *represent diffuse, unorganised interests* in addition to concentrated, well organised ones; to *ensure effective implementation* of government policies once they have been decided upon; to *ensure policy stability* so that they have time to work; to *make and maintain international commitments* in the realms of trade and national defence; and, above all, to *manage political cleavages* to ensure that the society does not degenerate into civil war.'

LOHC, giving it a sense of turning point in the policy approach taken to the management of health care by changing the governance structure of the system. The capability of innovating was cited by the enacting coalition as a result of the diffusion of their policies from the beginning of the nineties into other Autonomous Communities and into the health administration of the Spanish central government.

If the 1990 LOHC represents a turning point in the approach to the governance of health care, this requires the consideration of the *prospective* dimension of CiU's commitment problem. The bill presented by the governing CiU had to be vague enough to meet two contradictory objectives: it had to fulfil the GHL's mandate, which gave a clear priority to the public sector, and, at the same time, it had to consolidate the policies developed throughout the eighties in Catalonia, which gave a clear priority to a mixed provision sector. Initially, from 1990 onwards the capability to innovate in the existing public administration structures through the creation of the Catalan Health Service (CHS) focused on three themes which emerged as central issues during the negotiation and formulation processes of the law. These themes were first, the legal nature of the CHS as the health public authority and administration; second, the nature of the relationships between the CHS and the public and private providers; and third, the participation rights of administrative, political and social actors in the decision-making and management structures of the CHS. These issues emerged as three graduated *dimensions* along which the political parties represented in parliament negotiated:

- the margin of discretion of the CHS;
- the degree of integration of providers into the CHS; and
- the extent of social participation in the structures of the CHS[81].

The analysis of the documents issued throughout the process of formulation and passage of the 1990 LOHC allows the empirical testing of Horn's theoretical model in order to explain 'why the enacting coalition chose a particular institutional form instead of another for designing the public sector?'. As the analysis of these

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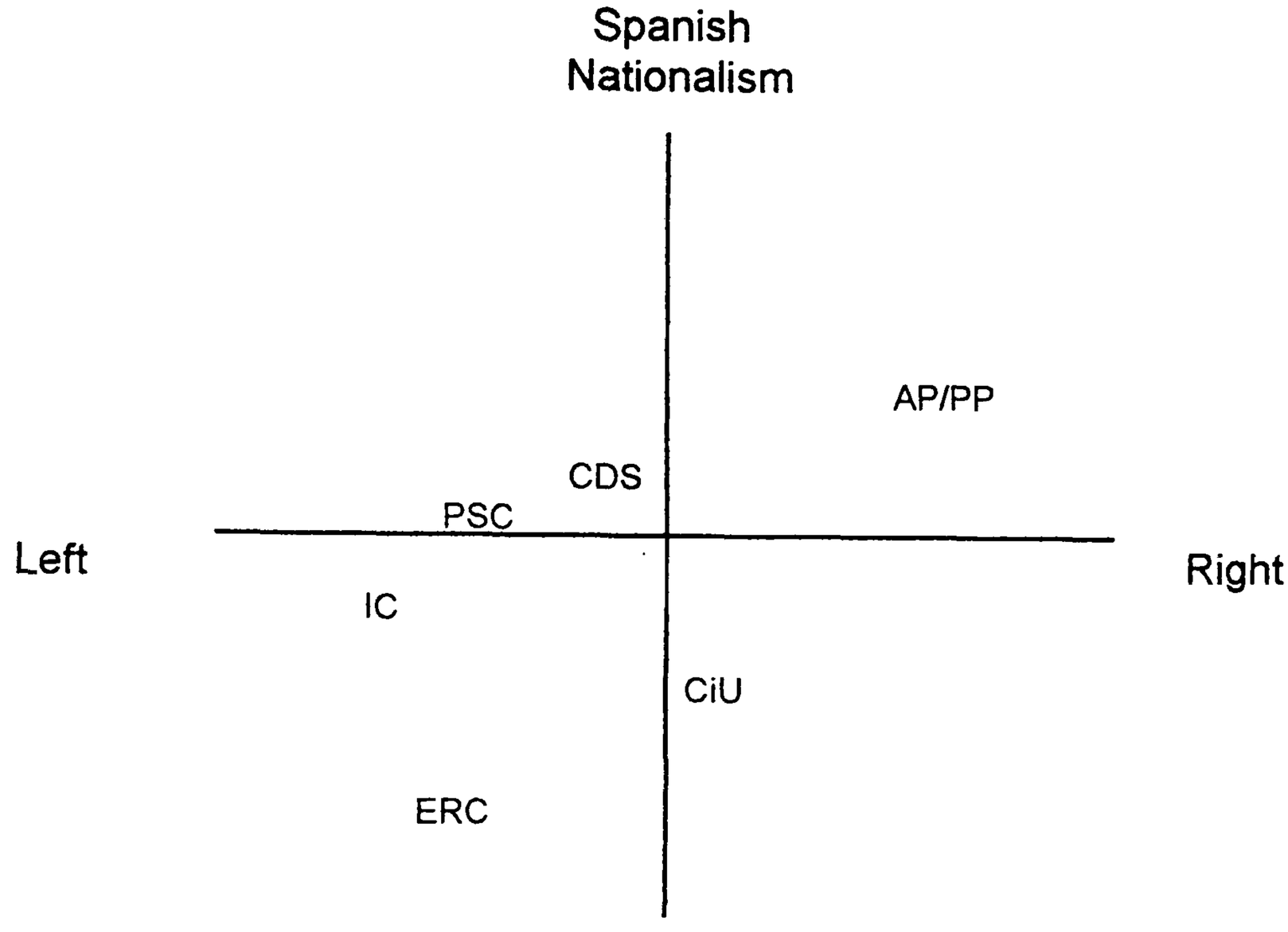
[81] At a further stage, following what key informants acknowledged as a 're-interpretation' of the LOHC, this capability to innovate was easily linked to the international trend of 'new public management' (NPM). Although some of NPM's defining features could be found within the very ambiguous provisions of the LOHC, it was not until after the law was passed in 1990 and the CHS was actually created in 1991, that the NPM terminology used in international forums like the OECD was readily adopted by the enacting coalition (see Chapter 5).

documents shows in this chapter, the LOHC and its modification were a case of institutional choice concerning the public sector. In particular, the three main *dimensions* of the negotiation leading to the passage of the LOHC - the margin of discretion of the CHS, the degree of integration of providers into the CHS, and the extent of social participation in the structures of the CHS - paralleled the transactions costs defined within Horn's theoretical model.

In addition to examining Horn's hypotheses about legislators' concern with these transactions costs, this chapter also maintains the focus set out in Chapter 1 on understanding why different political parties cared most about different transactions costs. Following Dowding's (1995, 1996) argument that resources play an important role in shaping both preferences and patterns of interactions among actors, this analysis traces legislators' preferences for a particular institutional solution to their commitment problem (in the case of the governing coalition) or to their policy priorities (in the case of the parties in opposition). Their preferences for a particular institutional form are in turn explained by looking both at parties' explicit ideologies (in this case views on what functions the health authority should perform) and their resources (for example, electoral support in different levels of government).

Although some of the exogenous variables pointed out by Horn as influencing the institutional choice formulated by legislators are common to both incumbent and opposition parties, some are or affect them in different ways. In particular, at any given time governing parties may face different commitment problems and transactions costs because of the effect of power distribution among the different administration levels (and political spheres) in an overall system of government. If they have different authority positions in other levels of government and administration they may care about different constituents and interests groups. This is particularly relevant in political systems such as the Spanish and the Catalan ones, where inter-governmental relations are of the utmost importance - not only owing to the territorial (and power distribution) structure of the state, but also because of the relevance of split voting affecting such relations. This split voting partly stems from the two-dimension ideological space characterising political competition in Catalonia (see Figure 4.1).

Figure 4.1. How Catalan voters in Catalonia positioned themselves in ideological space, by the party to which they felt closer in 1988.



Source: Montero and Torcal (1990) based on a survey by the Centro de Investigaciones Sociológicas (1988).

Tables 4.1 and 4.2 show that CiU has been a clear predominant party at the autonomous level of government, with an absolute majority in the Catalan Parliament for over 11 years, which it eventually lost in 1995. The PSC has consolidated its second place at this legislative level. By contrast, the parties positioned to the left of the political spectrum have enjoyed a majority of votes in municipal elections, with the PSC as the first party but facing an increasing percentage of CiU's vote share (Pallarès, Font, 1995). However, those leftist parties get their support from the largest, most populated municipalities, as can be inferred from the lower percentages of mayors they achieve - which usually indicates the percentages of municipalities where they have been the most popular party. This definition of spheres of political influence across different government

levels is not only confined to the internal politics of Catalonia, but also conditions the inter-governmental relations between local and autonomous governments[82].

This chapter focuses on institutional actors and in particular, on the political parties with largest parliamentary representation. The first section analyses the different projects they presented in 1989 for the design of an institutional form for a new health authority (the Catalan Health Service). These proposals are used as a basis for identifying either their commitment problems (in the case of the enacting coalition) or their interests and their policy preferences (in the case of the parties in opposition) in relation to the functions to be performed by that health authority. Both issues are originally concerned with certain transactions costs and with the institutional form they advocated during the formulation process of the new health authority, and this is examined in the second section. Here the focus is on the degree of the CHS's discretion (concerning agency costs); the degree of participation by social actors in the structure of the CHS (concerning legislative and participation costs); and the degree of providers' integration into the health administration, (which affects both agency costs, and uncertainty and risk assignment costs). Finally, section three assesses the extent to which CiU used the veto power derived from its absolute majority in parliament during the formulation process leading up to the passage of the LOHC in 1990.

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[82] As Montero and Font (1991) point out there is still a stronger division of spheres of political influence between the central and the autonomous government, this time based on a persistent split voting which favoured the PSC-PSOE at the general elections (for the central government) and CiU at the autonomous elections. This phenomenon was relevant for the modification of the LOHC in 1995, when the opposition of the PSC in the Catalan Parliament was conditioned by the support the PSOE needed form CiU in the Spanish central Parliament, after it had lost its absolute majority in the 1993 general elections.

Table 4.1. Autonomous elections in Catalonia, 1980-95: vote percentages and number of seats in the Catalan Parliament.

	1980		1984		1988		1992		1995	
Parties	votes	seats	votes	seats	votes	seats	votes	seats	votes	seats
CiU	27.7	43	46.6	72	45.7	69	46.2	70	41.0	60
PSC	22.3	33	30.0	41	29.8	42	27.6	40	24.9	34
PSUC	18.7	25	5.6	6						
IC					7.8	9	6.5	7	9.7	11[83]
ERC	8.9	14	4.4	5	4.1	6	8	11	9.5	13
AP/PP			7.7	11	5.3	6	6	7	13.1	17
PSA	2.6	2								
PCC			2.4							
UCD	10.6	18								
CDS					3.8	3				
Other	9.3		2.6		3.5		4.7		1.9	

NB: The Catalan Parliament has 135 seats.

Source: Parlament de Catalunya (1985:30), (1989:30), (1993:34-35), (1996:40-41); Generalitat de Catalunya (1996:65).

Table 4.2. Municipal elections in Catalonia, 1979-95: parties' shares of the vote and of mayoral positions.

	1979		1983		1987		1991		1995	
Parties	votes	mayors	votes	mayors	votes	mayors	votes	mayors	votes	mayors
CiU	18.6	23.2	24.9	46.9	32.5	63.9	33.1	63.0	30.0	63.3
PSC	26.6	9.1	39.4	16.1	37.1	15.2	36.8	16.0	32.8	15.3
PSUC	20.2	3.2	11.2	1.5						
IC					10.2	1.4	9.6	1.5	11.8	1.3
ERC	3.8	2.6	2.8	1.5	2.4	1.2	3.3	1.5	6.2	3.4
AP/PP	1.3	0.1	9.2	2.5	5.7	1.0	6.7	0.6	12.2	1.1
PCC										
UCD	13.3	13.6								
CDS			0.6	0.2	3.1	0.3				
Other	14.6	48.2	9.6	31.3			8.6	17.2	5.1	12.7

Source: Subirats and Vallès (1990), and ESE (1998) (forthcoming)[84].

[83] The fact that IC gets more votes but less seats than ERC derives from the impact of *where* they get their votes. Catalonia is divided into four electoral districts, which are the same as the four provinces (Barcelona, Tarragona, Lleida and Girona). The assignment and distribution of the 135 parliamentary seats among them is not based on a strict proportionality criterion. This means that in the most populated areas, from where IC obtains most of its votes, more votes are necessary to obtain a seat than in less populated areas.

[84] I want to thank Jaume Magre from the Universitat de Barcelona for allowing me to use the electoral data corresponding to the 1991 and 1995 municipal elections, which have been elaborated by F. Pallarès, J. Font, R. Canals and J. Magre, and which will soon be published (ESE, 1998).

4.1. The government's bill and alternative proposals.

There is an argument that the governing coalition in Catalonia, Convergence and Union (CiU), pursued a clear governance structure for the health system from the early eighties, and that its legal formulation into the LOHC was not possible until 1990 because the economic and ideological conditions both at the state[85] and autonomous level were not favourable until then. But this position is difficult to sustain. First of all, a distinction should be made between two interrelated components of a governance structure: on the one hand, the institutional form of the (health) authority and, on the other hand, the policy tools it is entitled to use. In this respect, the Catalan government's priorities proved to be much clearer concerning policy tools than the institutional form of the public health authority.

The Catalan government had full competencies to legislate over health, affecting both components, and a clear basis on which to do so as soon as the 1986 GHL was passed by the Spanish Parliament at the central government level. As Cernadas (1994:54-57) points out, three different draft bills internal to the DHSS were elaborated and dropped during the 1984-88 legislative period, before the bill that finally lead to the LOHC was drafted and sent to parliament. The first of those draft bills was rejected for being too close to the GHL - that is, too pro-public sector. The second draft was rejected for being too privatising. The third bill was sent to parliament but had to be dropped because the legislative period came to an end and the Parliament had to be dissolved.

Apparently, the main priority to which the Catalan government clearly did commit itself was the creation of the HNPU - directly related to the use of contracts as policy tools - in the mid-1980s, one year before the passage of the 1986 GHL. The formulation process of this Law lasted for three years and the model it defined was that of a National Health Service - publicly financed through taxes and stressing overwhelming public or Social Security provision, giving a minimal

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[85] In principle, though, the PSOE's commitment to the NHS model defined by the 1986 GHL might have been a basis for the Spanish central government to oppose CiU's health provision model if it had been made explicit through a law from the Catalan Parliament earlier than 1990. In fact, internal reports from the Ministry of Health and Consumption in relation to the 1989 CiU's bill reveal reluctance to accept the emerging definition of the CHS and the legalisation of the mixed provision network (MSC, 1989a, 1989b).

complementary role to the private sector. In order to ensure the persistence of the Catalan mixed provision, CiU and the main Basque nationalist party, PNV, in the Madrid Parliament negotiated with the PSOE - which controlled the Spanish core executive and had an overall majority in the Spanish Parliament. Their concern was that this Law's provisions referring to the organisation of health services were classified as non-basic, that is, not requiring mandatory implementation by the Autonomous Communities with health transfers (Vaqué, 1987; Rico, 1997).

In April 1989, the parliamentary group of the Party of the Catalan Socialists (PSC) presented a law proposal in the Catalan Parliament for organising health care in Catalonia, but it was rejected by the majority. Finally, in May 1989, CiU (from the Catalan executive) sent a bill to the Catalan Parliament on the organisation of the health system in the Autonomous Community. The negotiation process lasted until June 1990 when the LOHC was passed. In this process, two alternative texts to the CiU's bill were presented, by the parliamentary groups of the PSC and of the communist-leaning Initiative for Catalonia (IC). The remaining groups in the Parliament presented their respective amendments but with no alternative project formalised into a text. Crucial stages in the Catalan legislative process are, first, the legislative initiative[86]; followed by the presentation of amendments and the debate in the corresponding sectoral Commission[87] (the Social Policy Commission); and third, the debate in parliament on the text negotiated and agreed in the commission and on the amendments each parliamentary group reserved for this final debate. This final debate and voting is conducted on an article by article basis.

In this legislative process, the main modifications introduced to the CiU's bill text were agreed during the Commission debate, while the debate in parliament resulted in minor changes to the Commission's text. However, the executive itself

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[86] The legislative process may be initiated by the executive sending a bill to parliament, by members of parliament presenting a law proposal - five members of parliament or a parliamentary group-, by the representative organs of supra-municipal territorial demarcations presenting a law proposal, or by citizens (Internal regulations of the Catalan Parliament, 1987, article 92) (DOGC, n. 916, 18/11/87; DOGC, n.918, 23/11/87).

[87] In the Catalan parliament there are 14 Sectoral Commissions, of which eight are permanent Legislative Commissions (such as the one concerned in the LOHC case - Commission of Social Policy), three are permanent non-legislative Commissions, one is regulatory, and two are specific for the Accounting Magistracy (Sindicatura de Comptes) and for the Ombudsman (Síndic de Greuges) (Internal regulations of the Catalan Parliament, 1987, several articles) (DOGC, n. 916, 18/11/87; DOGC, n.918, 23/11/87).

supported by an overall majority in parliament could exercise a veto on those aspects to which CiU was strongly committed - for example, the legal nature of the CHS, and a system of mixed public and private provision. These key points had remained the same throughout the eighties as CiU had controlled the Catalan executive from 1980[88] and this coincided with the third consecutive legislative period (1988-1992) in which they had an overall majority in parliament. In a parliamentary regime such a situation guarantees dominance of the executive to the majority party and leaves negotiation with other parties subject to its political will.

The three texts presented by CiU, the PSC and IC represented three different reform projects concerning the choice of a new governance structure for organising the health system in Catalonia, stemming from their commitment problem (in the case of the enacting coalition CiU) or policy priorities (in the case of the PSC and IC in the opposition) in relation to their constituents and political stances[89]. However, not only did the governance structure each project defined differ substantially, but also few and ambiguous explicit links were made between these different 'solutions' ('institutional forms') and the 'problems' ('transactions costs') they were supposed to address.

The bill presented by the governing CiU came closest to an explicit statement of a problem concerning the existing distribution of competencies over health across different organs of the DHSS. This problem was defined as the need 'to overcome some particular deficiencies in the organisation of health, such as the detachment of the functions of organisation, planning and management of the health services, which were so far allocated to different organs' (BOPC, 5/6/89, nº78:4964). According to CiU, the solution to this problem required the creation of a single organism, the Catalan Health Service (CHS), which assumed the responsibility for all these functions under its authority, in order to achieve an adequate co-ordination between those matters. This institutional reform bringing together those functions was considered 'fully advisable, ..., bearing in mind the close interrelation between them'. The legal nature and organisation of the CHS ('a

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[88] Although they did not have an overall majority in parliament in the 1980-1984 legislative period they did not share government with any other party and governed as the largest minority.

[89] See BOPC, nº78, 5/6/89 for CiU's bill and BOPC, nº115, 4/12/89 for the PSC's and IC's alternative texts.

public entity of an institutional nature') as well as the policy tools available to it (private management techniques) were, in fact, *the* object of the whole project and the solution to that problem. Hence, CiU emphasised that its proposal was not a health law, but a law for organising the governance of health care. Another aspect identified as a problem in CiU's project was the dichotomy dissociating public health and health care, which had been the result of the overlapping distribution of competencies between different administrative jurisdictions. The Basic Health Area, as the lowest territorial unit of the CHS, was given the responsibility for integrating both functions. Both these options and the creation of the CHS with the corresponding organisation of the health sector was a mandate of the 1986 General Health Law.

In the introductory text presenting CiU's project there are no other explicit links between identified problems and supported solutions, not even other explicit problems to be addressed. However, three statements concerning CiU's objectives pursued by the reform appeared to be particularly relevant, as the parliamentary debate showed afterwards. First, there was the intention to favour:

> '... the introduction of private management mechanisms in accordance with the service nature of the health administration, its public nature notwithstanding.' (BOPC, 5/6/89, nº78:4965).

Second, the reform was meant to:

> '... consolidate ... a mixed health system based on making use of all resources, either public or private, with the aim of achieving an optimum hospital reorganisation which allows an adequate homogenisation of services and a correct use of physical and human resources, in line with the general trend in developed countries' (BOPC, 5/6/89, nº78:4965).

Third, there was the intention to:

> '... make progress in the adequate distribution of health resources, the optimisation of the economic resources allocated, the co-ordination of the whole system of public coverage, the participation of users in decision-making, and the improvement of the quality of health services, with the ultimate and essential aim of ... effectively enforcing the right to the protection of health' (BOPC, 5/6/89, nº78:4965).

CiU made its 'prospective' commitment problem explicit by means of these three objectives, which bore directly on its policy preferences. Those objectives concerned the consolidation of the mixed health system developed throughout the eighties, which implied the recognition of and support to a role of private providers in the health system of public coverage which was substitute rather than complementary to public provision. Moreover, it involved the expansion of private management techniques in the health sector. However, these objectives involved a specific option regarding *uncertainty and risk assignment costs* as far as private providers were concerned, because for many of them their economic situation made public funds indispensable for their survival. Additionally, a main concern with *agency costs* was also implied in the reallocation of competencies to a single authority, the CHS, and its endowment with powers to co-ordinate the whole health system. Finally, a brief reference to participation costs was also made.

Confirming its policy priorities during the parliamentary debate - the final stage in the legislative process -, CiU referred to the policy precedents developed by the Catalan government over the eighties and pointed out that the CHI, the management entity of the Social Security in Catalonia, had proved a 'good management instrument' throughout that process. The CHI, as a bureau form in Horn's (1995) terminology, had implemented a policy of contracting with non-Social Security hospitals, and had initiated changes in its own hospitals. At the same time, the CHI had initiated a reform process in primary care in 1985, a sector in which, in contrast to the hospital sector, the CHI owned and managed over 90 per cent of resources. In spite of acknowledging the CHI's task as the health administration in Catalonia from 1983, CiU considered that:

> 'This CHI, maybe enlarged, could have been transformed into the would-be-Catalan Health Service, as has happened in other Autonomous Communities of the state with their own respective [Social Security] management entity. If it had not been for this hospital scenario, with a scarce number of Social Security providers, it would have been very easy to create the Catalan Health Service, building on the enlargement of the Catalan Health Institute [CHI]. This [option] has not been possible owing to the hospital sector reality in Catalonia.' (DSPC-P, 13/6/90, nº68: 3251).

Additionally, CiU supported this arguments by highlighting three dysfunctions which had persisted despite the reforms of the eighties and which were basically a

matter of *agency costs*. First, there was the considerable lack of permeability between primary and hospital care. Second, the professionals of the Network of Hospitals of Public Utilisation (HNPU) still did not have incentive and promotional elements in their career. Third, there were services which were not regulated yet, such as mental health, labour health and family counselling. For all these reasons, CiU concluded, it was necessary to create a new legal entity which made it possible to encompass all these heterogeneous providers, different status professionals and services. In this respect, they emphasised that the debate on the private/public dichotomy had grown confusing. They claimed that the public character of a health system does not stem from the ownership of providers but from the universalisation of services and their being free at the point of provision.

In contrast to the CiU's bill, in which the need to reallocate competencies to a single authority, a public body, appeared as the main problem to be solved and the consolidation of a mixed health system the main problem to address, the alternative text presented by the parliamentary group of the PSC put the emphasis on the need to integrate all public health providers (CHI and non-CHI) into a single network. Thus, although they agreed with CiU that the health sector should at last be organised by integrating public health and health care under that authority, the problem stressed by the PSC was basically linked to *uncertainty and risk assignment costs* affecting a range of charitable and semi-public providers dependent on local administrations - in which the PSC had the greatest political stakes. Their text started with the general problem statement that 'the existing functional, organisational and technical structure of the health system is inadequate for meeting the health needs of the population as they have evolved'. It then advocated as a solution: 'it is necessary to reform the health system, adapting it to the needs of modern society, integrating all resources and optimising all services'. In this respect, and in accordance with the main problem the PSC identified, they claimed that 'the present administrative framework dating from 1983 organises under the same entity all public health resources transferred by the Social Security. However, the rest of public health services in Catalonia, mainly attached to municipal governments and provincial administrations - with a strong health tradition - were not integrated in that main public structure'. For them this was the key problem that had to be solved (BOPC, 4/12/89, nº115:7390-1; DSPC-P, 13/6/90, nº68:32-59).

The PSC's text stressed that the 1986 General Health Law provided the necessary legal base for the organisation and rationalisation of the health sector and for the full exercise of competencies by the Catalan government in this matter. Thus at in the late 1980s there was a legal vacuum in this respect in Catalonia because the General Health Law mandate had not been fulfilled, creating a problem of uncertainty. This reform, the PSC's text said, should involve the creation of an entity for the provision of health services - the CHS - with effective health management capacity, which ensured the use of all public health resources, overcame duplications and allocated specific functions to each resource. The CHS was the basic instrument for integrating and co-ordinating the efforts concerning health from all administrations in Catalonia (therefore, including local administrations, where the PSC had a political stake), as well as for co-ordinating the private resources which might be necessary for meeting the public interest. The repeated stress on the integration of all *public* resources, that is, from all administrations in Catalonia, showed that one of the PSC's main policy priorities was concerned with the role of local administrations (where they have a strongest political position in the most populated areas). Accordingly, they conceded a secondary role to private providers. In fact, in the final parliamentary debate, the PSC regretted the ambiguity concerning the legal nature of the CHS and the blurring of the distinction between the public and private sectors in health care:

> '... we are not against the private sector, ... in the health sector, it is good that private institutions work for the public sector on a complementary basis, and through a contractual regime which is clear and transparent. This is good and necessary, and this need is even more obvious in Catalonia, where the private sector comprises institutions leading the medical research in many specialities, and which are internationally competitive ... and which need to be given support and funding ... However, this law ... provides a legal nature which is basically designed for regulating the CHS through private law ... and we do not agree with this [...because...] it involves two kinds of risks ... On the one hand, the possibility of privatising those services which are profitable or may yield returns ... On the other, the possibility of a regime of subsidiarity of the public sector with respect to private initiatives which reach a crisis point.' (DSPC-P, 13/6/90, nº68:3261).

The PSC interpreted that CiU's 'general philosophy' was that the public sector was ungovernable by definition and that it was the private sector which had developed efficient management methods for the health sector. Thus, although the

DHSS had explicitly denied that they might go for either of the two possibilities pointed out by the PSC, this parliamentary group highlighted a sentence which was most frequently stated by the DHSS's *Conseller* and by CiU in Parliament and which the PSC did not fully approve of: 'We intend to manage the public health as if it was private and we think that this is the only way to survive' (DSPC-P, 13/6/90, nº68:3261-64).

In a similar vein to the PSC, IC's alternative text stressed the need to integrate all public health providers into a single network - showing a policy priority similar to the PSC's for their stronger position at the local administration level, although their electoral support was far lower in both autonomous and local elections. Thus, they put a stronger emphasis than the previous two groups on giving funding priority to providers of public ownership (non-Social Security providers owned and managed by other administrations) as a preliminary step to the CHS assuming their ownership. Above all, IC was concerned with an *agency costs* problem: they argued for an integration of all HNPU-member centres into the CHS, by which these providers transferred the use and management of their assets to the health authority - namely to the public administration. They argued that as long as those providers were publicly funded, they should also be publicly managed. In any case, though, contracts with private providers should be limited to those cases in which it could be demonstrated that public providers are not enough for covering the needs of the public health system, and even then for a limited period of time (DSPC-P, 13/6/90, nº68:3259). More resources were needed for the public system. In this respect, IC claimed that:

> '... the object of the law is to organise the Catalan health system giving particular priority to the public services and co-ordinating all the existing health services in Catalonia which will form the CHS ... The financing of the CHS has to give priority to those services which are owned by the Social Security (managed by the CHI), which conform to the majority of the existing health care services, but, given the existing heterogeneity of ownership, it also has to foresee the financing of those public services attached to local administrations or non-profit institutions of public interest, when there is a need to do so and which is objectively demonstrated. This financing is a step previous to the assumption of their ownership, if it is adequate and possible, into the public system.' (BOPC, 4/12/89, nº115:7378).

Finally, the need to fulfil the mandate of the 1986 GHL was also stressed by IC. They argued that there was a legislative vacuum in health care in Catalonia and that it was necessary to comply with the legal mandate of the GHL and give legal status to the right of Catalans to receive an integral public health care. However, the integral conception of health provided as an organising principle of the health system in the GHL was interpreted by IC in a slightly different way to CiU's approach. This integral conception did not require a reallocation of competencies to a single authority, as CiU stated, as much as to publicly cover a variety of dimensions of health (care, social, environmental, labour) which were not so far either covered by the public system or co-ordinated between them. IC insisted on an integrated social and health care in primary care, because, they claimed, both health and illness have a social dimension. In this respect, they argued, the DHSS and the Department of Social Welfare should be integrated.

So in contrast to CiU, which focused on an agency costs dimension of the problem, IC saw the problem as concerning uncertainty and risk assignment costs to citizens (and health professionals), rather than to providers as the PSC stressed. During the parliamentary debate on the law, IC emphasised the modifications of the CiU's bill which had been introduced during the Commission's debate as a result of IC's negotiations with CiU. Those modifications concerned:

- the addition of users' rights;
- the suppression of the possibility to charge taxes to citizens at the point of access to health providers (which CiU's text established);
- the participation of local administrations, unions and business associations in the CHS's Directive Council (which CiU's text had not included);
- the compromise to homogenise work and professional conditions across the HNPU, the assignment of planning and management functions to the lowest deconcentrated level established for the CHS (Health Sector);
- the strengthening of the public administration over the HNPU by reinforcing the accreditation system;
- a greater emphasis on primary care as the central structure of the health system (although IC still maintained a different model of primary care in which social and health care resources are integrated);
- the compromise to prepare the Health Plan in one year; and
- the relevance given to the Institute for Health Studies.

The rest of the groups which contributed to the parliamentary debate did so to a lesser extent both in terms of number of amendments presented, length of interventions and range of arguments defended, and without having presented alternative project texts. The Popular Party (PP) focused its criticisms of both the CiU's bill and the Commission's text on five main points which they insistently mentioned almost in every single intervention they made during the debate. They addressed uncertainty and risk assignment concerning both citizens and health providers but based on different policy preferences from those of the PSC and IC. First, they regretted that the texts did not recognise the diversity of health care models (both in terms of insurance and provision, rather than just provision) which were so traditionally rooted in the Catalan society and economy. This recognition, the PP claimed, had to imply the definition of those health care models as alternative to the compulsory Social Security model. That is, citizens should be allowed to opt out from the Social Security model and privately provide for their own needs through private insurance and provision. (In this respect, CiU argued that the possibility to opt out from the Social Security was not allowed by the legal framework in force and that, in any case, freedom should be made compatible with the guarantee of rights of citizens). Second, the PP claimed that official associations of health professionals should be represented in the management structures of the system and of providers, which was eventually included during the negotiations. Third, they considered that the project did not make it possible for citizens to freely choose their doctor. Fourth, the PP stressed that the 'group collectivism' characterising primary health care teams and centres did not guarantee freedom and quality in the service, as this model ran counter to inherent features of the exercise of medicine as a liberal profession. The PP insisted that the GHL did not require that primary care teams should exist, and that this health care organisational form did not lead to an individualised, humanised, quality and effective health care (DSPC-P, 13/6/90, nº68:3253-5).

Lastly, the PP claimed that CHI hospitals should be given full autonomy to manage and govern themselves. This was the closest formulation to an explicit NPM component (disaggregation and implicit separation of management and the role of the health authority) which appeared in the whole formulation process. In all these aspects the PP saw a lack of political will on CiU's part to fully use the autonomous legislative competencies of the Catalan government. Instead, the PP claimed, CiU had promoted a model too close to that enacted by the 1986 GHL,

which CiU itself had criticised for being too bureaucratic and statist. All this meant, according to the PP, that the value of freedom, which was a priority in the PP's ideology (and to CiU's, they asserted in amazement) had been surrendered[90].

The Party of the Catalan Communists (PCC) from the Mixed parliamentary group[91], rejected CiU's project and criticised the Commission's text for what they considered to be a project for privatising the health system. Their policy preferences were different from the rest of the parties' as well as their respective views about how to address uncertainty and risk assignment costs. The PCC claimed that they supported an efficient and effective public management without having to resort to private management practices. For this group, the introduction of private business management techniques showed CiU's inability and lack of political will to reform the public administration so that it could become an instrument to solve the problems of the public health system. They claimed that under-funding was a problem and that more resources were needed. The PCC rejected the very definition of the HNPU because, according to them, it implied the intervention of private interests and businesses in the management of public resources, over which, according to the PCC, the public sector had to have full responsibility. As for private interest and business the PCC explicitly mentioned multinationals, medical and pharmaceutical professions, private mutualities and insurance companies, all of whom, they stressed, were increasing their benefits. Instead of consolidating the HNPU as it had been defined, the PCC advocated (in line with IC's arguments) that all HNPU-member providers should progressively be integrated into the CHS and become public in all respects. In this process, the representation of unions ('workers were *de facto* co-owners') and local administrations was of paramount importance. In any case, for the PCC the main problems of health care in Catalonia were scarce economic resources, and primary care, and none of them were the object of the law (DSPC-P, 13/6/90, nº68:3255-7; DCPS-C, 14/6/90, nº69:3397).

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[90] These arguments are scattered in interventions which were relatively short in comparison to the interventions by the PSC and IC throughout the parliamentary debate (see for example, DSPC-P, 14/6/90, nº69:3357-8, 3362, 3368, 3372, 3393, 3395-6, 3398).

[91] The members of parliament whose political parties have got less than five seats are allocated to the Mixed group -there is no limit for the number of MPs who may be part of this Mixed group (Internal regulations of the Catalan Parliament, article 18) (DOGC, nº 916, 18/11/87; DOGC, nº918, 23/11/87).

Finally, the Social and Democratic Centre (CDS) focused its interventions on values about which there was little controversy. These included the need to guarantee universal coverage of health care free at the point of access; giving priority to non-profit providers when contracting health services from non-CHI providers; widening the range of health services to be covered; improving quality in general in all services; and ensuring public participation in the management structures of the CHS (DSPC-P, 13/6/90, nº68:3257-8).

In sum, the three main political parties with alternative projects, CiU, PSC and IC, sustained different views on what were the main problems to be addressed. While CiU cared most about the uncertainty and risk assignment costs affecting private providers and public non-CHI providers, both the PSC and IC were more pre-occupied about the uncertainty and risk assignment costs affecting first of all public CHI and non-CHI providers, and citizens. As for agency costs, they appeared to be most relevant in the discussion on the form the CHS should adopt.

According to Horn (1995) 'form follows function'. That is, the institutional form chosen for the fulfilment of particular functions in the public sector will depend on the nature of such functions and, therefore, on the kind of transactions costs such functions imply. From 1983 until 1990 the CHI (the Social Security management body) was the health authority and its institutional form was a 'bureau' in Horn's classification. In order to assess the extent to which 'form followed function' in the reform process of the Catalan health administration between 1989 and 1990, it is necessary to look at how the political parties' proposals assigned functions to the Catalan Health Service (CHS), the new health authority to replace the bureau form of the CHI.

The text of the CiU's bill defined a complex and extensive jurisdiction for the CHS, because it was assigned functions of very different natures, without making a functional classification of them explicit. In fact, the list of competencies for which the CHS was responsible included policy formulation, regulation, enforcement and funding of health services (those which are public and of public coverage), but also management functions. Later, after the final passage of the law in its final version by parliament, these management functions were re-interpreted in NPM terms and claimed to be 'functionally separable' to 'assign them to different agents'. Thus, on the one hand, in the CiU's bill the CHS had functions concerning the *formulation* of health policy, such as the organisation, planning, programming and evaluation of health, socio-health and public health services. It also had *regulatory* functions

such as the establishment of the general guidelines and the performance criteria which were binding for those health providers functionally assigned to the CHS. In addition, the *enforcement* functions of the CHS included the establishment, management and review of all kinds of quasi-contractual agreements held with health providers, as well as organising the inspection of health, socio-health and public health services. The CHS's *funding* functions concerned the distribution of economic resources, appropriated through the annual budget, for the universal coverage provided by the NHS in Catalonia. The CHS had *management* (that is, provision) functions, such as the management and administration of those providers integrated in the CHS (those within the CHI - the Social Security management body that had until then been the health authority), the management and implementation of health programmes, and the management of services and entitlements covered by the public health service.

In Horn's (1995) terms, the CHS had non-commercial objectives, and these were low-controversy core arguments. It was the concern with specifying in greater detail the health areas and specialities to be covered by the CHS that clearly differentiated the alternative texts of the PSC and IC from the CiU's bill. They regretted that the legislation was not a health law but essentially an organisational law. Their alternative texts not only provided a thorough and more detailed lists of the CHS's activities, but they also included specific articles stressing the CHS's responsibility for public health, health at school, health at the work place, mental health, primary care, hospital care, and health care specialities. However, in contrast to CiU's project, neither the PSC's nor IC's texts provided a very detailed definition of the management functions which the CHS was expected to perform in relation to these activities, whose coverage, it was stressed, was its responsibility as public authority. In this respect, the PSC's project assigned the CHS the functions of planning with rationalising criteria, developing specific training programmes, establishing agreements with non-Social Security health providers, functional co-ordination with public or private entities, the technical collaboration with municipal and provincial administrations, and the public health and health care so far covered by different administrations. Similarly, IC defined mainly management functions for the CHS: planning following an equitable distribution of resources according to needs assessment, the continuous training of administrative and health professionals, the management of contractual agreements with non-Social Security providers, co-ordination with private or public

entities in public interest matters, and the integration of health networks (social services, health care) emphasising different health areas to be covered.

4.2. The 'institutional form' of the Catalan Health Service: Three dimensions of disagreement.

The institutional 'form' of the CHS was bound to present a complex profile owing to the varied functions it was assigned by the different party proposals, a variety which was most remarkable in CiU's project. The main alternative projects, and the parliamentary debate around them, show that there were three main dimensions of disagreement between the political parties - about the discretion given to CHS, the integration of other providers with it, and the degree of participation by other social actors in its decision-making and management structures.

a) Margin of discretion.

The degree of discretion granted to a public organisation affects agency costs, and in the CHS's case two factors were crucial: first, the managerial autonomy it was assigned, and second the extent to which it is dependent from the Catalan core executive, that is, from the political level. The CHS's managerial autonomy was influenced by the definition of its legal nature, because it determined the policy tools it may use to fulfil its functions. Both its managerial autonomy and its degree of (in)dependence from the core executive were influenced by the definition of veto points in the process of administrative decision-making concerning the CHS, the Department of Health and Social Security and the Catalan core executive. It is possible to explore how the three projects by CiU, the PSC and IC differed in

relation to these aspects. While CiU advocated an CHS with a high degree of autonomy in the policy tools it was allow to use (private law tools), it gave it a low degree of independence from the executive. By contrast, the PSC and IC advocated a CHS which was more independent from the executive, but with less managerial autonomy in relation to the policy tools it could use (those explicitly allowed by public law to autonomous organisations).

The legal nature of the Catalan Health Service

In the CiU's bill the CHS was defined as a 'public entity' endowed with legal personality and full capacity for the fulfilment of its ends. As an instrumental body, the CHS was ascribed to the DHSS of the Catalan government, which was responsible for the direction, surveillance and guardianship of the CHS, as well as for the control, inspection and evaluation of its performance. Following the mandate of the 1986 GHL to organise and co-ordinate all providers offering public health coverage within each Autonomous Community, the CHS was at the same time defined as 'comprising' the providers of health and socio-health care owned by the Catalan government, the providers owned by the Social Security administration (those managed by the Catalan Health Institute (CHI) from 1983); the providers owned by provincial and municipal administrations, which were either integrated or functionally assigned to the CHS through the corresponding agreements; and other non-publicly owned providers which none the less provided health services of public coverage financed by the CHS.

Both the alternative text presented by the PSC and that presented by IC supported a different institutional form for the CHS - that is, a different legal nature. They defined the CHS as an 'autonomous organism' of the Catalan government, with legal personality, whose object was the protection and promotion of health, health and socio-health care, as well as the management and provision of the corresponding services. The CHS was also ascribed to the DHSS, which was responsible for the CHS tutelage. As a result of the negotiation at the Commission stage between the different representatives of the parliamentary groups, the text finally agreed and sent to parliament defined the CHS as a 'public entity of an institutional nature'. Afterwards, during the parliamentary debate, IC argued that although the CHS's legal nature had been modified from the extremely ambiguous

'public entity' in the CiU's bill to the still ambiguous 'public entity of an institutional nature' in the Commission's text, such a formulation was not a legally defined figure in administrative law and, therefore, its regulation was not subject to clear legal terms - nor was the control of its performance. By contrast the definition of the CHS as an 'autonomous organism', as advocated by IC and the PSC, was an institutional figure explicitly regulated by administrative law and there was no vagueness about the policy tools available to it or the control mechanisms to be used (DSPC-P, 13/6/90, nº68:3265).

In this same respect, the PSC pointed out that within the administrative law framework there were only three possibilities for designing an institutional form within the public sector: first, a public entity like a Social Security management body, such as the CHI from 1983 in Catalonia and the National Health Institute (INSALUD) at the central government level; second, a public entity regulated by private law, namely a state owned enterprise, which was regulated by the 1985 Catalan Law of Public Enterprises, and which were conceived of for activities of commercial, financial or industrial nature; and third, a public body regulated by public law, that is, an autonomous entity or body of an administrative nature[92]. The PSC argued that this legal figure also had the capacity to develop diverse and agile management forms, such as anonymous societies and consortia, which did not require private law regulations. In this respect, the PSC argued that such an ambiguity involved in the CHS definition had to be criticised not only for legal reasons but also for political reasons, because it left its further more concrete development and implementation to the discretion of the Executive Council - particularly, the generalised use of private law for the CHS regulations and performance (DSPC-P, 13/6/90, nº68:3271).

The PSC argued that the blurring of the distinction between private and public sectors was taken further by allowing both public and private interests a competing and common status within the structure of the CHS. This situation, the PSC stressed, weakened and biased the administration's capacity of intervention -

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92 The PSC referred to the autonomy of one of the existing autonomous organisms of an administrative nature (the Catalan Corporation of Television and Radio). In the law regulating this body there is no mention of the competencies of the Executive Council (the core executive) or of any department. Moreover, the law establishes that the administrative board has to approve the job structure of the Corporation and the staff remuneration, and also, that it has to give its opinion about the appointment proposal for the position of Director General. In the PSC's view these provisions made the Corporation more independent than the CHS in terms of decision-making.

in this case, the CHS[93]. In the PSC's view, CiU's definition of the CHS's legal nature and functions built on and strengthened what they considered:

> '... the politics of discretion, low transparency and difficulty to control the management of health performed by the Catalan Health Institute, and of the correct, effective, efficient and economic use of public financing sources carried out by the Executive Council from 1981' (DSPC-P, 13/6/90:3287).

The PSC claimed that they did not see how the new CHS could achieve CiU's priority objective of a more agile public management and contribute to a greater efficiency, efficacy and problem-solving capacity in the Catalan health system. Crucially, they argued, the chain of decisions in the CHS did not contribute to the flexibility, efficacy, efficiency, which supposedly justified the definition of the CHS as a 'public entity', because many key decisions had to be ultimately made by the Catalan Executive. Hence their criticism of what they saw as an unnecessary ambiguity in the definition of the legal nature of the CHS. The only difference they acknowledged between CiU's, and the PSC's and IC's proposals, though, was that the establishment of these management forms by an autonomous body of an administrative nature *had to be made by law*, that is, approved and passed by Parliament, while in CiU's project, the establishment of these management forms was left to the *discretion of the Executive Council.*

In this respect, CiU's argument was that they saw an obstacle for an 'agile and business-like public management' precisely in the fact that an autonomous organism of an administrative nature depended on parliamentary approval for the establishment of diverse management forms. This curtailed that organism's managerial autonomy. Finally, their answer to the PSC's and IC's interventions was that CiU's definition of the CHS's legal nature was the most adequate for the consolidation and management of a mixed health system and that it was their priority commitment. Moreover, they argued,

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[93] In line with IC and PCC, the PSC argued that CiU lacked the political will to undertake a reform of the public health sector, the CHI, in order to ensure its continuity and modernisation, following the example of other public administrations (provincial and municipal) in Catalonia, such as the case of the Municipal Institute of Health Care in Barcelona. This Institute was dependent on the Local Council of Barcelona which, under the mandate of the PSC, had promoted the gradual transformation of the statutory civil service-like regime of its staff into a labour market-like contractual system, as well as a gradual adaptation of its productive capacities.

> '... this CHS, we think, follows the present international trend in the most developed countries in the sense of using all health resources available, be they public or private, particularly in the case of Catalonia, with the tradition and characteristics which constitute the mixed heatlh system of our country.[94]' (DSPC-P, 13/6/90, nº68:3272).

Note, however, that during this debate for the passage of the LOHC there is no mention of NPM concepts or terms, such as splitting the functions of purchaser and providers, but just 'using all resources available'.

Managerial autonomy and independence from the Executive

The analysis of the design each party's project gave to the administrative decision-making process within the health authority shows the different degree of managerial autonomy and political independence assigned to the CHS. As Figure 4.2 shows, this decision-making chain involves the CHS, the DHSS and the Catalan core executive (the Executive Council or Government). The nature of the functions for which each of these levels has the ultimate decision power is an indicator of the degree of the CHS's level of discretion.

In the CiU's bill the central services of the CHS were structured into two kinds of organs. On the one hand were the directive and management organs, which included the Directive Council, the Director, and 'any other organ that might be created by executive regulations'. On the other hand, there was one participation organ, the Catalan Health Council. Among the directive and management organs, the Directive Council was the highest governing organ of the CHS (see Figure 4.3). Also in this bill, two groups of functions of the CHS's Directive Council may be distinguished: those for which the Directive Council had full autonomy, and those over which it had no final decision power but had to pass the matter on to a higher

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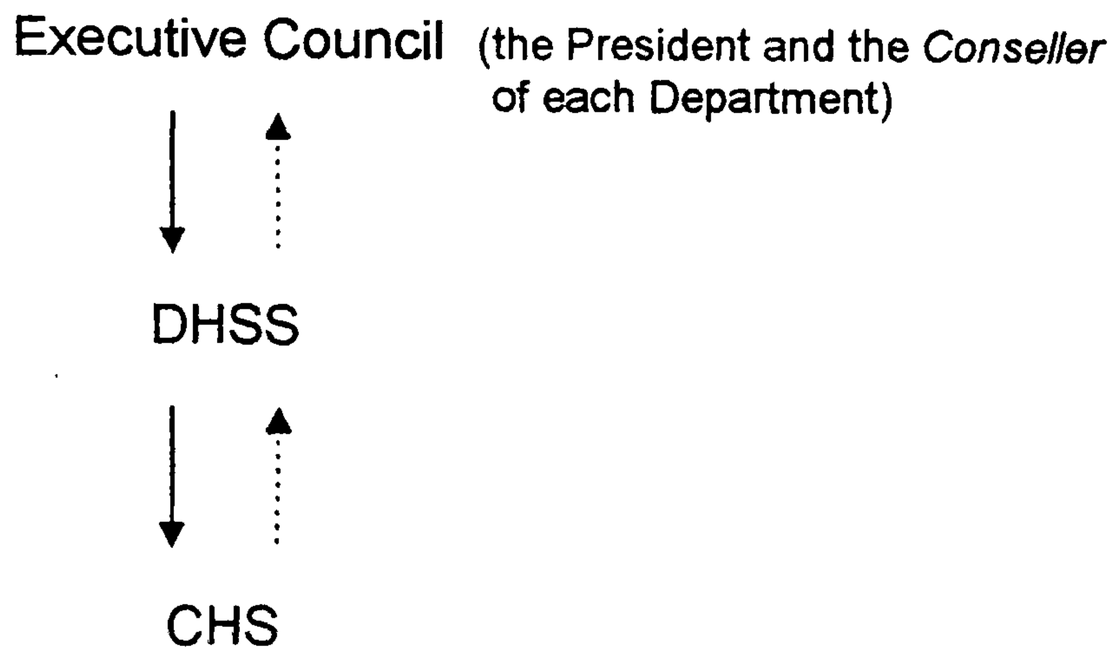
[94] Within the Catalan political system, those political parties which position themselves closer to Catalan nationalism than to Spanish nationalism as two extremes of an ideological dimension (see Figure 4.1), use the term 'country' to refer to Catalonia, and the term 'state' to refer to Spain. In this terminology, one country implies one nation with no inherent reference to a political or an administrative institutional structure. By contrast, one state refers to a political institutional structure and a governmental apparatus controlling either several nations or part of one or more nations which may themselves spread across different state borders.

level of hierarchy for a binding decision to be made - to the DHSS or the Executive Council.

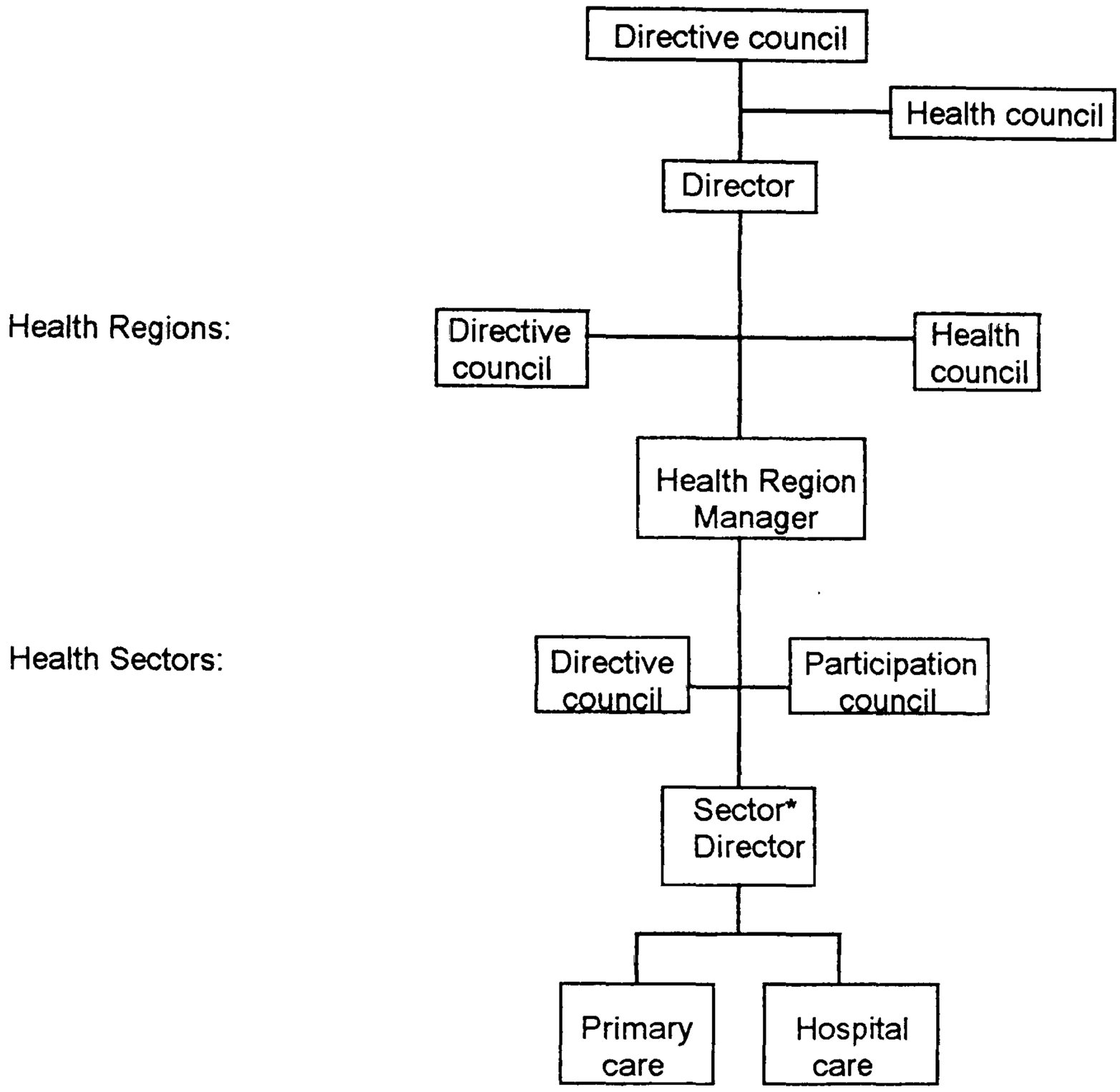
Figure 4.2. Administrative decision-making processes involving the Executive Council, the DHSS and the CHS.



Source: Own elaboration.

Those decisions for which the CHS's Directive Council had full autonomy concerned both policy formulation and regulatory functions. Policy *formulation* functions included establishing the criteria for the performance of the CHS within the health policy defined by the DHSS and the Catalan executive, approving the general proposals concerning health, socio-health and public health organisation and planning within the framework of the Health Plan, as well as the action programmes and general investment programmes of the CHS and its annual report. As for *regulatory* functions, the CHS's Directive Council established the criteria for the co-ordination of all providers within the network of public coverage and the criteria for reaching contractual agreements with non-Social Security health providers. The Directive Council also had to establish and update these agreements, and approve the internal regulation of the Directive Councils of the Health Regions (an indicator of centralisation). Finally the CHS's Directive Council might also agree the delegation of specific functions concerning health organisation, planning, programming and evaluation to the Health Regions.

Figure 4.3. Organisational chart of the CHS in the CiU's bill and IC's alternative project*.



*Instead, in the PSC's project the deconcentrated structure of the CHS comprised Health Areas and Basic Health Area, closely following the 1986 General Health Law's provisions

Source: DSSS (1992a).

Despite CiU's explicit intention to create an organisation structure appropriate for flexible and autonomous management, the functions over which the CHS's Directive Council had no final decision power (but had to pass the matter on to a higher level of hierarchy for a binding decision to be made or authorisation to be given) were mainly concerned with *management*. On the one hand, the decisions requiring to be passed on to the DHSS - after reaching an agreement at the CHS level - concerned the internal management of the CHS. These functions were the definition of the jobs structure of the CHS, the appointment and removal of the Health Region managers, the formulation of the draft bill of the Health Plan, the draft budget bill proposal for the CHS, and the documents about the economic and

accounting management of the CHS. On the other hand, the decisions to be passed on to the DHSS also concerned the *external management* relations of the CHS. These included the establishment of integrated or joint-management forms with either public or private entities, the creation of organisms with legal personality, consortia, and the participation of the CHS in any other legal entity, the proposal to set the prices and tariffs for the CHS's contracting with non-Social Security providers, and proposals for regulating matters under the competencies of the CHS.

However, only over some of these competencies did the DHSS represent the highest administrative decision-making point, that is, it was not required to pass them onto a the Executive Council for approval. These included the approval of prices and tariffs for the CHS's contracting with - and providing services through - non-Social Security providers, and the authorisation of any modification of the distribution and organisation of providers and services, as well as the updating of their required inventory and accreditation. The DHSS, and more specifically its *Conseller*, appointed and removed the members of the CHS's Catalan Health Council and Directive Council, the president and the members of the Health Council and the Directive Council of each Health Region, the manager of each Health Region, and the members of the Participation Council of each Health Sector - in all cases following the proposal of the groups to be represented. Finally, the DHSS authorised the internal operating regulations of the CHS's Catalan Health Council and of the Participation Council of each Health Region. None the less, there were crucial matters over which the DHSS had no veto power and had to be dealt with by the Executive Council for a final decision to be made: the approval of the Health Plan, the CHS's organisational structure, the CHS's proposals for the creation of consortia or for its participation in any other legal entity, and the draft bill of the CHS's budget.

In contrast to the CiU's bill, the PSC's alternative text designed a more independent CHS, as its Directive Council was the final decision-making point for all of its internal and external management functions. *Internal management* functions included: organising the central services of the CHS; approving the internal regulations of the CHS and of the Health Councils of the Areas; approving the health plans of the Areas; and appointing and removing their Directors (on the proposal of their respective Directive Councils) and members of their Health Councils (on the proposal of those organisations and institutions represented);

appointing and removing the directors of hospitals integrated in the CHS and the rest of their directive personnel (on proposal by the Directive Council of the corresponding Health Area and by the CHS Director General). In the CHS's *external management* its Directive Council had full autonomy to establish the necessary contracts for the achievement of its ends, to establish concerts for the provision of health services with non-public administration providers - but after having achieved an optimum utilisation of the public resources available- and to develop specific programmes for the training of human resources in the health sector.

However, in the PSC's alternative text the hierarchical relationship between the DHSS and the CHS was clear as far as those functions concerning *policy formulation*. In this respect, the CHS's Directive Council defined the criteria for the CHS's performance and planned resources following the directives of the Executive Council. It also approved the annual budget of the CHS and raised it to the DHSS for its incorporation into the draft bill of the DHSS's budget. It also considered the CHS's annual report including the economic results and approved investments, and raised projects of plans and works to the DHSS. However, the DHSS had veto power over some matters, since it was responsible for territorially organising the health services, for authorising the creation of new services and centres, for developing the regulation on health personnel approved by the executive, and for integrating the different health plans with the DHSS's plan. However, it had also an enabling role concerned matters such as facilitating the activities of health services users' associations and health non-profit entities and co-operatives as well as their co-ordination with the public health system, and co-ordinating research programmes and public resources of any source.

In line with this two-fold role of the DHSS, the PSC's alternative text defined the Executive Council as both a decision-making and an enabling organ. In the PSC's project the administrative decision-making of the Executive Council included establishing the required budget for covering the needs of all services which depended on public administrations, and approving the Health Plan and the statutory regime of civil servants. It was also responsible for establishing specific health plans with other administrations (such as the Spanish central government and local administrations), agreements between health centres and universities for training, agreements concerning the gathering and analysis of information on health, and the evaluation of investments according to economic and health

criteria. In turn, the *enabling dimension* of the Executive Council included the creation of technical commissions and committees and the establishment of agreements with other administrations for guaranteeing the efficacy and efficiency of health services; the guarantee of the democratic participation of those having an interest, including unions and business associations; and the promotion of the updating of health teaching, of interdisciplinary training and the financing of research.

The distribution of competencies provided in IC's project was very close to that defined in the PSC's project. The Executive Council's 'veto power' concerned the approval of the CHS's budget project and of the statutory regime of civil servants. As for the Health Plan, however, the Executive Council had to send it to parliament for approval. In turn, its *enabling role* concerned its competencies to establish specific health programmes, to promote co-ordination with other departments of the Catalan government, as well as health research, retraining and education, and to establish the political and administrative conditions for the democratic participation of social, political and local entities as well as citizens in the management and structure of the CHS. As far as the DHSS was concerned, IC demanded a clearer definition of the DHSS's political and administrative responsibilities over the CHS. IC assigned it the competencies to organise, regulate, co-ordinate and distribute public resources and all providers of publicly funded services across the territory - including the authorisation of the creation of new ones - according to criteria of socio-health needs assessment and on social, economic and territorial equity. Moreover the DHSS had to facilitate the health activities of social entities and non-profit health co-operatives.

In all three projects, the CHS's Director had a managerial profile. All three texts provided that the CHS's Director was responsible for ensuring that the CHS complied with all the regulations concerning the performance of its functions. The Director had to submit to the Directive Council all the proposals and documents over which the latter had to make a decision, either final or as a previous step to forward it to a superior level of hierarchy. The Director was also the head of personnel and was responsible for promoting, co-ordinating, inspecting and evaluating the organs of the CHS - following the directives of the Directive Council - and issuing the necessary internal orders concerning their functioning and organisation. Finally, the Director acted as a contracting organ of the CHS, authorising the CHS's expenditures and proposing the corresponding payments. In

all three projects, this figure was appointed and removed by the Executive Council on proposal by the *Conseller* of the DHSS. But the PSC's text stressed that the CHS's Directive Council had to be heard about the appointment proposal, and moreover, the Director put forward to the Directive Council the appointment and removal of the rest of directive personnel of the CHS. In the other two projects this power was not provided, but was left to the *Conseller* and the Executive Council.

b) Participation rights for political and social actors.

The ability of other political and social actors to participate in the CHS's structure was a major issue in the negotiation process. As a result of the negotiation, carried out at the Commission level, the participation issue had an impact on all collegial organs of the CHS and at the three management levels of its deconcentrated structure (central services, regions and sectors). In fact, it became the first case in Spain where, not only participation organs, but also the highest *directive* organ of an Autonomous Community's or central government's health authority included representatives of collective social actors like unions and business organisations. Participation experiences until then had only affected specialised participation organs, but not directive organs.

As Table 4.3 shows, neither the CiU's bill nor the PSC's project provided any participation share for social actors. CiU designed a Directive Council composed of representatives of the executive branch of the Catalan government, all of them being political appointees. The PSC's alternative text included representatives selected from different administrations: 50 per cent from the Catalan government and 50 per cent from two levels of local administrations. By contrast, IC designed a more heterogeneous Directive Council including 50 per cent of members representing the Catalan government, 30 per cent representing different local administrations, and 20 per cent representing social actors[95]. In all three projects,

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[95] In addition to this design, IC's project provided the formation of a Secretariat with executive powers which would meet monthly and which was composed of nine members: the *Conseller*, the under-secretary of the DHSS, three other members of the Catalan government, one of municipal governments, one of *Consells Comarcals*, one of the unions

all members were appointed by the Executive Council for four years and renewable, as suggested by the DHSS's *Conseller,* who had to listen to the proposals made by the collective interest which these members were to represent.

Table 4.3. Composition of the Catalan Health Service's Directive Council.

	CiU's bill	PSC's text	IC's text	Commission's text	LOHC
Catalan govt. admin.		5	9	4	4
DHSS					
(*Conseller*)	1	1	1	1	1
(Secret. Gral.)	1			1	1
(other+)	7				
CHS					
(Director)	1			1	1
(Health Region**)	7			4	4
DEF*	2			1	1
Municipal govt.		4	4	2	2
Provincial admin.		2[96]			
Comarca admin.++			2	2	2
Unions			2	2	2
Business assoc.			2	2	2
TOTAL	19	12	20	20	20

*Department of Economy and Finance of the Catalan Government.
**CiU's bill suggested seven Health Regions although later regulations defined eight Health Regions.
+CiU's bill required the same number of DHSS's representatives as the number of Regions' representatives.
++*Consells Comarcals* (supramunicipal administrative demarcations indirectly elected and territorially smaller than provinces).

Source: Own elaboration based on BOPC, 5/6/89, nº78; BOPC, 4/12/89, nº115; BOPC, 8/6/90, nº177; BOPC, 6/7/90, nº187; and Cernadas (1994).

and one of the business organisations. The functions of this Secretariat were not further specified.

[96] The PSC considered that, in order to simplify the health network under a single health authority, *comarcal* administrations and provincial administrations should not have health competencies. They argued that provincial administrations, despite having seen their competencies scratched since 1987, should be included in the law because they actually own important providers. In turn, municipal governments should gradually concentrate on public health and the Catalan government on health care.

In the three projects, the Catalan Health Council was conceived of as the central organ of community participation in the public health system. In the CiU's bill this Council's functions were defined as advisory and consultative concerning the draft bills of the Health Plan and the CHS budget, the CHS annual report, and the health care programmes and providers' performance, as well as their adequacy to the population needs. Its composition involved 30 members (see Table 4.4). The membership share was: one third representing the Catalan government, 20 per cent representing local administrations, 10 per cent representing the unions, 10 per cent representing business organisations in the health sector and health insurance companies, and 10 per cent for scientific and training entities. The remaining members corresponded to consumers' and users' associations, to health professionals associations, and to the Federation of Mutualities of Catalonia.

Table 4.4. Composition of the Health Council of the Catalan Health Service.

	CiU's bill	PSC's text	IC's text	Commission's text	LOHC
Catalan govt. admin.	9	3	9	9	9
DHSS (*Conseller*)	1	1	1	1	1
Municipal govt.	3	3	4	4	4
Provincial admin.		2			
Comarca admin.	3		2	4	4
Unions	3	4	2	4	4
Health sector unions				3	3
Health profess. assoc.		2		2	
Employers' assoc.	3	4	2	4	4
Health empl.' assoc.				3	3
Consum./users' assoc.	2	4	2	3	3
Professional assoc.	2	3	4	3	3
Universities	2	2	3	2	2
Scientific entities	1	3	1	1	1
Federat. of Mutualities	1				
TOTAL	30	30	30	43	41

Source: Own elaboration based on BOPC, 5/6/89, nº78; BOPC, 4/12/89, nº115; BOPC, 8/6/90, nº177; BOPC, 6/7/90, nº187; and Cernadas (1994).

In the PSC's alternative text, this organ was named the Participation Council of the CHS. Apart from making citizens' participation effective and advising on the draft bill of the Health Plan, of the budget and of the annual report before the Directive Council approves them, the Participation Council was also given the functions to control and supervise the implementation of programmes and the CHS management, and to advise the rest of CHS's organs, as well as raising proposals and complaints to the DHSS. The allocation of its 30 members to different collective actors in the PSC's project gave far less weight to the representatives of the Catalan government and raised the weight of the rest of actors. Its composition was designed as follows: 10 per cent for the Catalan government; 17 per cent for local administrations; 17 per cent for scientific and training entities; 17 per cent for health professional associations; 13 per cent for users' and consumers' associations; 13 per cent for the unions; and 13 per cent for the business organisations.

In IC's alternative project, the Catalan Health Council was defined in a different way. It was also conceived as a participation organ, but as the technical deliberation organ of the Directive Council - its functions were not decision-making but only of technical advice - and its members were appointed by the *Conseller*. This organ was composed of the members of the Directive Council as well as four representatives of the professional associations involved in the CHS, three representatives of the Catalan universities, one representative of the Catalan scientific entities, and two representatives of the associations of users of health services.

The participation issue and this negotiation pattern for determining the composition of the Directive Council and the Health Council of the CHS's central services also affected the deconcentrated management structures of the CHS. These management structures were the Health Region and the Health Sector (the latter comprising Basic Health Areas where primary care is organised) in the case of the CiU's bill and IC's project, and the Health Area and the Basic Health Area in the PSC's project, the latter resembling its homonymous in the other two projects[97].

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[97] In this point, the PSC closely followed the provisions of the 1986 General Health Law, which established this same territorial demarcation. Moreover, Health Regions as defined by CiU and IC were larger than Health Areas. In all three projects, though, the management structures of the CHS covered territorial demarcations defined on criteria of both health resources distribution and homogeneity of socio-economic, epidemiological and demographic aspects, as well as communication routes. A report of the Legal Cabinet of the Catalan government pointed out that 'The point of the draft bill [by CiU] which has to be

These deconcentrated management structures reproduced the directive, management and participation organs of the CHS's central services (Directive Council, Manager, and Participation Council), showing a similar initial proposal for their composition on the part of each parliamentary group, and reaching a final agreement which resembles that achieved for the central services' organs. This is consistent with the fact that the functions these organs have assigned parallel those at the central services level, though circumscribed to their territorial demarcation. These management structures were supposed to be the organisational channel for a bottom-up health planning and budgeting process which follows a gradual integration with upper management levels.

However, the PSC drew on two reports presented as antecedent documents to the legislation process to support its argument that the CHS's deconcentrated structure fell short of the expectations raised about a flexible and decentralised management. According to a report by Tornos (1989:7) there is a conceptual distinction to be made between decentralisation and deconcentration. 'In the first case, the areas would be entities with their own budget and with their own financial, personnel and physical resources; in the second case, just territorial demarcations with a deconcentrated organisation'. Health Regions were deconcentrated organisations and therefore less autonomous. Moreover, the Executive Council ultimately authorised the delegation of management to public and private entities and societies. Thus, the Health Region was not very autonomous, because it could not decide on the management of the centres within its territory. The competencies of its Directive Council also showed its low autonomy.

c) Providers' autonomy.

The third dimension of disagreement during the negotiation process of the 1990 LOHC was the degree of integration of providers into the CHS. This issue involved, first, the extent to which private providers and those public providers which were

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taken in more careful consideration is that referring to the territorial organisation of the CHS, as it creates health regions and basic health areas, while the GHL refers to Health Areas and Health Basic Zones.' (GJGC, 1989:11-12).

not part of the CHI (the Social Security management entity) but which had a contractual agreement with the health authority (the CHI until then and the CHS onwards), had to remain autonomous organisations or had to transfer the ownership of their assets to the CHS and be integrated into its administration structure. Second, there was the need to clarify the CHS's responsibility over those providers and over their performance in relation to the contractual agreements they signed. The alternatives supported by different groups in parliament ranged from full integration (IC, and also the PCC and the CDS) to full autonomy based on contracts implying no functional attachment (PP). In between laid CiU's and the PSC's preference for functional attachment without no transfer of ownership.

This issue was relevant for at least three reasons. First, because the health authority's commitment to the survival of such providers was at stake. Either their functional attachment through stable contractual agreements or their integration and transformation into budget units of the health administration ensured their survival as necessary providers of National Health System, that is, as publicly financed health services. While in the former case they may incur deficits and run financial risks, in the latter case they are financed through the budget. The second reason directly derives from this point, as integration or functional attachment to the CHS implied different policy tools available to the CHS for the fulfilment of its functions as health authority. The former reason involves hierarchical integration, while the latter involves contractual relations. Integration of providers into the CHS meant that they had to adopt the internal organisational and administration regulations of the Social Security providers. This option *precluded* the development of one of CiU's priority commitments: the widespread introduction of private management practices in the health sector by keeping the organisational and management autonomy of those heterogeneous providers. The third reason why this issue was relevant was that integration or functional attachment of providers involved different consequences for the role that local administrations could develop concerning providers which until then had been dependent on them and which had enhanced the importance of the municipalities' or provinces' competencies over health policy. The relevance of these reasons stems form the need to define a legal nature for the CHS ambiguous enough to encompass all these conflicting interests.

Functional attachment versus integration

As explained above, in the CiU's bill the CHS was defined as a 'public entity' endowed with legal personality and full capacity for the fulfilment of its ends. The LOHC, as finally passed by parliament reflected the agreement achieved at the Commission's stage, by which some ambiguity about its legal nature remained: the CHS was a 'public entity of an institutional nature'. This ambiguity was not clarified when, despite the CHS being an 'instrumental organism ascribed to the DHSS', all three projects and the final version passed established that the CHS 'comprised' the providers of health and socio-health care owned by the Catalan government, the providers owned by the Social Security administration and managed by the Catalan Health Institute (CHI) from 1983, the providers owned by provincial and municipal administrations (which were either integrated or functionally assigned to the CHS through the corresponding agreements), and other non-publicly owned providers financed by the CHS. This definition of the CHS raised questions such as whether the CHI was to be integrated into the CHS, and what the nature of the relationship was between the CHS and private and public non-CHI providers.

In principle, the option to fully integrate private and public non-CHI providers in the new health authority (the CHS) implied that they surrendered not only the ownership of their assets, but also the management and organisational autonomy they had had until then[98]. By contrast, their functional attachment to the health administration took for granted their managerial and organisational autonomy, as well as the ownership of their assets. Both CiU and the PSC favoured this latter option and agreed that within their autonomy, providers had to facilitate a participative management by objectives and performance control by results. Responsibility over management had to be clearly defined and the costs and quality factors had to be assessed. Moreover, these providers had to periodically provide the CHS with economic and health indicators, economic evaluation of their activities, and operational and economic auditing reports. Going a step forward, the same management approach was also required from all providers which were

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98 The internal organisation and management of those health providers which were part of the public administration, such as those included in the CHI, was regulated by executive regulations and replicated the much criticised model of the Social Security providers in the rest of Spain (rigid hierarchical structures, statutory personnel regulation, and budget management constraints).

HNPU-members, that is, all centres and establishments which were either integrated into or functionally attached to the CHS.

However, the debate on integration versus functional attachment was only consequential for the non-CHI providers. This debate did not focus at all on the CHI, which is the largest single provider in Catalonia, and which comprises all public Social Security providers. As the CHI providers are owned and managed by the public administration, being integrated into the CHS did not mean their transferring assets or managerial freedom. Thus, during the debate of the LOHC, the future of the CHI was left ambiguous. According to temporary provisions of both the CiU's bill and the PSC's project, those organs and services of the DHSS and the CHI which until then had performed functions now assigned to the CHS by the new law had to be transferred to the CHS. The consolidation of the CHS depended on the completion of the process through which all services, providers, and programmes being managed by the CHI are finally integrated or functionally attached to the CHS.

In any case, most parliamentary groups agreed on the providers that the CHS should 'comprise' - that is, those which will be publicly financed. The exception was the PP, which argued that health care models of an associative or co-operative nature which were so widespread in Catalonia should be explicitly included among the CHS resources. The rest of groups, including both the PSC and IC, agreed fundamentally with the CiU's bill. However, because of the mixed public/private character of these resources, the PSC demanded a clearer definition of the CHS's responsibility for providers beyond their contractual relationship. The PSC thought this clarification necessary even more when the distinction between private and public interests was blurred by providing the presence of both of them with the same status in decision-making in the managerial structure of the health authority. Moreover, in line with IC, the PSC claimed that the CHS had to assume responsibility for charitable health care foundations, either public or private attached to any public administration. Finally, the PSC stressed that the discretion of the CHS to resort to contracting with for-profit providers had to be limited, and priority should be given to non-profit institutions.

However, the PSC asserted that they did not support a 'state-isation' or 'publification' of health care provision in Catalonia. Rather all public provision from any administration should be integrated and modernised, while the private sector should have an important and necessary complementary role of in the provision of

publicly funded services. To achieve these two purposes, they claimed, it was necessary not to mix up both sectors because they had different legal management tools and interests (DSPC-P, 13/6/90, nº68:3287). By contrast, IC (together with the CDS and the PCC) advocated the gradual integration of the HNPU members into the CHS. They stressed that there should not be confusion between public and private sectors. Ownership was important because it conditioned the possibility of democratic control by both public administration and parliament. They claimed that the private sector was free to function, but with private money.

The role of local administrations.

The creation of the CHS by the autonomous administration involved a centralisation process. The reason was that the new governance structure of the health system required either integrating or functionally attaching all public health providers under the authority of the autonomous government. And this process was to take place within each Autonomous Community despite the fact that a considerable number of those providers were owned and managed by agents other than the Social Security administration (see Chapter 2). In Catalonia there are three levels of local administration - municipal, *comarcal* (supramunicipal demarcations) and provincial - of which the first and the latter often either own or manage health providers, and they were therefore affected by this process. However, the three projects presented by CiU, the PSC and IC took slightly different approaches to the matter of clarifying the distribution of competencies among them.

The CiU's bill focused the competencies of two of these levels - *comarques* and municipal governments. Apart from the competencies derived from their participation in the management structure of the CHS, *comarques* were assigned competencies over co-ordination between municipal health services and between them and those of the Catalan government, over provision of supra-municipal services related to environmental and public health, over participation in health planning through their membership of the Directive and Health councils of the Health Region, and over provision of information and statistical support about their activities to the Catalan government. In turn, municipal governments were assigned

competencies basically related to the health control of the environment - for example, industries, services, means of transports and noise, distribution and over delivery of food, buildings, housings, and cemeteries.

In contrast to the CiU's bill, the PSC's project gave a more thorough consideration to the health competencies of municipal governments and provincial administrations - though not to those of *comarques* - and took a more active approach to their role in health policy. The PSC stressed the need to give a role in health competencies to the rest of the public administrations in Catalonia. They argued that this would deepen decentralisation and help to co-ordinate, clarify and simplify the competencies over health on a complementary basis as well as unifying all public health care networks into a single one, under a single health authority (the CHS). And it would help, they claimed, if the model of administrative decision-making was not so centralised, with so many decisions having to be sent to the Executive Council and the DHSS in CiU's text.

Thus, the PSC demanded that the transfer of provincial and municipal administration providers to the CHS should be made according to specific transfer agreements; that the health personnel of the services attached to municipal governments would remain functionally dependent on local governments, though organically on the Basic Health Area; and that local administrations should not compulsorily help to finance the services they transfer. The PSC's project included a positive list of the compulsory services to be provided by municipal governments - as established by the legislation on municipal regime - and it highlighted that they might take any actions to promote the interest of their community including complementary activities to those performed by other administrations, emphasising the central government because of the possibility of obtaining earmarked funding[99]. In addition to participating in the management of the CHS and in the management of hospitals and care services, both municipal and provincial administrations had the competencies to create new providers within the framework of the Health Plan and on approval by the DHSS, and to establish agreements for the provision of services with non-public administration providers and agreements between universities and health entities. For the fulfilment of their competencies, local governments may resort to financing sources such as the Fund for Local Co-

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[99] In the line with the PSC, the PCC also emphasised the need to establish specific action programmes and negotiated their funding with other administration, emphasising the central government.

operation. As far as provincial administrations were concerned, they were given the competencies of participating in the co-ordination between local administrations and the Catalan government, co-ordinating the municipal health services between them, providing municipal governments with legal, economic and technical co-operation, as well as health services of a supra-municipal character, and administering the health interests of its territory.

In IC's project, local administrations were given a lower profile than in the PSC's project. In fact, they were assigned basic competencies derived from the centralisation of the new governance structure of the health system and the creation of the CHS. Thus, both municipal governments and *Consells Comarcals* (the administrative organ of *comarques*) were assigned the competencies to participate in the management of the CHS and in the management, planning and implementation of the health plan of the Health Region to which they belonged. Moreover, municipal governments received and channelled citizens' voices, while *Consells Comarcals* co-ordinated municipal health services between them and provided the supra-municipal services for which they were responsible.

Policy tools available to the CHS.

All three projects presented by CiU, the PSC and IC agreed that the financing source of the CHS and the public health system must be a line item budget, following the traditional classification of expenditure, which forms part of the global and single budget of the Catalan government. Within the Department of Economy and Finance, the General Treasury of the Catalan government is in charge of the CHS treasury function, centralising the CHS resources, including those transferred by the Social Security and other entities. The CHS has to distribute these resources with the objective to cover the population's needs. The policy tools the CHS was allowed to use had therefore the financial constraints of the budget it was assigned.

The CiU's bill emphasised in its introductory paragraphs that one of the aspects which differentiated their proposal from laws creating health services in other Autonomous Communities was the diversity of management forms which the CHS was allowed to use. For the fulfilment of its managerial responsibilities - the management of the 'services and providers integrated in the CHS', and the

'management and implementation of health programmes' - the CHS as a 'public entity' could resort to different 'management forms' (BOPC, 5/6/89, nº78:4964-5, and article 7.2 of the CiU's bill and of the LOHC). The CHS might develop those functions directly or through organs with or without legal personality which might be created and ascribed to the CHS. Alternatively, the CHS might also exercise those managerial functions indirectly by establishing agreements, signing quasi-contractual relations, or using forms of joint or integrated management with either public or private entities. The CHS might also create consortia of a public nature with either public or private entities, which may be endowed with legal personality, as well as creating or participating in any other legal entity. However, the CHS's freedom to develop its managerial responsibilities through indirect forms was constrained by the requirement that the creation of new entities and the participation of the CHS in them had to be authorised by the Executive Council.

The PSC's parliamentary group admitted that the Catalan administrations might establish contractual agreements with other providers for the provision of health services of public coverage. However, this possibility was subordinated to three conditions. First, public administrations had to take into account the optimum utilisation of the health resources they owned before making the decision to contract with other providers. Second, if such a decision was finally made, priority for contracting had to be given to non-profit providers when indicators of efficacy, quality and costs were analogous. Third, public administrations were not allowed to contract with other providers when the economic and social objectives established in the Health Plan were contradicted.

Additionally, the PSC's text stressed the need for the Executive Council to regulate such contractual agreements as the standards of services contracted and the tariffs to be paid for them, their financing by the CHS and the prohibition that providers make any profit from the services contracted, the previous accreditation of those providers, the reciprocal rights and duties of both administration and provider, the time span of the contract, as well as the conditions for the physical, administrative and economic inspection of providers by the contracting administration[100]. Specific reference was made concerning private providers and

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[100] Without prejudice to the cost-free status of the public health services of universal coverage, CiU's bill established the possibility that both the CHI providers integrated in and providers functionally attached to the CHS might charge an amount authorised by the DHSS -on proposal by the CHS-, for services which are not strictly health care (Fourth Additional

their relationship with the CHS. In this respect, the PSC's alternative project recognised the free enterprise principle in the health sector, and provided that any private providers might apply for a status of functional attachment to the CHS, reaching an agreement which had to be reviewed every three years. However, this agreement had to be conditioned both by the provisions of the Health Plan and budget availability. In any case, though, the private providers functionally attached to the CHS had to keep their private ownership and management capacity over their internal labour relations.

IC's alternative text also gave a clear priority to public providers, though with a stronger emphasis on the possibility of ownership transfer to the CHS from all private providers and non-CHI providers having a contractual agreement with it. As an exception, the CHS may establish contractual agreements with private centres when it is necessary to ensure coverage, following criteria of proximity to the citizen where there are no CHS providers. These agreements had to be public documents and might cover a period no longer than three years, clearly specifying the services contracted, including a compromise to transfer the use of their assets for that period, and tailoring the payment by the CHS to the accomplishment of the performance agreed.

By contrast to the PSC's and IC's alternative texts, the CiU's bill approached the theme of the relationship between the CHS and the diversity of providers existing in Catalonia through the global reference to the Hospital Network of Public Utilisation (HNPU) created in 1985. In this respect CiU's project explicitly intended to consolidate:

> '... a mixed health system based on making use of all resources, either public or private, with the aim of achieving an optimum hospital reorganisation which allows an adequate homogenisation of services and a correct use of physical and human resources, in line with the general trend in developed countries' (BOPC, 5/6/89, nº78:4965, and article 39 of the LOHC).

Provision of CiU's bill). This provision was strongly opposed by the PSC's and IC's projects, as well as by the CDS and the PCC.

This network was to be composed of all health care providers which were either integrated into or functionally attached to the CHS[101] - namely, the HNPU. The former are owned by public administrations, the latter by any other private agent, but all of them regularly satisfy the needs of the public health system coverage, as the main instrument of the CHS for the implementation of the health policy. Those providers which are not integrated in the CHS but are functionally attached to it must have achieved the accreditation requirements. As HNPU members they were required to develop not only health care services but also health promotion and education, illness prevention activities, and medical teaching and research. They also had to submit to the CHS the statistical, management and economic information required as well as facilitating the controls and inspections carried out by the CHS.

However, the PSC was sceptical about the HNPU member hospitals meeting the compromises listed in the law (articles 43 and 44 of the LOHC), because five years after its creation in 1985, when those same compromises were agreed, they had not yet been met either by the CHI or by the contracted-out hospitals. In addition, the mechanisms for integrating non-hospital specialist health professionals into the different providers of the HNPU in order to achieve an adequate co-ordination between health professionals of primary and hospital care were not clearly defined in the CiU's bill. In general, the PSC criticised the lack of definition of the hospital sector model, which, they considered, had evolved chaotically and was immersed in an ideological and planning crisis. For the PSC, the causes of this situation were firstly, the concentration of providers in Barcelona and the metropolitan area and particularly providers with high technology and high costs, which was against equity and efficiency principles. Secondly, the existence of a minority Social Security hospital sector, discriminated against in the allocation of resources, and the existence of a larger private sector, was leading to a conflict of interests in the distribution of resources. Finally, the PSC pointed to a conceptual crisis about for the role of the hospital in the health sector and in health care. For example, different rationalising initiatives, such as the 1986 Plan for the Reorganisation of the Hospital Sector in Catalonia, had not been implemented and hospital planning had not been made dependent on needs.

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[101] The HNPU covered acute care. The creation of a network for chronic patients is left open as a possibility which would build on the existing health care centres which are not HNPU-members.

The closest formulation of a clear idea related to NPM policy tools was made by the PP. On the relation between the health authority (the CHS) and autonomous providers, the PP demanded that the performance criteria defined by the CHS to be followed by hospitals should not be binding for those which *opted out and became self-governed*. The PP also came close to NPM formulations of purchasing roles but without mentioning it, by arguing that a two-year period should be set for giving the Health Regions functional, budgetary and management autonomy to have a decentralised and effective system. Additionally, the design of strictly contractual relations between autonomous entities, the PP claimed, required the clarification of how controversies between citizens and private providers holding a contract with the CHS should be dealt with, and the legal relationship between the CHS and those providers.

CiU's answer to these interventions was to reassert that the fact that:

> '... the HNPU model has been maintained within a CHS defined as a public entity ... [It] has nothing to do with the privatisation of the Catalan health sector ... It is clear what the option of the Catalan government has been in this respect. The health sector which is public and of public utilisation is just that: public and of public utilisation; it is neither private nor for privatisation. The fact that we adopt this form stems, on the one hand, from the historical elements I mentioned, and [on the other hand] from the will to go ahead in pursuit of finding more flexible management forms, of applying the principles of private management to the public sector; in sum, following the internationally accepted and practised trend of using all existing resources in a context of economic constraints' (DSPC-P, 13/6/90, nº69:3364).

Another major policy tool on which contractual agreements were supposed to find their *raison d'être* was the Health Plan for Catalonia. In comparison to the other issues discussed, the Health Plan as a policy tool central to the reform was a matter of considerable agreement between the three different projects presented. All of them agreed that the Health Plan consisted of the guidelines for the development of the activities, programmes and resources of the CHS in order to achieve the health policy objectives of the Catalan government. The Health Plan was meant to cover a three-year period and was approved by the Executive Council on proposal by the *Conseller* of the DHSS, making its objectives compatible with those of socio-economic and welfare policies. The Health Plan had to include an assessment of the starting situation in terms of economic and human

resources, programmes and services being provided, and the administrative organisation of the health system. The Plan also defined the objectives to be achieved concerning health promotion and protection, illness prevention, health care and rehabilitation, upkeeping of health centres, homogenisation and balance of resources between Regions, efficacy, quality, cost and users' satisfaction. In addition, it formulated the services, programmes and actions to be developed, together with the economic and financial resources available. Finally, it included mechanisms for evaluation of the implementation of the Plan had to be provided.

All three party projects also agreed on the process for defining and elaborating the Health Plan. The DHSS formulated the general health policy framework and its own plan concerning its functions. Within these general guidelines, each Health Region (or Health Area in the case of the PSC's project) elaborated the draft bill of its own health plan and put it forward to the CHS's Directive Council. The latter integrated the Regions' health plans (which had in turn integrated the health plans elaborated by the Health Sectors) with its own plan of common and general services for the whole health system in Catalonia and forwarded the whole document to the DHSS. In turn, the DHSS integrated this document with its own plan.

There were, however, some specific disagreements. The PSC wanted to explicitly link the content of the Health Plan to the financing sources and to stipulate that there should be a mechanism of parliamentary control of the implementation of the Plan. For the PSC, the content of the Health Plan should be given more detailed consideration and should include the timetable for the reforms to be carried out in health care. Contracting should be clearly subjected to the provisions of the Plan. Similarly, IC argued that the Health Plan should not be, as CiU's project established, an indicative tool and reference framework, but rather a necessary tool for all public interventions in health care - such as investments, health programmes and allocation of resources. It should also take into account a health map. The Health Plan should be the basis for the Health Regions' and Sectors' health plans, and clear objectives of the Health Plan should concern efficacy, efficiency and control by the administration.

4.3 Legislative negotiation and the government's power.

In the negotiation process leading up to the passage of the 1990 Law for the Organisation of Health in Catalonia (LOHC) the CiU government relied on its absolute majority in parliament and on the institutional rules characterising a parliamentary regime - namely the dominance of the executive in the legislative process when it can count on a parliamentary majority which is, moreover, subjected to party discipline. In essence CiU had the power to reject any amendments, but to see how far it used that power it is necessary to identify the modifications introduced in the CiU's bill, first as a result of the Commission's negotiation[102], and second as a result of the parliamentary debate. The extent to which those changes are marginal or central to the three main dimensions of disagreement analysed above gives an indication of the extent to which CiU did use its power.

On the CHS's managerial autonomy and degree of dependence on the Executive (which jointly defined the CHS's degree of discretion), CiU used its power so that its first preference remained unchanged throughout both the Commission's negotiation and the parliamentary debate and was finally passed as the LOHC (see Figure 4.4). However, and in contrast to the alternative texts, those functions for which the Directive Council of the CHS had full autonomy in the CiU's bill concerned both policy formulation and regulatory functions, while those over which the CHS had no veto power but had to pass the matter on to a higher level of hierarchy for a binding decision to be made - the DHSS or the Catalan core executive - concerned both internal and external management.

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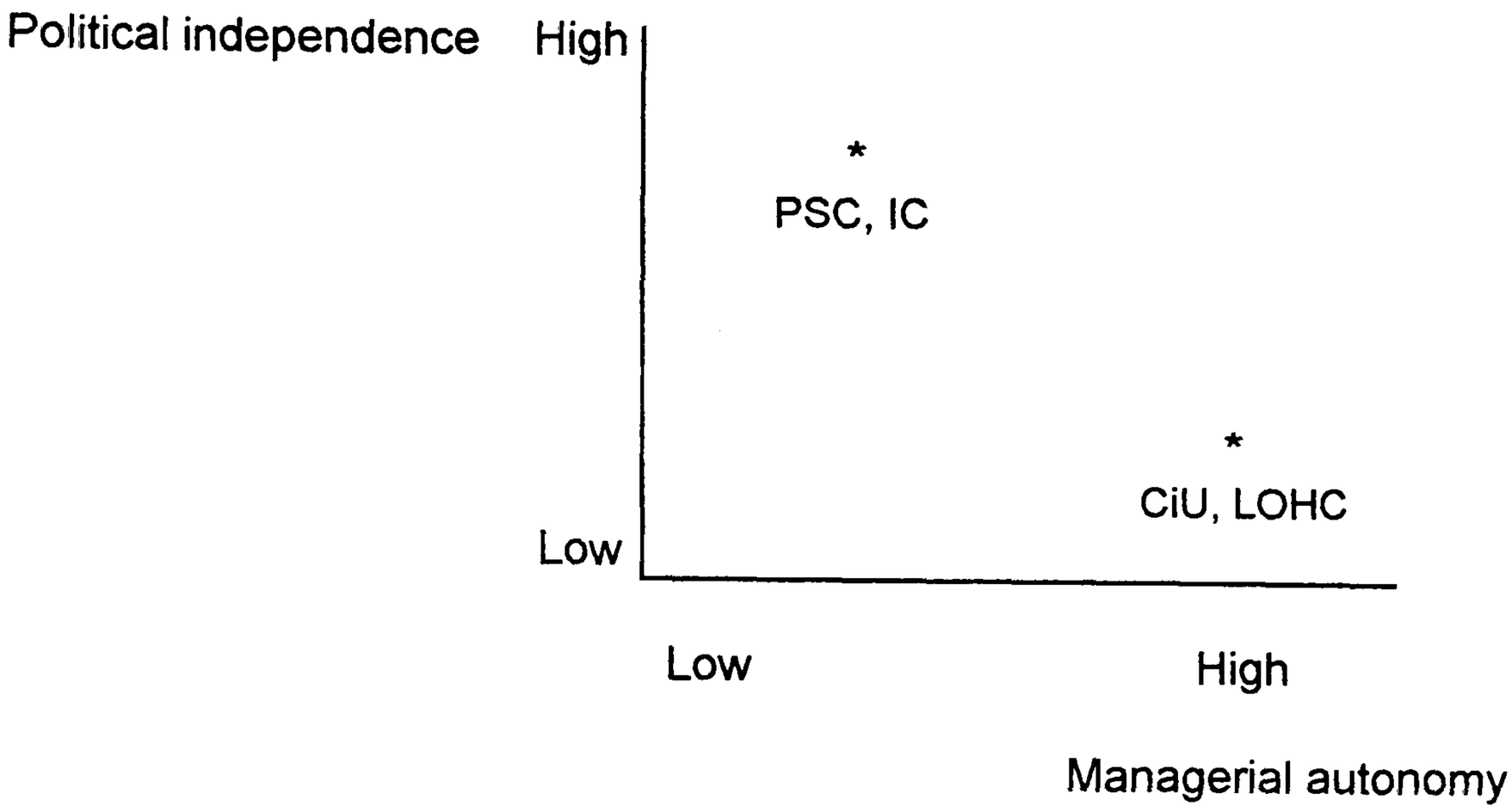
[102] Parliamentary groups present and discuss all their amendments - including whole alternative texts - at the Commission stage of the formulation process, but they may also leave the discussion of some of their amendments for the debate in parliament. In the case of the LOHC the amendments presented were published in BOPC, 8/6/90, nº177 and BOPC, 18/5/90, nº167.

Figure 4.4. Margin of discretion of the Catalan Health Service.



Source: Own elaboration.

The text law agreed at the Commission level defined the legal nature of the CHS as a 'public entity of an institutional nature', endowed with legal personality and full capacity for the fulfilment of its ends. Thus, it did not change CiU's initial definition ('a public entity') in any consequential respect in relation to the PSC and IC's arguments. However, some concessions to these two groups' worries about the CHS's discretion were made during the negotiations at the Commission level. In this respect, a clause was added to the CiU's bill so that in the formation of public consortia, promoted by the CHS with either public or private providers, must be of a non-profit nature. Similarly, the renewal of contracts for the provision of health services of public coverage by private providers had to be conditioned by the previous consideration of an optimum use of the public health resources available. Accordingly, the CHS had to plan the criteria for the rationalisation of resources according to the directives of the executive, as well as the necessary measures for improving the services managed by the CHS. In this respect, it was specified that the assignment of levels of complexity to HNPU-member hospitals had to be done within the guidelines defined in the Health Plan. Thus, the criteria had to be established, by administrative regulation, for guaranteeing the required level of care quality as well as of efficacy and efficiency of the management of the centres.

Finally, a controversial temporary provision of the CiU's bill was eliminated and, instead, it was made explicit that the centres and services integrated in or functionally attached to the CHS were not allowed to charge for the provision of cost-free services established with a general character by law.

As a result of the negotiation process in the Commission, and in answer to the opposition groups' demands that the CHS's goals be stressed and detailed, the following points were added to the CiU's bill: 1. the distribution of health resources had to be conditioned by the socio-economic, health and population characteristics of the territory; 2. the modernisation of the health system had to affect both physical equipment and the retraining of personnel; 3. the CHS's organisation had to ensure the protection of the rights of users: the right to the protection of health had to be fulfilled respecting individual freedom and privacy, without any kind of discrimination; the CHS had to inform its users on their rights and duties as well as their freedom to choose a doctor within the existing availability in the public system; and the CHS had to ensure that users have every possibility to express their complaints on any service received for which the CHS is responsible at the level of Health Region. The Commission's text also included new functions for the DHSS, which had to guarantee that the CHS fulfilled its goals, functions and activities[103]; for the CHS's Health Council, which apart from advice and consultation also had control functions[104]; and for the Executive council, which might create research organisms for the management, co-ordination, financing and evaluation of research in health sciences[105].

The participation issue was a clear theme of initial disagreement between the alternative projects, and here CiU did negotiate and change its stated preferences. As Horn's model suggested, the vagueness of legislation implies more participation by beneficiaries - in this case, the non-institutional policy elite. In the Catalan case

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[103] This point was eliminated after the debate in parliament.

[104] During the parliamentary debate this control function was eliminated and two other were added: supervision and oversight.

[105] The Commission's text added relevant articles which had been omitted in both CiU's and IC's text, and which concerned the organisational structure (directive and participation organs) of the Health Sectors. Moreover, some provisions were added establishing that the Basic Health Area was the backbone of the health system, and several section were added specifying the health personnel and non-health personnel necessary for their management, as well as the conditions of local civil servants, and the need to co-ordinate the health resources with the social resources of the local administration.

the participation issue was relevant because it focused not only on the participation organs of the CHS but crucially on parts of the health authority with decision-making power. Three main groups of actors had a stake in such participation: representatives of the executive branch (that is, the administration of the Catalan government, including the CHS), representatives of local administrations (politically controlled in the most urbanised areas by parties in the opposition in the Catalan Parliament, mainly the PSC), and social actors (such as unions and employers association) to whom IC in the opposition was particularly committed.

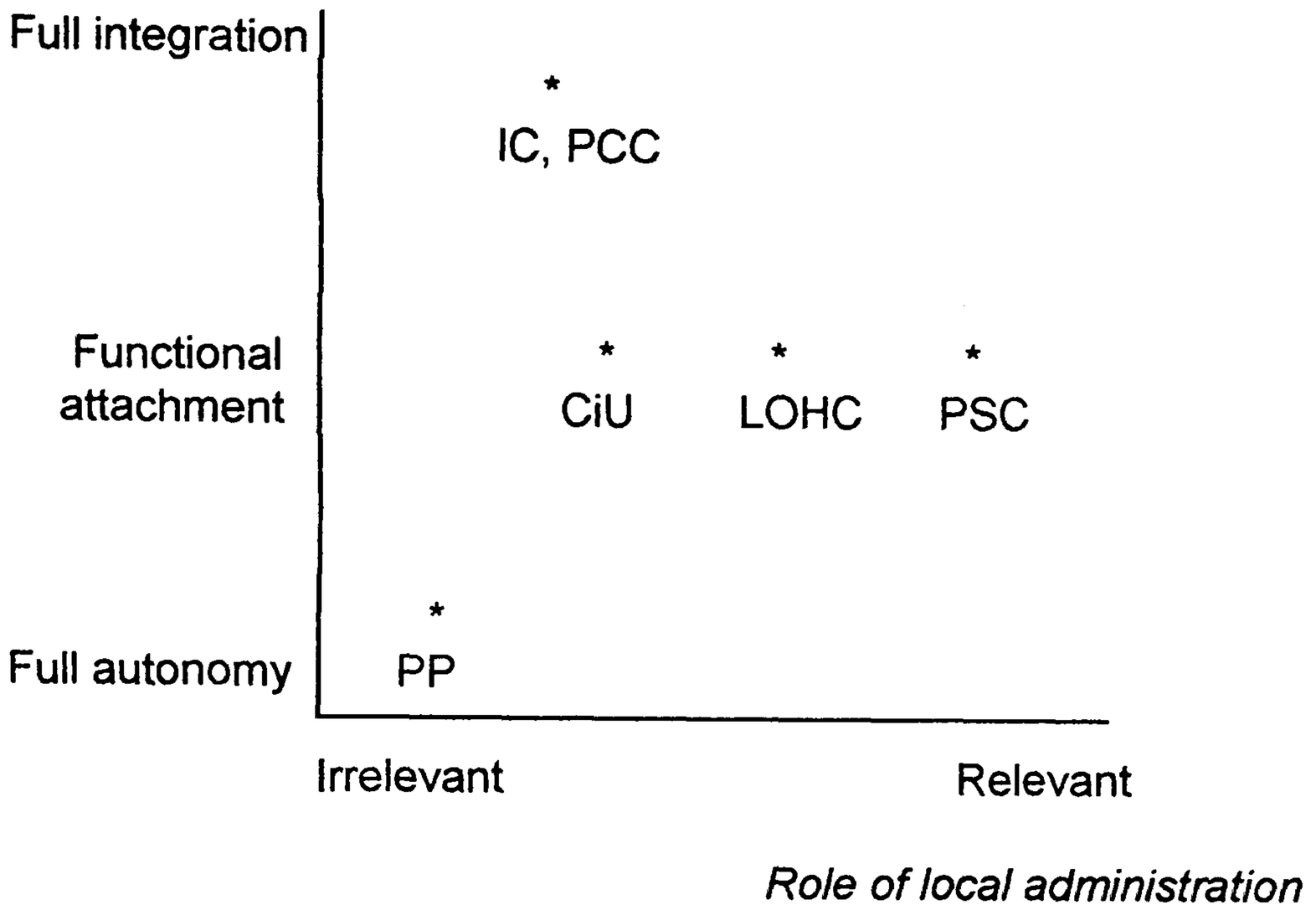
Table 4.5. Participation shares in the Catalan Health Service's Directive Council.

	CiU	PSC	IC	Commission	LOHC
Autonomous adminis.	100%	50%	50%	60%	60%
Local adminis.		50%	20%	20%	20%
Social actors			30%	20%	20%
TOTAL (n)	19	12	20	20	20

Source: Own elaboration.

The negotiation at the Commission level reached an agreement which remained unchanged after the parliamentary debate. As Table 4.5 shows in the participation issue CiU did not use its power and made substantial concessions. This is no puzzle because the impact of participation provisions in principle may be diminished by the high political dependence of the CHS on the core executive as an ultimate locus for key decisions. Following Horn's model, the different stances taken by the main political parties show that CiU mostly cared about *agency costs*, the PSC about the *uncertainty* and *risk assignment* to local governments, and IC about *uncertainty* and *risk assignment* both to citizens and to local governments.

Figure 4.5. Degree of integration of non-CHI providers into the Catalan Health Service.



Source: Own elaboration.

According to Horn's concepts, the main political forces in the Catalan Parliament cared about different transactions costs because they had different policy preferences concerning the role of public administration in the CHS. CiU was clearly driven by *the agency costs* related to the discretion of the CHS. Aware of CiU's veto over this explicit commitment, the PSC and IC concentrated their efforts, first, on the participation issue in order to influence a CHS which was clearly dependent on the core executive. Second, these opposition parties struggled to clarify the ambiguous relation between the CHS and the non-CHI providers. In principle, the CHI was to be integrated in the CHS and the rest of providers were to be either integrated or functionally attached to the CHS. In this respect, the PSC and IC focused on the transactions costs associated with uncertainty and risk assignment affecting providers, but took different stances because they had

different policy preferences and different interests and policy priorities. IC advocated the full integration of all HNPU providers into the health administration, meaning an effective transfer of ownership. By contrast, as the largest political force in terms of votes at the local government level, the PSC not only advocated the functional attachment of HNPU providers via stable contractual relations with the CHS, but also the reinforcement of local governments' role in health policy, which appeared diminished in the face of an Autonomous government with exclusive competencies over this field (see Figure 4.5).

CiU did actually take the same stance as the PSC concerning the attachment of HNPU providers. However, the text agreed in the Commission reflects the negotiation between these two parties in relation to the role of local administration. The PSC's commitment to the local administration's role in relation to those providers in which it had a stake (financial or representational in their administrative boards), was partly satisfied by some modifications in the CiU's bill. This modification specified that the integration or the functional attachment of non-CHI health providers owned or managed by provincial and municipal administrations would be subject to the corresponding transfer norms to be approved. The civil servants of those providers were not to be directly integrated to the CHS by virtue of the LOHC, as CiU's initial project ambiguously provided. Moreover, a provision was added that the core executive should gradually homogenise the work conditions of the personnel working in HNPU-member centres over a three-year period. Also, temporary provisions established the role of provincial administrations - as they actually owned important providers - and the contributions that local administrations had to transfer to the CHS for the health competencies it covered, all based on explicitly signed agreements. Finally, there was a more detailed specification of the competencies of the municipal governments, involving the re-assertion of the principle of 'general competencies' (Page, 1991). This principle states that the municipal governments may not only carry out activities complementary to those which are the competency of other administrations, but also within the framework of the sectoral legislation they may those services and activities that satisfy the needs and aspirations of their community - particularly the defence of consumers and users of health services, participation in the management of primary care, the protection of environmental health, and the protection of public health.

Comparing the final version further passed by parliament with the text agreed at the Commission level shows that the parliament majority did not exercise a relevant veto power. Some basic points introduced at the Commission level were reinforced. For example, for the public coverage of health needs the CHS could count on private providers as long as they are preferably *non-profit* and *indispensable* to satisfy needs of the public health system - as stated in the required agreements. In any case, the CHS's function concerning the management and administration of health services integrated in the CHS had to pursue the promotion of the management autonomy of health centres. Also, the Health Plan of Catalonia, once approved by the Executive had to be sent to parliament in thirty days so that the latter was fully informed. As for local governments, a more detailed specification of the competencies of the municipal governments was elaborated, including the provision of the minimum compulsory services required by the legislation on a municipal regime and detailed areas of municipal responsibility over health standards and plans. Furthermore, the text mentioned those competencies that the Catalan government might delegate according with the existing regulation of the local government.

In more general terms, the comparison between the CiU's bill and the text agreed at the Commission level reveals the opposition's concern for specifying the principles which had to guide the performance of a new health authority whose discretion and ambiguous legal definition aroused in them a sense of distrust. Regretting that the LOHC was not a health law but an organisational law, the opposition and CiU agreed to reassert health principles as the basis for the CHS's performance. Thus, the object of the law was redefined as the organisation of the health system of Catalonia *and* the general regulation of all actions which made effective the right to the protection of health. In particular, the principles guiding the CHS's functions and activities were not only to be concerned with management but also with the right to health: universalisation of individual and collective health services, equity, overcoming the social and territorial inequalities in the provision of health services, promotion of the individual, family and social interest in health by means of an adequate health education, health control of the environment, and community participation in the formulation of health policy and the control of its implementation.

Conclusions

The need to modernise the institutional design of the health authority in Catalonia was not explicitly taken up by the Catalan government until 1989. Some previous draft bills internal to the DHSS, and a law proposal by the PSC's parliamentary group, did not lead up to a public debate or an extended formulation process. Throughout the eighties, the introduction of innovative policy tools and the structurally incremental consolidation of a differentiated provision model had been carried out 'despite' the institutional design of the CHI, the health authority . And it was precisely this design which in 1989 was seen as a hindrance to further developing the Catalan 'model'. The LOHC initiative gradually evolved into an innovative institutional reform of health administration. In spite of the ambiguity of the actual legislation passed in 1990, two main points were made clear: Contracts with providers were the main tool in the hands of the new health authority (the CHS) for governing the health sector, and the new body would operate within a private law framework in its external relations. Thus, the CHI had to redefine its role into a provider-only one, although its degree of structural and organisational autonomy with respect to the CHS was not clearly established at this stage.

The analysis of the three alternative proposals presented by CiU, the PSC and IC and the result of the further negotiation process for the institutional design of a new health authority shows that legislators did care about the transactions costs defined by Horn (1995): decision and participation costs, the commitment problem, agency costs and uncertainty and risk assignment costs. However, their respective concern with and perception of each of these transactions costs were different for each party, depending on what their interests and policy preferences were about the public sector functions. Because they had different perspectives, stemming from both their ideology and from the varied resources on which they counted, they tried to face different transactions costs, which led them to advocate different institutional forms for the new health authority.

The enacting coalition's (CiU) 'prospective' commitment problem was to preserve and consolidate the mixed provision health system and the private management model it embodied, through the use of policy tools based on a contractual system, in which long-standing trust relationships and bilateral

agreements played a key part. However, no reference was made to possibly extending this system to the Social Security providers owned and managed by the previous health authority, the Catalan Health Institute (CHI). Instead it was assumed that the CHI would be integrated into the CHS. Both the CiU's bill and the final version of the law passed by parliament in 1990 was ambiguous in this point, and about the complex blend of functions assigned to the CHS. Thus, CiU designed a CHS as a 'public entity' with a wide managerial autonomy to act within a private law framework, but which, at the same time, was very dependent on the political level - the Catalan core executive.

By contrast, in their respective alternative projects the PSC and IC designed a CHS which was more independent from the political level but which had a lesser degree of managerial autonomy, because it was clearly subjected to the policy tools that public law explicitly provides for an 'autonomous organism'. However, the first policy priorities of these political parties were different. The PSC was mainly concerned with ensuring the CHS's economic responsibility over the public and semi-public providers in which local governments (where the PSC had a strong representation) had a stake as owners or managers. At the same time, though, the PSC wanted to preserve the ownership and managerial autonomy of those providers, in line with CiU, but giving a stronger role to local governments than the CiU's bill provided.

Although IC agreed with the PSC on the institutional form of the CHS, they advocated the integration of all private and public non-CHI providers which were contracting with the health administration into the CHS, which would involve an eventual asset ownership transfer. In contrast to the PSC, IC's policy preference was not supported by a large political stake in any government level. This maybe a reason why it was the only party that took the participation issue as its strongest negotiation issue facing what it viewed as an extremely vague definition of a health authority which moreover enhanced the discretionary power of the core executive. While the CiU's bill did not establish any participation share in the CHS structure for any actor other than the executive branch, the PSC wanted to include a representation of local governments and provincial administrations, and IC wanted a prominent participation share for social actors (such as unions) among which it has its largest political stake.

There were three main dimension of disagreement during the negotiation process which paralleled the transactions costs defined by Horn. First, the margin

of discretion of the CHS, including the legal nature of the CHS, and the administrative decision-making process (managerial autonomy and independence from the executive). These themes were connected to the costs derived from refining legislation - leaving the definition of the CHS's legal nature ambiguous - and to agency costs in the relation between the core executive, the DHSS and the CHS. Second, the issue of participation rights of political and social actors in the CHS's structures was related to the decision/negotiation costs, as supporters of these rights conceived them as a way to counteract the discretion of the health authority. Third, the theme of providers' autonomy from or integration into the CHS - including functional attachment versus integration, the role of local administrations, and the policy tools available to the CHS - was related to the uncertainty and risk assignment costs affecting non-CHI providers which had a stable contractual relation with the health authority. The result of the negotiation process showed that CiU only used its absolute majority power in the first dimension (the discretion of the CHS), by not accepting any relevant change to its first formulation. On the third issue dimension, CiU did negotiate and accepted clearer statements concerning the role of local administrations as demanded by the PSC. But CiU reinforced its commitment (and that of the PSC) to consolidate the existing mixed provision network and its autonomy from the health administration. Only in the participation issue did CiU fully change its initial preference, by accepting not only the participation of local administrations but also that of social actors in the directive and participation organs of the CHS, at all levels of its deconcentrated structure.

The vagueness of the final text passed by parliament in 1990 as the LOHC was criticised by all political parties. In Horn's terms, leaving legislation vague instead of refining it through negotiation was the result of the enacting coalition's effort to reduce decision-making costs. This legislative vagueness concerned the relations between principal and agents (health authority and providers respectively) and increased the discretionary power of the health authority (and of the executive). In turn, this ambiguity involved higher agency costs (monitoring implementation) and higher costs derived from assigning risk to private agents (providers). However, all the institutional and non-institutional policy elites admitted that the LOHC's vagueness also allowed its reinterpretation in 'new public management' (NPM) terms shortly after it was passed. This discourse diffusion process, which derived from the reforms being carried out in several OECD

countries, involved the definition of the CHS as a purchasing body, and the decision not to integrate the CHI into the health authority, but instead to transform it into a separate provider body which may eventually contract with the CHS.

Chapter 5

Introducing purchaser/provider separation, 1990-95.

The fact that legislators' decisions about institutional design are influenced by political transactions costs involves a forward-looking attitude concerning the further implementation process. That is, the way in which decision and participation rights are defined and allocated and the way in which risk is assigned to different actors at the policy formulation stage involve expectations that the enacting coalition's commitment problem will be solved through the implementation process. However, Horn's (1995) model does not provide a consistent conceptual framework encompassing also the analysis of the role of transactions costs arising throughout the implementation stage. Moreover, the formulation of an institutional design may not necessarily be clear and explicit, but rather ambiguous and prone to be reinterpreted as a result of either discourse and/or practice. Thus, in this research the analysis of the implementation process has been based in other theoretical models which complement Horn's decision analysis with concepts that are relevant for the specific kind of reform studied - namely, 'new public management' (NPM).

The 1990 Law for the Organisation of Health in Catalonia (LOHC) was consensual for two main reasons, according to actors in the policy elite. One view is that the LOHC did not introduce a fundamental policy change, but rather gave a legal framework to a governance structure of health care which had gradually been developed throughout the 1980s in Catalonia. Moreover, this 'Catalan model' of health care had not been designed from scratch, but was the result of modernising and consolidating the health market structure which had traditionally characterised the sector. A second view is that the negotiation process between the different political parties in the opposition and the Catalan government led to a final formulation of the LOHC which was so ambiguous that all forces could see their interests reflected in the text of the law to a certain extent.

However, this ambiguity in the actual formulation of the reform not only allowed for different discursive interpretations, but also for a considerable margin of

manoeuvre to enforce different implementation options. Shortly after the LOHC was passed a NPM discourse emerged as the basis for the prevailing interpretation of the legislation. A discourse diffusion process was evident from several conferences in which the main advocacy coalitions in the health policy domain participated between the second half of 1990 and 1994. On those occasions representatives of the main collective actors openly assumed that a NPM reinterpretation was the most accurate reading of the LOHC. Moreover, a report issued in 1991 by the consulting firm McKinsey helped formalise and clarify such a reinterpretation. According to this NPM discourse, the redesign of the macro-institutional structure of the health administration had to basically focus on the separation of the financing/purchasing and provision functions. Thus, crucial reform processes were identified as both the creation of the Catalan Health Service (CHS) as a financing/contracting agency and the subsequent reorganisation of the existing Catalan Health Institute (CHI) as a provider only.

Assessing the extent to which the definition and separation of those roles was actually implemented between 1991 and 1995 requires, first, analysing the reassignment of competencies among these bodies within the DHSS, as well as the internal reorganisations derived. However, for these reassignment of competencies to have an effective impact on the role which these bodies are supposed to perform, a reallocation of budgetary resources is needed, which enables the restructuring of their respective budgets in accordance with their new roles. Thus, the analysis and comparison of the budget structure of the DHSS, the CHS and the CHI before and after the reform should give evidence on the roles these organisations were actually assigned.

This approach is based on Dunleavy's (1991) typology of agencies, which infers function-based roles for public agencies from the analysis of their budget structure. In order to analyse the structure of an agency's budget Dunleavy distinguishes between four types of budgets into which all components or items of the total budget of an agency may be classified. These are the core budget, the bureau budget, the programme budget and the super-programme budget. By calculating the relative weight of each of these types of budgets within the total budget of an agency it is possible to identify the main functions the agency in question is expected to perform. To this end, the line-item budgets of the DHSS, the CHS and the CHI are analysed in this chapter, and budget ratios are taken as

an indicator of the role actually assigned to these organisations beyond the formal distribution of competencies.

If the implementation had followed the NPM discourse which emerged as the prevailing interpretation of the LOHC, then the DHSS should appear to be a control agency, the CHS a contracts agency, and the CHI a delivery agency, each of them showing the corresponding budget structure defined in Dunleavy's model. However, if the implementation of the reforms between 1990 and 1995 had followed the actual formulation of the LOHC, which defined a much more complex function-based roles definition specially for the CHS, then a much more mixed picture should be expected to emerge concerning the actual assignment of roles between these three public bodies - which should be reflected in the structure of their corresponding budgets.

Table 5.1. Expected agency types and budget structures in the reformed Catalan health administration as formulated in its NPM version.

Agency	Expected agency type derived from NPM	Expected budget structure derived from NPM
Department of Health and Social Security (DHSS)	control agency	.small core budget and bureau budget, .relatively large programme budget including transfers to other public bureaux
Catalan Health Service (CHS)	contracts agency	.relatively small core budget absorbs 20-30 per cent of programme and core budget together, .bureau budget absorbs most of programme budget
Catalan Health Institute (CHI)	delivery agency	.large core budget (mostly staffing costs) absorbs a high proportion of bureau and programme budget

Source: Own elaboration based on Dunleavy (1991).

As Table 5.1 and Table 5.2 show, the DHSS was expected to perform the same control role it had before the reform, either in the case the LOHC was actually implemented or in the case its NPM re-interpretation prevailed. By contrast, the CHS was expected to conform a different type of agency and have a different

budget structure depending on whether the LOHC provisions or the NPM discourse was implemented. In the former case the complex mixture of functions assigned to the CHS should be reflected in a mixed budget structure, while in the latter case the CHS should be a clear-cut contracts agency with a specific corresponding budget structure. Finally, the CHI was expected to play very much the same provider/delivery role whether the original LOHC formulation was implemented - integrating the CHI as a provider with no contracting competencies in the new health authority - or the NPM postulates took the lead.

Table 5.2. Expected agency types and budget structures in the reformed Catalan health administration as formulated in the 1990 LOHC.

Agency	Expected agency type derived from the LOHC	Expected budget structure derived from the LOHC
Department of Health and Social Security (DHSS)	control agency	.small core budget and bureau budget, .relatively large programme budget including transfers to other public bureaux
Catalan Health Service (CHS)	contracts agency	.relatively small core budget absorbs 20-30 per cent of programme and core budgets together, .bureau budget absorbs most of programme budget
	regulatory agency	.core budget absorbs a high proportion of bureau and programme budget, .small budgets as most costs are externalised onto the agents whose behaviour has to limit or control
	control agency	.small core budget and bureau budget, .relatively large programme budget including transfers to other public bureaux
	transfers agency	.core budget absorbs a very low share of bureau budget .bureau budget absorbs most of programme budget, mostly on transfers to private agents
Catalan Health Institute (CHI)	delivery agency	.large core budget (mostly staffing costs) absorbs a high proportion of bureau and programme budget

Source: Own elaboration based on Dunleavy (1991).

In any case, whether the formal or the discursive formulation prevailed in the implementation of the reform is an empirical matter. In this respect, both the distribution of competencies and the budget structure seem to indicate that at least the CHI was clearly affected by the role definition stemming as much from the LOHC as from its NPM interpretation. In both cases the CHI should cease to be the health authority and become only a provider, though the LOHC suggested it should remain inside the new health authority (the CHS) while the NPM interpretation required it to become an independent contracted provider.

The analysis is divided into two sections. The first section focuses on the re-interpretation of the LOHC on a NPM basis as the result of a discourse diffusion process among the policy elite. The second section deals with the reforms at the macro-institutional level to see whether the NPM discourse or the actual formulation in the LOHC was implemented between 1990 and 1995. On the one hand, the reorganisation of the DHSS - including the creation of the CHS and the reforms of the CHI - is explored, both in terms of the assignment of competencies and budget structures. On the other hand, the reforms affecting the organisation and operation of the CHI in order to shift from a role of health authority to a role of provider are analysed, so as to assess the extent to which formal indicators of competencies and budget reassignments had a real impact on the previous health administration.

5.1. Re-interpreting the legislation in 'new public management' terms.

Arguably the widespread diffusion of the NPM discourse and concepts among the health policy elite in Catalonia can be dated in the second half of 1990. In the original bill for the LOHC, the alternative projects of two parliamentary groups, the Commission's report, the parliamentary debate and the final version of the LOHC passed in June 1990, there was no single mention of NPM terminology, not even of the strict separation of roles which NPM implies and its impact on the CHI. This means that the NPM conceptual framework was not part of their mind-sets at that

time. By contrast, in the several conferences and congresses organised by the DHSS[106] - with the participation of the UCH, the CHC, the CHI and academic figures - shortly after the passage of the LOHC, the NPM terminology and concepts were not only profusely used, but they were also explicitly assumed by all participants to be the clearest interpretation of the LOHC (DSSS, 1991a; DSSS, 1991b; DSSS, 1992a; DSSS, 1992e; DSSS, 1993; DSSS, 1994b).

According to this prevailing NPM interpretation, the LOHC established a separation between the financing and provider roles both of which the Catalan Health Institute had performed until then. To this end the LOHC created the Catalan Health Service (CHS) as an agency ascribed to the DHSS and endowed with the role of contracting services for the virtually universal public coverage existing in Catalonia as part of the Spanish NHS. Therefore, this new actor had to manage budgetary resources that until 1989 had been allocated by the Catalan Health Institute or CHI (the Social Security management entity in Catalonia) and channelled through it until 1990[107]. In turn, the provider side is composed not only of the public and private non-CHI providers, but also of the CHI itself. Thus, contrary to what the LOHC provided, the CHI was not to be integrated into the CHS but was to become a public 'provider-only' which, instead of receiving a budgetary allocation, would eventually contract with the CHS, just like any other provider. This process was supposed to require the CHI's transformation into a public enterprise and its further disaggregation into its member provider units (11 hospitals, of which ten were the highest technology, research and medical training hospitals in Catalonia, and over 90 per cent of all primary care centres).

Therefore, the CHS had monopsonistic financing and purchasing roles. The former derived from its position as the single public insurer. The latter derived from its responsibility to contract/purchase the health services necessary for the population. The actual performance of these roles was subjected to the pursuit of the health policy objectives established in the Health Plan for Catalonia. In this framework, contracts were defined both as a tool for translating health policy

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[106] These conferences themselves are evidence of a purposeful consensus-building process led by the DHSS among the policy elite. They were held in September 1990, November 1990, November 1991, November 1992 and April 1994, and since the very beginning the NPM interpretation of the LOHC was taken for granted and unquestioned.

[107] Even after its allocation was a competency of the DG of Economic Resources of the Health System from 1989.

objectives into operational purchasing decisions, and as a tool for managing competition among providers. That is, contracts had to include incentives in order to induce providers to adapt their cost and provision structures to the health policy objectives and to improve their efficiency and effectiveness.

Several provisions of the 1990 LOHC actually fitted this discourse. Thus, the CHS was to organise the provision of health services according to the criteria of equity, efficiency, territorial balance and quality. The need to follow these criteria was a recurrent argument for the CHS to use diverse management and organisational forms in dealing with the complex and diverse health care provision network in Catalonia. In this respect, the CHS was entitled to manage these resources either directly or indirectly, with the authorisation by the Catalan core executive. Such indirect management forms included: creating new providers such as public companies, establishing agreements for integrated management forms with other providers, creating public consortia which in turn could create instrumental bodies (quasi-autonomous providers), and creating or taking part in other public or private organisations (LOHC, article 7).

Other principles central to the LOHC which fitted the NPM discourse were management decentralisation and deconcentration[108] (LOHC, article 2). Accordingly, as Figure 5.1 shows, the design of the CHS organisational structure included: (1) the corporate centre, which was responsible for resources planning, policy formulation, and contracts; (2) Health Regions, which were in charge of the execution and control of the CHS's policies, the management of resources through contract setting, and policy planning within the Region; (3) Health Sectors within Health Regions, which integrated and provided Health Basic Areas (HBA) with management infrastructure, and were in charge of resource management and evaluation, as well as having to participate in the planning process at Sector level (DSSS, 1992a:13). According to the model, within the Health Basic Areas - first defined in Catalonia in 1985 - health care centre managers were responsible for the implementation of contracts and agreements.

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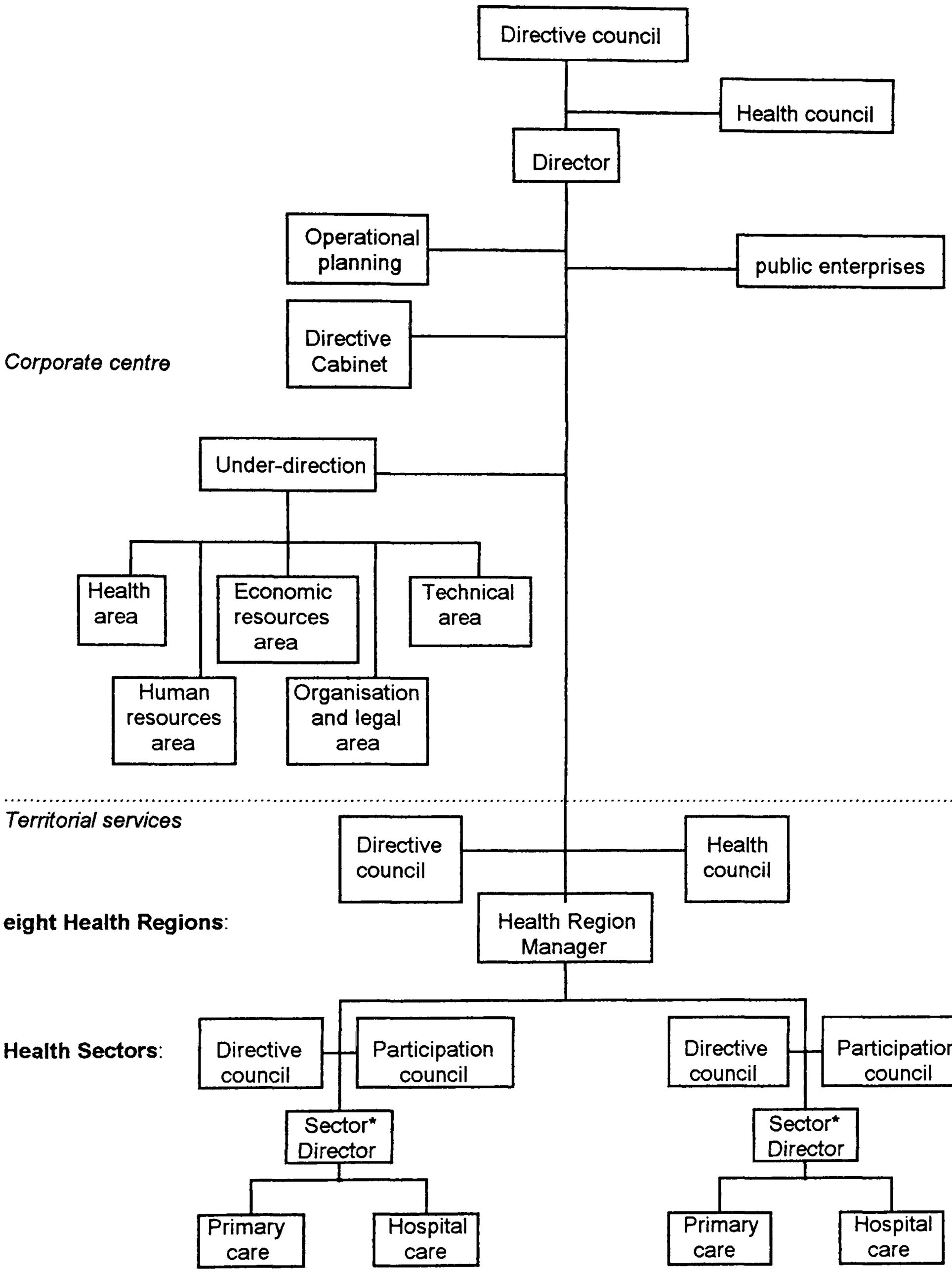
[108] Decentralisation may be territorial or functional. In this case it means both, referring to an organisational technique which involves the creation by a territorial administration or authority of instrumental entities with their own legal personality -different from that of the parent administration-, for the exercise of specific functions or the provision of specific services. De-concentration is the process by which competencies are transferred on a permanent bases from a superior to an inferior organ, central of peripheral, of the same public entity (Parada, 1997:40-47).

Figure 5.1. Organisation chart of the Catalan Health Service, 1995.



*The structure of the Health Sectors after the 1993 budget law and the modification of the LOHC in 1995 comprises two units (Programming and Analysis and Clients' service) instead of the ones in this organisation chart.

Source: SCS (1996a:32).

This structure was conceived of as being the base for a decentralised bottom-up planning process for the elaboration of the Health Plan for Catalonia (SCS, 1992; SCS, 1994a). According to the LOHC, the Health Plan was the indicative document and reference framework for all public interventions in the health sector in Catalonia. In the context of economic crisis in the early 1990s, in which the existing principles structuring health services were questioned, the Health Plan involved a different conception of resource allocation processes and, consequently, of organisational models (Via, 1994a:60-1). The planning of health care resources was no longer to be based on the supply structure available, but on the health problems of the population defined as a matter of policy priorities. In fact, the health plan 'becomes policy' when being approved by the Catalan executive, after a bottom-up elaboration process in which the Health Plan 'becomes a matter of politics ' as different social actors took part in its specification (Via, 1992:49). In the policy formulation and monitoring processes the introduction of community participation mechanisms was also an innovative feature of the LOHC. In contrast to the INSALUD and other Autonomous Communities' health authorities, directive and participatory organs of the CHS were present at all levels of the deconcentrated structure of the CHS (see Figure 5.1).

Efficiency and effectiveness in solving health problems were to derive from this process which was supposed to indirectly shape the business structure of providers. Within this framework, health care centres were required to develop both management by objectives and output control mechanisms so as to inform the CHS on the economic valuation of their activities including health and economic indicators (LOHC, article 50). These data were to be included in the budget of each centre, which was the base to elaborate the Health Region's budget. This decentralised budgetary process was expected to provide Health Region managers with information to decide on contracts, agreements and resource reallocations between providers within their Region, once the budgetary exercise has already started. Credit transfers between centres belonging to different Regions would be decided by the CHS's director, though. In this model, Health Region managers were supposed not to interfere with the management of health centres but to provide efficient and effective criteria and arguments to strategically assist health centre managers (Barea, 1991:27-8).

Arguably for this conception of the Health Plan to be effective an organisational change was necessary. In particular, a structural differentiation

between planning, evaluation, financing and purchasing functions on the one hand, and provision and management functions on the other was needed. The instrument which was intended to help translating health objective priorities into health services supply was the contract. The perfection of contracts was expected to facilitate the shift from a financing to a purchasing role by the authority responsible for the health policy (the CHS), through the introduction of elements to enhance a managed competition scenario.

A report issued by the consulting firm McKinsey & Company early in 1991 reinforced such a discourse and gave consistency to the 'Catalan model' (DSSS, 1992a). This report was ordered by the DHSS at the end of 1990. Its recommendations stressed the need for clarifying responsibilities by splitting purchaser and provider roles, as well as for enabling the introduction of private sector management-style on both sides. The report asserted that managed competition would serve the objectives of efficiency and effectiveness as much as those of the better quality, consumer-oriented services set by the LOHC (DSSS, 1992a:4-5).

Thus, on the one hand, the CHS had to take the purchaser role. The responsibilities this role involved were defining and assessing health needs (that is, planning) and ensuring coverage by allocating resources through contracts with providers. For the first aspect, the LOHC contemplated already a bottom-up planning process based on the deconcentrated structure of the CHS, where Health Sectors within Health Regions would play a key role. The latter required that the CHS set objectives and achievement indicators so as to supervise the accomplishment of contracts and evaluate the efficiency and quality of the services provided. Therefore, the CHS would not be responsible for inefficient providers but for wrong planning and competition management through the incentives of contracts (DSSS, 1992a:4-8). On the other hand, providers had to compete for the CHS's contracts in terms of efficiency and quality of services. The CHI should undergo a reform process to become a public provider of services contracted by the CHS, just like any other provider, instead of receiving an 'as of right' budget allocation. Moreover, diversification of providers would also be fostered in primary health care, thus breaking the CHI's monopoly in this field. In general, providers should become more entrepreneurial and competitive, developing their information and management systems and changing their organisational cultures (DSSS, 1992a:9-14).

An advisory commission within the DHSS itself suggested that a further differentiation could be made between financing and purchasing roles (DSSS, 1992b:7). Thus, resources should be allocated to purchasers on a per capita basis, and to providers on a service basis. Wider choice could also be given to citizens by giving providers the capability to charge for higher standards than those established and covered through contract by purchasers (DSSS, 1992b:8,10). Altogether, clarification of responsibilities was supposed to increase the transparency of economic fluctuations, costs of services, and efficiency of both individual providers and the whole system itself.

To summarise, the reinterpreted LOHC was aimed at clarifying and consolidating certain features of the governance structure of health care which were claimed to be intrinsic to the 'Catalan model'. In this sense, the purchaser/provider split was defined as the centrepiece for consolidating such a governance structure. To this end, three processes appeared to be interrelated: the reassignment of competencies within the DHSS, the subsequent reallocation of resource flows and the redesign of budget structures, and the internal reform of the CHI to become a provider only.

5.2. The new structure of the Department of Health and Social Security.

In this section, both the reallocation of competencies within the DHSS and the changes in the budget structure of the CHS and the CHI will be taken as indicators of the actual impact of the reforms implemented at this macro-management level [109].

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[109] Ortún (1995) defines the macro-management level as the venue where health policy is formulated and where regulation, intervention in the market or organisation of public services are dealt with. The meso-management level refers to the co-ordination mechanisms between the macro-management level and the organisations (providers) which are actually implementing policies. Finally, the micro-management level defines the internal management of each organisation -which in the case of the health sector

a) Assigning competencies.

The DHSS of the Catalan government underwent several reorganisations throughout the 1980s as a reflection of several processes of competencies reassignments. However, the reassignment of competencies derived from the prevailing interpretation of the 1990 LOHC and the creation of the CHS proved to be more consequential. The distribution of key health functions were at stake: planning, organisation of the health provision, financing, organisation of physical resources, and contracting/purchasing with non-Social Security providers, that is, non-CHI providers. A precedent to this reorganisation process was relevant. As explained in Chapter 2, in 1989 a DG of Economic Resources of the Health System was created by decree and was made responsible for allocating and evaluating economic resources, accrediting physical resources, and for the budget management and financial control of both the CHI and the non-CHI providers holding contracts with the CHI.

As a result, the CHI had, first, its powers to plan and negotiate contractual agreements with non-CHI providers removed, although not the budget to do so, which was channelled through its budget appropriation until the CHS was created in 1991. Second, the CHI had an internal restructuring mandated, by which the units holding managerial tasks were to be directly attached to the CHI's manager - a figure created in 1986 - thus breaking some hierarchical features of its organisation. To this end, the Under-DG of Administration of the CHI disappeared and the role of health area managers was reasserted - although they went through a high turnover rate in office, which was said to be concomitant to changes in organisational culture (Roma, 1994a:127).

However, the functions of the DG of Economic Resources of the Health System created by the 1989 decree were closely related to those held by the DG of Health Organisation and Planning - created six years earlier in 1983 - which apart from several health programmes was responsible for planning and organising primary and hospital care and pharmaceutical services, as well as for the accreditation, evaluation and inspection of providers. This DG disappeared in 1991, when the CHS was created. In turn, the DG of Economic Resources of the Health

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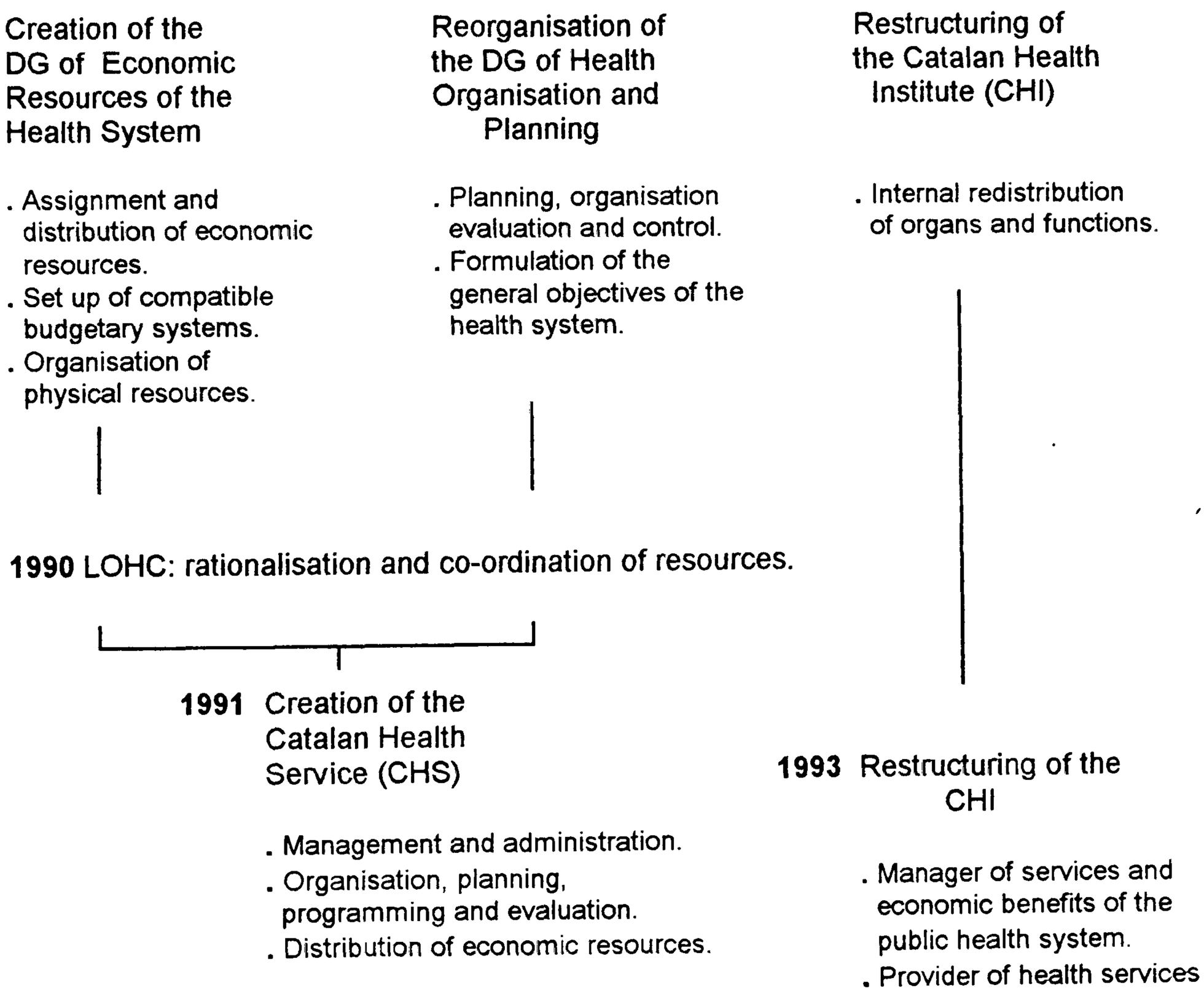
corresponds to the techniques of clinical management.

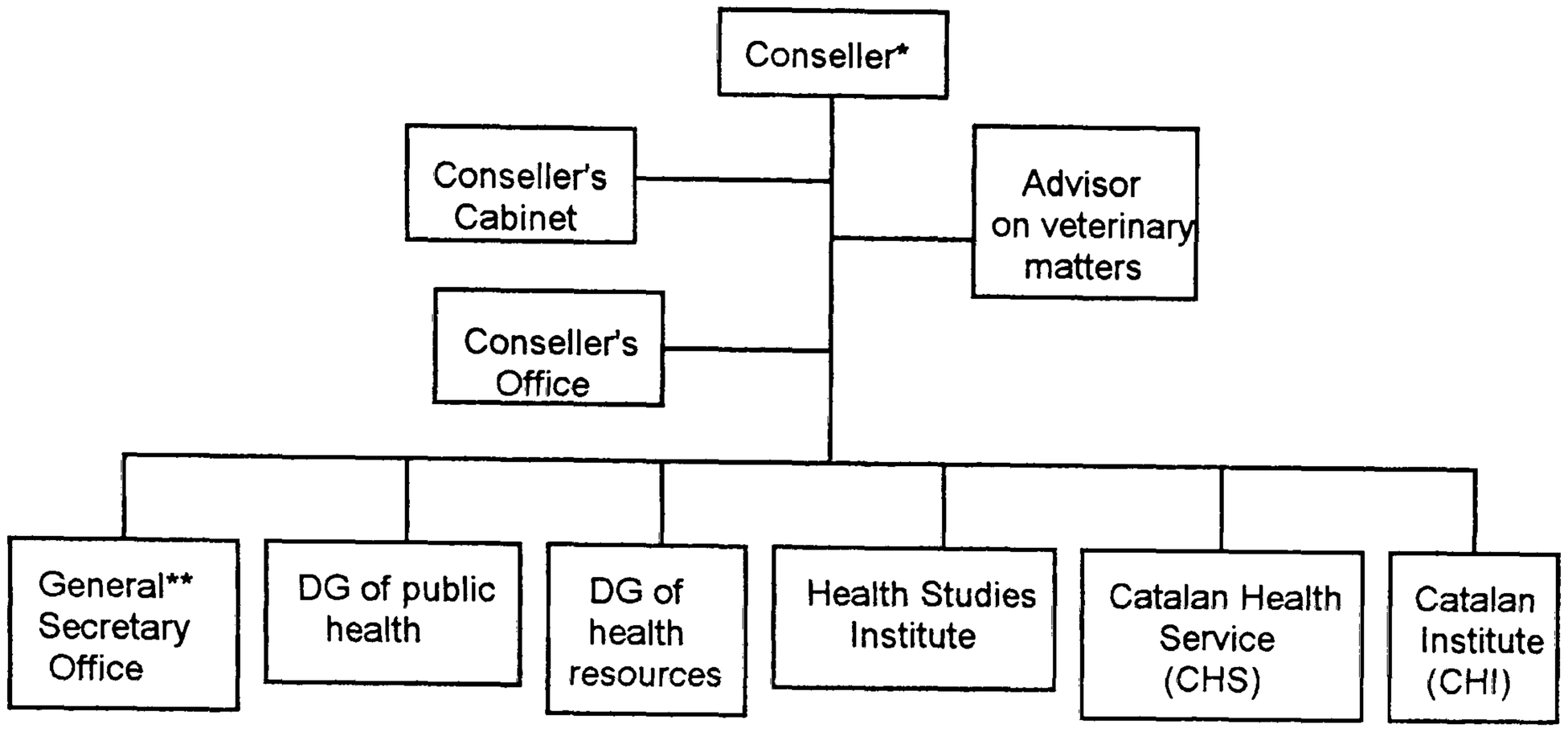
System was re-named as DG of Health Resources and concentrated most regulatory functions. As a result, the DHSS organigram was designed as Figure 5.3 shows. By 1994, though, further changes included the disappearance of the *Conseller*'s Office, the incorporation of the DG of Public Health and the DG of Health Resources under the line of hierarchy of the Secretary General Office, and the location of the Health Studies Institute as a staff agency instead of a line bureaucracy of the *Conseller* (see Figure 5.4).

Figure 5.2. Restructuring of the Department of Health and Social Security, 1989-91.



Source: Vallribera (1994:39).

Figure 5.3. Organisational chart of the Department of Health and Social Security, 1991.



*Political head of the Department and member of the Catalan executive.
**Comprises under its line of hierarchy the four territorial delegations of the DHSS (Barcelona, Tarragona, Lleida and Girona).

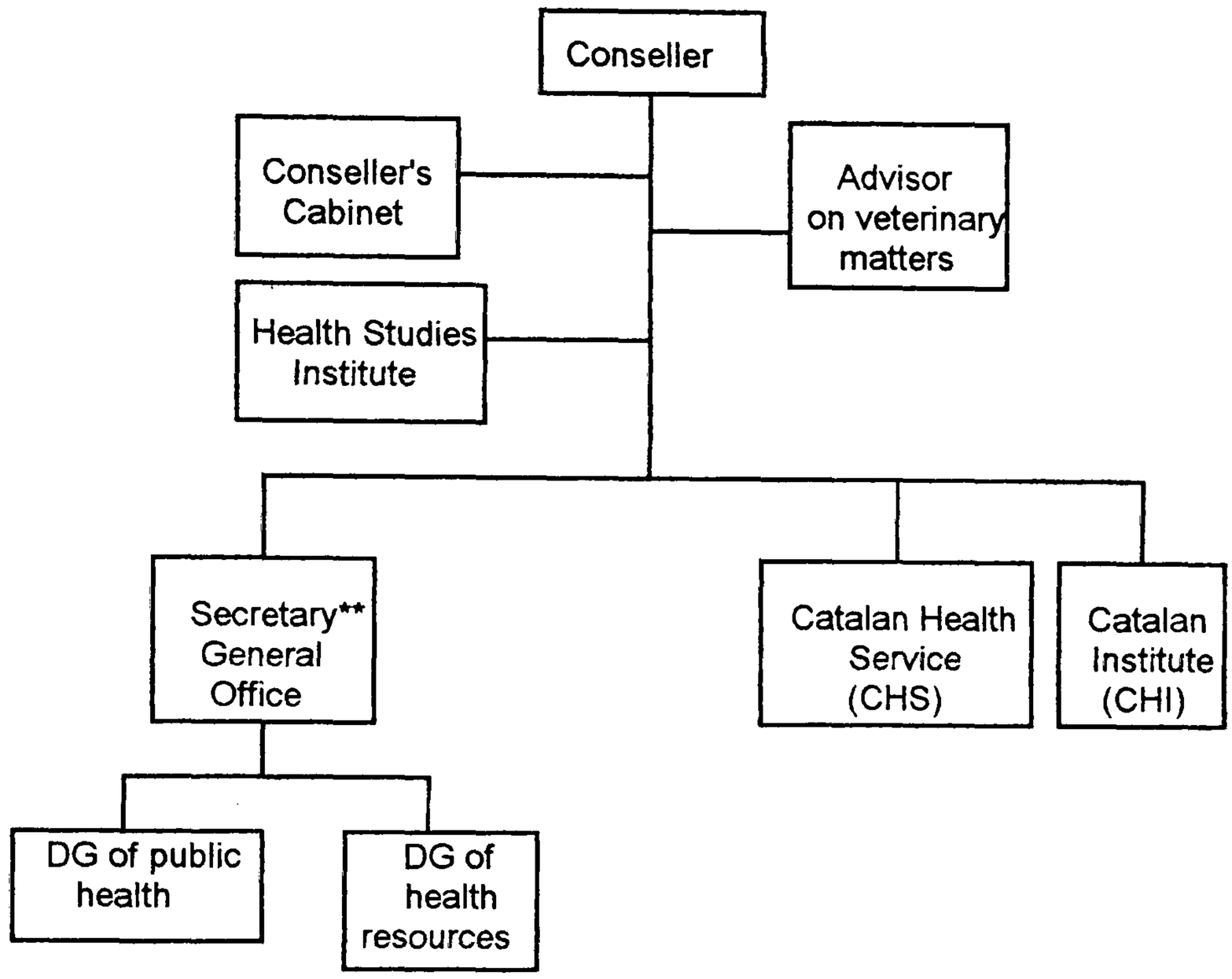
Source: DSSS (1992c:13).

These organisational charts, though, do not show the substantial differences between the organisational nature of the DGs and the Secretary General's Office on the one hand, and the CHI and the CHS on the other hand. The CHI is the management entity of the Social Security (see Chapters 2 and 3) and was endowed with an autonomous administrative nature. The CHS represented an innovation in the field of structuring the health administration and managing health care. As explained in Chapter 4, the CHS was defined by the LOHC as a public entity which, in administrative law terms, has an 'institutional' character, that is, it has a differentiated legal personality and freedom to manage for the fulfilment of its objectives. In contrast to the 'autonomous organisms of an administrative nature' described in Chapter 2 (the INSALUD and the CHI being two examples), institutional public entities such as the CHS are usually subject to administrative law only in their internal functioning[110], while they may operate under private law in

[110] Public law is the compulsory framework for these instrumental bodies when administrative powers are being exerted -relations with other administrations; heritage, financing, budgetary and accounting systems; contestation of administrative acts; and situations derived from the right to public health care coverage (Viñas, Lafarga, 1996).

their external relations. These 'instrumental organisations' are usually of a commercial, industrial or financial nature, and are good examples of the trend towards 'escaping administrative law' (Parada, 1997:243-54).

Figure 5.4. Organisational chart of the Department of Health and Social Security, 1994.



**Comprises under its line of hierarchy the four territorial delegations of the DHSS (Barcelona, Tarragona, Lleida and Girona).

Source: DSSS (1995c:17).

Two features framed the instrumental nature of these organisations. On the one hand, the political responsibility for their organisation and operation stays with the office holder of the administration parent agency. On the other hand, the relation between the latter and the former is not hierarchical but one of dependency and administrative supervision concerning budgets, appointments and creation and dissolution of the body itself (Parada, 1997:243-54). In the case of the CHS the role of the parent agency belonged to the DHSS of the Catalan government. The DHSS kept for itself the definition of health policy, while devolving authority to the instrumental body - the CHS. As a result, the CHS was defined as an institutional

public entity 'consisting'[111] of all the health care providers which were public or of public coverage - irrespective of their ownership or legal nature, in Catalonia.

Comparing the actual formulation of the LOHC and its NPM interpretation it appears that the role allocated to the CHS was initially defined in a complex way, having different kinds of functions assigned, while in its NPM interpretation its role was mainly to be concerned with purchasing/contracting. According to the complex and ambiguous role defined for the CHS by the LOHC, the CHS's responsibilities included: a) organisation, planning, programming, evaluation and inspection of health, socio-health and public health services; b) distribution of the economic resources for the financing of services provided by the health system (public and of public coverage) as well as the definition, management and up-dating of agreements and contracts (*convenis*, contractual agreements with public providers; and *concerts,* contractual agreements with private providers); and c) management and administration of infrastructures and services of the health system - those public and public coverage providers 'integrated'[112] in the CHS -, as well as the provision of all services of the health system through either private or public law management forms.

So the CHS had functions concerning the *formulation* of health policy, such as the organisation, planning, programming and evaluation of health, socio-health and public health services. It also had *regulatory* functions such as the establishment of the general guidelines and the performance criteria which were binding for those health providers functionally assigned to the CHS. In addition, the *enforcement* functions of the CHS included the establishment, management and review of all kinds of quasi-contractual agreements held with health providers, as well as the inspection of health, socio-health and public health services. The CHS's *funding* functions concerned the distribution of the economic resources, appropriated through the annual budget, for the universal coverage provided by the Spanish National Health System in Catalonia. Finally, the CHS had *management functions* (that is, provision functions) such as the management and administration of those *providers integrated in the CHS* (those within the CHI), the management

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[111] See the analysis of the LOHC in Chapter 4 for the discussion on the ambiguity of this term.

[112] See the analysis of the LOHC in Chapter 4 for the discussion and interpretation of the phrase 'integration of providers' into the CHS.

and implementation of health programmes, and the management of services and entitlements covered by the public health service.

The explicit objective pursued by allocating all these responsibilities to one single body was said to be to overcome the dysfunctions derived from the previous organisational model of the DHSS, where the organisation, planning and management of health services were split among different departmental Directions Generals of the DHSS, which made co-ordination difficult (Vallribera, 1994). In fact, when the DG of Economic Resources of the Health System was created in 1989, the DG of Organisation and Planning was not dissolved, thus leading to overlapping in the regulatory functions of the health administration. In 1991, when the CHS was stablished, this DG of Organisation and Planning was dismantled and its functions assigned to the CHS - except for the accreditation ones which remained with the new DG of health resources.

Nevertheless, these developments were contradictory. First, the fact that the DG of Health Resources in Figures 5.3 and 5.4 kept the competencies over evaluation and accreditation from 1991 onwards contradicted the LOHC, which defined these competencies as concomitant to the CHS's functions regarding planning and organisation. Second, the concentration of all these functions in a single organism also contradicted the NPM postulate concerning the clarification and separation of function-based roles between different organisations. In fact, this concentration of powers in the CHS had initially been intended to include also the functions of the CHI, which would have ceased to be a Social Security management entity in order to be integrated into the CHS. In this respect, the explicit aim of getting rid of the rigidities derived from the CHI's structure and nature was to be achieved through the creation of a new instrumental body, the CHS, which was to assume both kinds of responsibilities again.

However, this interpretation only prevailed until the end of 1990. By the time the CHS was created in 1991, the reform policy actually implemented followed a NPM interpretation. Instead, the purchaser-provider split prevailed and the CHI did not 'disappear' but underwent a profound internal reform process with the objective of becoming a competitive manager and provider of public health services. In this sense, a top official of the CHS distinguished between two different 'readings' of the 1990 LOHC:

'The separation of the financing and provision roles are not clear in the LOHC - the LOHC provisions are ambiguous. The separation of roles is a later interpretation ... The first reading was that the CHS involved financing and management of health centres. It was a new entity which included the CHI. The CHI has a different nature from the Catalan government but it is ascribed to the DHSS, it is a clear provider entity which before had also the functions of services financing and purchasing and planning allocated. Thus, [in the first reading of the LOHC] the CHI was absorbed by the CHS and then disappeared. But also the CHI's legal nature was transformed - it disappeared as a management body of the Social Security, it got incorporated into the CHS, and the latter adopted again this double role ... The good step this reading took was to make the CHI disappear and give it a different legal nature as a public body subjected to private law [that is, the CHS] - making a rigid legal nature [that is, the CHI] disappear. This first version lasts from July to December 1990. Afterwards we have a re-reading of the LOHC, based on a report by the consulting firm McKinsey: we have to go for the separation of roles, although it is not what the LOHC says. It was the same critique we did to the CHI, thus it is necessary not to repeat it again - the CHS continued to have direct management of services although it was a more agile [flexible] entity. With this second reading we went for the separation of roles.'

In this same sense, a former prominent political figure of the DHSS recognised that:

'There were things in which we were wrong. When we designed the CHS, one of the possibilities we thought of was that the CHI would end up disappearing, and one year afterwards we realised that would be a mistake - the CHI had to get transformed but not to disappear. And the truth was that the CHI is an enterprise of a very important potential and what it has to do is to get the maximum turnout. Another thing is whether the hospitals within the CHI ought to have their own legal personality or not. An this is a transformation which has not yet been done. We had a design which we have been adapting according to the experience of how things have been working'.

Therefore, the LOHC created the CHS as an instrumental body and provided not only that it was responsible for a complex blend of functions, but also that in order to perform them the CHS was free to resort to either public or private law management tools. In fact, the CHS 'consolidates the possibility of developing formulae of entrepreneurial management currently used by the Catalan health administration, such as the figure of managers and different management formulae (direct, indirect and jointly-led)' (DSSS, 1990:19), which have proliferated since 1986. Only the functions of regulation and finance of the health service were

subject to administrative law, that is, public law. In turn, the CHI would be transformed into a provider only, though different from the rest in that it was the most important one in terms of resources and it received a budgetary allocation directly from the CHS instead of having a contract with it. Thus, it appears that this reassignment of competencies had an impact in defining the CHI as a provider by shifting its contracting functions to the newly created CHS, while the latter was designed as a complex body concentrating formulation, regulatory, enforcement, funding and management functions. Whether this reassignment of competencies was in fact consequential for the role redefinition of each agency should be reflected in its impact on their respective budget structures.

b) Allocating budgets.

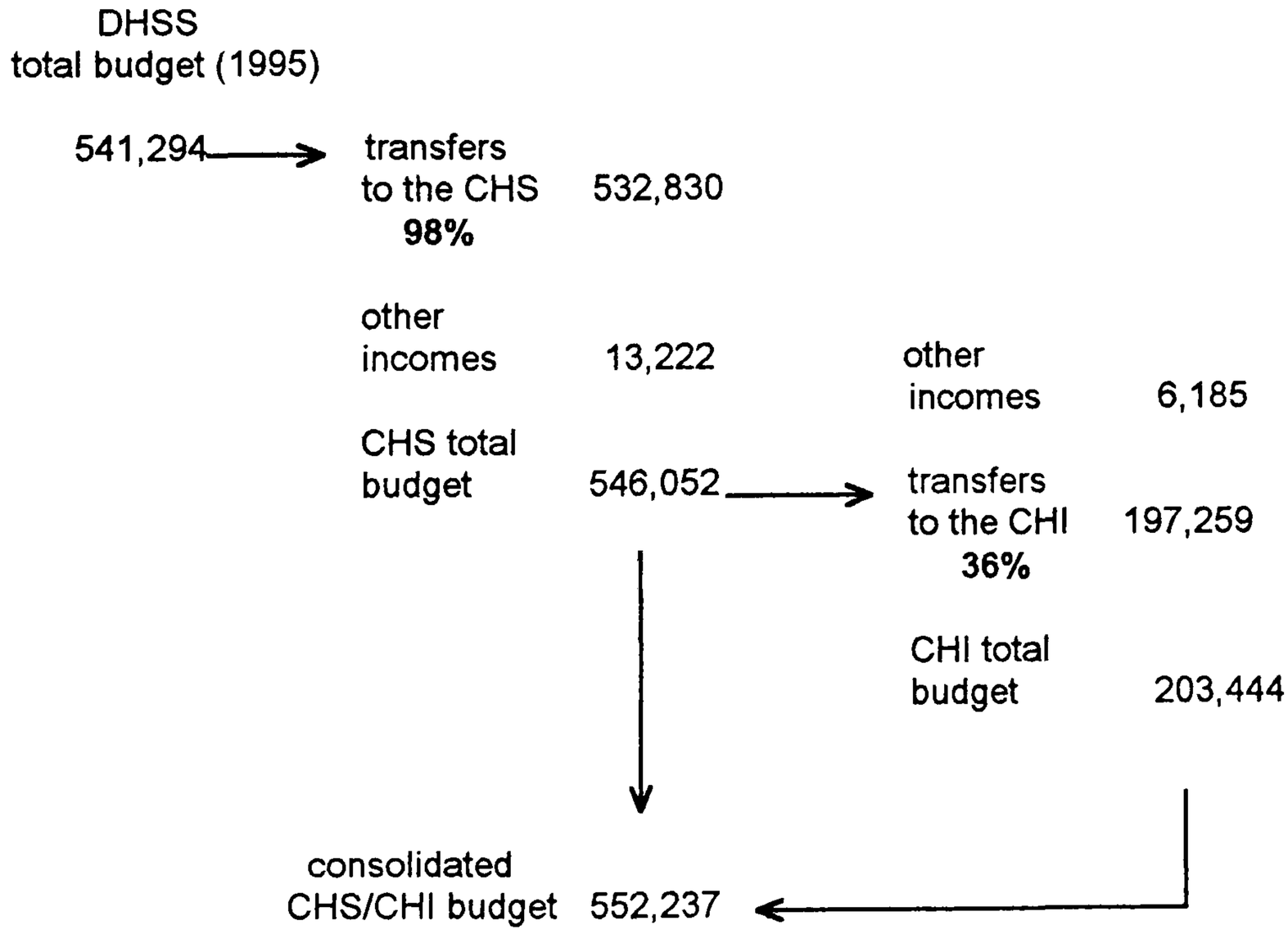
For this reassignment of competencies to be consequential in terms of clarification of roles and allocation of decision rights it has to be accompanied by an effective reallocation of budgetary resources among the organisations in question. Thus, in order to assess the extent to which this reform went beyond the formal allocation of competencies it is necessary to analyse from two different angles: first, the changes in the nature of resources flows between agents, and second, the resulting structure of such agents' budgets.

Key resources flows at stake occurred between the DHSS, the CHS and the CHI. As the highest health authority in Catalonia, the DHSS received the health budget and transferred well over 90 per cent of it to another public agency - the CHI before the 1990 reform and the CHS afterwards. According to the new governance structure defined in the NPM discourse resources flows between the CHS as the monopsonistic financing/contracting agency and the CHI as a provider had to follow contractual channels - just as they did in the case of the non-CHI providers - instead of budgetary allocations. However, despite the formal reassignment of competencies in this respect, the actual budgetary relations between them shown in Table 5.3 do not reflect a contractual relation - instead, the CHI received a conventional budgetary allocation from the CHS.

Moreover, for the sake of the discussion and approval of the CHS/CHI's consolidated annual budgetary appropriation, both the CHS's budget and the CHI's budget were the object of negotiations between the Department of Economy and Finance of the Catalan government, the CHS and the CHI. From 1992, though, a 'mock' contract between the CHS and the CHI was annually formulated, as a training exercise for the further introduction of a real contract. As a senior official of the CHI put it:

> 'From 1992 we have a 'fictional' contract with the CHS, in the same way contracted hospitals have. The difference is that we still have a budgetary appropriation insured. The CHI each year has an expenditure budget which we negotiate with the CHS and [the Department of] Economy and Finance, as the CHI's budget is still approved by the Catalan Parliament, and therefore it is a three-headed negotiation'.

Table 5.3. Budgetary relationship between the Department of Health and Social Security, the Catalan Health Service and the Catalan Health Institute, 1995 (in million pesetas).



Source: DSSS (1995c:48).

All this meant, first, that formally the CHI did not have an 'independent' budget as it is not a state-owned enterprise but a Social Security management organism, and second, that the CHI could not formally incur deficits or indebt itself, because it was financed through budgetary allocations. The deficit was held by the DHSS. That deficit could be inferred for the CHI, but it did not involve the risks of bankruptcy that non-Social Security providers run. However, as it will be explained below, the risk of the latter possibility has also been absorbed to a certain extent by the DHSS in what critics see as a distortion of the whole reform (see Chapter 6).

The nature of these resources flows between agents indicates to some extent their individual potential roles. However, the analysis of the structure of the budgets which each of those agents managed gives a more accurate account of the functions they actually performed. In this respect, taking Dunleavy's (1991) agencies typology as a framework, two sets of budget structures and corresponding agency types could be expected to emerge from the analysis of the Catalan case. On the one hand, the types of agencies and corresponding budget structures derived from the actual formulation of the 1990 LOHC, and on the other hand, the types of agencies and budget structures derived from its NPM interpretation[113].

From the comparison of the budget structure of the DHSS before and after the creation of the CHS in 1991, in Tables 5.4 and 5.5, it is apparent that the reassignment of competencies within the DHSS did not have a relevant impact on its role[114]. In both cases, the DHSS's budget structure corresponded to that of a *control agency* according to Dunleavy's (1991) typology, with a small core and bureau budget and a large programme budget including transfers to other public agencies. The DHSS received a budget which represented a third of the total budget of the Catalan government, transferred well over 95 per cent of its budget (programme budget) to another public agency (the CHI until 1990 and the CHS from then on), and supervised how these transfers were spent and how policy was implemented.

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[113] Dunleavy defines the four budgets in a nested way: the super-programme budget includes all other budgets, the programme budget includes the bureau and the core budgets, and the bureau budget includes the core budget (see Figure 1.2). In the analysis below, each of the four budgets will be taken as individual elements, without including any of the others, so as to identify the specific importance of their components.

[114] For a detailed disaggregation of these budget structures see Tables A.10 and A.11 in Appendix 1.

As a control agency, in 1990 the DHSS passed over to the CHI 92 per cent of its funding in intra-governmental transfers and five per cent in concept of capital investments. A control agency's primary task is both to channel funding to other agencies, bureaux or levels of government, and to supervise how these transfers are spent and policy implemented. The core budget, comprising mostly administrative costs, was two per cent of the DHSS's total budget, and remained at such a low level since the consolidation of the DHSS's competencies over health policy, following the transfers of the Social Security health services from the Spanish government in the early 1980s. The bureau budget - that is, major capital works, contracts with private agents, and money going to client groups - was also a minor part of the money transferred and of the total budget (0.2 per cent), a pattern which is also characteristic of control agencies. As explained in Chapter 2, this control and supervision function was defined as central to the institutional and inter-organisational relationship between the DHSS and the CHI since the latter began managing the Social Security health services in Catalonia. This framework remained unchanged until the creation of the CHS in 1991.

Table 5.4. Budget structure of the Department of Health and Social Security of the Catalan government, 1990 (in percentages over the total DHSS's budget)*.

	Cabinet of the *conseller*	DG of health organisation and planning	DG of econ. resources of the health system	DG of public health	**CHI**	Total % of total budget
Core Budget	0.5	0.2	0.03	1.3	-	2.0
Bureau Budget	0.03	0.00	-	0.2	-	0.2
Programme Budget	0.06	-	-	-	**97.0**	97.1
Super-programme Budget	-	-	-	-	-	-

*All calculations are based on the initial budgetary appropriation (332,195 million pesetas).
Source: Own elaboration based on Dunleavy (1991) and DEF (1990).

Table 5.5 shows the budget structure of the DHSS for 1995, four years after the creation of the CHS, when the reform had supposedly been consolidated in terms of budget reallocation in accordance with the redefinition of policy roles provided by the new legislative framework of the 1990 LOHC. From these data, it appears that the DHSS had kept the same role of *control agency* it had before the reform. Its core budget and its bureau budget each represented even a smaller share of its total budget (1.3 and 0.2 per cent respectively) than in 1990. Moreover, the DHSS transferred 98 per cent of its budget to the CHS (95 per cent as intra-government transfers, and four per cent in concept of capital investments). This means that the weight of the programme budget (98.8 per cent of the total budget) reveals again the DHSS's clear role as a control agency after the reform which, in this respect, remained unchanged.

Table 5.5. Budget structure of the Department of Health and Social Security of the Catalan government, 1995 (in percentages over the total DHSS's budget)*.

	Cabinet of the *Conseller*	DG of econ. resources of the health system	DG of public health	Territorial delegations	**CHS**	Total % of total budget
Core Budget	1.1	0.1	0.00	0.03	-	1.3
Bureau Budget	0.1	0.02	0.1	0.00	-	0.2
Programme Budget	0.1	0.00	0.00	-	98.7	98.8
Super-programme Budget	-	-	-	-	-	-

*All calculations are based on the initial budgetary appropriation (541,294 million pesetas).
Source: Own elaboration based on Dunleavy (1991) and DEF (1995).

By contrast, the redefinition of the role of the CHI from a financing, contracting and provider agent (a complex role) into a provider *strictu sensu* had a clear impact on the budget structure of this body. As expected from the LOHC

formulation and the NPM discourse alike, the CHI became a much purer *delivery agency*, in terms of Dunleavy's model, after the reform. From Table 5.6 it appears that the pre-LOHC CHI was a complex agency, because its budget structure reflected competencies involving different functions. First, the CHI had a strong role as a *delivery agency*. Because this kind of agency directly produces outputs or deliver goods (health care in this case) using their own personnel to implement policy, staffing costs represent an important share of its total budget. In 1990, the CHI's core budget (42.5 per cent) represented a substantial share of the bureau and the programme budget - staffing costs amounting to 34 per cent of total budget. Second, before the creation of the CHS, the CHI spent 35 per cent of its total budget on contracting with non-CHI providers. This implied a strong role as a *contracts agency*. Finally, the pre-LOHC CHI also had a role as a *transfers agency* because it also controlled the budget transfers for pharmaceuticals (16 per cent of its total budget), included in the bureau budget. Both the contracts and transfers roles were assigned to the CHS in 1991 by reallocating the corresponding share of the budget to it, and the CHI remained a *delivery agency*.

Table 5.6. Budget structure of the CHI pre-LOHC, 1990 (in percentages over total budget)*.

	Central Services	Specialised care	Primary care	Health profess. training	Total % of total budget
Core Budget	2.4	21.9	17.3	0.1	42.5
Bureau Budget	0.3	32.9	23.5+	-	56.7**
Programme Budget	0.02	0.2	0.5	-	0.7
Super-programme Budget	-	-	-	-	-

*All calculations are based on the initial budgetary appropriation (326,888 million pesetas).
**: 35 per cent of total budget was spent on contracting with non-CHI providers (30 per cent with hospitals and 5.6 per cent with primary care).
+: 16 per cent of total budget is transferred to pharmacies for the payment of 60 per cent of the price of pharmaceuticals sold to patients on medical prescription (40 per cent of the price is paid by patients).

Source: Own elaboration based on Dunleavy (1991) and DEF (1990).

Table 5.7. Budget structure of the CHI as a provider, 1995 (in percentages over total budget)*.

	Corporate centre	Specialised care	Primary care	Health profess. training	Total % of total budget
Core Budget	2.9	49.3	44.3	2.5	99.0
Bureau Budget	0.2	0.5	0.3	-	1.0
Programme Budget	-	-	-	-	-
Super-programme Budget	-	-	-	-	-

*All calculations are based on the initial budgetary appropriation (203,444 million pesetas):
Source: Own elaboration based on Dunleavy (1991) and DEF (1995).

However, the identification of a *contracts agency* role was not straightforward in the case of the pre-LOHC CHI, that is, when it was the health authority. According to Dunleavy's (1991) model, contracts agencies' core budget should absorb only a modest part of the programme and core budgets (between 20 and 30 per cent), which was not the case of the CHI in 1990. Moreover, according to the model, contracts agencies' main task is to work on research and development of equipment or service specifications, on capital projects for tendering, contract management and compliance, and letting contracts to either private agents or public organisations run on a commercial basis. However, as explained above these competencies were not held by the CHI. Instead, these competencies were shared by the DG of Organisation and Planning and the DG of Resources of the Health System in 1989 - both directly accountable to the *Conseller* (the political head of the Department), and by the DG of Resources of the Health System and the CHS from 1991 onwards. Therefore, this distribution of competencies in 1989 did not have an impact on the budget structure of the CHI, as it had after the CHS was created. As Table 5.7 shows, in 1995 the CHI was a clear *delivery agency* in terms of budget structure. Its core budget represented 99 per cent of its total budget (78.5 per cent was spent on personnel and 20.5 per cent on the purchase

of goods and services - which included ancillary services in the health sector). Before the reform, the CHI received 98.5 per cent of its budget from the DHSS, and around the same amount (97 per cent) from the CHS after the reform[115].

Table 5.8. Budget structure of the CHS a the financing/purchasing agency, 1995 (percentages over total budget)*.

	Corporate centre	Specialised care	Primary care	**CHI**	Total % of total budget
Core Budget	1.4	-	-	-	1.4
Bureau Budget	0.6	35.6	25.5**		61.4***
Programme Budget	0.04	0.6	0.4	**36.1**	37.1
Super-programme Budget	-	-	-	-	-

*All calculations are based on the initial budgetary appropriation (546,053 million pesetas).
**: 18.2 per cent of total budget is transferred to pharmacies in payment for 60 per cent of the price of pharmaceuticals bought by patients on medical prescription (patients pay 40 per cent of the price).
***: 39.2 per cent of total budget in spent on contracts with non-CHI providers (33.5 per cent with hospitals and 5.7 per cent with primary care centres).

Source: Own elaboration based on Dunleavy (1991) and DEF(1995).

In the same way that the pre-reform CHI was a mixture of agency types in terms of Dunleavy's typology, the new CHS arrangement after its creation in 1991 did not convey a clear-cut identification based on its budget structure either (see Table 5.8)[116]. As pointed out above, the DHSS directly transferred 94 per cent (plus four per cent in concept of capital investments) of its budget to the CHS, which in turn represented 98 per cent of the CHS's budget. The CHS had a small

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115 For a detailed disaggregation of this budget structures see Tables A.12 and A.13 in Appendix 1.

116 For a detailed disaggregation of this budget structure see Table A.14 in Appendix 1.

core budget of just 1.4 per cent of the programme budget, so it was clearly not a delivery agency. The CHS's most important role in narrow share of the budget terms is that of a *contracts agency*, a role it completely took over from CHI before the reform. The CHS's bureau budget represented 61.4 per cent of the total budget - contracts with non-public providers amounting to 39 per cent. But the monies passed on to another public body, the CHI, also amounted to 36 per cent of the total budget, and hence implied a strong secondary CHS role as a *control agency*. Transfers to pharmacies accounted for 18.2 per cent of the CHS total budget and hence implied also a relevant role as a *transfers agency*.

In sum, the mixed type of agency and the budget structure which characterised the CHS after its creation in 1991 did not conform to the NPM interpretation of the LOHC, which postulated a clear contracts role. Instead, this empirical analysis shows that the CHS actually adopted the complex mixture of functions the LOHC assigned to it, as reflected in its budget structure. However, among this complex blend of functions, the assumption by the CHS of the contracts function performed by the CHI before 1990 took on an increasing relevance. As explained above, the CHS spent 39 per cent of its budget on contracting with non-Social Security (non-CHI) providers to ensure universal health coverage. Contracts were particularly relevant for specialised care (33.5 per cent of the CHS's total budget). The trend from the early nineties pointed to introducing this contractual framework in the rest of the health sector in the form of 'programme-contracts' - namely, with CHI hospitals and Primary Care Teams. This expansion of contracts was however conditioned by the fact that the CHI owned and managed, as a single provider, 11 hospitals (most of which were high-technology) and more than 90 per cent of the primary care providers in Catalonia. Thus, the reform of the CHI beyond the reassignment of competencies and the restructuring of the budget was a crucial issue once the CHS was created. A senior official of the CHS asserted in 1995 that the strategy was to eventually transform the legal nature of the CHI into a state-owned enterprise:

> 'The CHI still has the same legal nature it had in 1983, when it was created as a recipient of the INSALUD's transfers. But now it is following a different process of transformation, innovation and modification. It is projected for the next legislative period that a bill be presented to parliament to transform the CHI into a holding company of public providers. This is necessary for the separation of the financing and provision roles to be effective.

Nevertheless, as another senior official of the CHI explained, the tactics were to gradually change its management culture as a necessary previous step to such a legal formalisation:

> 'The impact of the LOHC on the CHI is that the CHI changes its mission. The CHI is no longer 'the health administration' but just another provider. It has to rethink its structure and culture a change in basic strategies. This needed two phases: first, to develop culture, tools, management styles, but without changing the legal framework; second, to give legal status to those developments.'

c) The role of the Catalan Health Institute.

The CHI is the Social Security management entity in Catalonia and the largest employer (among both public and private sectors) in this Autonomous Community, with 17,000 personnel in primary care, 16,000 in the hospital sector and 400 in its corporate centre (ICS, 1995a:56-7). By the late 1990s the CHI was still going through a profound reform process in order not only to become 'just' a provider of health services, but also to eventually transform its budget allocation into a real contract with the CHS. However, this reform process was being developed within an administrative law framework which constrained the CHI managerial freedom to improve its level of efficiency. According to a manager of a CHI hospital and senior officials of the CHI, some of the management tools defined by administrative law which were particularly burdensome were: the personnel regulations assimilated to the civil service regime (statutory personnel), the strict line-item budget management procedures (annual budget law), and the subjection to the State Contracts Law - which overburdens with *ex-ante* controls the purchase of goods and services and the contracting processes. In this sense, the manager of a CHI hospital argued that:

> 'These three basic instruments for the management of the Social Security health services - statutory personnel regime, budget management, and purchase of goods and services under the State Contracts Law - apply to all CHI hospitals, and have not changed either

before or after the LOHC. This is different in the hospitals which are not directly managed by the public administration .... The reform of the health administration has not been done. The LOHC has certainly affected the debate on the role of the public administration but not the role of the public administration when managing hospitals. For example, the separation between financing and provision but the CHI continues acting subject to this management framework. The LOHC has given conceptual clarity so that the public administration can start this second reform.'

Within this framework, the CHI has gradually modernised its management systems in order to improve efficiency. In 1989 the CHI's corporate centre introduced information systems on the health activity of the hospital and primary care sectors, a computerised system of health care management indicators. This change allowed for the gradual codification of discharges, covering 99 per cent of cases in the 11 hospitals by 1994. This was the previous step for the introduction in 1992 of case-mix tools[117]. The tool developed was the Patient Management Category, a classification of patients according to medical panels in order to define the health care resources necessary for their diagnosis and treatment. This information (variables on basic activity and physical and human resources) was sent by hospitals to the corporate centre each month. The analysis of these data was on the one hand, the bases for calculating the intensity of necessary resources for the management of cases, and on the other hand, it was a tool for making decisions on the allocation of resources by the corporate centre (ICS, 1995c:173-5). Throughout the early nineties, an improvement in management was apparent from the evolution of costs indicators of the CHI hospitals: as Figure 5.5 shows, costs substantially decreased between 1992 and 1994, with the exception of costs per bed, which, according to this report stemmed from the reduction of 31 beds in 1994.

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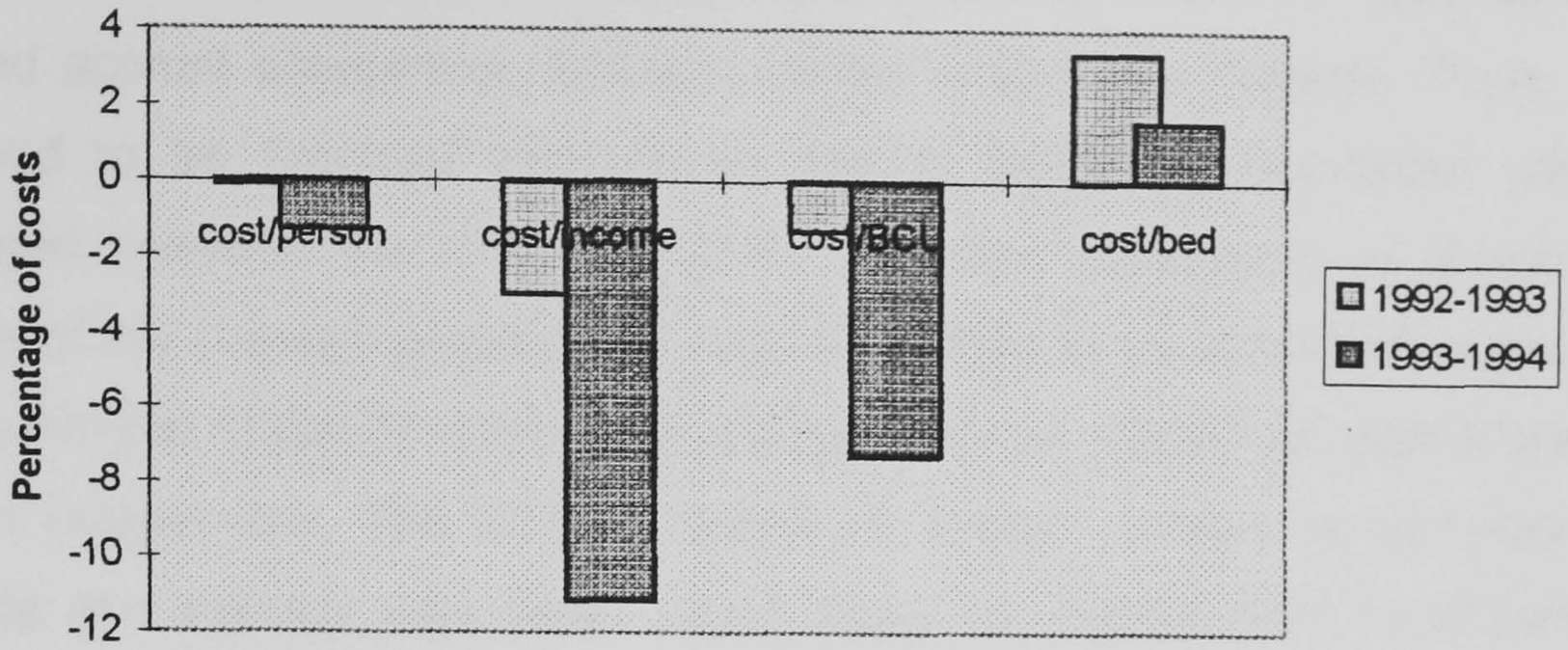
[117]Case-mix management comprises a series of patients management activities based on decision making about information on typologies of the patients treated. These tools are at the core of clinical management is based on information which allows for analysing the casuistry, functioning, quality and consumption of resources within a period and compare them with those of other periods, with the objectives set and with other hospitals (Casas, 1994: 317).

Figure 5.5. Evolution of costs indicators of the CHI hospitals, 1992-94.



Source: ICS (1995a:18).

A number of debates inside the CHI characterised its situation in 1992: there was no group or direction spirit and some management levels were considered superfluous; there was a lack of career incentive; quality was hardly measured (technical quality in hospitals seems good but services to users are poor); there was no 'provider culture'; the budgetary approach fell outside cost-efficiency and effectiveness measures; and CHI hospitals were disadvantaged in costs' terms compared with competitors (ICS, 1992:6). Faced with this situation and the need to overcome these problems, the CHI defined its own strategic objectives as being: providing services of quality competitively and efficiently, focusing on 'client's' satisfaction within the contractual framework set by the CHS, and enabling professionals' and staff's self-fulfilment and involvement. In order to pursue these objectives the CHI defined the following management principles: independent management and responsibility over outputs - bearing in mind the eventual contractual relation with the CHS; entrepreneurial criteria incorporating quality standards and income and costs concepts; and the development of an organisational culture oriented to clients and based on internal meritocracy (ICS, 1994a).

From 1992 onwards the annual budgetary allocation to the CHI was 'translated' into contract terms (a 'programme-contract'), a tool which was regarded as a prior necessary condition for further pursuing those objectives and enhancing those managerial criteria. Senior officials of the CHI viewed the introduction of

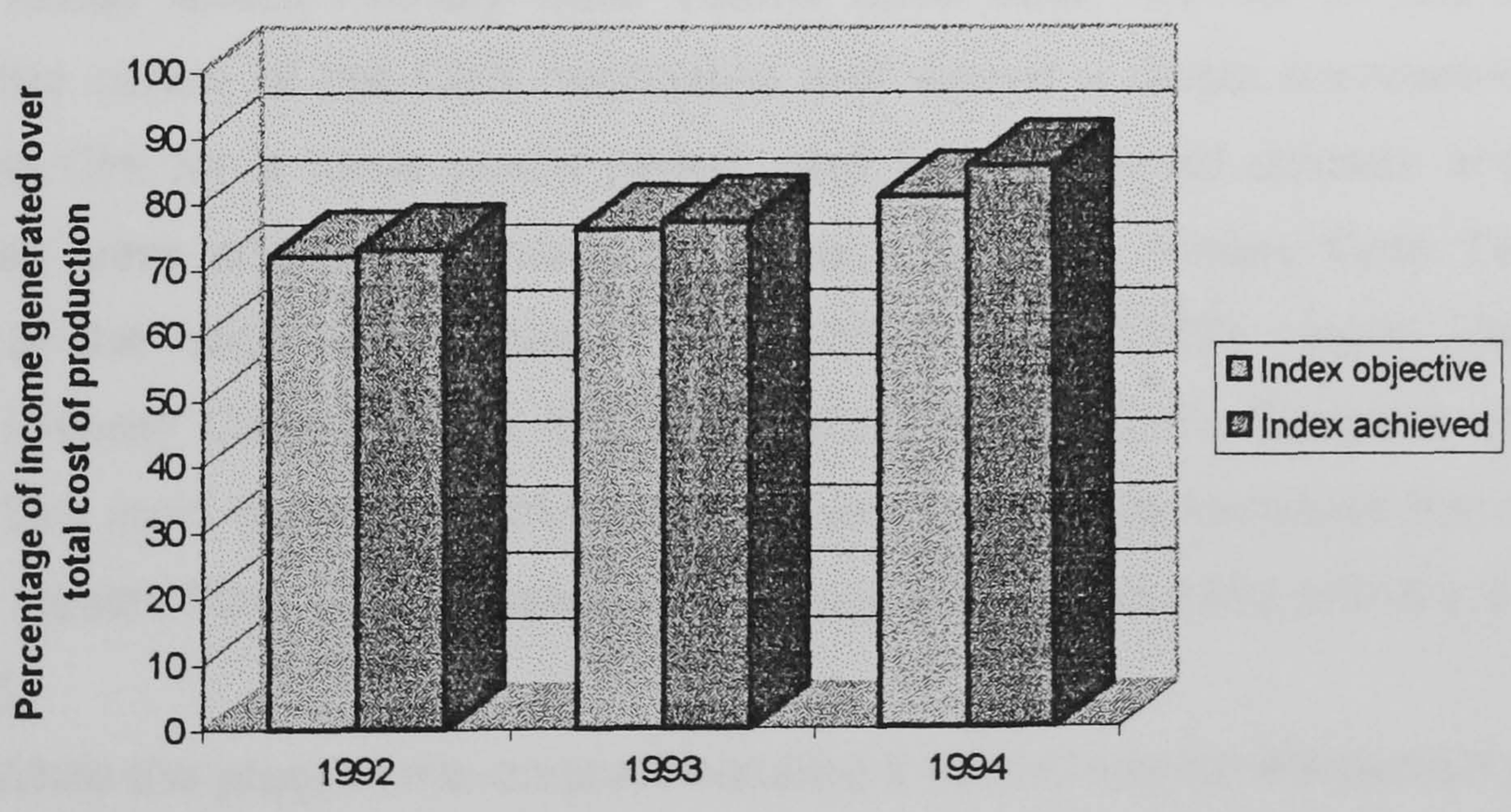
these programme-contracts as the origin of the cultural change they were trying to develop within formal rules which by mid-1998 have not yet been reformed. Programme-contracts were accompanied by the introduction of external auditing, cost and accrual accounting, financial control and billing systems. Thus, the CHI continued to be financed through an annual budget appropriation which was negotiated between the CHI, the CHS, and the Department of Economy and Finance of the Catalan government, and which had to be submitted to the Catalan Parliament (the CHS/CHI consolidated budget) to be passed as part of the annual Catalan budget law. The CHI allocated its budget among its provider units - hospitals and primary care units, which have no independent legal personality, because formally the CHI is a single provider. The innovation introduced in this process by the programme-contracts was that each hospital negotiated a programme-contract with the CHS - though previously agreed with the CHI's corporate centre - by which their budget allocation was explicitly linked to the services they provided. This meant that, for the first time, hospitals under the CHI's authority had to compulsorily bill all their services so that the budgetary allocations distributed to them by the CHI's corporate centre could be cost/activity related (Roma, 1994b:48-9). This change was accompanied by the introduction of financial and cost accounting techniques in hospitals so that each hospital had an operating account. On this basis, the link between budget and activity was calculated in terms of prices or tariffs set by the CHS for different kinds of activity expressed in Basic Care Units (BCUs). These programme-contracts made providers aware of the level of self-financing they would achieve in case such contracts were not fictional but economically binding contracts. So this exercise revealed the level of deficit they would incur in case they had a real contract, by making explicit the difference between what they spent through the budget (cost of their activities) and what they would be paid for those activities through prices, if they were actually selling their services to the CHS. In this sense, a top manager of the CHI argued that,

> 'When the contract is a real, valid instrument - not only for knowing what we do but also as a financing instrument - then there will be the possibility of signing a real contract. But this will have been a maturing process, not a traumatic change. Among providers - UCH, the CHC, the CHI - the CHI has been asked a tougher effort ... We have this vocation [to become a competitive provider], but we need to be given the necessary instruments to have the same management capacity than

the others. We want a fair deal, not a preferential treatment. But then we do not want rigid [management] instruments.'

A significant datum concerning an improvement in the self-financing capacity of the CHI was measured by the evolution of the 'coverage index' of its hospitals - the percentage of the income generated over the total cost of the services produced. This index included the income derived from the contract (budget allocation) with the CHS and the services sold to third parties. The 'coverage-index' or self-financing level of the CHI hospitals rose from 73 per cent in 1992 to 88 per cent in 1995 (see Figure 5.6).

Figure 5.6. Evolution of the coverage-index of the CHI hospitals, 1992-94.



Source: ICS (1995a:17).

Real financial consequences could follow from the existence of 'fictional' deficits. A senior official of the CHI explained that the negotiation process of the programme-contract started between the CHI's corporate centre and the CHS's corporate centre, which agreed on an overall provision level to be supplied (BCUs).

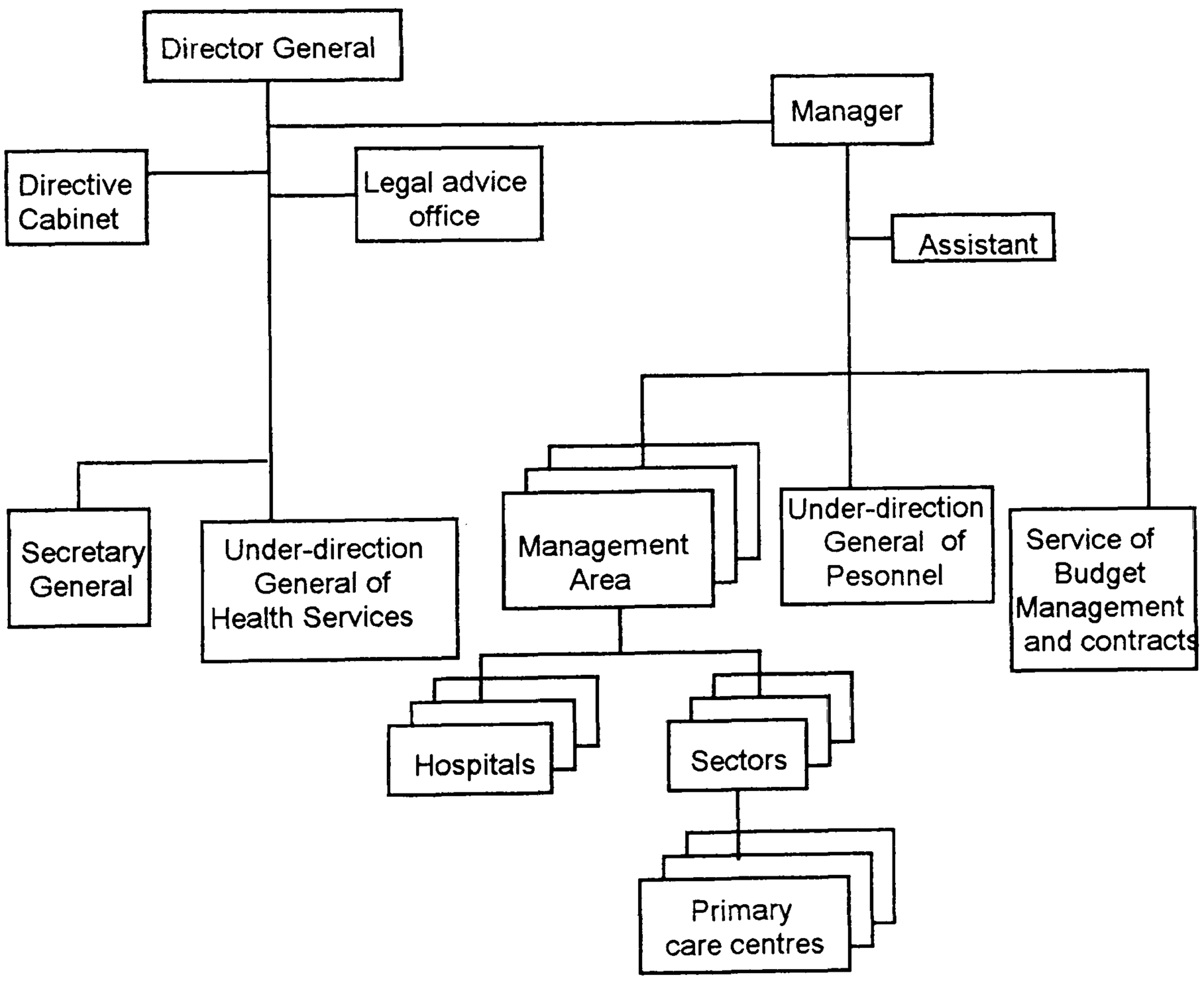
Then, the Director of the CHI's hospital division negotiated with hospital managers the amount of BCUs they would provide. This was the offer which hospital managers then negotiated with the corresponding CHS's Health Region manager. Although the CHI only owned and managed 26 per cent of the hospitals beds of the HNPU, the relevance of this negotiation stemmed from the fact that most of these beds belonged to level C (high technology) hospitals. In fact, out of the CHI's 11 hospitals, four were high technology and university medical training hospitals, five were the reference hospital of their respective CHS Health Region and two were basic hospitals (ICS, 1995b). Each programme-contract was eventually signed by the CHS director, the CHI manager and the hospital manager. With respect to this process, a former senior CHS official contended that the creation of a 'contracts unit' at the CHS's corporate centre level in 1995 showed a re-centralising trend within the CHS, which was not letting Health Region managers play the role they were supposed to have in a deconcentrated purchasing structure.

In 1993 not only 'fictional' contracts but also evaluation mechanisms were also introduced in the CHI's reformed primary care sector - namely those Health Basic Areas where Primary Care Teams have been formed. In this case, the corporate centre of the CHS negotiated and signed a single framework protocol with the CHI for a three year's period, and then additional clauses and specific annexes were added (and annually revised) for each Primary Care Team as a result of the negotiation between the corresponding CHS's Health Region, the CHI's Primary Care Division and the corresponding CHI's Direction of Primary Care. The main objective of this process was to gradually introduce the objectives of the Health Plan in the contractual negotiations concerning primary care (ICS, 1995a).

While the programme-contract became a central tool for the pursuit of a more efficient management in the CHI, two other strands of reform were being developed from the early nineties in order to fulfil the strategic objectives of the CHI (ICS, 1995c). First, as the CHI was no longer 'the health authority/administration', but a provider, it no longer needed a territorial structure. Therefore, its organisational structure was shifting from being based on geographical criteria (which became intrinsic to the health authority role the CHS played from 1991) to criteria based on the lines of services that the CHI produced. Thus, the divisions of corporate centre, hospitals, and primary care were allocated to the CHI's manager

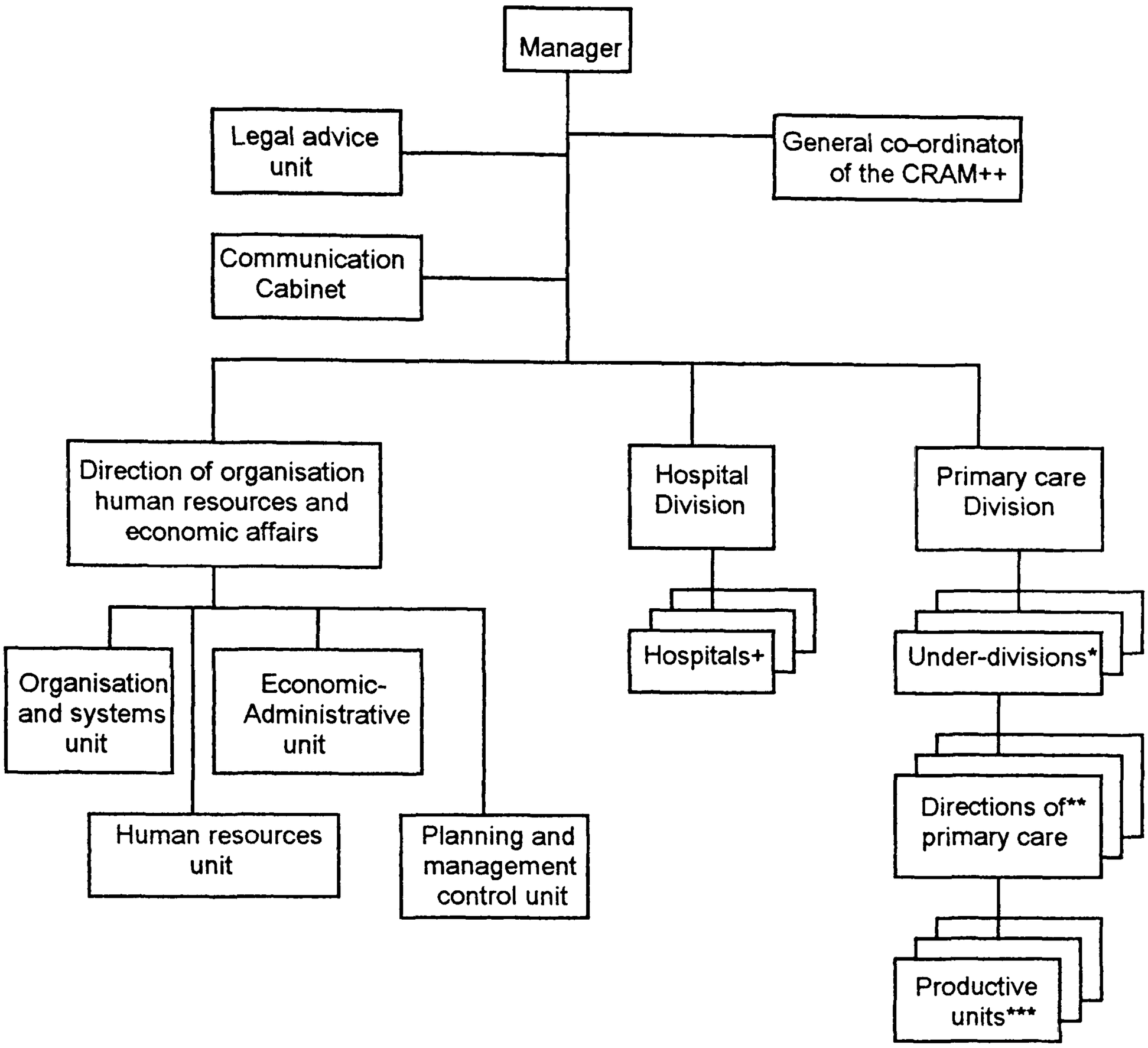
responsibility. This shift is shown in Figures 5.7 and 5.8. In 1989 the restructuring of the CHI partly broke the hierarchical organisation by attaching the units holding managerial tasks under the manager figure, which had been created in 1986 as a co-ordinating figure between the territorial structure of the Management Areas and the corporate centre of the CHI. By contrast, in 1994, the role of health authority represented by the Director General disappeared, and a divisional structure with a corporate centre (Direction of Organisation and Human Resources and Economic Affairs) and two divisions (Hospital and Primary Care) was established.

Figure 5.7. Organisational chart of the Catalan Health Institute, 1989-93.



Source: DSSS (1990b:20), ICS (1994b).

Figure 5.8. Organisational chart of the Catalan Health Institute, 1994.



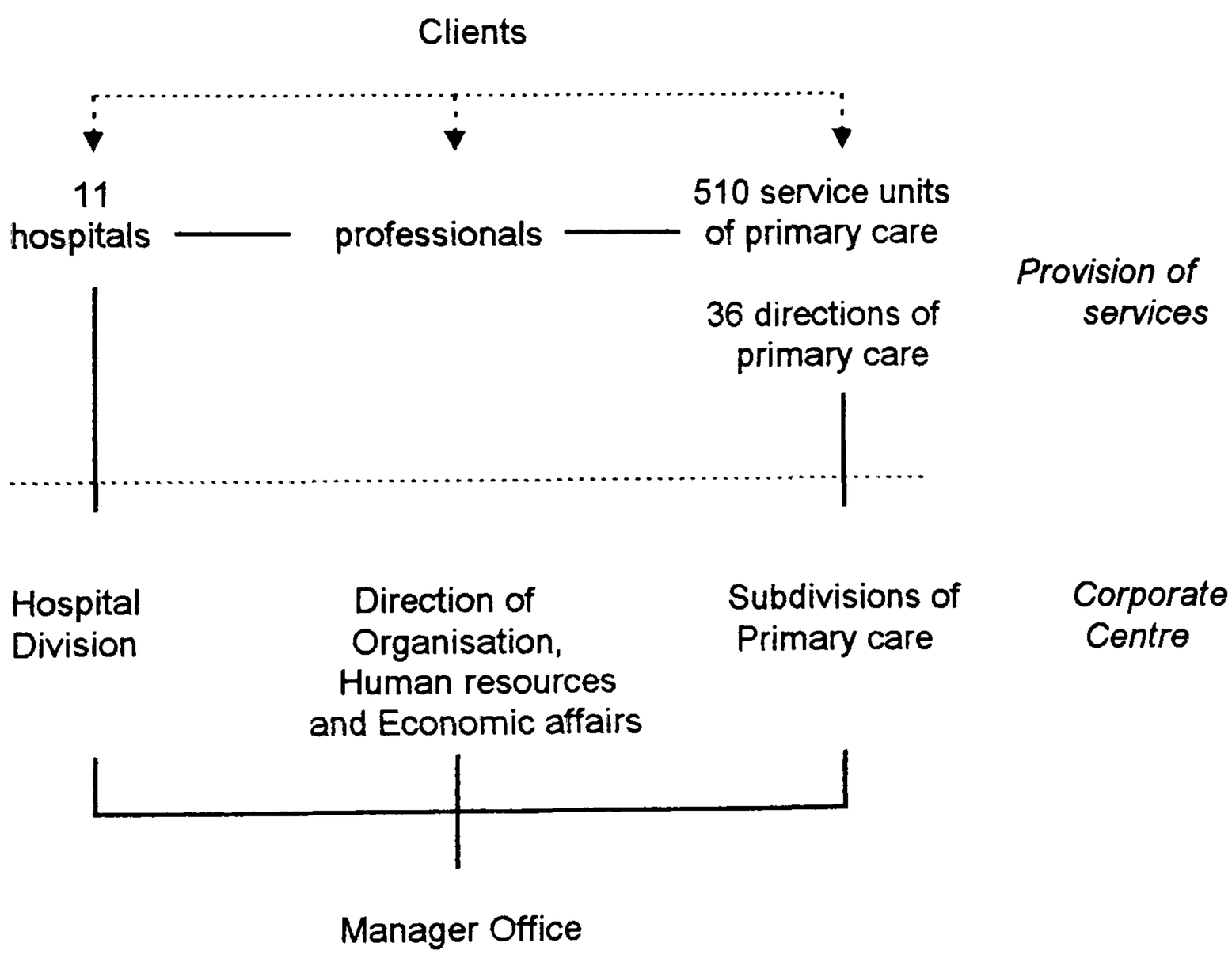
+11 hospitals.
++Centre of medical examination of social security benefit claimants.
*Four territorial subdivisions.
**36 Directions of Primary Care.
***510 Productive units: 341 units of basic services (primary care teams, non-reformed primary care centres, emergencies services), 47 specialised units (primary care centres with specialists), 53 units of services of specialised support (women care programmes, units of rehabilitation, others), 49 units of intermediate products (laboratories, radio-diagnostic centres), 20 units of complementary services (care at home, others).

Source: ICS (1994b) and DSSS (1995a:28-9).

A second type of reform saw a change in CHI's management style which intended to enhance professionals' and staff's participation and responsibility (Massaguer, 1994:56). Figure 5.9 and Table 5.9 show the combination of new structures and management tools and style as viewed within the reform process.

The corporate centre negotiated with the CHS the global CHI budgetary appropriation - though 'translated' into contract terms - and distributed it among health centres - hospitals and provider units of primary care (ICS, 1992:36). The management of resources by the CHI centres would follow a decentralised pattern involving the flexibilisation of staff policies, and the development of output control systems. Unlike hospitals, the definition of operational units within primary care centres would revolve around flattening hierarchies and creating 'Primary Care Teams' of professionals within the ongoing primary care reform from the mid-eighties (ICS, 1993:24).

Figure 5.9. A projected divisional structure for the Catalan Health Institute.



Source: ICS (1995a:19).

Within this process of reorganisation of the CHI, its corporate centre was defining a new approach to the management of its provider units which was intended to evolve towards a model resembling a divisional structure for a near future (see Figure 5.9). However, as explained above, in terms of budgetary

structure such a new organisational approach was not reflected in a change of the 'type' of agency (in Dunleavy's terms) the CHI still was. That is, by mid-1998 its legal personality and configuration have not undergone the 'holding-style' reorganisation which was considered to be the next major step to disaggregate it. Instead, hospitals and primary care centres do not have an independent legal personality and such key management functions as personnel (human resource management) and management of the budget allocations are still centralised at the corporate centre of the CHI. In sum, the formal and binding organigram of the CHI after being transformed into a provider - though a single one - in the early 1990s is as Figure 5.8 shows. These organigrams together with the budget structure analysed above shows the provider role of the CHI has as a *delivery agency,* as a result of the reforms.

Table 5.9. The Catalan Health Institute's reformed approach to organisation and functions, 1992.

Level	Common elements	Specific elements
Corporate level	Direction and organisation of provider units	Operational support and centralised process execution for primary care
Provider units of primary care	Output oriented management Specific or general contracting units	Network approach to primary care centres
Hospitals	Full time management teams	Individual approach plus co-ordination

Source: ICS (1992:9).

According to senior officials of the CHI and the CHS, the NPM model would be taken furthest by disaggregating the CHI - namely, by establishing a contract between each operational/provider unit (hospitals and primary care teams) and the CHS itself, rather than with the CHI centre. In this sense, a Health Region manager of the CHS argued that the CHI should become a stated-owned enterprise in the form of a holding company:

'We are interested in signing the contract as close as possible to the professional who does the work. We have defined in our information system two things: the providers' entity [the CHI] and the productive unit. We argue that we should sign the contract with the productive unit, where the allocation of resources should be established - it is necessary to define the contract well. The role of the provider entity would be to guarantee the logistic, financial and organisational support so that the productive unit could devote itself to the provision of the service.'

Conclusions

The separation between purchaser and provider involved in the institutional design of the new Catalan health authority was the most innovative feature of the health reform launched in 1990. Nevertheless, its innovative character was more relevant in relation to the Spanish context, for which it was a pioneering experience, than in Catalonia itself, where the separation between health authority and most providers was clarified from 1985 with the creation of the HNPU and the consolidation of the contracting system. However, the explicit definition of this central NPM component was left ambiguous in the 1990 LOHC, and did not find its way into the political discourse of the reform until shortly after the law was passed. It was then that a number of conferences in which the main policy elites participated gave evidence of the diffusion of a NPM discourse which happened to fit central features of the Catalan model, and which easily became the prevailing interpretation of the LOHC.

Thereafter the actual implementation of the new institutional design of the health authority had two different formulation sources: an endogenous legal source (LOHC), and an exogenous source (the NPM discourse). At least two different implementation scenarios could be expected. First, if the implementation had followed the actual formulation of the reform as established in the LOHC, then a complex role had to be expected for the CHS as the new health authority. According to the LOHC the CHS was endowed with competencies over health policy formulation, regulation, enforcement, financing, contracting and management. In tum, the CHI was redefined as a provider - that is, it had its

contracting competencies removed -, and was to be integrated into the CHS. By contrast, if the implementation had followed the NPM reinterpretation of the reform, then the separation of roles between CHS and CHI necessarily involved their organisational separation - the CHS should have become solely a purchaser agency, and the CHI should become just another (large) provider structurally independent of the CHS.

The analysis of the actual restructuring carried out between 1991 and 1995 shows first, that, the CHS's role was closer to the actual and ambiguous formulation of the LOHC than to the clear-cut role interpretation forwarded by the NPM discourse. Two indicators support this conclusion: the complex mix of functions formally assigned to the CHS and its budget structure, which clearly revealed a mixture of contracts, transfers, and control types of agency as defined by Dunleavy (1991). In the case of the CHI, the actual implementation process followed closely its redefinition as a provider both in terms of the competencies it was assigned and in the redesign of its budget structure. Thus, while the pre-LOHC CHI's role and budget structure revealed a mixture of contracts, transfers and delivery agency, the same indicators after the reform showed a clearly dominant delivery role. In the case of the DHSS, both the distribution of formal competencies and of budgets confirmed its control agency type before and after the reform.

So the CHI is the agency upon which the implementation of the reform has had a clearer impact, since it has demonstrably shifted from being the health authority to being a large provider. Moreover, the CHI has undergone several processes of management improvement which are reasserting a more efficient orientation to the performance of that provider role. Thus, in this point, the implementation followed both the LOHC and the NPM discourse. Nevertheless, other indicators show a more ambiguous assessment of which of the two formulations was more closely followed. For example, the fact that the CHI remained as an organisation independent from the CHS fitted the NPM discourse rather than the LOHC. By contrast, the fact that the relationship between the CHS and the CHI is not based on a real contract but on a budget allocation - though one 'translated' into contract terms - with no financial risk, fitted more closely the actual formulation of the LOHC than its NPM interpretation.

However, the formal reallocation of competencies and the reassignment of budgetary resources are only static indicators of the extent to which an effective clarification and separation of roles has been implemented. That is, the actual

implementation of a NPM governance structure is by no means directly inferable only from such indicators. The reason is that the dynamic interactions between these institutional actors - the health authority (CHS) and a provider which is itself part of the public administration (CHI) - and the rest of the health policy elite representing a heterogeneous network of providers are based on resource dependence and exchange relationships. Therefore, the very use and impact of the policy tools which are central to a governance structure - for example, contracts in the case of NPM - may be shaped by these repeated interactions among mutually dependent actors. These issues will be examined in the next chapter.

Chapter 6

Implementation: relations between the Catalan Health Service and providers, 1990-95.

Implementing a new institutional form of a public authority and its corresponding policy tools within a particular policy domain involves redefining the relations between public officials and both individuals and interest groups. Horn's (1995) definition of transactions costs was mainly of a political nature and concerned with the decision costs associated to the formulation stage of a new governance structure. His model was not clearly extended to consistently interpret the implementation process, which does not only involve political but also economic transactions costs. Thus, the nature of the implementation or agency costs defined by this author are bound to depend not only on political considerations but also on the economic and social nature of the policy domain in question - health care in this case. For this reason, Horn's model needs the complement of other theories which deal with this economic dimension of transactions, thereby helping identify how the political nature of the agency or implementation problem affects the economic dimension of policy.

In Williamson's (1985) terms, a form of governance - whether market, hybrid or hierarchy - is supposed to be an efficient answer to a particular pattern of transactions frequency and to a certain degree of asset specificity of investments. Taking into account that in the health sector most investments are either highly asset-specific or mixed (asset specific to a relevant extent), a governance structure which is not to be unified but based on hard contracts could be expected to conform to the hybrid type rather than to a market type. This new form of governance should in turn be supported either by neo-classical contracting if transactions are occasional - where conflict is solved by resorting to a third party - or by relational contracting if transactions are recurrent, where adaptation is achieved bilaterally through the contractual relation. Thus, in principle, theory predicts that in the health sector, where transactions are recurrent and investments

are highly (or mixed) asset-specific, if hierarchy is discarded (as NPM prescribes) then the new governance structure should be hybrid and based on relational contracting. As will be shown, this expectation fits to a large extent the developments in the Catalan case.

Apparently, both the policy precedents and the distribution of resources among different actors within the health policy subsystem in Catalonia provided a scenario structurally favourable to the introduction of NPM. In the Catalan case, an NPM discourse diffusion process came to legitimate on an *ex-post* basis a health care model which it happened to fit. That is, the Catalan government recognised an emergent strategy, in Mintzberg's (1987) terms, which had been reflected in the gradual setting and maintaining of policy priorities over a decade, and decided to give it a formal, legal status. This strategy was widely supported by a core institutional and non-institutional policy elite which had been highly stable throughout that period. However, one unintended result of this discourse diffusion process was that it opened a gap between the actual formulation of the reform in the 1990 LOHC and its NPM re-interpretation. Another was that the adoption of this new discourse led the policy elite to assess the subsequent implementation of the reforms in relation to the NPM discourse instead of in relation to its actual formulation in the LOHC.

The repeated interactions among the different actors of the health policy domain are based on flows of resource exchange and mutual dependence, and the implementation of a new governance structure in the Catalan health sector inspired by NPM postulates involved a change in those flows patterns. The incentive-based contractual system which had channelled resources from the health authority (the CHI until 1990) to non-CHI providers was redefined in 1990. As a result, this contractual system was to be the main interrelation pattern between a new health authority (the CHS) and all providers alike, and the CHI had to gradually shift from depending on a budget allocation to having to negotiate a contract with the new health authority in the same terms as the rest of providers. Moreover, contracts as a tool for managing arms length relationships, were projected to be extended from the hospital sector, where it was almost the rule, to the primary care sector, where it represented an innovation.

However, contracts are not only channels for arms length resources flows, but also tools for designing bridging strategies across organisational boundaries. Thus, for example, contracts may involve both incentives and hierarchical elements

in the relationship between contracting parties (Stinchcombe, 1985). Moreover, when contracts become the main tool of a system of external control of semi-autonomous organisations - such as health providers which depend on contracts with the health authority - inter-organisational power relationships come into play. According to Pfeffer and Salancik's (1978) resource dependence theory, an organisation may enter a boundary-setting strategy by shaping its relative influence and control over activities and resources which are critical for the survival of other organisations. In this respect, the shift from a hierarchical command-and-control system to a system of external control of autonomous organisations via contracts involve features such as resource importance, discretion over their allocation and use, concentration of their control, and asymmetric dependence.

These features were central to the implementation of the new governance structure for the health sector in Catalonia. The distribution of key complementary resources between the health authority and a heterogeneous network of health providers was the basis for the development of such bridging and boundary setting strategies. However, these strategies led to divergences between the widespread NPM discourse which the policy elites had adopted as the prevailing interpretation of the 1990 LOHC and the implementation of the reform. Thus, the assessment the policy elites tended to make of implementation was guided by NPM discourse rather than by the 1990 actual formulation of the reform.

This chapter is divided into three sections. The first section analyses the impact of the new governance structure on the relationships between the health authority and the hospital and primary care providers. These relationships were mainly affected by the consolidation of contracts with the former and by the introduction of contractual relations with the latter. The second section focuses on how the content of the 1995 Law modified the LOHC and its relevance for the governance structure being implemented. The third section concentrates on the nature of the divergences between the NPM discourse and the implementation of the reforms between 1991 and 1995.

6.1. Developments in the contractual system and governance structure.

The reforms implemented in Catalonia from the formulation of the 1990 LOHC to its modification in 1995 involved not only a redefinition of the purchaser/financing and provision roles at the level of the health administration by reassigning competencies and budgets, but also the further development of contracts and of private management tools for the governance of the health system. In the hospital sector contracts were consolidated as the main tool for shaping hospitals' service provision, extending its use also to the Social Security hospitals within the Catalan Health Institute (CHI). In the primary care sector contracts were introduced for the first time as a means to translate the objectives of the Health Plan into the actual provision of services. In this sector the contracting process was accompanied by a purposeful diversification of management forms, because in contrast to the hospital sector, the CHI was almost the only provider of public primary care in 1990.

a) The regulated hospital network.

One of the primary objectives of the LOHC was the organisation of the health system on the following principles: first, to create an integrated health system which consisted of all the health and socio-health providers whether public or of public coverage and which was based on an integral conception of health allocating the health planning and management functions to one single body[118] - in contrast to the traditional dichotomy between public health and health care-; and second, to sustain a mixed health system, owing to the historical configuration of health providers in Catalonia (Tosas, 1993:150). In this respect, a policy precedent on which the LOHC built was the 1985 creation of the Hospital Network of Public

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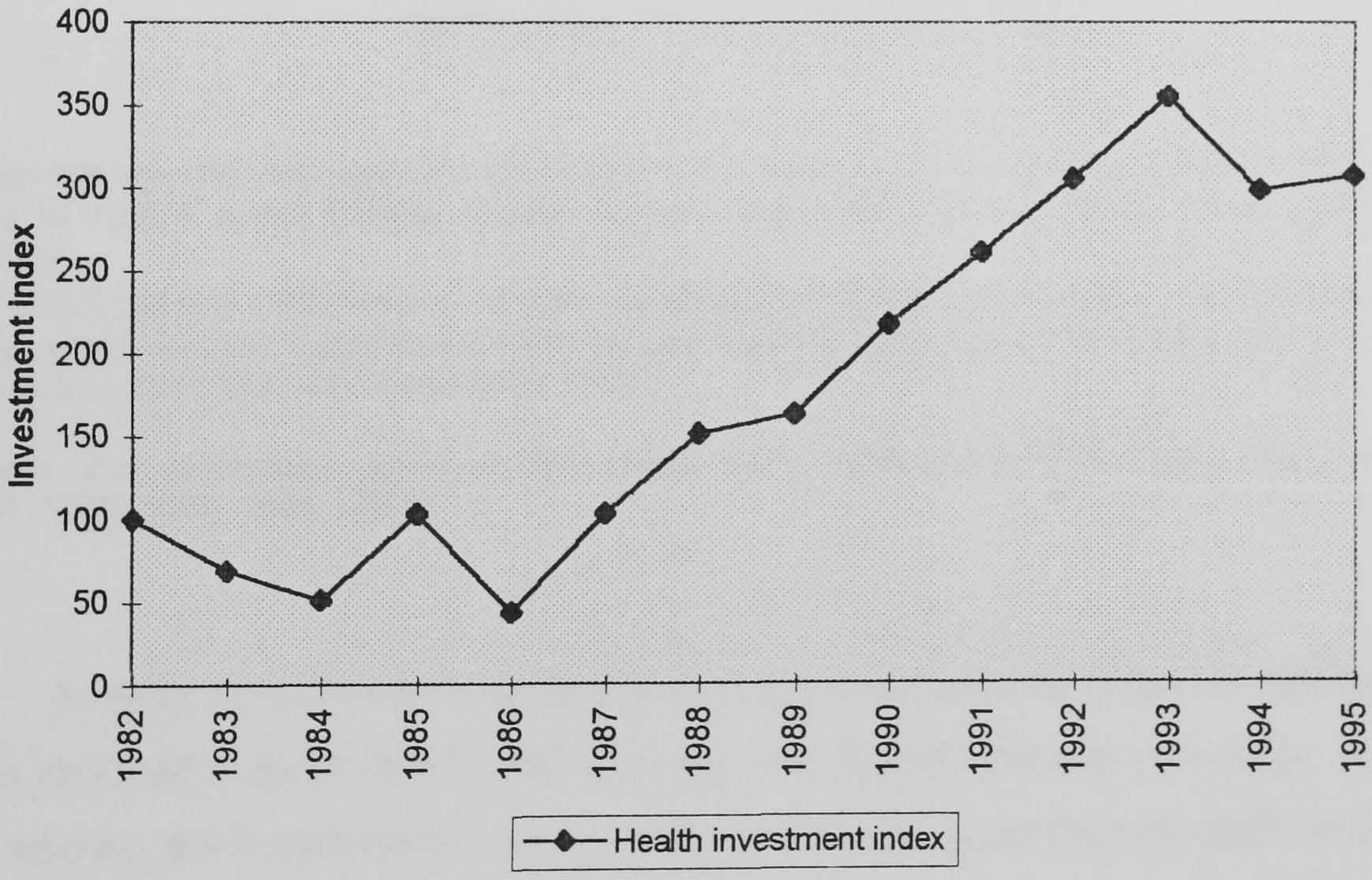
118 See Chapters 4 and 5 for the discussion of this ambiguous assignment of competencies which was afterwards modified by the NPM discourse.

Utilisation (HNPU), which involved an explicit two-fold policy option. On the one hand, it intended to reinforce the heterogeneity of provision management forms and ownership existing within the Catalan health sector. On the other hand, it had the long-standing aim of progressively transforming the Social Security providers included in the CHI (26 per cent of the HNPU-hospital beds, and over 90 per cent of primary care resources) in the line of such diversity. The implementation of these policy options required, first, a considerable investment effort and, second, the consolidation of contracts as the main tools for governing the relations between the health authority and hospital providers.

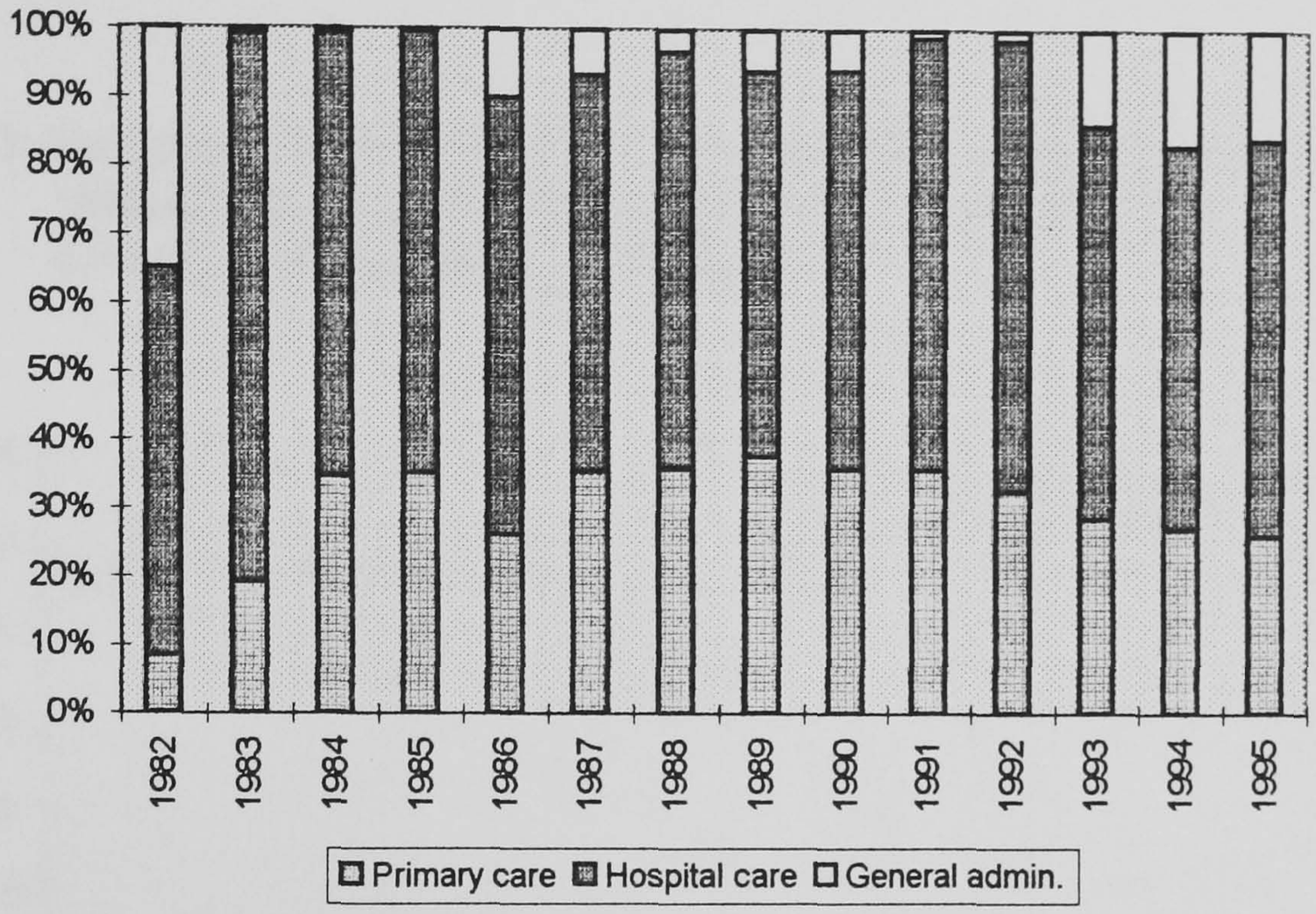
Figure 6.1. Evolution of total investment in health care in Catalonia by the corresponding health authority*, 1982-95 (indexed 100 in 1982).



*From 1982 to 1983 the health/financing authority is the DG of Social Security Health Services, from 1984 to 1990 it is the Catalan Health Institute, and from 1991 onwards it is the Catalan Health Service.

Source: Own elaboration based on DEF (1982, 1983, 1984, 1985, 1986, 1987, 1988, 1989, 1990, 1991, 1992, 1993, 1994, 1995).

Figure 6.2. Distribution of investments in the Catalan health sector, 1982-95 (in percentages over total investment in health by the corresponding health authority*).



*From 1982 to 1983 the health/financing authority is the DG of Social Security Health Services, from 1984 to 1990 it is the Catalan Health Institute, and from 1991 onwards it is the Catalan Health Service.

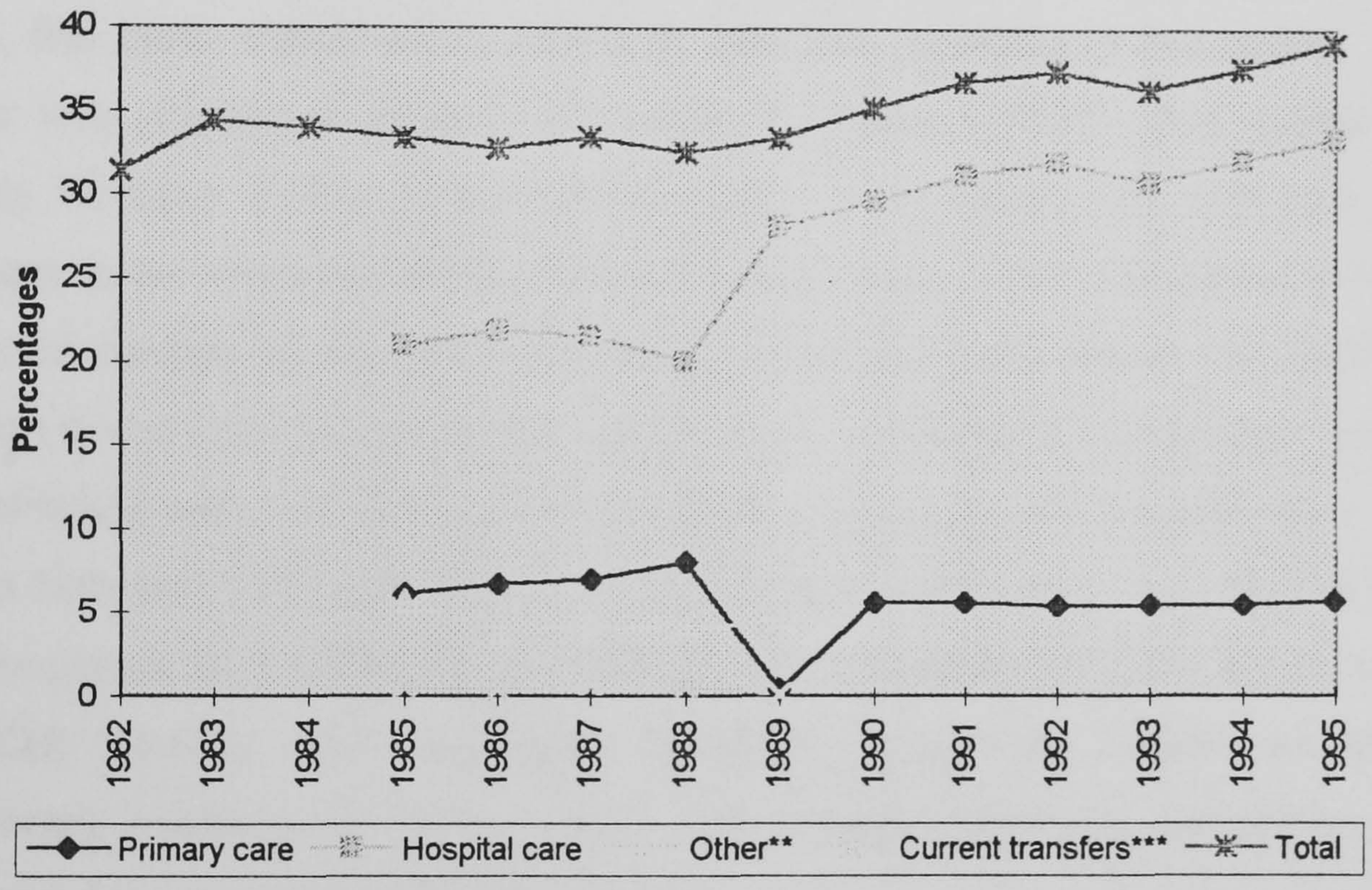
NB: From 1982 to 1984 there is no item classified as 'investment in general administration', but as 'other' and it includes urgent investments programmes for infrastructure and equipment, prices review and other (which was very important in 1982).

Source: Own elaboration based on DEF (1982, 1983, 1984, 1985, 1986, 1987, 1988, 1989, 1990, 1991, 1992, 1993, 1994, 1995).

In order to achieve these two objectives a remarkable public investment effort was required in both non-Social Security and Social Security providers. As Figure 6.1 shows, the investment index in 1993 was seven times that of 1986, after having followed an uninterrupted rising trend in that period. Only in 1994 did the investment effort decrease, to slightly rise again in 1995. Moreover, as it appears from Figure 6.2, the largest part of this public investment in the health sector was made in the hospital sector. After the passage of the LOHC in 1990, the investments share spent on hospitals rose from representing 58 per cent of total investments in health in 1990 to 66 per cent in 1993. By contrast, the investment share corresponding to primary care followed the gradual decrease it had started in 1989, when it had reached a maximum of 38 per cent of total investment in health,

and fell to represent 26 per cent of total health investment in 1995. However, between 1993 and 1995 investment in both hospital and primary care lost relative weight within the overall share in favour of the investments classified as general administration[119].

Figure 6.3. Budgetary share spent on contracts with non-CHI providers, 1982-95 (in percentages over the total budget of the corresponding health authority*).



*From 1982 to 1983 the health/financing authority is the DG of Social Security Health Services, from 1984 to 1990 it is the Catalan Health Institute, and from 1991 onwards it is the Catalan Health Service.
**Specialists services and other, in 1989 it also includes haemodialysis.
***To families, and non-profit institutions (one-off regulatory payments, prostheses, vehicles for handicapped patients, and other).

Source: Own elaboration based on DEF (1982, 1983, 1984, 1985, 1986, 1987, 1988, 1989, 1990, 1991, 1992, 1993, 1994, 1995).

The second requirement for reinforcing the heterogeneous network of non-Social Security (non-CHI) hospitals was the consolidation of contracts as the main tool for governing the relations between the health authority and those providers.

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[119] For a more detailed disaggregation of these data see Table A.5 in Appendix 1.

As Figure 6.3 shows, the weight of the budget share spent on contracts for health services with non-CHI providers by the corresponding health authority within the DHSS gradually increased from the early eighties, when the Social Security health services were transferred from the INSALUD to the Catalan government. Between 1982 and 1995, there was an increment of eight percentage points in the budget share spent on contracts (from 31 to 39 per cent), which basically affected the hospital sector. In fact, the overall increase of the budget share spent on contracts with non-CHI hospital services by the corresponding health authority rose 13.5 points from 1985 to 1995. Although the largest relative increase in the budget share spent on contracting with non-CHI hospitals took place between 1988 and 1991, the trend continued to increase after the passage of the LOHC - but in a lesser way, having experienced a slight decrease in 1993. The overall trend of steady increase of the budget share spent on contracts with non-CHI providers appears to be more remarkable if this budget share is not calculated in relation to the total budget of the corresponding health authority within the DHSS but in relation to the total budget of the DHSS itself. In that case, the budget share spent on contracts with non-CHI providers - both in primary and hospital care - rose 12 points between 1982 and 1995, and the budget share spent on contracts with non-CHI hospitals 14.5 points[120]. By contrast, the budget share spent on contracts with non-CHI primary care providers remained remarkably stable excepting the budgetary exercise of 1989 - when the budget share for contracted hospitals registered its most important increase.

However, the evolution of the budget share spent by the corresponding health authority in contracting with non-CHI hospitals does not necessarily imply that those contracted providers were actually providing a proportionally increasing percentage of publicly financed health services. In fact, the period 1991-95 showed the same pattern of distribution of resources and activity between CHI and non-CHI hospitals as did the period 1987-90 analysed in Chapter 3. That is, although the budget share spent on contracting with non-CHI hospitals rose substantially, the distribution of resources and activity between them and the CHI remained remarkably stable between 1991 and 1995.

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120 For a more detailed disaggregation of these data see Table A.6 in Appendix 1.

Table 6.1. CHI hospital resources and activity, in percentages over total CHI and contracted non-CHI hospital resources and activity for acute care in Catalonia, 1991-95.

	1991	1992	1993	1994	1995
General					
Hospitals	16.4	16.4	17.6	18.1	18.3
Beds*	26.3	26.0	26.3	26.7	27.3
40 h. health personnel**	36.4	36.2	37.0	36.2	34.7
Discharges	26.6	25.8	25.7	26.5	26.8
Stays	27.3	26.9	27.5	27.7	28.5
Outpatient visits	22.0	23.0	22.1	22.5	24.1
Emergencies	23.2	22.6	22.6	22.9	23.0
Discharges paid by Soc. Sec.	26.5	26.8	26.8	26.2	24.4
Running costs	37.1	36.5	34.3	34.5	29.2
Income	37.8	37.0	34.4	34.1	29.3
Health personnel/bed	*2.4*	*2.4*	*2.4*	*2.4*	*2.3*
Occupation ratio	*84.8*	*84.8*	*87.3*	*86.6*	*87.4*
Soc. Sec. dischar./Total disch.	*84.7*	*95.0*	*96.2*	*87.9*	*81.1*
Acute care					
Beds	27.5	27.7	27.6	28.2	28.8
Discharges	26.7	25.9	25.8	26.6	27.0
Stays	28.8	28.7	29.1	29.5	30.4
Occupation ratio (%)	*84.8*	*84.8*	*87.2*	*86.5*	*87.3*
Rotation ratio	*31.6*	*31.6*	*32.8*	*34.7*	*35.5*
Average stay	*9.8*	*9.8*	*9.7*	*9.1*	*9.0*
% over total stays	*99.3*	*100*	*98.2*	*98.2*	*98.2*
Long stay care					
Beds	4.0	0	7.3	6.9	7.0
Discharges	17.7	0	10.9	9.7	8.0
Stays	3.7	0	7.3	6.9	7.0
Occupation ratio	*88.9*	*0*	*93.2*	*94.7*	*94.9*
Psychiatric care					
Beds	0	0	0	0	0
Discharges	0	0	0	0	0
Stays	0	0	0	0	0

*Includes incubators.
**Personnel weighted at a timetable of 40 hours a week.

Source: DSSS (1994c): 112, 114; Service of Information and Studies of the Direction General of Health Resources of the DHSS of the Catalan government (Data base: *Estadísitica d'Establiments Sanitaris en Règim d'Internat*, 1992, 1993, 1994, 1995).

Table 6.2. Hospital resources and activity of non-CHI hospitals contracted for acute care services, in percentages over total CHI and non-CHI contracted hospital resources and activity in Catalonia, 1991-95.

	1991	1992	1993	1994	1995
General					
Hospitals	83.6	83.6	82.4	81.9	81.7
Beds*	73.7	74.0	73.7	73.3	72.7
40 h. health personnel**	63.6	63.8	63.0	63.8	65.3
Discharges	73.4	74.2	74.3	73.5	73.2
Stays	72.7	73.1	72.5	72.3	71.5
Outpatient visits	78.0	77.0	77.9	77.5	75.9
Emergencies	76.8	77.4	77.4	77.1	77.0
Discharges paid by Soc. Sec.	73.5	73.2	73.2	73.8	75.6
Running costs+	62.9	63.5	65.7	65.5	70.8
Income	62.2	63.0	65.6	65.9	70.7
Health personnel/bed	*1.5*	*1.5*	*1.5*	*1.5*	*1.6*
Occupation ratio	*80.8*	*81.0*	*82.2*	*82.3*	*82.3*
Soc. Sec. dischar./Total disch.	*85.7*	*90.7*	*91.3*	*89.6*	*92.7*
Acute care					
Beds	72.5	72.3	72.4	71.8	71.2
Discharges	73.3	74.1	74.2	73.4	73.0
Stays	71.2	71.3	71.0	70.5	69.6
Occupation ratio (%)	*79.9*	*80.6*	*81.2*	*80.9*	*81.0*
Rotation ratio	*33.0*	*34.5*	*36.0*	*37.4*	*38.9*
Average stay	*8.8*	*8.5*	*8.2*	*7.9*	*7.6*
% over total stays	*92.1*	*91.6*	*90.6*	*89.7*	*89.5*
Long stay care					
Beds	96.0	100	92.7	93.1	93.0
Discharges	82.3	100	89.1	90.3	92.0
Stays	96.3	100	92.6	93.1	93.0
Occupation ratio	*95.4*	*86.2*	*93.0*	*95.4*	*94.5*
Psychiatric care					
Beds	100	100	100	100	100
Discharges	100	100	100	100	100
Stays	100	100	100	100	100
Occupation ratio	*86.6*	*87.7*	*94.7*	*100*	*100*

*Includes incubators.
**Personnel weighted at a timetable of 40 hours a week.

Source: DSSS (1994c): 112, 114; Service of Information and Studies of the Direction General of Health Resources of the DHSS of the Catalan government (Data base: *Estadísitica d'Establiments Sanitaris en Règim d'Internat*, 1992, 1993, 1994, 1995).

As Table 6.1 shows, between 1991 and 1995 slight changes affected the weight of the CHI resources and activity within acute care: its beds percentage rose one point, its 40-hour personnel decreased nearly two points, its stays rose over one point, its outpatient visits rose two points and the discharges paid by the Social Security decreased two points. The most remarkable change affected the relative weight of its running costs and income as percentages within the total running costs and income of publicly financed acute care - both decreased around eight points. As in the period 1987-90, acute psychiatric care was provided by non-CHI hospitals, and long-stay care provided by the CHI increasingly lost weight within the system. The reverse of all these trends applied to non-CHI hospitals (see Table 6.2).

This distribution of publicly financed acute care resources and activity between CHI and non-CHI hospitals is part of a wider health system in which both publicly and privately financed resources and activity have a place. From Table 6.3, it appears that by 1995, the CHI hospital beds represented 15.5 per cent of total beds available - namely, 1.5 points more than in 1975 (see Table 3.1). Thus, the decision to confine the relative weight of the CHI resources to the size it had when those resources were transferred to the Catalan government in 1981 was clearly fulfilled. Most of the main general activity indicators show that the weight of the CHI within the health system represented between a quarter and a fifth of the total activity in 1995. In turn, the aim to consolidate the contracted acute non-CHI hospital network (HNPU) was also achieved. In 1995, those contracted acute hospitals bore 65 per cent of all outpatient visits and 68 per cent of all emergencies, and they registered 73 per cent of all discharges paid by the Social Security. Moreover, socio-health care (for long-stay patients) was also consolidated as a contracted sector, most of it as a *de facto* network apart from the acute HNPU. Finally, non-contracted, mostly private hospitals continued to have a relevant weight: for example, in 1995 they registered 21 per cent of total hospital discharges, while the CHI itself registered 20.4 per cent.

Table 6.3. Distribution of hospital resources and activity in Catalonia, 1991 (in percentages).

	CHI hospitals	Contracted acute non-CHI hospitals	Contracted socio-health non-CHI hospitals	Non-contracted hospitals	Total
General					
Hospitals	7.5	33.5	33.5	25.4	100
Beds*	15.5	41.4	29.7	13.4	100
40 h. health personnel**	27.7	52.2	9.3	10.8	100
Discharges	20.4	55.7	2.8	21.1	100
Stays	16.2	40.7	32.4	10.7	100
Outpatient visits	20.7	65.1	0.9	13.3	100
Emergencies	20.2	67.6	1.4	10.7	100
Discharges paid by Soc. Sec.	23.4	72.6	3.0	1.1	100
Running costs	23.2	56.3	7.5	13.0	100
Income	23.2	55.8	7.7	13.3	100
Health personnel/bed	*2.3*	*1.6*	*0.4*	*1.0*	-
Occupation ratio	*87.4*	*82.3*	*91.2*	*66.7*	-
Soc. Sec. dischar./Total disch.	*81.1*	*92.7*	*0.0*	*0.0*	
Acute care					
Beds	23.6	58.2	1.4	17.0	100
Discharges	21.0	56.8	0.8	21.5	100
Stays	26.1	59.7	0.9	13.3	100
Occupation ratio (%)	*87.3*	*81.0*	*50.8*	*62.2*	-
Rotation ratio	*35.5*	*38.9*	*23.0*	*50.6*	-
Average stay	*9.0*	*7.6*	*8.1*	*4.5*	-
% over total stays	*98.2*	*89.5*	*1.7*	*76.0*	-
Long stay care					
Beds	1.4	18.9	76.7	3.0	100
Discharges	2.3	27.0	68.2	2.5	100
Stays	1.4	18.6	77.2	2.8	100
Occupation ratio	*94.9*	*94.5*	*96.5*	*86.6*	-
Psychiatric care					
Beds	0.0	1.8	87.0	11.3	100
Discharges	0.0	13.0	72.0	15.0	100
Stays	0.0	2.1	87.0	11.1	100
Occupation ratio	*0*	*100*	*88.6*	*86.7*	-

*Includes incubators.
**Personnel weighted at a timetable of 40 hours a week.

Source: Service of Information and Studies of the Direction General of Health Resources of the DHSS of the Catalan government (Data base: *Estadísitica d'Establiments Sanitaris en Règim d'Internat*, 1995).

The development of this policy option to consolidate the heterogeneous provision structure existing in Catalonia had as a guiding tool the accreditation system introduced in 1981. Those hospitals passing the accreditation requirements for acute care gradually became members of the HNPU. The process of consolidating the HNPU involved the creation of several consortia, comprising existing health centres and public enterprises. All these providers had in common their subjection to private law instead of to the administrative law framework characterising the operation of Social Security health providers - namely those included in the CHI. Those centres which did not meet the accreditation requirements for acute care either disappeared or were accredited as eligible for socio-health and chronic care services - within the 'Life to Years' programme - or for psychiatric care. Some of these centres held relatively stable contracts with the CHS. This latter sector confronted dire financial difficulties in consolidating a network comparable to the acute care HNPU, because these services are not covered by the National Health System.

The weight of the CHI, which is a provider with a single legal personality and comprises the Social Security providers, was not only relevant for the bed percentage it represented within the HNPU in 1994 (26 per cent), but also for the size of its hospitals (see Table 6.4). They concentrated high technology treatments and university medical research and employed over 30,000 people. These aspects reveal the importance of the debate which intensified after the passage of the 1990 LOHC about the possible gains from disaggregating, managerialising and reorganising the CHI. These proposals were linked to suggestions concerning the need to change the procedural and bureaucratic regulations of personnel and budgetary processes derived from the administrative law framework in which the CHI operated. The other most relevant providers were foundations and mutualities, as well as public and semi-public consortia (governance structures comprising owners, local councils and the Catalan government). The latter achieved ten per cent of the HNPU beds by 1994. Among the HNPU hospitals there were nine which were profit, non-charitable, comprising over 2,350 beds - that is, an average of 262 beds per hospitals - and representing 13 per cent of the HNPU beds.

Table 6.4. Distribution of bed ownership in Catalonia for HNPU-member hospitals, 1994.

Ownership	Number of hospitals	Number of beds	Mean number of beds per hospital	% of beds of the HNPU
Private total	*36*	*9,449*	*262*	*53*
Foundation	17	3,200	**188	18
Mutuality	7	2,028	290	11
Society	6	915	153	5
Church	3	888	296	5
Red Cross	3	610	203	3
Consortium	*5*	*1,808*	*++362*	*10*
Public total	*28*	*8,449*	*302*	*47*
Soc. Sec./**CHI**	10	4,762	473	26
Municipal govt.	+6	1,234	206	7
Other	!1	996	996	6
Foundation	-4	777	194	4
Catalan govt.	*6	586	98	3
Diputació***	1	130	130	1
Total	*69*	*17,878*	*282*	*100*

**1 has 833 beds, the mean of the rest is 147.9.
***Provincial admin. governing organ.
++1 has 825 beds, the mean of the rest is 245.7.
+4 are managed by consortia, and 2 by societies.
-1 is managed by and individual firm, and 2 by societies.
*2 are managed by public bodies, 2 by societies, 1 by a mutuality , and 1 by the CHI.
!is a consortia of only public administrations.

Source: Own elaboration based on data from DSSS (1994b).

As for those centres not included in the HNPU (see Table 6.5) those with a greater weight belonged to societies and the Church, not only in terms of number of hospitals and percentage of beds but also regarding the size of the centres. Among these non-HNPU hospitals, 59 were private non-charitable, of which 31 had some sort of contract with the CHS. These 31 hospitals had an average of 146 beds each (over 4210 beds in total) and represents 32 per cent of this non-HNPU hospital beds.

Table 6.5. Distribution of bed ownership in Catalonia for non-HNPU member hospitals, 1994 (socio-health care for chronic and mental patients and acute private care).

Ownership	Number of hospitals	Number of beds	Mean number of beds per hospital	% of beds of the HNPU
Private total	*103*	*11,004*	*107*	*83*
Society	45	5,830	130	44
Church	16	2,783	174	21
Foundation	15	931	62	7
Mutuality	6	377	63	3
Employer mutual.	5	223	45	2
Association	7	213	30	2
For-profit cooperat.	1	360	360	3
Individual firm	5	127	25	1
Other	2	103	52	1
Red Cross	1	57	57	0.4
Consortium	*1*	*30*	*30*	*0.2*
Public total	*12*	*2,166*	*181*	*16*
Municipal govt.	3	712	237	5
Catalan govt.	3	682	227	5
Diputació***	2	584	292	4
Foundation	3	112	37	1
Soc.Sec./CHI	1	76	76	1
Total	*116*	*13,200*	*114*	*100*

***Provincial administration.

Source: Own elaboration based on data from DSSS (1994b).

A defining feature of this HNPU was that, although being internally diverse regarding ownership and management forms, its funding was public, based on contracts with the CHS. There was, however, an essential difference between the programme-contract signed between the CHS and the CHI as a provider and the contracts signed between the CHS and the rest of providers. Although both of them were formally the same written document, following the same pattern of activity-measuring and pricing, the former was not enforceable, because it did not involve financial risk. Instead, it was conceived of as a tool for helping improve efficiency and managerial awareness among its providers (see Chapter 5). By contrast, the

latter were in principle hard contracts. From 1986 the contracts with HNPU providers were based on a system of tariffs for the payment of the Basic Care Units (BCU) provided by each hospital. In these contracts there appeared, first, the global volume of activity to be provided, the number of BCUs; second, the tariff to be paid for each BCU, which varied according to the technological level of providers (A, A/B, B, B/C, C); third, the corresponding penalisation if the hospital did not provide the activity agreed; and fourth, a variable number of additional clauses for the financing of activities which were not classifiable into BCUs (health programmes) (Ramis *et al.* 1997:23). The calculation of BCU tariffs was based on the relative cost of providing different services:

one stay (overnight and meal)	=	1 BCU
one emergency visit	=	0.5 BCU
first outpatient visit	=	0.4 BCU
successive outpatient visits	=	0.2 BCU

The tariffs to be paid per BCU depended on the level of technology complexity of each provider. This complex dimension was classified into three levels named A (Basic General Hospital), B (Reference Hospital), and C (High Technology Hospital), and two intermediate levels, A/B and B/C. This classification had a two-fold aim. On the one hand, it simplified the previous situation in which there were 21 levels, defined with a corresponding variety of tariffs and financing systems. On the other hand, it was intended to reflect the different cost structure each technological level had for the production of each BCU. The assignment of a level of BCU tariff was in principle dependent on the physical and human resources of each hospital, assuming them to be an indicator of their technological complexity and of the kind of patients treated. According to a senior official of the CHS:

> 'A public payment system, when it fixes prices, it has to take into account the cost elements, otherwise they would throw themselves onto us. You cannot guarantee quality if you cause them [providers] deficit. The increment of the prices of the BCUs is made on the same criterion as the budget increment. But we cannot decrease activity in order to increase the tariff of the BCU. We can do less hospitalisation and more day surgery but we cannot reduce the total number of discharges. Contracts are revised annually. Now providers have contracts for three years and in the new regulations [in 1997] they will be for five years.'

The payment system of these contracts was based on two different transfers. First, a fixed 70 per cent of the whole amount resulting from multiplying the activity contracted (BCUs) multiplied the price (tariff) set by the CHS was transferred monthly to each provider regardless of the activity it actually provided. Second, the remaining 30 per cent was variable and was paid monthly for the activity actually provided. That is, if they produced less BCUs than contracted providers did not receive the whole amount of payment agreed. And if they produced more than the activity contracted for, each additional BCU was paid only at 30 per cent its price (Artal, 1995). However, the tariff paid for each BCU did not cover the full BCU cost, which gradually contributed to an increasing accumulation of deficits in the contracted sector. Figure 6.4 shows the difference between the BCU tariff and actual costs in 1993 for different hospital sizes and levels of technological complexity[121]. Although in some levels and hospital size groups the tariff coverage of the cost was twice that of other levels and groups, activity was under-funded in all cases (see Figure 6.5). However, the very calculation of the level of BCU tariff applicable to each hospital was a matter of controversy, because there was a lack of relevant information[122] such as the kind of patients treated by each hospital or the cost of each kind of patient (Ramis *et al.* 1997:25).

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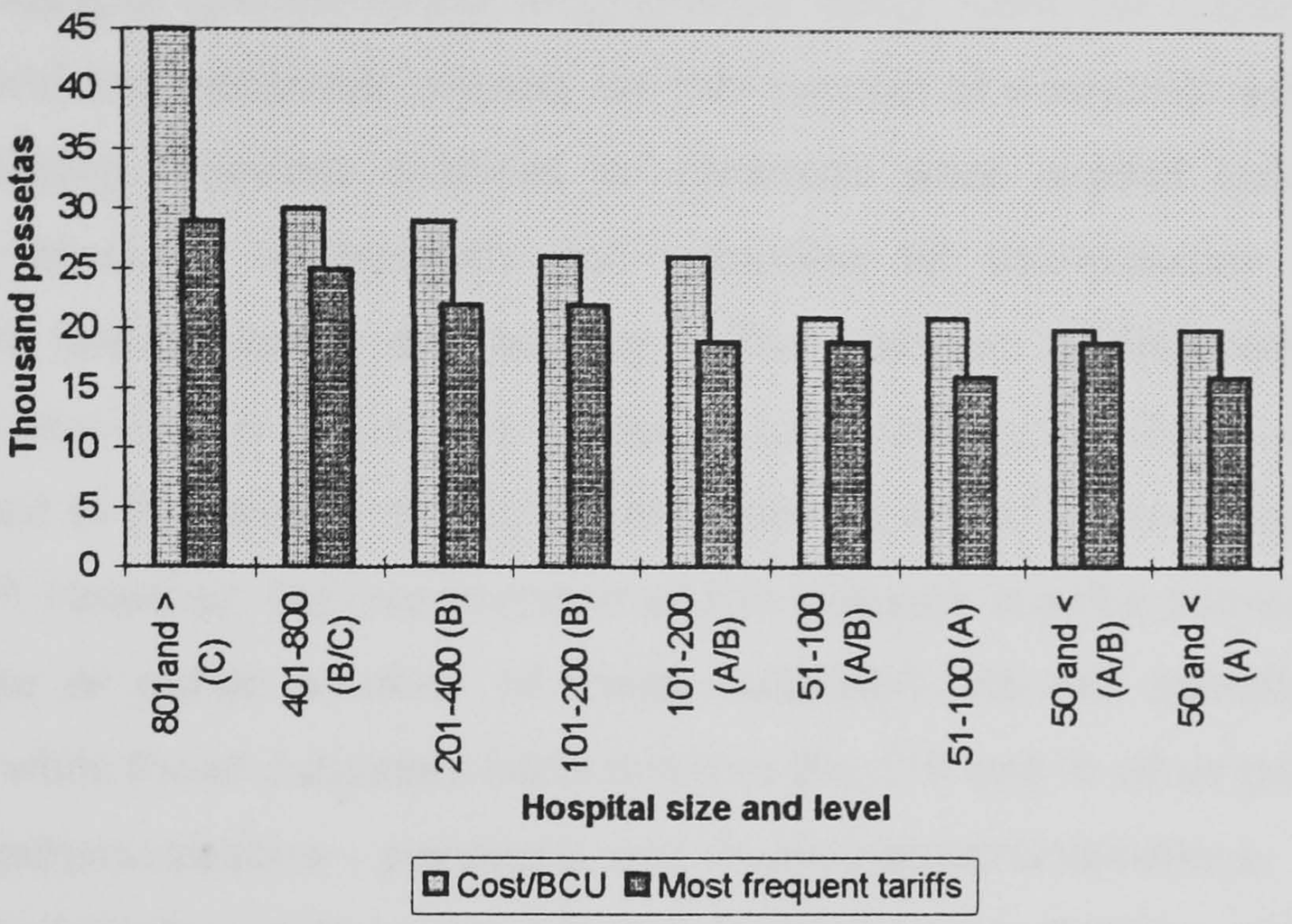
[121] For a detailed disaggregation of these data see Table A.7 in Appendix 1.

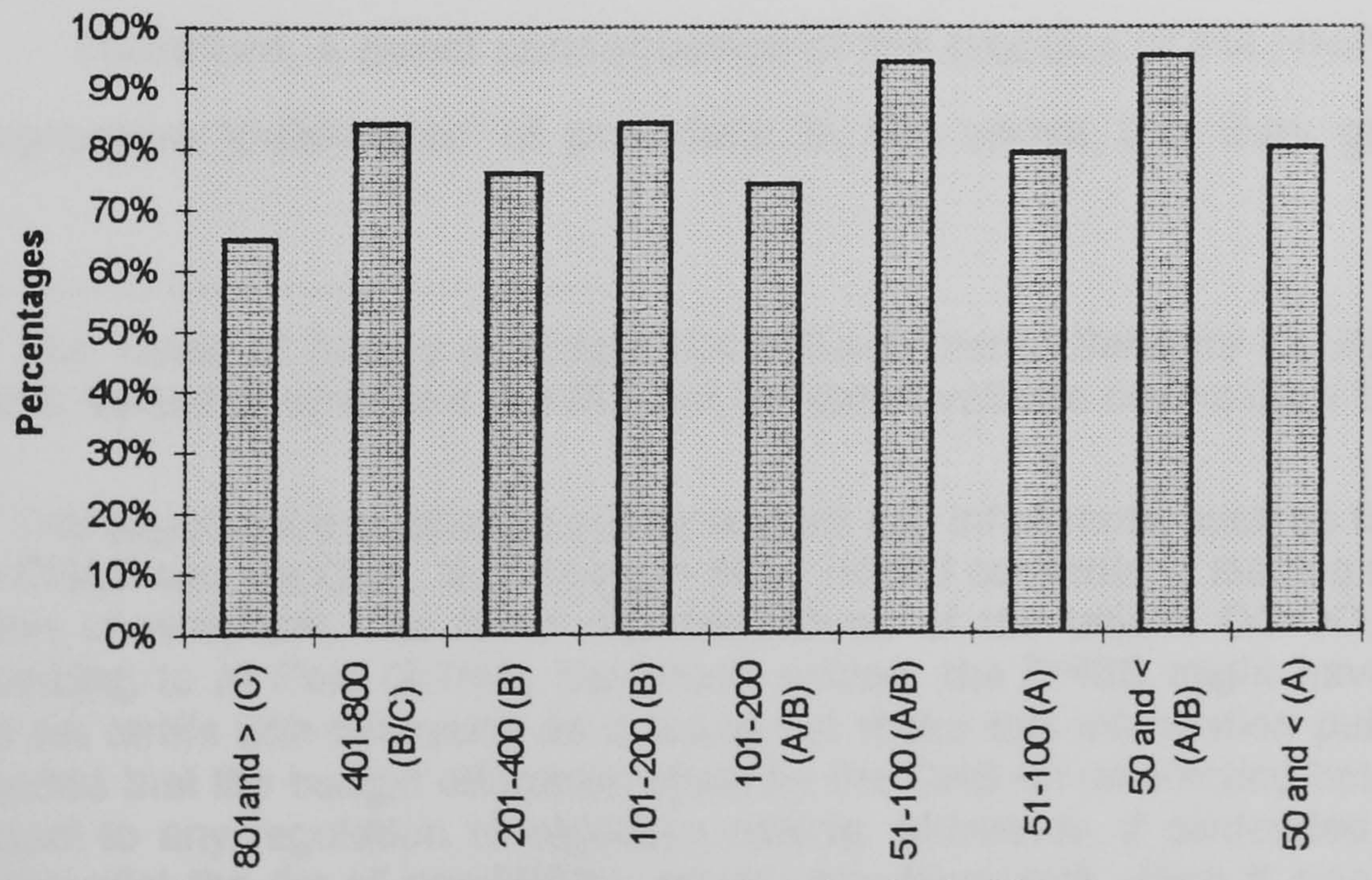
[122] From the early nineties the CHS has consolidated its Balance Centre (*Central de Balanços*) as an economic and financial analysis tool, together with the information system on hospital discharge basic data (Minimum Data Base of Hospital Discharges). Its objectives covered the analysis of the financial and economic situation of the HNPU, the elaboration of comparative analysis on providers' performance by homogenising the information data base collected by them, and giving providers accounting technical support (DSSS, 1992d). The development of this information database, which includes costs per type of output, has provided the CHS with the necessary knowledge to potentially act as a purchaser by improving contract definition and planning with a view to further classify diagnostic related groups (DRG) and patient management categories (PMC). In this respect a new payment system was designed to be in force from 1997 onwards. This payment system could enable, for the first time in Spain, the introduction of patient management categories and diagnostic related groups in the contractual process with a view to endowing the CHS with 'purchaser' power. In fact, from 1997 a new contracting system was been implemented which weights four structural cost components of hospitals: hospitalisation (based on GDR calculations), outpatient visits (weighting first and subsequent visits), emergencies (distinguishing between infrastructure and activity), and techniques, treatments and ambulatory processes. Moreover, the possibility is included that additional payment may depend on specific equipment and activities (prosthesis, pharmacy and health programmes) (CTSP, 1996).

Figure 6.4. Difference between BCU cost and BCU tariff for difference hospital sizes and contract levels in Catalonia, 1993.



Source: Ramis *et al.* (1997:26) based on *Estadística d'Establiments Sanitaris en Règim d'Internat* (EESRI) (1993).

Figure 6.5. Percentage of BCU cost covered by BCU tariff for different hospital size and technological level in Catalonia, 1993.



Source: Ramis *et al.* (1997:26) based on *Estadística d'Establiments Sanitaris en Règim d'Internat* (EESRI) (1993).

In order to make up for this under-funding additional financing mechanisms were designed which were both internal and external to contracts. The main additional financing mechanisms internal to contracts were the additional clauses for the funding of specific health programmes, which were not classifiable in terms of BCU, and the additional clauses for the support of economic activity. The two main financing channels external to contracts were explicit subsidies to the operating accounts of hospitals and subsidies for capitalisation linked to the investment needs across the territory. The data on explicit subsidies to the operating accounts is one of the indicators collected by the DHSS of the Catalan government in the annual survey on the hospital sector it conducts from the mid eighties[123]. However, the interpretation of this indicator may be misleading because the private or public sources of these subsidies are not specified. Thus, for example, while those subsidies transferred to the CHI and to other providers owned by other administrations - provincial and municipal administrations, for example - are mainly transferred from the general budget of the Catalan government, the subsidies that other providers of different ownership categories receive may be from private sources (for example, donations) to a certain extent. This difference is not reflected in the indicator in question. The fact that public subsidies for capitalisation (investments) and to the operating accounts of hospitals were not measured in terms of unitary pricing, as in the case of BCUs, led to some criticisms about the margin of discretion the DHSS and the CHS might have in their allocation [124] (Ramis *et al.* 1997:29-31).

Therefore, a direct consequence of the creation of the HNPU in 1985 was the progressive 'publicness' of providers, in the sense that they gradually increased

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[123] The name of survey is *Estadística d'Establiments Sanitaris en Règim d'Internat*. The DHSS started to conduct it in 1983, but the data available covers from 1985 to date.

[124] This argument was pointed out by several key informants, such as former top officials of the DHSS and the CHS, the manager of an HNPU consortia, a leading figure of the Catalan Union of Hospitals, and three representatives of the unions CC.OO, CATAC and CTS. According to *El País* (2/7/95) Barcelona edition, the DHSS might have allocated services and set tariffs with discretion as it would not make this information public. This newspaper asserted that the budget allocation spent by the CHS on contracting health services was not subject to any regulation or objective criteria. Moreover, it contended, the DHSS kept as confidential the list of non-HNPU, private providers with which it signed contracts for the provision of intermediate products such as rehabilitation, haemodialysis, image diagnosis, clinical blood test and nuclear medicine. These products were purchased directly by the CHS, instead of by hospitals or primary care centres, from these private out-hospital providers which are proliferating as commercial societies.

their dependence on the funding derived mostly from the contracts with the CHS. In this respect, a former senior official of the CHS asserted that the result of creating the HNPU was that instead of having the CHI assimilated to the characteristics of the private providers within the HNPU, the latter have ended up adopting the same resource dependency that the CHI had on the public administration. So an entrepreneurial style of managing hospitals as efficient providers of services has not developed, because neither market pressure nor structural incentives were introduced by the health authority[125].

At the same time, the drive for diversifying the provision forms in health care was deepened in the early nineties. From 1990 to 1995, five new consortia were created, always following the active initiative of the Catalan government. Among this second group of consortia - the first was created in the second half of the eighties - three were providers of intermediate products, such as diagnostic and laboratory analysis. In this period, a new management form was also introduced in the health sector: nine public enterprises were created for well defined activities, such as emergencies, diagnosis, cancer research, health centres management by contract, and evaluation of medical technology. In some cases, these were units or activities previously integrated in CHI hospitals or other public hospitals which thereby 'lost' them in terms of direct budget management.

According to a senior official of the CHS, the reason for the creation of these two kinds of intermediate product providers was to introduce elements which would allow quasi-market relations to be developed in a near future. However, in the view of a senior official of Barcelona's local council and a top figure in a HNPU consortium, these developments of the Catalan model pursued a consolidation and an increase of contracted health services to the detriment of the CHI provision -

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125 In this respect, in the mid-1990s a debate emerged on the need to focus on the micro-management of hospitals, after having seen that the incentives derived from the macro- and meso-management structures had not led hospitals to change their cost structure. A central idea was that a private sector legal framework had to replace the existing administrative law regulations - namely the civil service status of health professionals and the subjection of resource management to administrative law. Another basic theme was the need to transform the vertical organisation based on specialities (Medical Direction, Nurses Direction), into a horizontal, matrix-like structure organised by process - that is, treatment packages for defined pathologies. Professional team work should be coupled with flattened hierarchies and professionals should be given responsibility for a rational use of resources, which required a participative managerial approach to the operation of each hospital or health centre (Monràs, 1995; IES, 1994).

part of whose capacity was being left under-used[126]. This senior official thought that this policy was not rational in economic terms because resources were being unnecessarily duplicated, particularly in the case of intermediate products such as diagnosis, radiology, and analytics.

In principle, the intention to create a quasi-market and to consolidate the contracted sector was hindered by the Public Administration's Contracts Law passed by the Spanish central Parliament in May 1995. This Law intended to counteract several corruption affairs which were affecting the public sphere at the state level, by extending the controls over the contracting and procurement processes carried out by public administrations to those entities which were mostly financed by the public sector. According to a senior official of the CHS this Law affected the contracting processes internal to the HNPU:

> 'When there is no pre-established network (like the HNPU), the new contracting has to be done via public competition under this new contracts law. But public enterprises and the centres of the HNPU are affected by this law regarding the procedure they will have to follow in order to buy the services they sub-contract. For example, a hospital will not be able to buy diagnostic services from whomever it wants but will have to do a public offer. This constrains the idea of the direct contracting of the Catalan model. We had the idea of purchasing final products from hospitals and primary care centres, but not intermediate ones (analytic, radiology, diagnosis). We wanted to create an internal market between providers themselves, but this new law is a burden for them. If it is too burdensome they will think about doing it in-house even if it is more expensive than to externalise it - they save on transactions. The problem is for our providers to sell and buy services between them. Signing and cancelling contracts is more burdensome [with this new Law].'

However, this 1995 law was modified in the 1996 budget law so as to include health provision contracting in the list of the exceptions to the rule of having to organise a public bidding, so that contracts with health care providers may be directly allocated (DSCD, 19/11/96, nº41:1968). Later on, in June 1996, a royal decree-law of the Spanish central government further reasserted the possibility to contract directly or indirectly with entities of any legal nature for the provision of publicly financed health services, as well as the possibility to diversify management

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[126] See for example *El País* (4/11/94) Barcelona edition.

and provision forms. These possibilities were further supported by a law passed by the Spanish central Parliament in April 1997[127].

The diversification of provision pursued in Catalonia in the early nineties involved contracting the management of both hospitals and primary care centres to public and private enterprises. A recent research found that different kinds of management contracting-out were taking place. In some cases the enterprise assumed financial risk. In other cases, the CHS assumed the enterprise's financial risk. And in other cases an enterprise engaged in contracts mixing both possibilities. This research concluded that in many cases, the analysis of the economic flows between the CHS, the enterprise and the hospital or primary care centre in question was extremely opaque. Income and expenditure structures were not clearly disaggregated, and the perception of the actual financial situation of the enterprise was misleading, because the payment conditions were based on bilateral agreements with the CHS (Ramis *et al.*, 1997:37-41).

b) Primary care provision and management.

The reform of primary care formulated in the mid-eighties - in a 1984 decree of the Spanish central government, and a 1985 decree of the Catalan government - was reinforced as a central piece of the health system by the 1986 General Health Law. This reform defined a model characterised by homogeneous public provision structures. Primary care services were organised within Health Basic Areas (HBA) where a Primary Care Team of professionals had the responsibility for health care, health promotion and illness prevention. This team was formed by general practitioners, paediatricians, dentists, nurses, social workers and non-health personnel, who had a statutory, civil service-like status, and a working timetable of 36 to 40 hours a week. Personnel were hierarchically organised under the direction of a medical co-ordinator and a nurse assistant, into a closed model of primary care centre. The reinforcement of this primary care level involved also the provision that emergency services had to be assumed by it on a day-long access bases.

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[127] Royal Decree-Law 10/1996 of 17 June, and Law 15/1997 of 25 April.

The implementation of this model not only involved a massive restructuring of the personnel policy but also large investments in infrastructure. The reasons were, first, that the existing surgeries and equipment were insufficient and inadequate both in the rural and urban areas; and second, that the reform required a remarkable increase in personnel and in their tasks and working hours (Ris, Pané, 1997). However, in contrast to other Autonomous Communities, the implementation of the primary care reform in Catalonia was conditioned by the enabling character with which it was informed. The Catalan health authorities gave priority to the rights of professionals and developed a gradual reform process whose implementation depended on professionals being prepared to become members of Primary Care Teams and adopt the corresponding regulations.

Table 6.6. Primary care Health Basic Areas in Catalonia - reformed and non-reformed primary care -, 1995.

Health Region	HBA created	HBA projected	% HBA created	% population covered	primary care centres
Costa de Ponent	41	57	72	**73**	47
Lleida	22	29	76	**72**	26
Tortosa	7	9	78	**69**	13
Centre	49	69	71	**68**	63
Tarragona	21	32	66	**58**	33
Girona	20	36	56	**50**	31
Barcelonès Nord i Maresme	18	40	45	**48**	31
Barcelona City	23	66	35	**29**	52
Total	*201*	*338*	*60*	***54***	*296*

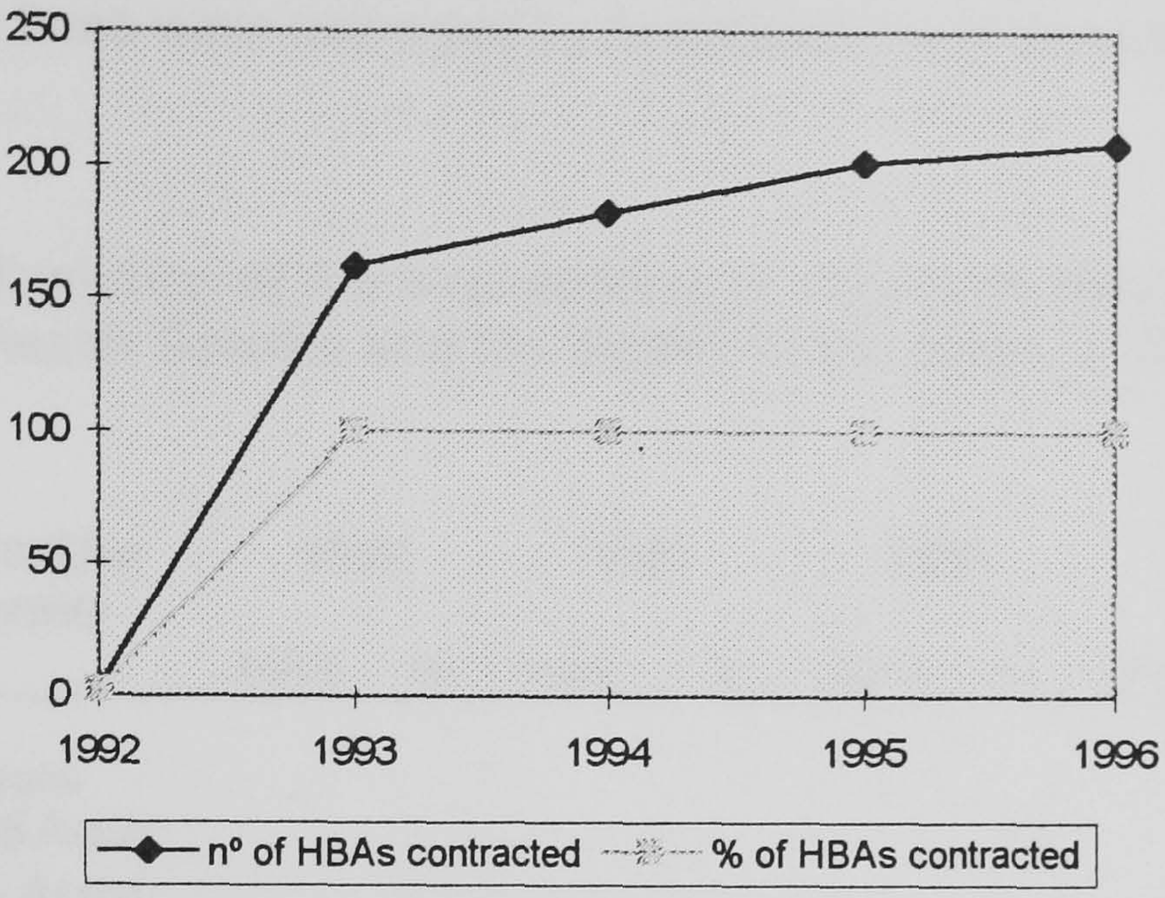
Source: SCS (1996a:21)

From 1990 to 1995, 63 primary care centres were built or had some part of them re-built. By 1995, the reformed primary care network represented almost 60 per cent of the 339 Health Basic Areas (HBA) projected. Some 201 teams, one per area covered 54 per cent of the population (3,290,000 inhabitants approximately). The CHI manages over 90 per cent of these teams (180 teams), while ten per cent

(21 teams) are managed by non-Social Security providers. The Health Region of *Barcelona City* is an outlier, with the lowest implementation rate of the reformed network, covering only 29 per cent of its population. As in Barcelona, urbanisation, industrialisation and population density are also defining features of the other three health regions with low implementation rates in terms of population covered (Barcelonès Nord i Maresme, Girona, and Tarragona) (see Table 6.6).

According to senior officials of both the CHI, the CHS, the DHSS, and some doctors who were directors of non-CHI primary care centres, there are several reasons why the primary care reform was not pursued to the same extent as in most of the other Autonomous Communities in Spain. First, this model was considered to be too expensive because it required big investments in infrastructure and large expenditures on personnel payroll - the model prescribed higher personnel ratios per population and longer working timetables. Second, a voluntaristic approach was adopted so that only those professionals wanting to be included in a reformed Primary Care Team might apply for it. Being a member of a Primary Care Team required longer working timetables than the previous provision model, which, not only hardened their working conditions but also prevented professionals from exercising private practice as a liberal professional to the same extent as before - a situation which is particularly relevant in Barcelona. Third, in Catalonia, the health policy priority had been the consolidation of a dense, territorially even network of basic level hospitals, which had absorbed huge investments. This latter argument is confirmed by the data in Figure 6.2 above. The investment trends did not show a shift of resources from the hospital sector to the primary care sector. However, the argument that the primary care reform as it was formulated was not economically viable is difficult to support only from the data available, because in principle the decisions involved were a matter of investment priorities. From 1993, the primary care sector was also affected by the introduction of contracts between the Catalan Health Service and primary care providers. Contracts were signed with each new HBA as they were created. As Figure 6.6 shows, while in 1992 only 2 HBAs were contracted, from 1993 contracts affected all HBAs as a result of the introduction of the programme-contract (protocol framework) with all HBAs managed by the CHI. It does not mean, though, that all primary care was contracted, but instead that all the *reformed* primary care centres were contracted - that is, 60 per cent of the HBAs projected (see Table 6.6).

Figure 6.6. Evolution of the introduction of contracts between the CHS and HBAs in Catalonia, 1992-96.



Source: SCS (1996a:21)

As in the case of the hospital sector, the introduction of contracts in primary care was accompanied by an attempt to diversify provision and management forms. In primary care though, the CHI owned and managed over 90 per cent of resources. One of the characteristics of the CHI model which was usually mentioned as a hindrance to improving efficiency was the dissatisfaction of professionals. This was said to stem, on the one hand, from their lack of influence in the organisation and management of primary care centres, and, on the other hand, from the lack of individualised incentives related to the quality of the service provided or to the achievement of objectives.

These arguments reflect the origin of the drive for diversifying the provision models of primary care in the early nineties. These new provision models involved private management forms. Thus, while originally the CHI managed all public primary care in Catalonia, the reform process based on the demarcation of HBAs and the creation of Primary Care Teams was taken as an opportunity to contract out the management of new HBAs to providers other than the CHI - even if the CHI had been managing primary care in those particular areas. As Table 6.7 shows, in 1992, there were three HBA whose management was contracted with providers other than the CHI, and by 1996 there were 22. That is, ten per cent of Primary

Care Teams were no longer under the CHI's authority or responsibility. Instead, 13 HBAs were managed under contract by several consortia which also managed hospitals in the same area, three HBAs were managed under contract by public enterprises, three were managed by foundations and three by a mutuality.

Table 6.7. Evolution of the introduction of contracts between the Catalan Health Service and the Health Basic Areas in Catalonia, 1992-96.

Provider entity	1992		1993		1994		1995		1996	
	HBA	%	HBA	%	HBA	%	HBA	%	HBA	%
Badalona Gestió Assist.					1	0.5	1	0.5	1	0.5
Cons. Assist. Baix Llobregat			1	0.6	2	1.1	2	1	2	1
Cons. Corporació Sanitària					1	0.5	1	0.5	1	0.5
Cons. Sanit. de Barcelona			1	0.6	1	0.5	2	1	2	1
Cons. Sanit. de Mataró			1	0.6	1	0.5	1	0.5	1	0.5
Cons. Sanit. de La Selva					1	0.5	1	0.5	1	0.5
Cons. Sanit. de Terrassa	2	1,2	3	1.6	4	2	4	1.9		
EAP VIC-V SL									1	0.5
Fund. Centres Assist. i Urg.					1	0.5	2	1	2	1
Fund. Sant Jaume d'Olot							1	0.5	1	0.5
Inst. d'Assist. Sanitària							1	0.5	1	0.5
Catalan Health Institute **(CHI)**	154	95.1	168	92.3	180	89.6	186	89.4		
Mútua de Terrassa	2	1.2	2	1.1	3	1.5	3	1.4		
SAGESSA	1	0.6	1	0.5	2	1	2	1		
Total HBAs with contract	3	2	162	100	182	100	201	100	208	100
Total HBAs created	149		162		182		201		208	

Source: SCS (1996b:3).

In primary care contracts were made at the level of HBA. However, in the case of the CHI a protocol framework was also signed between the CHI and the CHS, and the financing channel was the budget instead of payment based on tariffs per activity set on the contract. In the case of non-CHI providers contracts were allocated for a period of three years (objectives and tariffs were reviewed every year) and, in principle, it might be renewed for three more years if objectives were achieved to a reasonable extent. Both the programme-contracts signed with the CHI's Primary Care Teams within the CHI's protocol and the contracts signed with these new primary care providers were different from those signed with hospitals. Primary care contracts were not based on prices set for each unit of specific and quantified services to be provided. Instead they were contracts for services which established a global obligation to provide health care (Ramis *et al.* 1997). Moreover, prices were calculated on previous costs rather than on population or activity criteria, and funding covered only care activity without responsibility over the generated cost (such as, radio-diagnosis, laboratories, pharmaceuticals, specialised care) (Castillejo *et al.* 1993). The payment of these contracts was divided into a monthly payment of a fixed 95 per cent of the global amount set, and an annual variable part of five per cent which was paid depending on the achievement of specific indicators[128].

The introduction of contracts in primary care helped bring about a qualitative improvement in the kind of information collected in this sector. Traditionally, this information concerned quantitative aspects of the health care activity collected on a routine basis in each centre. The introduction of contracts and the evaluation process of the Health Plan for Catalonia involved the need to collect information also on the content of the health care activity and on its results in terms of health and users' satisfaction with the service. Moreover, some HBAs developed cost accounting by analysing costs per product and processes. After the first evaluation of contracts in 1993, a system of 39 indicators was agreed between the Central Services of the CHS and the Health Regions. These indicators gave information on population coverage, use of records, quality of services concerning specified priorities, availability of protocols on preventive activities, users' satisfaction, the

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[128] There were five indicators: realisation of 100 per cent of the activities contracted, percentage of open medical records, number of patients derived to hospitals (maximum of 200 per 1,000 inhabitants), percentage of hyper-tens controlled (minimum of 65 per cent), and children vaccination coverage (Gervás, Ortún, 1995:26).

content of the health care activity of the centre, and achievement of the Health Plan objectives (SCS, 1994b). As the Health Regions are the direct interlocutors of providers in the contracting process, they were made responsible for the evaluation of individual contracts through standardised questionnaires. On a complementary process, the central services of the CHS were made responsible for monitoring this evaluation by integrating all the information collected by Health Regions, so as to provide a global analysis which could orient the purchasing priorities (SCS, 1995b).

However, according to a recent CHS's report, the widespread interest in evaluating contracts placed an excessive demand on the system, both on professionals and on the health administration. In some centres there were not adequate information systems for collecting and processing the data required, and the analysis of the information collected appeared burdensome and with a lack of clear objectives (SCS, 1998). Professionals found themselves having to provide different data for different evaluation processes - the evaluation of the Health Plan, the evaluation of contracts, the evaluation of the providers' entity. Moreover, as a result of the increase in the services contracted to Primary Care Teams, the indicators system was burdened with an increasing demand on information, which, according to this report, was based on the wrong assumption that the focus on individual contracts evaluation could make up for the lack of other more general evaluation instruments[129]. So it became apparent, first, that new tools were necessary to complement the evaluation of each individual contract and to provide more global assessments in order to inform the strategic decisions on the purchase of services. Second, it was acknowledged that it was necessary to set priorities concerning the information needed by clarifying the objectives of the evaluation process and by accordingly consolidating the information systems in every single health care centre.

Although information systems were an essential tool for efficient and effective contracting by the health authority, some directors of non-CHI primary care centres acknowledged that when a new reformed HBA was to be created and the explicit DHSS will was not to have the CHI manage it but to introduce a different provider,

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[129] For the 1996 contracting process three different groups of indicators were defined based on how long the Primary Care Teams had been operating and on how urgent the information was in relation to its availability: group A (11 indicators per Team having operated for less than one year), group B (11 indicators per Team having operated for longer than one year, urgent information), and group C (35 indicators per Team having operated for longer than one year, non-urgent information) (SCS, 1996b).

the contract was implicitly allocated to the main private or non-CHI public or para-public provider in the area. And in most cases, this was a HNPU-member hospital sector provider[130]. Contracts were agreed on a bilateral basis, as the usual case was that such a provider had a long trust relationship both with the population in the area and with the DHSS itself, having usually emerged as a private initiative where the presence of Social Security services had historically been scarce. According to a manager of a mutuality:

'When the public bidding for the allocation of this Health Basic Area was announced nobody else presented an offer for consideration. All this is agreed on in advance, even more when it is a pilot experience. In a public bidding the contact with the DHSS is crucial, its philosophy, the credentials of the prospective provider ... This public bidding was the DHSS's idea to try a new management formulae although the CHI was already there. Before the contract this mutuality had been providing primary and hospital care here for twenty-five years. These were the only health infrastructures here - two primary care centres which used to agree contracts with Madrid, they were ours. Others are the CHS's ... The local council gave the site, our Director General presented the project, and the DHSS financed it ... We have to follow the same legal framework as any other private enterprise, both in labour relations aspects and in financial aspects.'

According to its supporters, this diversification of providers gave an element of contrast and reflection on the prevailing CHI organisational model by facilitating comparison between different experiences (Ris, Pané, 1997). Thus, for example, in 1993 and 1995 two teams of an associative basis were created for the management of two HBAs. These alternative (non-CHI) providers had freedom to design their organisational and operational arrangements. They were not subjected to the detailed regulations stemming from the 1985 decree on primary care, which required a specific staff ratio per population, a weekly working timetable of 36 hours, and specific internal organisation provisions. According to some professionals of these non-CHI primary care providers were critical with this 1985 model (that of the CHI Primary Care Teams). The actual implementation of that primary care model was leading to half the projected time being spent on actual

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[130] The direct allocation of management contract to these providers was the object of controversy. While unions rejected the legality of direct contract allocation, the CHS insisted that it is legal as they consider these cases to be pilot experiences (see, for example, *El País* 2/12/92, Barcelona edition).

health care activity as a result of 'too many useless co-ordination meetings where nobody has decision-power' - as the medical director of a non-CHI Primary Care Centre and former CHI general practitioner put it. The features of the CHI model they tried to avoid were the lack of freedom to reallocate personnel and to have flexible timetables and personnel ratios, and the impossibility of introducing individual payment-on-performance. According to the medical director of a non-CHI primary care centre:

> 'What makes our model different from the CHI is the management capacity regarding resources, organisation. We are not obliged - despite having to meet the quality and equity standards of the CHI - to follow its same organisational and structural criterion (personnel ratio per population) ... We try different initiatives and then evaluate their efficacy and efficiency ... The utilisation rate and workload depend on the distribution of pathologies ... It is necessary to agree this programme with the professional because he [*sic*] is who knows best the amount and kind of work he has. Thus, we have clinic session every day, which may deal with some aspects review, activity analysis, organisational analysis, prescriptions, specialities. They are either evaluative or formative ... The key of this 'managed care' is that the exercise of the medical profession involves criteria for co-responsibility in the management of resources, in the rationalisation of resources.'

In this respect, a senior official of the CHI's primary care division argued in 1996 that the CHI model was going through a process of culture change which was intended to transform it into a viable provision option within the Catalan model, which was evolving towards a diversity of provision forms:

> '[In 1992] we started to be contracted by the CHS, we were asked for a series of objectives and internally we implemented management by objectives: an agreement between the enterprise (the CHI) and the Primary Care Team of each HBA on what you expect from them according to both the contract with the CHS and to our own objectives ... It is necessary to go beyond this fiction and make this management by objectives operative, something that links it to the professional it is necessary to change the remuneration model ... We are thinking about a model in which each member of the Team is paid differently depending on whether this person does things better or worse. A remuneration model which pays, on the one hand, a fixed amount and, on the other hand, an amount on capitation (according to the number of people you cover). But a third thing is needed: pay on results, on objectives ... which implies incentivisation for rationalising pharmaceutical prescriptions, tests, etc.'

From the end of 1996 a new form of non-CHI provision established by the 1995 modification of the LOHC (see below) was implemented in one HBA as a pilot experience. This new management form, namely self-management by stake-holder professionals, applied to CHI professionals wanting to opt out and constitute an association legally entitled to hold a contract directly with the CHS. Their statutory place in the CHI was safeguarded for three years in case they wanted to go back to it. Furthermore, there were two basic differences between this new model and the CHI model. First, there was the possibility to distribute profits to share-holders instead of being obliged to invest any savings - in such a way, though, that only the professionals working in the centre were allowed to be share-holders, that is, owners. Second, they had the same flexibility for personnel policy and self-organisation which characterised the other non-CHI providers. In this sense, a professional of this self-management pilot experience argued that:

> 'First of all [in our model] there is an important change in the labour status of professionals, which involves a change in the involvement of health professionals in the job they carry out within the team .... The job is much more important... there is a reorientation of the time spent on health care activities. In the CHI it is 36 hours a week in theory but, in reality, the time spent on care was much less. Instead, our contracts are for 40 hours a week which have to be spent on care tasks, and when there are common spaces they tend to be devoted to technical aspects rather than organisational. In the CHI system, teams waste a lot more on organisational dynamics, decision-making was not well regulated - it is dealt with through assembly methods, and there is no clear directive role.'

However, the way this pilot experience was implemented was strongly criticised. The formal requirement of having a public tender process for allocating contracts to non-CHI providers for the management of primary care within HBA was upset by the DHSS in 1996 in this particular case of self-management. The DHSS directly allocated a contract to the team managing this first pilot experience[131]. Widespread criticism focused, first, on the non-publicised financial support given to this experiment by the Official Medical College of Barcelona (apart from its explicit support to the self-management model) and by the DHSS - these professionals had the infrastructure paid and build from new. Second, criticism focused on the

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[131] In this respect see *El País* (11/2/95) Barcelona edition; and the opinion article by Martí, E. in *El País*, 22/2/95, Catalunya supplement:2. Barcelona edition.

better funding conditions this pilot experience enjoyed in the contract they held with the CHS compared to other primary care teams. And third, the security financial clauses of the contract allocated to the team in question wereattacked[132].

Finally, regarding this drive for diversifying provision and contracting out management there was an argument which was around since the mid-eighties and which gained new strength in the early nineties (Carreras, Balaguer, 1988). It emphasised the need to revitalise the role of mutualities in the provision of health services, by maintaining the level, which was slightly declining, of double public and private health insurance coverage present in Catalonia, which affected 21 per cent of the population. The argument was that the public compulsory system would be too under much strain if it had to actually cover those people who were contributing to financing the public system but were using the private system. For this reason, it was argued that a new role for private insurance companies should be defined in the field of health services provision (DSSS, 1995b:32) in such a way that citizens could choose having either public or private insurance[133].

6.2. Further legislative changes in 1995.

In contrast to the long negotiation process which led to the passage of the 1990 LOHC, a Modification Law was sent to Parliament by the Catalan executive in July 1995 to be handled under an urgent procedure. It was finally passed in September 1995, two months before the autonomous elections in which the governing

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[132] These criticisms were expressed by the medical director of a non-CHI primary care centre, a senior directive of the CHC, a senior directive of the UCH, and a member of the class-based union CC.OO.

[133] It should be noted that only seven insurance companies cover 73 per cent of the market in terms of premiums collected, and that, for example, the second in the ranking owns a chain of six hospitals of which four regularly hold contracts with the CHS as members of the HNPU (DSSS, 1995d). It is apparent that the pursuit of this kind of reform would involve the end of the monopsonistic power of the CHS. In the theme concerning the need to give mutualities and insurance companies a more relevant role in health and pensions see EFE news agency in Catalonia, report (19/3/96); the opinion article by Antràs, J. in *La Vanguardia* (24/10/96:23); and *El Periódico* (9/10/97).

Convergence and Union (CiU) lost its absolute majority in Parliament. As in the case of the formulation process of the LOHC in the previous legislative period, CiU counted again on a disciplined absolute majority in Parliament and, therefore, it had the same formal power as in that occasion. However, its relationship with the Party of the Catalan Socialists (PSC), which had not been very fluent throughout the negotiation of the LOHC, was mediated in 1995 by CiU's relationship with the Spanish Workers' Socialist Party (PSOE) at the Spanish central government level. The PSOE had lost its absolute majority in the central Parliament in the 1993 general elections and had reached an agreement with CiU, which supported the PSOE on a per-issue bases. This situation conditioned the extent to which the PSC could exercise its opposition role in the Catalan autonomous Parliament. This time, the strongest (and only) opposition came from the leftist coalition Initiative for Catalonia-The Greens (IC-V), and the PSC obtained a much criticised concession from CiU (see below).

The parliamentary debate leading to the passage of the 1995 modification law of the LOHC, following the negotiation at the Commission level, showed a consensus between all political parties on what the main characteristics of the health governance structure designed by the 1990 LOHC had been. The actual ambiguity of the LOHC had finally given way to a clear NPM interpretation. According to the *Conseller* of the DHSS who spoke on behalf of CiU, such characteristics were:

> 'On the one hand, the *separation between the financing and purchasing of services*, which is the health administration's function, *and the provision of services*, which is carried out by a diversity of health care centres, adequately accredited, either of public or private ownership-, thus following the trend in the most developed countries of using all health resources and respecting, on the other hand, the health reality in our country. The other characteristic of the Catalan health model established by the LOHC has been the introduction of mechanisms of private management, particularly in the publicly owned centres. In this line, we have created 11 health consortia and nine public enterprises, with the aim of improving the degree of effectiveness, efficiency and quality in the provision of health and socio-health services of public management' (DSPC-P, 20/9/95, nº128:7162, my emphasis).

Later on in the debate CiU's spokesman for health policy rejected IC-V's criticisms of what they interpreted as a privatising reform. First, he asserted that the introduction of private management practices in public entities had nothing to do

with privatisation and that CiU was not supporting the latter. Second, he argued that:

> '...by means of the LOHC, we confirmed the mixed health system of Catalonia and ratified a health policy based on the separation between financing and purchasing of services and their provision. This is the policy which is becoming predominant ... in the health debate in the context of developed countries ... where the use of all existing health resources, regardless of their ownership, is the main priority.' (DSPC-P, 20/9/95, nº128:7170).

The 1995 Modification Law of the LOHC introduced both some re-assertions and some contradictions in the LOHC principles. The main modifications introduced concerned the legal nature of the CHS, the management forms used for the provision of primary care services, an ambiguous provision concerning the possibility to change the legal nature of the CHI, and a modification of the organisational structure of the CHS. The first three were the object of debate among the policy elite as suggested by the draft bill presented by CiU. The last element was not part of the draft bill, but the result of a negotiation process which further originated a debate on the distortion of the 'Catalan model'.

The first draft bill CiU elaborated provided two main modifications of the LOHC. First, the legal nature of the CHS was changed from a public entity of an institutional nature to a public enterprise as defined by the 1985 law of the Statute of the Catalan Public Enterprise. Thus the CHS now had its own legal personality and was attached to the DHSS. In its external relations (contracts, procurement of goods and execution of public works, under the principles of publicity and free competition) the CHS was subject to private law. The supporting report of the bill argued that this modification clarified any ambiguities about the legal nature of the CHS and its subjection to private law, and that this clarification was necessary in order to avoid the legal insecurity that may exist when creating public enterprises dependent on the CHS. Second, CiU's draft bill extended the private management contracts for the provision of primary care by giving health professionals the possibility to opt out of the CHI and form associative entities for contracting with the CHS, while preserving their statutory post for three years in the CHI in case they wanted to go back.

However, the final version of the Modification Law passed by Parliament defined the CHS's legal nature in a more ambiguous form than as a public enterprise. The CHS was defined as a 'public body of an institutional character, endowed with a legal personality of its own and full capacity for the fulfilment of its ends, ascribed to the DHSS [...]. With respect to its external legal relations, it is subject in general to private law'. That is, there was an explicit mention of the CHS's entitlement to act, as a rule, within private law provisions in its external relations - within the framework established by the Law regulating Catalan public companies -, a point which had been established by a 1994 Decree specifying the CHS's core structure, organisation and regulations (Viñas, Lafarga, 1996). Moreover, this final version of the Modification Law widened the possibility for private contracting in primary care to include personnel of other public and private providers and health professionals in general - not only doctors. So Health Regions may now sign contracts for the management of primary care centres with entities of an associative basis formed totally or partially by CHI personnel opting out of the CHI with reservation of their post for three years, and by other personnel from local health technical corps of the state, civil servants of the autonomous administration attached to the CHS, and personnel transferred from other administrations.

According to the only parliamentary force that opposed the reform, namely IC-V, this legislative initiative was meant to give legal status to the private contracting which the CHS had been developing by decree and without the required legal base. According to *El País* (21/6/95;15/7/95; Barcelona edition), the 1991 and 1993 decrees regulating the CHS after the LOHC did not fulfil the requirements stated by the Legal Commission of the Catalan government. Those decrees regulated the private contracting of the CHS, while, according to this Commission that could only be regulated by law.

The stances taken by the main policy elites in relation to these two modifications of the LOHC were made explicit before the passage of the final version, and were initially directed at CiU's draft bill. Thus, in the UCH's view, giving the CHS the legal nature of a public enterprise implied a greater control over the CHS by the Department of Economy and Finance of the Catalan government and 'therefore, maybe, what will be gained in terms of more legal security will conversely be lost in autonomy and flexibility' (UCH, 1995b:1). In any case, though, the UCH did not think it necessary to change the legal nature of the CHS, because

a public entity of an institutional nature is also legally empowered to create public enterprises. As for the CHI, the Catalan Union of Hospitals (UCH) argued that its reform should be the object of a specific law which transformed it into a public enterprise and made it a more independent agent. According to the UCH, instead of approaching it in an clear and comprehensive way, the 1995 bill adopted an ambiguous an piecemeal stance. Moreover, the UCH (1995b:2) contended that at that time there was no consistency in the Catalan health 'model'. For example, they claimed, the implementation of the Health Regions structures and functioning according to the CHS interpretation of the decentralisation principle had made apparent the need to centralise the definition of the basic criteria for planning and evaluation. The reason was the lack of homogeneity they observed between the criteria set by different Health Region managers. And the assignment of competencies between the central services of the CHS, Health Regions and Sectors was not sufficiently clear.

The Hospital Consortium of Catalonia's (CHC) arguments contesting the CiU's 1995 draft bill of modification of the LOHC mainly referred to what they viewed as an attempt to change the health system 'model' approved by the LOHC. They claimed that there was a contradiction between the intention to reinforce the CHI as a provider stated in the supporting report document of the bill, and the transitional situation defined for this organisation by the LOHC - with a view to its eventual integration into the CHS. In relation to the provision that the CHI personnel could opt out of the CHI and form private associations for contracting with the CHS, the CHC thought there was no need to regulate in such a detailed way the working conditions of these CHI personnel (those to which the bill referred originally) because, in fact, the CHS was already legally empowered to contract with private or public health care providers. In any case, the compliance with accreditation norms should also be required for primary care. In sum, the CHC argued that:

> 'It would be a good moment to debate again on the Catalan health model based on the differentiation between providers and planners and financers, *which was a model that nobody had in mind at the time the LOHC was passed in 1990*, and to carry out a wider reform in order to adapt the legal framework to the actual performance being developed, redefining as well the future role of the CHI.' (CHC, 1995:2, my emphasis).

However, the groups which most strongly opposed this reform of the CHI were those which until that moment had been at the outskirts of the core process leading up to the definition of the Catalan 'model'. These grouping embraced the trade unions, whose arguments focused on labour relations, working conditions and the professional careers of health professionals. Thus, in the view of CC.OO and UGT, the two main modifications of the LOHC were an example of a selective attempt to redress the ongoing reforms in a specifically privatising direction, five years after a vague consensus had been reached in 1990 through the LOHC (CC.OO, 1995a, 1995b; UGT, 1995). They interpreted the redefinition and clarification of the legal nature of the CHS as a signal of a definite will to deep the process of privatisation of this body. The aim was to escape the control mechanisms of public law in the activities of the CHS. As for the second main modification of the Law concerning the possibility that the CHS would contract with associative entities managed by professionals, they interpreted it as a further step in the process of increasing the presence of labour contracts to the detriment of civil service contractual relations or statutory regime, and as a drive for the commodification of the relationship between professionals and the CHS through the delegation of management.

These trade unions argued that this modification came at a time when the objectives set by the LOHC were clearly out of reach by the deadlines approved in 1990 and, moreover, did not tackle the main problems of the system. Concerning deadlines, the reform of primary care was projected to cover all the population by mid-1996 but by mid-1995 only 52 per cent of the population was covered by the reformed network of primary care. Also, by 1995 the participation organs of the CHS's Health Sectors had not been created yet and this Modification Law was suggesting a change in their directive bodies when the participation machinery had not yet been developed[134]. Moreover, the deadline of mid-1993 was established by the LOHC to achieve the standardisation of the collectives which were members of the CHS or of organisations dependent on it, and for the equalisation of the working and professional conditions of the CHI personnel and of the HNPU. Two

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[134] The Catalan 1993 Budgetary Law for 1994 changed the organisational structure of Sectors from having a Hospital and a Primary Care units to have a Programming and Analysis and a Clients' Service units. This 1995 Modification Law, moreover provides that chiefs of operational units (health professional teams within health centres) will be members of their Health Sector Directive Council -an aspect relevant enough as the Health Sector has a crucial role in the health planning process.

years after the 1993 deadline neither of these provisions had been accomplished. Even so, the modification bill provided the opposite, that is, for further diversification of health workers' situations instead of their homogenisation, by professionals opting out and forming associated private teams. In addition to the Modification Law ignoring these implementation deficit, it did not tackle the main problems of health in Catalonia either, which they identified as being: insufficient and unreal budgets, inequitable financing of Autonomous Communities' health services, lack of exertion of the CHS's functions of planning and organisation, insufficient socio-health care, lack of transparency in the assignment of contracts for the provision of health services to non-CHI providers.

This concern with the transparency of the system was further deepened by a third main modification which was not in the original CiU's draft bill but which was introduced as a result of the negotiation process with a political party in the opposition, the PSC, and which became part of the final version of the Modification Law. This point concerned the organisational structure of the CHS. The functions of the CHS's Health Region of Barcelona City (Health Regions are deconcentrated levels of the CHS) were transferred to the Health Consortium of Barcelona. This consortium was a provider itself which had been founded in 1987 by the local council of Barcelona and which was jointly re-founded in 1992 by the municipal government of Barcelona and the Catalan government. This modification clearly upset the principle of separating the purchasing and provider functions[135]. However, according to a senior executive of the Health Consortium of Barcelona:

> 'Giving the role of CHS Health Region authority to the Health Consortium of Barcelona was a political agreement: there was a situation of duplication of functions which needed to be solved. ... The Consortium had been initially created in 1987 (Hospital Consortium of Barcelona) to plan and co-ordinate all health care services in Barcelona as a single area. In 1992 it is re-founded as Health Consortium of Barcelona, after an agreement between the mayor of the local council and the president of the Catalan government to solve the financial problems of the health services in the city. When the LOHC was passed there appeared two organs with planning and organisation functions over Barcelona - the CHS's Health Region and the Consortium. This duplication was unnecessary'.

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135 The relevance of this decision in contradicting the model is apparent, as Barcelona's local council is governed by the PSC, which is in the opposition in the Catalan Parliament. Although the Consortium's administrative board is controlled 40 per cent by the local council and 60 per cent by the Catalan government, the political visibility for the municipal health policy is associated with the local council, and therefore with the PSC.

The argument prevailed, though, that power relations between political spheres of influence were at stake in giving the Health Consortium of Barcelona the status of a Health Region authority within the CHS structure. This argument was based on the fact that the PSC had a prevailing influence in this consortium as the governing party in the local council of Barcelona, while this same party was in the opposition in the Catalan Parliament. According to *El País* (14/9/95, Barcelona edition) CiU agreed to give the Health Consortium of Barcelona the authority of the CHS's Health Region of Barcelona City in exchange for the PSC's support for passing with a wide consensus one of the two main modifications initially proposed in CiU's draft bill[136]. This provision established that the CHS was entitled to contract health services not only from health care centres, but also directly from health professionals constituting associative teams (enterprises, anonymous or limited societies). The PSC accepted the clause but demanded that such provision covered not only CHI professionals, but also non-CHI professionals. A controversial point was that this model of professionals' self-management introduced the possibility for them to make profit. As a member of the first 1996 pilot experience on this model explained:

> 'If we have a surplus balance from the contract with the CHS that is profit that stays with the enterprise. There are no intermediaries, the contract is with the CHS. This is the first case of an enterprise of professionals in which there are no intermediaries, because in the cases of ... and ... which are part of the consortium ..., the contract is established by the CHS and the consortium, and then the consortium sub-contracts the service to a group of professionals. In that group, not all the stake-holders are workers, but they would be, in a more strict sense, capitalists. Here, all the stake-holders have to be workers devoted to the enterprise'.

This case was an example of the diversity of management forms the CHS was entitled to develop for ensuring the provision of health services, which was one of the most innovative aspects of the LOHC when compared to other Autonomous

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[136] Referring to this provision, the director of a non-CHI primary care centre expressed that: 'I very much doubt that this initiative would have been passed under another government. They [the PSC] voted in favour of it in exchange for the Health Consortium of Barcelona and the Health Region'. Also, a top figure of the class-based union CC.OO suggested that: 'The PSC did not exercise any opposition to this measure, now they [the Catalan government] give the Health Consortium of Barcelona the management of the Health Region of Barcelona City'.

Communities' Laws creating their respective Health Services. The 1995 Modification Law reasserted such an innovation and explicitly enabled the Catalan government to create any public enterprise of the kinds defined in the Law regulating Catalan public enterprises. However, according to a former senior figure of the DHSS, a top-official of the CHS, a leading representative of the UCH, a top managerial figure of the CHI and a manager of a CHI hospital, deepening the diversification of health providers might eventually require the change of the legal nature of the largest single provider - the CHI - from a management entity of the Social Security into a public enterprise. This change might in turn require that the CHI's responsibilities for managing public health services were not hindered by the CHS's supervision responsibilities (SCS, 1996a).

The post-LOHC clarification the 1991 McKinsey Report made of the CHS's role as a financing and purchasing body had two interrelated consequences for the CHI: not only were the its functions not to be absorbed by the CHS, but also the CHI was to be redefined as a 'provider'. In this respect, the 1995 Modification Law set out that that the CHI had to develop its functions within the CHS general guidelines - following the legal framework applicable to a Social Security management entity - *as long as such a legal nature is not modified*. This possibility depended on the DHSS's decision, which, according to the key informants above, might be on the line of transforming the CHI into a multi-divisional public enterprise with its production units (hospitals and primary care centres) as autonomous units. However, according to a former high official of the DHSS and former manager of the CHI,

> 'Over many years the Catalan government has gone ahead of the central government in the reform of and innovation in the health system in the line of international trends of managerialism, partly because of the comparative advantages derived from the heterogeneous provider network on which it counted. However, the Catalan government stopped its gradual progression in health policy at a point around 1992-1993. The next step necessary to give consistency to the Catalan model and to the spirit of the [1990] LOHC is, first, the transformation of the legal nature of the CHI, a management body of the Social Security, into a public enterprise. Second, this transformation would also involve giving legal personality and management autonomy to each of the providers presently integrated in the CHI. Taking this step would mainly mean confronting the opposition of the unions, and thus, the whole statutory civil service personnel employed by the Social Security administration'.

6.3. Divergences between implementation and 'new public management' discourse.

The 1990 LOHC was aimed at clarifying and consolidating certain features of the governance structure of health care which were claimed to be intrinsic to the 'Catalan model'. Shortly after the LOHC was passed, this reform formulation was reinterpreted in NPM terms, a discourse which was widely assumed by the policy elite to be *the* content of the LOHC. So in the prevailing climate of assessment among the policy elites the reference point was not the actual formulation of the reform in the LOHC, but its NPM reinterpretation. However, for an assessment of the implementation of these reforms to be meaningful, it is necessary to distinguish between policy displacements, implementation deficits and unintended consequences. This analysis traces the extent to which the divergences between NPM discourse and implementation stem from attempts to manage the same transactions costs which influenced the definition of the 1990 Law. The same transactions costs had to be faced during the implementation process and the way the health authority dealt with them partly explains the actual implementation of the reforms.

a) Policy displacements.

Policy displacements involve taking steps in a different direction from the model/policy formulated. In Horn's (1995) terms, the policy displacements characterising the Catalan reform process were traceable to both *agency costs* derived from controlling and monitoring providers and to the costs derived from the *uncertainty* associated with *assigning risk* to providers.

The first policy displacement in the Catalan reforms distorted the purchaser/provider split by affecting the relationship between the macro- and the meso-management level, that is, between the purchasing/political authority and the providers' management and directive boards. In the view of some former senior

officials of the CHS, this relationship reflected a pervasive administrative interventionism which was justified at a discursive level by the positive effects of a 'functional collusion'. Power relations between these two levels of management were mediated by the composition of administrative boards, where political appointment to posts prevailed (Via, 1996). For example, in 1996 the CHS owned 100 per cent of nine public enterprises and held a share in another, all created between 1986 and 1995, and was a member (as one of the owners) of the administration board of ten consortia which had been created during the same period. That membership was represented by the Health Region manager, a figure who therefore represented two roles - financing and provision. The CHS's answer to this criticisms was to maintain the owner role of the CHS in those providers but through different persons (except in the case of public enterprises, where there was no change). That is, the CHS's member of those administrative boards would not be the health region manager but another official from the CHS (*Diario Médico*, 1/10/96, 9/4/97).

As early as 1990, the highest representatives of the UCH explicitly wondered in a conference organised by the DHSS what concessions might have been given to reach such a consensus on the approval of the LOHC in 1990. They warned that if the further regulative developments of the LOHC showed an interventionist character impeding the management autonomy of providers, the spirit of the reform would be distorted. The LOHC was seen by the UCH as an opportunity for de-bureaucratising health in Catalonia. However, they feared that both the health authority's interventionism and the foreseeable resistance of civil servants (namely the CHI providers) to this project might jeopardise such an opportunity - because they might try to preserve their share of power, their corporatist privileges and their vested interests. They claimed that if there was no definite will to de-bureaucratise the public sector (the CHI) in the first place, other organisations might end up becoming bureaucratic themselves and adapt to the dynamics of the institutions on which they depended financially - namely the health administration (CHS) (Martí, 1991b).

The UCH regretted the results of the process developed from 1986 onwards by which some hospitals which were owned by foundations, trusts or mutualities had modified their statutes and had been 'municipalised formally or informally through, for example, the creation of consortia. As a result they had become *de facto* 'public' bodies and fully dependent on the health authority. The UCH claimed

that this process had two main consequences. First, it involved to some extent a bureaucratisation of such providers, more administrative intervention, and a loss of their management autonomy (UCH, 1995b). Second, the UCH argued that this 'municipalisation' of some providers had led to their politicisation, evidenced by the appointment of managers on political criteria rather than because of technical or qualification considerations[137]. A consequence of this situation was also the excessive turnover of the directive/managerial personnel of hospitals, which made health professionals view managers as temporary personnel. This situation was also reinforced by other factors such as the difficulty of managing so complex an organisation, the financing system of hospital contracts, and the lack of realism in the management of both the system and the hospitals (Martí, 1993).

In answer to criticisms about political intervention in the management of the health care network - particularly about the appointment of managers of the contracted providers - a former senior official of the DHSS argued that regardless of the extent to which such an intervention may or may not have taken place,

> 'There has not been, either, any trust or foundation which has made the decision to appoint a manager without having made sure that the *Conselleria*[138] approved of him [*sic*]. And this is understandable in this sector where interpersonal relations and constant negotiations are the rule for maintaining consensus. I would say that from 1980 to date the list of people who somehow have been around in this sector are 80 or 90 people, and we all know one another and we all know one another's weak and strong spots and origins. And when a hospital has had to appoint a manager, it has always wanted this manager to have more or less the blessing of the *Conselleria*.'

However, the most visible policy displacement in the Catalan reforms was formulated in the 1995 Modification Law when the financing/purchasing role of the Health Region of Barcelona City was allocated to a provider, the Health Consortium of Barcelona. This example was important both in terms of the resources involved

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[137] This point was acknowledged by several key informants: a former member of the Abril Commission, a former senior official of the CHS, and a senior official of the CHI.

[138] The *Conselleria* is the political level of any Department - namely, the counterpart of a Ministry in the Spanish central government. The *Conseller* is the counterpart of a Minister in the central government, that is, the highest political head of a Department and member of the core executive.

and in terms of political/power relations[139] (see Section 6.2). In order to counteract the criticisms of policy displacement, the Health Consortium had its internal organisation re-designed to differentiate internally a purchaser structure and a provision structure[140].

b) Implementation deficits.

Implementation deficits include reforms initiated on the line of the policy formulated but which were not fully accomplished. The first implementation deficit affecting the Catalan reforms concerned the actual endowment of Health Regions with an effective purchasing power. This relates to *agency costs* concerning their *discretionary power* and *autonomy* and the costs derived from devolving to them a wider margin of managerial freedom. An in-built centralising tendency driven by the central services of the CHS curtailed the devolution of the purchasing role to Health Region managers. Thus, although Health Region managers were in principle 'free to manage' their total budget for contracts, they had to give priority to achieving the degree and nature of coverage defined as health policy - even if that hindered the achievement of economic objectives. As acknowledged by a Health Region manager, they are not entitled to determine priorities as for financial processes timing - they could order payments but not their timing, which falls under the sphere of authority of the Department of Economy and Finance of the Catalan government (Gallego-Calderón, 1996). According to a senior official of the CHS, the degree of 'freedom to manage' is necessarily constrained as much by budgetary and economic conditions as by equity considerations:

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[139] Concerning the allocating the role of Region Health Authority to the Health Consortium of Barcelona and its consequences for the purchaser/provider split see the article by health economist López , G. in *La Vanguardia* (19/10/96:2), supplement 'Health'. In this respect see also *Diario Médico* (10/4/97), where the CESM - referred to as Medical Union of Catalonia - opposed this modification of the CHS's structure.

[140] According to an internal auditor of the Health Consortium of Barcelona this change was not consequential for the internal structure of this providers because it had already developed a quasi-divisional structure, by distinguishing between the hospitals and primary care centres it is composed of, on the one hand, and a managerial level which distributed economic resources and allocated workload, on the other.

> 'It is meant to be a free market but planned. The Regions could have a double role: they could be delegates, with clear directives and ample powers to act as purchasers; or they could just be decentralised levels from an operative point of view ... Now the first option is not possible ... It is necessary that the corporate centre of the CHS ensures its presence in the Regions within a framework: maximum budget for contracting, kind of coverage, ... and degree of accessibility, territorial equilibrium and equity ... The degree of freedom to manage depends on the environment we are in - it can be a dynamic model, rather than a static one. At present the budgetary environment is very hard, thus the maximum strictness is required - and this involves centralisation and the control of the maximum levels of resource allocation within Regions ... This may have implications for the principle of separating purchase and provision, and it is also an argument for continuing interference with the supervision of management.'

However, the implementation deficit concerning the purchasing function of Health Region authorities also applied to the CHS as a whole. Although the diversity of management forms allowed by the LOHC facilitated putting some of the 1991 McKinsey Report's recommendations into practice, the CHS evolved to adopt an insurer/financing role rather than the 'selective' purchaser role it was supposed to take on. In this respect, efforts were made at a discursive level to explain the model pursued as one of 'managed competition' (Moreu, 1994:23). The reason for this implementation deficit was the awareness that the CHS could not do without providers' services in most cases. In fact, as a former senior official of the CHS asserted, the purchaser had to be co-responsible for the viability of providers so as to ensure that it could meet the needs of its clients, namely, the population whose needs were to be covered. As pointed out by a Health Region manager, the principle underlying this 'compromise' was equity, which was explicitly contemplated in every piece of the legal framework. In sum, there was not an effective risk-shifting process either to managers in health centres or to professionals. Instead private providers transferred risk to the purchasing authority (namely, the public administration), sure in the knowledge that being members of the HNPU made them eligible for subsidies where they were required.

In this respect, the degree to which contracts were effectively used to gradually shape providers' productive capacities towards the objectives established in the Health Plan was openly questioned and identified as a second implementation deficit. The driving idea of this model of governance structure was the need for the CHS to manage demand. That is, rather than proceeding with

provision in terms of the supply structure available, the CHS had to plan according to needs assessments, and design contracts in order to cover those needs (Roma, 1994c). Since 1993 contracts were conceived of as a tool to operationalise the guidelines specified in the Health Plan (first edition 1993-95, second edition 1996-98). However, as an interviewee involved in managing a HNPU consortium explained, there were dysfunctions derived from combining this outcome-oriented planning with the output-oriented financing system based on contracts. As a result, it became apparent that the restructuring of hospitals' productive capacities had not been accomplished - while a dense network of basic hospitals had been consolidated throughout the 1980s. Most controversially, the extra-contractual financing channels of HNPU providers (such as subsidies to operating accounts or subsidies for capitalisation), and the financing mechanisms which despite being internal to contracts were not classifiable in BCUs (such as additional clauses of support to economic activity and special health programmes), both cast doubts on the NPM foundations of the contractual model[141]. In sum, according to a senior representative of the UCH and some former top officials of the CHS itself, the CHS as the financing/funding authority took too powerful a role by accumulating the competencies of planning, financing and arbitrating. Instead, they argued, the DHSS should exercise those competencies, and the CHS, within that framework, should effectively purchase (*Diario Médico*, 9/4/97, 19/4/97).

In this respect, in a conference organised by the DHSS in April 1994 both the the UCH and the CHC insisted that the contracting system based on bilateral negotiations between providers and the health administration was not transparent. The criteria for allocating contractual and extra-contractual financing were not explicit, which made that, in practice, each hospital got paid a different price for BCUs. Moreover, they claimed that there had been a lack of evaluation of results of the health services provided, which should have been necessary in order to defend contractual and extra-contractual financing. However, these associations differed in some of their proposals. The UCH supported a gradual shift towards the liberalisation of patient movements based on a free choice of providers. In fact, the UCH made explicit that it intended to help those centres and institutions which

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141 This latter point was acknowledged by the following experts interviewees: three managers of non-CHI hospital providers, a leader of the union CC.OO., a leader of the hospital association UCH, a senior official of the CHS, two former senior officials of the CHS and a senior official of the CHI.

competed in the free market so that they found a place among providers and purchasers (Martí, Ruiz, 1995; Salazar, 1995). By contrast, the CHC was mainly concerned with the planning role of the health authority and the equitable distribution of resources across the territory according both to the production structure of providers and the health needs of the population. They supported capitation criteria for distributing economic resources between sub-sectors - primary, specialised, hospital, socio-health care[142]. In addition, providers should be enabled to direct the movements of patients between levels of care (care continuum and vertical integration of resources) and between territories (through fusion, groups, collaboration agreements) (Bagó, 1991; Abelló, 1994).

The third implementation deficit was two-fold and concerned the reform of the health administration after the creation of the CHS and the transformation of the previous health authority (the CHI) into a provider only. First, both the CHC and the UCH agreed that it was necessary to simplify the administrative structures of the health system and reduce the expenditure derived from duplication of posts, proliferation of organisations and procedural burdens. Second, a main issue on which not only the CHC and the UCH agreed but also the DHSS and the CHI itself, was the need to transform the legal structure of the CHI (the management body of the Social Security and the largest health provider in Catalonia) into a more de-bureaucratised and independent agent. (Manté, 1994; Martí, 1994;).

This view was also shared by the directive figures of the CHI right after the passage of the LOHC. In a conference organised by the DHSS in 1991, the manager of the CHI regretted that, at that time, the survival of an organisation in the publicly financed health sector and the professional status of its personnel did not depend on the efficiency and quality of its service, but on the negotiating ability and on the power position the leaders of the organisation enjoyed within the existing institutional framework. In this respect, a qualitative change in the management culture and techniques was necessary not only in the publicly financed health sector in general but particularly in the CHI. According to this CHI's representative it was necessary to increase the risks borne by managers and professionals. Economic responsibility should be assigned to the person who makes the decisions which generate expenses and income. This kind of measures would be most effective, he concluded, if competitiveness mechanism were also

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142 On this CHC's proposal see *El País* (20/11/93, Barcelona edition).

introduced with the objective of changing behavioural patterns in the process of service provision. In this sense, the CHI had to pursue balanced budgets, that is, finance itself by adjusting the cost of their activity to the value of the programme-contract signed with the CHS. The tools to do so included the establishment of clear and quantified objectives, a system of indicators and information on costs, management control systems and the introduction of suitable incentives in the financing system. However, those tools could only yield results if a change in the value system was also driven forward by giving more priority to efficiency and productivity. In fact, he claimed, the politics of diversification of management forms different from that which the CHI had developed from the mid-eighties had embodied a basic policy option not to enlarge the CHI and the management model it represented (Garcia-Prat, 1991).

Nevertheless, four years later another top manager of the CHI pointed out that there were some reasons why these reforms were bound to be a matter of disagreement and conflict. The CHI was a complex organisation which was not only the first employer in Catalonia in terms of personnel (over 30,000 employees) but also a very particular provider. The legal nature of the CHI as a Social Security management body with a single legal personality entailed that its personnel had statutory, civil service-like contractual relations, and that its economic operating regime followed the budgetary process and regulations, the procurement and contracts regime, and the procedural rules of the administrative law framework. Moreover, nine of the 11 CHI hospitals were the reference hospitals for their respective geographical area of influence. Only in one Health Region did the reference hospital not belong to the CHI. In addition, seven CHI hospitals had a university category for research and training of specialists, with the corresponding costs. And finally, the CHI undertook the provision of health care programmes of high cost and technology (Gorricho, 1995).

However, this CHI's manager stressed that during the late eighties and early nineties some steps had been taken to improve the CHI's management. Horizontal services had been created by the CHI's corporate centre concerning contracting out and procurement policy. New legal forms were defined for disaggregating part of the organisation into self-contained units of specific services which could operate under private law. And new modes of service delivery had been developed (such as ambulatory surgery, non-hospitalisation treatments at home). As a result, there had been an efficiency improvement reflected in the budgetary coverage

index (see Chapter 5), beds reduction, and rationalisation of human resources (Gorricho, 1995). Nonetheless, the expected and much announced reform of the CHI was not tackled comprehensively, but rather in a piecemeal way by the main legal initiative, the 1995 Modification Law.

c) Unintended consequences.

The combination of policy displacements and implementation deficits led to a general unintended consequence: the *de facto* 'publicness' of the HNPU derived from its dependence on the contracts financed by the health administration. While the initial objective of the 1980s reforms was to keep the HNPU at arms length from the health authority, the objective of the early 1990s was to induce providers to be efficient in response to the 'selective purchasing' policy of the CHS. However, the main result of these reforms was that contracts with the health authority became the major source of financing for most HNPU members. According to Horn's theory, the costs behind this gradual increase in the 'publicness' of health providers were the transactions costs derived from the *uncertainty* associated to the *assignment of (financial) risk* to those providers.

The main policy elites acknowledged that the lack of transparency of the contracting system, which involved discretion in the allocation of subsidies to operating accounts and for capitalisation, lay behind this gradual trend towards increasing 'publicness'. However, during a parliamentary session, and in answer to a question by IC-V on the criteria for the allocation of these clauses, the *Conseller* of the DHSS argued that:

> 'The need to guarantee homogeneous services to the population involves taking into account the reality and environment of each of the hospital centres, therefore the resources assigned to the different centres cannot, in some cases, be the same. For this reason, ... the CHS channels different specific payments through the concession of additional clauses of economic support to different centres of the HNPU, which allow for their redistribution in an equitable way'. (BOPC, 14/6/94, nº239:15158).

In this same answer, the *Conseller* mentioned four criteria for the concession of this economic support which are not taken into account by the system payment based on BCUs. These were, first, the 'geographic isolation or unproductive dimension' of a centre including cases of redevelopment of infrastructures; second, the need to ensure the economic viability of some centres which have encountered problems stemming from the restructuring process of the health system; third, the introduction of new technology; and fourth, the expenditure increase for a hospital (in terms of patients flows, services and technology) when it is upgraded to the level of 'reference hospital' of its area. However, the interpretation and application of these criteria is in itself a matter of controversy which has been particularly stressed by one opposition political force in the Catalan Parliament - IC-V, the only party which voted against conceding financial support to bankrupt private hospitals[143].

Although the lack of transparency of the system was acknowledged by most of the policy elites, only the leaders of the unions CESM, CC.OO, CATAC and CTS and the leader of the leftist IC-V interviewed for this research asserted that this situation was an intrinsic result of the health model implemented throughout the eighties and nineties. Several key informants including those interviewees, a top representative of the UCH, a top representative of the CHC and two former top officials of the DHSS, pointed out the argument that the NPM contractual model

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[143] Two outstanding cases were given relevant media coverage and were a matter of question time and debates in the Catalan Parliament. The first case concerned a non-HNPU hospital which had its origin in a private initiative launched in the 1970s. Its promoters intended this hospital to have high technology services and to offer ancillary non-care services of a higher quality than the average. However, when the hospital was opened in 1985 it was apparent that it was not financially viable. By 1992-93 the financial crisis in which it was immersed was taken to the fore in the Catalan Parliament. To tackle this situation, two economic endorsements were passed by the Catalan Parliament (with the opposition of IC-V) as part of bills introduced by the Catalan executive extending public credit for the maintenance and support of productive sectors of the economy. Second, a special collaboration agreement for the provision of health services was established between the Catalan executive and the hospital in question. Third, this agreement required that patients in the waiting lists of the Health Region in which this hospital is located, were assigned to that hospital for treatment (DSPC-P, 25/9/96, nº139:27-65). The second case of controversy related to the economic support given to private hospitals by the Catalan government concerned a mutuality, four hospitals of which are HNPU-members. In 1995 this mutuality was the second in the ranking of the 72 entities of insurance in Catalonia, both in terms of premiums (13 per cent of the market), and people covered (over 180,000 people -13 per cent of the people with double coverage). (The first in the ranking covers 14 per cent of people with double coverage but represents 26 per cent of the premiums collected by the 72 entities, and is linked to the Spanish Collegial Medical Organisation. The first four of the ranking represent more than 50 per cent of all the premiums collected) (DSSS, 1995d). In neither case the crisis situation has been solved.

could not possibly be implemented unless the pending problem of the deficit of the health sector was given a political solution. All of them agreed that the origin of the debt in the Catalan health sector was, in the first place, the miscalculation of the value of the transfers negotiated between the Catalan and the Spanish central government in the early eighties. At that time the deficit in Catalonia was already large as a result of a comparatively lesser amount of per capita investment on infrastructures and equipment by the Social Security there compared with other parts of Spain. In this context, the strategy of the Catalan government from 1980 was to gradually recover this financing deficit depending on the evolution of the electoral political in Spain as a whole and the need to exchange political support through inter-governmental relations. Also, political clientelism was pointed out as a distortion of the model. This aspect was said to have affected decisions such as defining the level (A, B, C) at which a specific hospital was to be categorised as a HNPU member - that level involves higher or lower prices to be paid for the BCUs which they contract to provide for the CHS[144].

By the mid-nineties, the economic crisis in the hospital sector was characterised as being similar to its situation in 1984-85. From 1992 to 1996 the public health system spent 240,000 million pesetas more than budgeted, of which 130,000 millions corresponded to the deficit accumulated by the DHSS and 96,400 millions were borne by the contracted providers as at 31 December 1994 (*El País*, 7/9/95, 11/2/96 Barcelona edition; *El Periódico*, 7/9/95). Leading figures in IC-V, the DHSS and the union CC.OO agreed that the debt of the Catalan health sector was an indicator of the health model's wrong approach to management. In their view, the authority in this model no longer had a command-and-control role over providers, whose decisions might run counter the planning needs. Moreover, deficit was being transferred to the periphery of the system, that is, it was being dispersed across providers. In this system expenditure was more difficult to control; the principal-agent problem increased as a result of bilateral processes of contractual negotiations; and the reliance on private initiative created and maintained more provision than was necessary. This kind of situation, they contended, jeopardised

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144 In fact, this clientelism - or the role of power relations in the operating of these decisions - was documented for a specific hospital case (Via, 1994b).

the aims of planning and rationalising of the public authority as well as its role in constraining deficits[145].

Conclusions

In the early 1990s the implementation of new governance structures in the Catalan health sector involved the introduction of policy tools which are central to the NPM reform trend - namely, expanding the use of contracts between purchaser and providers into new areas such as CHI hospitals and primary care, and the widespread introduction of private management techniques. These policy tools are supposed to link the health authority and hospital and primary care providers in a way that meant purchasers could shape providers' behaviour. The health authority, the CHS, was supposed to design and use an incentive-based contract system in order to purchase the required services for covering the population health needs, taking for granted that providers would gradually be induced to alter their cost and productive structures to come into line with the CHS's health and purchasing policies.

However, the actual operation of the new system revealed considerable continuity with earlier systems operated in the 1980s. What was defined as a hierarchical contract system for a hybrid form of governance turned out to perform as a relational contractual system where adaptation was to a considerable extent decided on a bilateral basis between the health authority and each provider. In Stinchcombe's (1985) terms, there were various hierarchical features in the contracting system implemented in the Catalan health sector. They included: the overall control of the incentive system by the health authority; the health authority's

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[145] The creation of the Agency for Health Technology Assessment in 1994 -as a public enterprise dependent on the DHSS- had the purpose to promote that the introduction, adoption or diffusion and utilisation of medical technology follows criteria of effectiveness, reliability, efficacy and efficiency (Rius *et al.* 1995). This agency built on precedents which were the first of its kind in Spain such as the Advisory Commission of High Technology (1984), the High Technology Programme (1988), and the Technical Office of Evaluation and Medical Technology (1991) (Granados, 1995).

specification of binding operating procedures that went beyond the indicative setting of health objectives; the relative isolation from the market or the court system of dispute resolution procedures; and a non-market pricing system which in practice tended to be related to providers' costs. Thus, for example, the contract negotiated by the CHS with the CHI amounted to a translation of the latter's budgetary allocation into contractual terms, without involving real financial risk either in the case of hospitals or of primary care. Moreover, where real contracts were held with non-CHI hospital providers, the persistent funding of the activity contracted at below its real cost led the health authority to complement the contracting system with additional financing mechanisms. Some of these channels were internal to contracts in the form of additional clauses for the financing of health programmes which were difficult to translate into BCUs. Other channels were external to contracts, such as subsidies to the operating accounts of providers, and subsidies for capital investment. In contrast to hospital contracts, primary care contracts were not based on quantified units of service delivered for a set price, but were contracts for services with a global obligation to provide them and with prices calculated on previously incurred costs.

These hierarchical features of the contractual system extensively conditioned the repeated interactions among actors which were mutually dependent in terms of resources. On the one hand, these interactions were influenced by asymmetric power relations: for example, the CHS had discretion over the allocation of scarce financing resources within the system, which gave it leverage over the governance of the health sector (Pfeffer, Salancik, 1978). On the other hand, the bridging mechanisms between the CHS and health providers (contracts and private management tools), and the resources flows based on exchange and dependency relations between them, conveyed a picture close to a relational market where long-standing, trust relations with a stable number of asset-specific agents were crucial (Ferlie *et al.*, 1996).

So in the Catalan case relational contracting emerged as the contract law supporting a bilateral, hybrid governance structure, which, in principle, conformed to the hypotheses suggested by transactions costs economics (Williamson, 1985). However, according to the theory, bilateral governance is most suitable for recurrent transactions which are based on mixed asset-specific investments. In health care, transactions are recurrent between the health authority and providers, but investments are to a large extent idiosyncratic, that is, highly specific. In this

situation, theory suggests a unified governance structure as the most suitable arrangement. Thus, the question remains as to why hybrid forms of governance in the form of NPM found their way into a sector like health care.

A tentative answer may derive from the characteristic market failures of health care itself and from the emerging divergences between NPM discourse and implementation in practice. The analysis of the actual use of NPM policy tools in the Catalan case reveals a number of such divergences. Implementation deficits included: the incompleteness of primary care and CHI hospital contracts, which were not really enforceable because they did not involve financial risk; and, in the case of real contracts with non-CHI providers, the existence of additional contractual and extra-contractual financing mechanisms. Policy displacements in the mid 1990s, such as the allocation of the role of Region Health authority to a very important provider (both politically and in terms of resources) cast doubts on the separation between purchasing and provision functions. Finally, unintended consequences included the increasing 'publicness' of a health care network which had been intended to be clearly separated from the health authority and in an arms length relationship with it.

These divergences between implementation and the NPM interpretation of the 1990 Law for the Organisation of Health in Catalonia (LOHC) had their origin in the enacting coalition's attempt to promote the consolidation of a heterogeneous health care network. In order to solve the possible commitment problems involved, and to face the transactions costs derived from them, a particular institutional form was designed for the new health authority (the Catalan Health Service), as part of a hybrid governance form based on relational contracting. Thus, in Hom's (1995) terms, the need to reduce *uncertainty* and *risk assignment costs* led the enacting coalition (CiU in the Catalan government) to commit itself to the economic survival of both CHI and non-CHI providers, regardless of whether they had a real or a 'fictional' contract. The difficulties in dealing with *principal-agent relations* affected both the internal operations of the CHI (between the corporate centre and its provider units) and the relations between the CHI and the CHS. The costs derived from those principal-agent relations were at the origin of the difficulty in formulating a change in the CHI's legal nature (maybe leading to its disaggregation) and in establishing a real contract between the CHI and the CHS. Finally, the *participation costs* borne by agents external to the health administration in the a vaguely

formulated CHS structure were exemplified by the decision to give the role of Region Health authority to a provider.

Thus, the implementation of the reforms could be interpreted as being relatively close to the actual vague formulation contained in the 1990 LOHC and to the relational contract law predicted by transactions cost theory for a hybrid form of governance. Nonetheless, the policy elite tended to assess the reform's success or failure in relation to an imported NPM discourse. This discourse happened to fit both the policy precedents and the distribution of resources among the policy elites in the Catalan case, and easily became the prevailing reinterpretation of the vague reform legislation passed in 1990. In fact, the analysis of the implementation of the reforms shows clear divergences from the NPM formulation, though far less in relation to the LOHC and to transactions cost theory itself. The explanation of such divergences between implementation and NPM discourse is traceable to the institutional form chosen by the enacting coalition for the Catalan Health Service as the new health authority. This institutional form was designed to face the transactions costs derived from the commitment problem of the enacting coalition. Those transactions costs arose again in the implementation process and were accordingly dealt with within the relational contracting framework inherent to the hybrid governance structure designed. But this design and the very concern with solving those commitment problems and with reducing those transactions costs through relational contracting were incompatible, not only with NPM's defining postulates, but also with the health care sector's characteristic features.

Chapter 7

Transactions costs, institutional choices and policy change.

The 'new public management' (NPM) reform trend represents a shift in the governance structure of the public sector, that is, in the institutional form of the public authority and in the policy tools on which it may rely for setting policy in each domain. This analysis of the Catalan health care reforms between 1985 and 1995 shows how transactions costs played a key role in the political processes by which public officials and interest groups made decisions about institutional reforms and policy tools for the governance of health care. Although these reforms turned out to be in line with new public management ideas, their gradual design over the 1980s did not follow an explicit NPM discourse. The Catalan health policy elite did not adopt a NPM view of the world until it was given consistency as a new governance 'paradigm' by both the international academic and political communities in the early 1990s. The definition and labelling of NPM came on a *ex-post* basis for all countries experimenting with it. Thus, the analysis of the actual formulation and implementation of the reforms in each case is a necessary step both for characterising NPM and for assessing the extent of policy change that it has brought about. The reason is that the emphasis on particular components of NPM, such as incentivisation - including economic and non-economic incentives, and asset ownership -, disaggregation and competition, is influenced by both exogenous and endogenous stimuli in each reform case.

The first section of this chapter draws conclusions concerning these main themes through the analysis of the Catalan case. These include: the characterisation of NPM, the extent of change derived from the reforms, the role of transactions costs in the institutional design of the new health authority and the role of transactions costs in the choice of policy tools to be used by it. The second section uses the evidence in this case of divergences between the 'formalised' NPM discourse and implementation in practice as a basis for briefly re-thinking present and further developments of NPM

in the health sector in the light of broader trends. Finally, the third section examines the theoretical lessons drawn from the use of a transactions costs approach for the analysis of institutional change processes in the public sector.

7.1. Continuity, consensus and change in the Catalan reforms.

The gradual introduction of NPM components in the Catalan health sector was based on a structurally favourable distribution of key resources among relevant policy elites. However, the development of the reforms not only built on the consolidation and expansion of existing features but also on the introduction of innovative changes. In both cases, the reforms were incremental and based on a wide consensus built up throughout the 1980s. At the same time, the emerging characterisation of NPM as a new governance structure for health care in Catalonia was conditioned by two main exogenous variables: the decentralisation process of the Spanish state generally, and the creation of an integrated NHS-type of health system by the Spanish central government level. Interpreting the first as an enabling factor and the second as a constraint for the development of the Catalan 'model' of health care governance helps understanding of the policy outputs analysed in this case study.

Spain in the 1980s was characterised by a profound political reform which involved a large scale institution-building process. This process was launched by the democratic transition of the late seventies and involved not only the democratisation of all political institutions, but also a shift from a highly centralised to a quasi-federal, highly decentralised state structure through the creation of Autonomous Communities. Decentralisation was conceived of as an open process operating at different speeds in various parts of the country and for the achievement of different competency ceilings. In a few cases, such as the Communities of Catalonia and the Basque Country, the institution-building process of their respective legislative and executive institutions paralleled in time the institutional reform process of the same institutions at

the central government level. In the case of Catalonia the negotiations for the transfer of health competencies as early as 1980 were explicitly driven by the political will to assert autonomy.

These transfers started the gradual decentralisation of competencies allowed by the 1978 Spanish Constitution and assumed by the respective Statutes of Autonomy. Within this legal framework the Spanish central Parliament had the competency to pass the basic legislation on health care. The Autonomous Communities with a higher level of competencies, and with their health transfers agreements accomplished, had the powers to develop and implement such legislation and to organise health care provision in their territory. Only Catalonia met both criteria in the early eighties[146]. It was not until 1984 that Andalusia accomplished its transfers agreement - followed by five other Communities from 1987 to date (mid 1998). Thus, by 1981-82 Catalonia had, in principle, both the resources and the formal powers to organise health care in the absence of a basic legal framework, which was not passed by the Spanish central Parliament until 1986.

The long and controversial formulation process which led up to the 1986 General Health Law revolved around the political will of the governing PSOE to create a National Health Service model of health care, involving universal coverage and publicly-owned and managed health care providers. This provision model did not fit the policy options which the Catalan government had taken up since the health competencies were transferred. In contrast to the rest of Spain, Social Security hospital beds in Catalonia represented less than a fifth of total available beds - and less than a third of acute beds - of a network which was heterogeneous in terms of ownership and management forms. To ensure coverage in Catalonia, the Social Security had been contracting with the remainder of existing providers, although on a precarious basis, because these providers were not considered as substitutes for Social Security hospitals but as providing a possibly temporary complement to its services.

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[146] However, fully meeting these two criteria was not a necessary condition for Autonomous Communities to create their respective health services as part of the institution building process of their administrative apparatus. Moreover, because the process of negotiating the transfers tended to be long and complex, legislation by Autonomous Communities might be passed before the end of the process - or even before it started. That was the case of the Basque Country, which passed a health law creating its regional health service in 1983 - some months before Catalonia -, and of Madrid, which created its health service in 1984 (Rico, 1997:232-4, 280).

In 1981 the Catalan government created an accreditation system which aimed to reverse this approach and to give non-Social Security providers the same status as Social Security providers in the public system. This option involved, first, confining the existing Social Security model (namely, the embryo and basic component of the projected NHS at the Spanish central government level) to the size it had at that time. Second, this option required investing in the rest of the providers, which were in a dire economic and financial situation. A further and clearer diversion from the NHS-type being discussed in the Spanish central Parliament was deepened and consolidated in 1985 with the creation of the Hospital Network of Public Utilisation (HNPU), which was composed not only of the existing Social Security providers, but above all of an accredited, heterogeneous group of non-Social Security-owned providers, which provided the majority of hospital care and had freedom of organisation and management.

Apart from these exogenous stimuli, there were endogenous factors which also influenced the eventual characterisation of NPM in this case, mainly concerning the stability of the policy elites' leadership throughout the 1980s and into the 1990s and the distribution of key resources among them. While the Catalan government had both the competencies (the formal authority) and the economic resources (the budget) to exercise the governance of health care, the political or ownership representation of providers was to a large extent distributed among local governments and profit and non-profit private owners. Moreover, both the apparent split voting by Catalan electors between the autonomous and local governments - the former controlled by CiU and the latter controlled mainly by PSC and in some cases by PSUC/IC in the most urbanised areas - and the location of managerial expertise among private providers configured a choice situation in which co-operation became a rational strategy.

In the Catalan case co-operation was ensured by giving every relevant policy elite a stake in the system in terms of control of resources. However, the success of this strategy as a basis for consensus-building was crucially facilitated by the compatibility of policy preferences and interests among the main policy elites. The central NPM theme in Catalonia during the 1980s was asset ownership in the hospital sector. In contrast to the prevailing stances being debated at the Spanish central government level, the main policy elites in Catalonia agreed that the ownership of providers should remain in their initial local or private hands. Thus they rejected any

form of integration into an NHS-type structure which might involve a loss of managerial and organisational autonomy for providers.

In fact, when the autonomous government refused to assume responsibility for the management of providers dependent on local governments during the economic crisis of the mid-1980s, it was apparent that the Catalan government intended to keep the health authority (the public administration) separated from the non-Social Security providers with which it contracted. On their part, local governments and private providers defended their ownership and managerial position concerning their assets, but required from the Catalan government an explicit and definite commitment to their survival. This support came in the form of the HNPU created in 1985 and in the subsequent increasing investments and creation of local public-private consortia for the rationalisation and reinforcement of the network. Moreover, in the second half of the decade the health budget share spent on contracting with these non-Social Security providers steadily increased, while the distribution of resources and activity between them and Social Security and providers (those integrated into and managed by the Catalan Health Institute) remained remarkably stable. This same trend in investments, contracts and distribution of resources and activity characterised the first half of the 1990s (see Tables 3.5, 3.6, 6.1, 6.2, and Tables A.5 and A.6 in Appendix 1).

In sum, the introduction of NPM components in the Catalan reforms throughout the 1980s involved disaggregation and incentivisation. The disaggregation of the non-Social Security hospital sector was consolidated by maintaining the managerial and organisational autonomy of the private and local hospitals and their contractual relationship with the health authority. This policy option involved reinforcing the status quo in terms of asset ownership, which is itself an element of the NPM incentivisation component. In NPM discourse keeping asset ownership in private and public local hands was considered to be an in-built incentive for potential efficient behaviour. In the first half of the 1980s, incentives were also channelled through the implementation of an accreditation system which became the basis for the further creation of the HNPU. The definition of Basic Care Units as the foundation for the contractual pricing system in 1986 and the further introduction of a penalisation mechanism, (a 30 per cent variable payment part for either falling short of or exceeding the amount of activity contracted), were also central elements of the incentivisation component.

However, these developments of the 1980s did not affect the primary care network, which was overwhelmingly owned and managed by the Catalan Health Institute or CHI (the decentralised Social Security health management entity in Catalonia). From the mid-1980s to date it has by contrast been the object of the same NHS-type of reform as in the rest of Spain. As Table A.6 of Appendix 1 shows, the percentage of the health budget spent on contracting with non-CHI providers has followed a gradual and clear upwards trend. However, the origin of that increasing trend is in the hospital sector. Contracting with non-CHI primary care providers slightly increased in the second half of the 1980s, only to decrease in 1989 and stabilise between 1990 and 1995 at around 5.5 per cent of the health authority budget - a lower level than before. However, even this NHS-type of primary care reform did not follow the same pace as the reform and consolidation of the hospital sector. In fact, by 1995 and after ten years since its formulation, the reformed primary care network only covered 54 per cent of the population (see Table 6.5). An indicator of these different speeds and intensity of reform in the hospital and primary care networks is the share of investments received by each of them. As Table A.5 of Appendix 1 shows, the largest share of investments were made in the hospital sector (including both CHI and non-CHI hospitals). The share of investments spent in primary care, which has been undergoing an allegedly expensive reform, was kept at a fairly constant level (between 36 and 38 per cent of total public investment in health) and even decreased by ten points during the first half of the nineties (from 36 to 26 per cent).

The institutional design of the Catalan health authority of the 1980s involved a two-fold policy. On the one hand, the CHI created in 1983 inertially replicated the organisation from which it was decentralised - the Spanish Social Security health authority (INSALUD) - in terms of organisation and management form. That is, CHI hospitals (less than a third of HNPU beds) and primary care providers (over 90 per cent of primary care resources) were cost units of the CHI, without any autonomous legal personality or managerial freedom - despite the introduction of the Area and hospital manager figure in the early 1980s. The CHI itself went on contracting with the non-CHI hospital providers, thus having both provider and purchaser/financing roles. On the other hand, the non-CHI hospitals, that is, the non-Social Security hospital sector was expanded and consolidated. The second half of the 1980s saw continuity in the institutional design of the CHI - except for the introduction of the manager figure at its corporate level - and inertia in the primary care reform, which closely followed

the NHS model being implemented in the rest of Spain from the mid-1980s. At the same time, the expansion and consolidation of the non-Social Security hospitals were intensified through investments and the creation of consortia between public and private actors.

In contrast to the continuity and inertia in the institutional design of the Catalan health authority, the design of the policy tools it was entitled to use did involve innovation. In 1981 the Catalan government created the first accreditation system in Europe. In the early 1980s contracts were regulated by clarifying and simplifying technological and complexity hospital levels. And in 1986 the measurement of Basic Care Units was defined as the foundation for assigning unitary prices to the health services contracted. Finally, as a precedent of a complete separation between a financing/contracting health authority and providers, the CHI lost its contracting functions in 1989, which were allocated to the Direction General of Economic Resources of the Health System. Thus, although the corresponding budget share for contracts was still channelled through the CHI, their negotiation was no longer in its hands.

The separation between the financing/contracting health authority and both CHI and non-CHI providers became the main reform theme characterising NPM from 1990. In the early 1990s Catalonia's health policy elites were no longer concerned with the incentives derived from the allocation of asset ownership, but with the need to induce managed competition among providers through a contract- based incentive system. The emphasis on these NPM components was meant to enhance the efficiency of providers and of the whole health system - although the government's commitment to providers' survival was not questioned. This new characterisation of the reforms derived from a remarkable rhetorical change in the second half of 1990, shortly after the passage of the Law for the Organisation of Health in Catalonia (LOHC), and as a result of fully adopting the NPM discourse being elaborated in international academic and political venues.

The definition of this new governance structure was central to the formulation process of the 1990 LOHC. The innovative institutional design of a new health authority (the Catalan Health Service or CHS) subjected in its external relations to private law, emerged as the main thrust of the reforms. For the first time the government view clearly emerged that the CHI was an unsatisfactory institutional design for governing the health system on the basis of a contractual network.

Although the meaning of this assertion was not made more explicit until shortly after the law was passed, and the legislation's ambiguity was clarified in a new managerial discourse, the main tenet of the LOHC was that the CHI had to become a provider only. Less immediately apparent was that contracts as policy tools used by the CHS had to be extended also to the CHI providers, including both its hospitals and its primary care centres - in the latter case linking health objectives to those set by the Health Plan for Catalonia. The reform was initially presented as a matter of institutional modernisation that was necessary to further develop the model created throughout the 1980s.

In the formulation process of the LOHC, considerations about transactions costs played a central role in the politics of institutional choice in the public sector. The main dimensions of discussion and negotiation between the coalition in government and the opposition parties involved: first, the margin of discretionary power of the CHS - including its legal nature, its political independence from the executive, and its managerial autonomy for the use of private management policy tools -; second, the participation rights for political and social actors in the organisational structure of the CHS; and third, the degree of autonomy of non-CHI providers in relation to this new health authority. The stances taken by the main political parties in relation to these themes depended on their commitment problem (in the case of the governing coalition) and on their policy priorities and interests (in the case of the parties in the opposition). The respective policy preferences derived from both their ideology and their resources and mainly concerned the functions for which, in their view, the health authority should be responsible. The stress on different public functions implied an emphasis on different transactions costs and, therefore, led different political parties to advocate different institutional forms and policy tools for the new health authority.

The discussion about the margin of discretion of the CHS revealed concern with the transactions costs derived from the principal-agent relations involved in the implementation of health and contracting policies. While the governing coalition (CiU) advocated a CHS which was highly dependent on the executive and with a wide margin of manoeuvre to use private management tools, the opposition advocated a more politically independent CHS which clearly acted within a public law framework. Over this point, CiU used its absolute majority in parliament by not allowing any important change to its bill. By contrast, the main point open for negotiation was the theme of participation rights for political and social actors in the CHS's structures and

the transactions costs derived from them. While the coalition in government had not planned for any significant participation by other political or social actors in its bill, the alternative project of the largest party in the opposition (the PSC) with a large political stake in local governments centred on giving local administrations participation rights. The alternative project of the second largest opposition force (the coalition IC) also demanded participation rights for social actors, such as trade unions, among some of which this coalition had considerable support. The parties in the opposition saw this point as an opportunity to mitigate the impact of the discretionary power of the health authority - which had moreover been ambiguously defined. The debate on the degree of autonomy of non-CHI providers directly pointed to the transactions costs derived from the uncertainty involved in assigning risk to private and local interests. On this point all parties agreed on the commitment to the economic survival of providers - although IC alone supported an effective transfer of ownership to the CHS as a pre-condition for such a commitment. The PSC made a big theme of clarifying the non-integration of providers, with a particular emphasis on preserving local governments' role in their management, ownership representation and in public health policy. As in the case of the discretionary power of the CHS - including both its legal nature and its managerial autonomy - the CiU's bill was vague in relation to the degree of providers 'integration or functional attachment' to the CHS, even though its commitment to the separation between them and the health authority was clear.

The extent of change derived from this institutional design involved the effective split between financing/contracting and provision, by defining the CHI as a provider which was organisationally and managerially autonomous and separated from the new health authority (the CHS). The CHS was allocated the planning, financing and contracting functions, as well as the budget to perform them. The use of contracts was expanded in 1992 to the eleven CHI hospitals and to the Primary Care Centres responsible for health care in Health Basic Areas. In the latter case, the introduction of contracts only affected the reformed primary care - every new Health Basic Area was subjected to a contract. From 1993 all existing Health Basic Areas held a contract.

However the actual role developed by the CHS in terms of policy tools use did not turn out to follow the 'selective purchaser' role postulated by the NPM discourse for the public authority, which was supposed to induce competition through a contract-based incentive system. In the case of the CHI providers, contracts are still (in mid-1998) a training exercise with no enforceability as real contracts. In all other contracts,

although price incentives were included for closely meeting the volume of activity agreed, extra-contractual financing channels - such as subsidies to operating account or for capital investments - revealed the CHS's commitment to the survival of providers despite their actual level of efficiency and effectiveness. Contracts themselves included clauses of activities such as specific health programmes, which were not classified in terms of Basic Care Units by the corresponding price. One of the main difficulties in making contracts hard and binding documents stemmed from the historical under-funding of the Catalan health system, which was in turn the main reason for the difference between the prices set for each Basic Care Unit contracted and the real cost of each Basic Care Unit produced (see Table A.7 of Appendix 1).

These implementation deficits were in fact a feature of continuity from the policies developed in the 1980s, and were at the origin of an unintended consequence which the strongest supporters of the NPM discourse among the Catalan policy elite regret: the *de facto* 'publicness' of the HNPU. That is, in their view the public actors not only include the CHI but now crucially also the non-CHI providers, which receive over 90 per cent of their income from the contractual and extra-contractual financing channels linking them to the CHS. Therefore, genuine or 'hard' competition as a component of NPM was clearly down-played as not viable - at least as defined in NPM discourse terms. Moreover, disaggregation, which already characterised non-CHI providers, could only appear as an innovating NPM feature if it affected the CHI (covering 26 per cent of acute hospital beds and over 90 per cent of primary care centres). So far, this remains as just a proposal within academic and political forums.

While the implementation of the institutional design of the CHS and the use of contracts as a policy tool between 1991 and 1995 were characterised by implementation deficits in relation to the NPM discourse, in 1995 a more explicitly intended policy displacement was introduced. The functions and role of health authority in the CHS's Health Region of Barcelona City was allocated to a large provider, the Health Consortium of Barcelona. Shortly afterwards this Consortium modified its statutes to separate out purchasing and provider functions within its own structure to fit the new role, and to avoid the emerging criticisms about the distortion of the NPM model entailed by its dual role as purchaser and provider. However, the same blurring had also been present since the creation of the CHS in 1991, because the health authority created several public enterprises (providers) in which it was the

largest or even the only owner. CHS was also present in numerous administration boards of public and semi-public consortia, which were supposed to be providers clearly detached from the health authority with whom they contracted.

However, these divergences between the NPM discourse and the governance structure actually implemented bear a clear relationship to the transactions costs considerations that drove the institutional design of the CHS in 1990. A common commitment of the main policy elites was to ensure the economic survival of the heterogeneous hospital network consolidated through the 1980s, taking for granted both the existing asset ownership distribution and its financing by the health authority. However, the need to reduce the transactions costs derived from the uncertainty involved in assigning risk to providers conditioned to a large extent the implementation of the new health governance structure. Thus, providers were not integrated into the CHS and contracts were the main tool for shaping their production of services. Nonetheless, at the same time, extra-contractual financing mechanisms were also part of the system, and the 'fictional' contracts signed with CHI providers were just tools for inducing performance improvement.

Arguably, the ambiguous formulation of the LOHC implied also uncertainty in the principal-agent relations between the health authority and providers, which was counteracted by the discretionary power given to the executive branch. The enacting coalition's concern with the implementation costs derived from principal-agent transactions led it to use its absolute majority power and design a CHS which was highly dependent on the executive and which at the same time had managerial freedom to operate to a large extent within a private law framework. Principal-agent problems were also at the origin of the difficulties in changing the legal nature of the CHI and implementing the repeated recommendations by the academic and political elite to disaggregate it into its provider units. Finally, social and political actors relatively close to the parliamentary opposition bore the transactions costs derived from participation in the structure of a health authority which, against their first preferences, had been ambiguously designed and given a wide margin of discretionary power.

Radical NPM supporters tended to assess the extent of change brought about by these reforms as a distortion of the governance structure formulated in 1990, while radical NPM opponents defined the reforms as a privatisation strategy. However, the analysis of this case shows that the reforms between 1990 and 1995 represented a

blend of both continuity and innovation. Continuity affected the policy tools available to the health authority, the reassertion of the asset ownership *status quo*, and the commitment of the health authority to the economic survival of the heterogeneous network of providers. Innovation affected the institutional design of the health authority - including its legal nature and its managerial autonomy - and the idea that the Health Plan should guide health and contracting policies. Lastly, competition among all providers and disaggregation of the CHI were innovative ideas in relation to the main NPM components of the 1980s. Nevertheless, the former was first redefined as 'managed competition' and eventually not implemented, and the latter has not even been formally proposed yet.

Therefore, the extent of change brought about by the NPM health reforms in Catalonia was of an incremental nature, even though the starting situation was structurally favourable to the creation of such a governance structure. The clarification of the Catalan 'model' in NPM terms was gradual and consensual through a process of mostly endogenous partisan mutual adjustment. Although the policy developments in the rest of Spain were also characterised by a mixture of continuity and change, they built on a clearly different model - an integrated NHS. The main developments in the Spanish NHS over the 1980s were basically characterised by continuity in the hospital sector, and by change in the primary care sector. In the hospital sector, the creation of the NHS from 1986 mainly involved the co-ordination and consolidation of the existing network of Social Security providers owned and managed by the INSALUD with the rest of providers owned by other public administrations, together representing over 70 per cent of hospital beds available. The achievement of universal coverage was more of a qualitative than of a quantitative nature because by 1986, when the General Health Law was passed, 96 per cent of the population was already covered by the public health system (see Table A.4 of Appendix 1). Big steps towards a financing model based on taxes instead of on social security contributions was taken in 1989, when the percentage of the INSALUD's budget financed by general taxes increased from 25 to 70 per cent, and in 1997, when taxes financed 92 per cent of the INSALUD's budget.

By contrast, the creation of the Spanish NHS required change in primary care through a massive reconversion of the existing primary care services. This process involved an increase in the number of professionals and of their working timetables as well as investments on physical resources, with the aim of reinforcing the role of

primary care in the health system. Even so, the main share of public health expenditure was made in the hospital sector: in 1982 this represented 55 per cent of total health expenditure, and in 1990 it rose to 63 per cent (see Table A.1 of Appendix 1). Finally, the decentralisation of the INSALUD's competencies was characterised by a very gradual process - still unfinished -, which itself led to little innovation in health governance structures in most of the Autonomous Communities receiving the transfers until the mid-1990s.

In contrast to the Catalan reforms, the introduction of NPM in the Spanish NHS was brought about suddenly and as a result of exogenous pressures - namely, the 1992 Convergence Plan derived from the Maastricht Treaty[147]. An early explicit NPM reform proposal, the 1991 Abril Report had to be side-lined in the public arena to cool down political and social contestation. So far, though, the extent of NPM change in the Spanish NHS has been confined to a few cases in which programme contracts, prospective budgeting and the calculation of activity measures were being used for making managers aware of the results of their performance. Also, under the new PP government, a 1996 Royal Decree-Law and a Law of April 1997 established the possibility to contract directly or indirectly with entities of any legal nature for the provision of publicly financed health services, as well as the possibility to diversify management and provision forms. In any case, introducing NPM in the whole Spanish NHS in a comprehensive way would involve a radical change, because the use of contracts as a policy tool is new to the system.

In September 1997 a Sub-Commission of the Spanish central Parliament for the Consolidation and Modernisation of the Health System issued a report recommending rationalisation measures for the use of resources. This report had the support of the governing conservative PP, the Catalan nationalist CiU, the Basque nationalist PNV and Canary Coalition, and was rejected by the socialist PSOE and the communist-leaning coalition United Left (IU). According to this report, a law had to define the selective financing of the services which the NHS should cover as a matter of right, and the criteria of need, health and social utility, and cost/effectiveness. Second, technology assessment and evaluation had to be *sine qua non* conditions for the NHS to finance new treatments or the treatment of new illnesses. Third, a clear distinction between health and socio-health services had to be made, the latter not being

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147 For an analysis of the impact of external pressures (European Community membership, Maastricht Treaty) on the Spanish ecomomy and politics from the mid-eighties to the early nineties, see Heywood (1993).

financed by the NHS but by patients. Fourth, the role of mutualities should be made clearer. Fifth, priority criteria and time-span limits should be introduced in the management of waiting lists. And finally, there should be free election of doctor and health provider (*El Periódico*, 1/10/97).

Table 7.1. 'New public management', transactions costs and institutional design in the Catalan and Spanish health care systems.

	Reform stimuli	Extent of change	Transactions costs (TC) and institutional design	Transactions costs and policy tools
1980s Spain	*Endogenous stimuli*: Left's political commitment to NHS. Conflictual, ideological debate on deep (normative) core.	NHS model: *incrementalism* and continuity in hospital sector, *innovation* in primary care. Only complementary role for private providers.	*TC focus*: risk assignment (universal coverage, tax-financed NHS), implementation (no managerial autonomy, hierarchical integration).	*Continuity*: incremental budget allocation to INSALUD, which has single legal personality. Administrators instead of managers in its providers. *Governance structure*: unitary.
1980s Catalonia	*Exogenous stimuli*: democratisation, decentralisation, Spanish NHS. *Endogenous stimuli*: asset ownership distribution, split voting, compatible interests and preferences, strategic consensus.	Implicit NPM: *incremental* in structural terms: reinforcement and consolidation of contracted hospitals and creation of the HNPU. *Innovative* in primary care though following Spanish NHS model. *NPM*: designing incentives, consolidating disaggregation.	*Inertial*: CHI mimics INSALUD. *Innovative*: giving the contracted sector the status of public providers as substitute for the insufficient CHI's resources, choosing to expand the former instead of the latter. *TC focus*: risk assignment to non-CHI providers (commitment to their survival).	*Innovative*: in contracted sector -first accreditation system in Europe, re-classification of hospital levels, BCU measure of activity and price setting process, manager figure in both CHI and contracted sector, creation of consortia for rationalisation of hospital network. *Governance structure*: unitary (CHI) and hybrid.

Source: Own elaboration.

	Reform stimuli	Extent of change	Transactions costs (TC) and institutional design	Transactions costs and policy tools
1990 reform formulation in Catalonia	*Endogenous stimuli*: several internal CiU's bill drafts, law proposition by PSC, 1980s consolidation of the Catalan model. *Exogenous stimuli*: 1986 GHL mandate, NPM in other countries. Long negotiation and strategic consensus.	*NPM*: CHI became a provider, new health authority (CHS) finances, contracts and plans, private law as framework for CHS's external relations. Focus on: contract-based incentives for competition and efficiency, and suggestions of possible CHI disaggregation.	*TC focus*: legislative vagueness, participation rights, implementation, risk assignment to providers. *Themes*: discretion and managerial autonomy of health authority, innovation in participation rights. *Innovative*: private law framework for health authority.	*Innovative*: Health plan as a framework for contracts, extension of contracts to CHI's hospitals and reformed primary care.
Operating the new governance structure in Catalonia	*Exogenous stimuli*: historical under-funding of both Spanish and Catalan health care, but deeper in the latter, which together with large investments, and delays in INSALUD's annual budget transfers, have led to increasing debt.	Complex CHS's role: transfers, control and contracts agency, also regulatory and planning functions. CHI: provider agency role, but no disaggregation. Incentivisation through contracts, but no competition.	Centralisation in the CHS's corporate centre of contracting processes, to the detriment of Health Region Managers' purchasing functions. 'Fictional'-contracts with CHI providers. Health Plan objectives in primary care contracts.	*Governance structure*: hybrid bilateral. *Contract law*: Relational, contracting. Both contract and extra-contractual financing sources. Promotion of non-CHI providers. Actual publicness of HNPU-members
Early 1990s Spain	*Endogenous stimuli*: 1991 Abril Report, 1996 decree and 1997 law, 1997 report by a parliamentary Sub-Commission. *Exogenous stimuli*: 1992 Convergence Plan, NPM recommended by OECD.	Experimental, selective and limited change. Great difficulty with opening a public debate on a reform which would involve radical change if it followed international NPM lines.	*Continuity* in INSALUD's organisation, management, legal nature, and role in the health system, despite programme, fictional contracts with its providers since 1992.	Programme contracts, prospective budgeting, activity measures, providers viability plans, agency for the evaluation of technology, selective financing of medicines.

Source: Own elaboration.

7.2. The evolution of 'new public management' strategies in health care.

The divergences between the NPM discourse and the actual implementation of the reforms identified in the Catalan case as policy displacements, implementation deficits and unintended consequences have continued to characterise the governance structure of the health sector from 1995 to date (mid-1998). The interventionist stance taken by the DHSS reveals a higher profile in times of budgetary constraints, such as the present year. The 1998 budget froze the share to be spent on the health services contracted, and the *Conseller* made it clear that the existing financial deficit would eventually require rationalisation measures for the use of health resources. However, the *Conseller* first of all reasserted the politics of consensus and incrementalism which has characterised the development of the Catalan model: the DHSS would *negotiate* with the Catalan Union of Hospitals and the Hospital Consortium of Catalonia about the selective application of the necessary rationalisation measures *for the present year*, reviewing the situation of hospitals on *a case-per-case* basis (*La Vanguardia*, 28/5/98, my emphasis)[148]. That is, consensus will be the result of bilateral negotiations which, moreover, will only focus on the short-term.

Despite these implementation short-falls it could be argued that the Catalan health care reforms have been driven by the political will to shift from a public integrated model of health system to a public contract model by reinforcing the existing contracted sector. According to international reports on current health care reforms this is the model to which quasi-market reforms seem to be shifting. Each generic model of health system has its own inherent problems. The reimbursement model (in both its compulsory and voluntary versions) has problems of cost-containment. The public contract model has problems of lack of competition between providers and excessive regulation. And the public integrated model has problems of management deficit (micro-economic objectives) and of citizen-orientation (OECD, 1992). However, while the present institutional designs of the financing function of

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148 I want to thank Mireia Grau for pointing out this reference on http://www2.vanguardia.es/cgi-bin/hrp_cc1_new?

third party payers adequately perform the insurance and access functions of these health systems, none of them satisfactorily performs the agency function. Thus, the aim of current reforms is to find adequate incentives so that the financing body monitors and purchases health services under criteria of efficiency and equity.

The health care reforms of the 1980s and early 1990s aimed to improve both the macro- and micro-economic efficiency of health systems. Macro-economic measures on the demand side included initiatives such as cost-containment (services catalogues, cost-sharing) and stabilisation of the proportion of health expenditure in relation to the GDP. On the supply side the main macro-economic measures were control of the total volume of activity, global budgets for hospitals and capitation payment for primary care providers. In turn, the measures adopted for the improvement of micro-economic efficiency included elements of quasi-markets, such as competition-led incentives and regulations for providers and insurers. Thus, managed competition has been introduced between physicians (in Germany and in United Kingdom), between pharmaceutical products (in Germany, and in the Netherlands), between hospitals (in Germany, the United Kingdom, and the Netherlands), and between insurers or 'fundholders' (in the United Kingdom and the Netherlands) (OECD, 1992). Nonetheless, a number of common problems derived from quasi-market reforms which are directly related to the introduction of contracts have emerged. These are: the definition of indicators and activity measures; cost-based *versus* price-based payment systems; monitoring and *ex-post* control as mechanisms for bridging the information asymmetry in relation to contractors as policy implementors; ensuring accountability for management; defining the scope of political responsibility; and designing and implementing participation channels in the management and evaluation of public services.

According to Propper and Le Grand (1996) the evolution of quasi-markets is making apparent the need to redefine the role of government. In a quasi-market government collects taxes and allocates resources to purchasing agents for them to cover the population's health needs. However, apart from its budget setting and allocation function, the intervention of government in a quasi-market faces a challenge to make two other public functions compatible: promoting competition and achieving effective planning. The reason is that health care quasi-markets are far from perfectly competitive, so that the contracting process may not be a suitable mechanism for making relevant planning and investment decisions - either because they may be

beyond the funding capability of purchasers, or because co-ordination and collaboration for obtaining economies of scale may be hindered by competition itself.

However, these authors point out that while the promotion of competition in the United Kingdom has been important in sectors such as privatised utilities, in the case of health care this government function has encountered recurrent difficulties. For example, regulation of monopoly providers through the rule of price equals average cost has not only been criticised for not providing incentives to long-term economic efficiency, but such a rule has also been widely broken. Similarly, in the United Kingdom the introduction of some pro-competition tools (such as the elaboration of league tables and the Private Finance Initiative) has not been enough to overcome political and social pressures against one of the consequences of a contestable market - namely, the difficulty of closing inefficient hospitals. Moreover, governmental intervention in the United Kingdom has directly hindered competition and managerial freedom - for example, providers' pricing, investment and cash flows decisions are limited by the financial regime within which they have to operate. And purchasers (except General Practitioner fundholders) have to stick to the priorities set at the central government level, often lacking the required adaptation to local needs. Propper and Le Grand (1996) argue that underlying these developments in the role of government in relation to quasi-markets is the tension between the drive to give managers a wider margin of manoeuvre in a competitive environment and the need to ensure political control (and accountability) over the policy outputs of quasi-markets.

Other recent studies on the evolution of quasi-markets in health care reveal the emergence of new concepts such as transformational change, which being top-down and power-led have had an apparent impact on organisational culture and conceptual mind-sets. Power shifts induced by the reforms are making administration boards and their effectiveness more important (in terms of accountability, balanced membership, and non-executive members' role). Also important is the emergence of renewed professional roles, which are the result of adaptation or appearance of hybrid new individual roles. In health care this is tending to favour groups such as public health directors, clinical and medical directors, General Practitioner fundholders and entrepreneurial clinicians launching new commercial products. Finally, the concept and reality of relational markets as an agency system based on long-term contractual relations between hybrid forms of organisation (financed by both budgets and

commercial activities) may be replacing the NPM idea of quasi-markets (Ferlie *et al.*, 1996).

It could be argued that the introduction of NPM/quasi-market reforms in the public sector was initially aimed to gradually change the nature of incentives by replacing internal political control over implementation processes by external economic control of outputs. That is, organisation and structural reform (namely disaggregation) came to facilitate competition, which was in turn expected to make the most of incentivisation. Therefore, incentives as opposed to administrative controls, would no longer increase political control costs, but would be 'spontaneously' generated by competition (Gallego-Calderón, 1996). However, the analysis of the evolution of these reforms to date shows that different emphasis on different components of NPM have led to the emergence of different variants of NPM and different possible scenarios (Ferlie *et al.* 1996; Lane, 1997). In these contexts, aspects such as locating the lever of change on the demand side or on the supply side (purchasers *versus* providers), and clarifying the role given to citizens in a system which is supposed to enhance their voice and exit possibilities within the public services system, appear as crucial questions to be answered in any further development of the public sector reforms.

7.3. Implications for wider debates about transactions costs.

The initial theoretical assumption made in this research was that explaining the adoption of NPM reforms did not require a tailor-made theory, but a general theory of institutional choice in the public sector, which aimed to explain not only why NPM as a particular reform trend came about, but also might address questions about why any public sector reform comes brought about. Public sector reform was defined here as the redesign of the governance structure of any policy domain. And governance structure was defined as the set of rules governing the relationship between the

relevant actors in a policy domain. Two main components of a governance structure were identified: the institutional form of the public authority and the policy tool mix with which it was endowed for the fulfilment of its responsibilities.

The second main theoretical assumption made in this study was two-fold. On the one hand, institutions were conceived of as purposeful policy outputs of vital political concern (Moe, 1990a), resulting from the interactions and negotiations between boundedly rational individuals facing structure-induced constraints and opportunities (Dowding, 1996). On the other hand, an analytical differentiation between group or individual interests and institutions is not only possible but necessary in order to search for a causal link between institutional design as a purposeful policy option and the interest-based strategies of groups or individuals (Lane, 1993; Dowding, 1994).

This theoretical stance is at odds with the sociological strand of new institutionalism (March, Olsen, 1984, 1989; Meyer, Rowan, 1977), which rejects the idea that institutions are explicable in terms of purposeful strategies developed by actors. And it is also at odds with the economic version of new institutionalism (Shepsle, Weingast, 1981; Williamson, 1975, 1985), because this latter approach conceives of politics as a domain dominated by an economic rationale - a stance which confines their explanations to a limited understanding of the politics of institutional choice as a voluntary exchange process. Moreover neither the sociological nor the economic approaches integrate the organisational and political dimensions of the public sector governance structure into a theory of institutional choice (Moe 1990a, 1990b, 1991).

Horn's (1995) account of the variables driving legislators' decisions on the structure of the public sector tries to overcome this dissociation of the organisational and political dimensions of the public sector. He argues that legislators will design the institutional form which best helps them address the transactions costs they face, most of which deriving from the need to overcome their commitment problem. These transactions costs stem first, from the decision costs involved in the negotiations and conflicts associated with refining legislation, and the trade off with the likely agency costs implications of leaving legislation vague, or the other main trade off of allowing greater participation rights to civil society interests in the structure of the new institution. Second, transactions costs derive from the costs of monitoring implementation and maintaining control of agencies to whom powers are delegated.

Third, transactions costs are involved in assigning risk to private actors who may or may not be able to control or insure against them.

The perception of these transactions costs by legislators depends on the functions they expect the public sector to perform. I took this hypothesis as a starting point and reformulated it by arguing that depending on their ideology and resources, different actors should be expected to be concerned with different functions to be performed by the public sector and should therefore be expected to care about different kinds of substantive transactions costs. As a result, they will support different institutional forms for the public sector. Moreover, this reasoning and the final institutional design of the new public authority is expected to be influenced by the pattern of relationships between political and social actors.

Building on this theoretical framework, the research questions asked were why legislators chose NPM structures in health care, and why NPM policies were not fully implemented (despite favourable initial conditions)? These questions were answered for a specific case, by analysing the political processes by which public officials and interest groups made decisions on the governance structure of the health care in Catalonia from the early 1980s to the mid 1990s. The analysis shows that the actors involved in this process did take into account such transactions costs when formulating their preferences about the governance structure of the health sector, and accordingly negotiated with the rest of relevant actors. Moreover, not only did those transactions costs have an impact on the institutional choice finally agreed, but they also conditioned the actual implementation of the reforms.

However, the role of political transactions costs in Horn's theory are circumscribed to both the decision-making stage of the policy process and to the specific institutional design which is the object of legislation. However, the way political transactions costs are perceived and dealt with reflects also the impact of policy precedents concerning other institutions and other policy domains. In order to complement Horn's model, this study resorted to examining how other external policy processes had a cross-influence on the decisions made on the Catalan health policy subsystem. In this sense, relevant concepts from Sabatier's and Jenkins-Smith's (1993) advocacy coalition theory were taken as heuristic tools. First, two sets of factors -exogenous and endogenous to the policy subsystem - were examined and were shown to create constraints and opportunities for the policy elite to elaborate and redefine their preferences and arguments. Second, this research analysed the

interaction between public officials (legislators and bureaucrats) and non-institutional actors (interests groups) throughout a decade-long policy incubation period, in which both the development of key policy tools and the participation of interest groups in their formulation and implementation played a strong role.

In Horn's model legislators are defined as forward-looking, that is, the institutional design and the policy tools they formulate are intended to solve their commitment problem throughout the further implementation process. Nevertheless, the model was not clearly extended to consistently interpret how political transactions costs affected the implementation process through which the enacting coalition intended to solve its commitment problem. The formulation of an institutional design may not necessarily be clear and explicit, but rather ambiguous and prone to be reinterpreted as a result of either discourse and/or practice. Therefore, the analysis of the implementation process of this study resorted to Dunleavy's (1991) bureau-shaping model, which complemented Horn's decision analysis with concepts that are relevant for the specific kind of reform studied -namely, 'new public management' (NPM). Moreover, the implementation process does not only involve political but also economic transactions costs whose nature depend not only on political considerations but also on the economic and social characteristics of the policy domain in question - health in this case. For this reason, Horn's model was complemented with other theories which deal with this economic dimension of transactions, thereby helping identify how the political nature of the agency or implementation problem affects the economic dimension of policy. These theories included Williamson's (1975, 1985) governance structure models and Pfeffer and Salancik's resource dependence theory.

The analysis showed that, while theories about the variables inducing the adoption of particular governance structures in economic organisations define useful concepts for analysing public sector structural reforms, they fail to explain why economic theories' predictions are not confirmed in the political domain. The reason is that political transactions costs are different from economic transactions costs. In the world of economics transactions are defined as a matter of voluntary exchange, and transactions costs derive from writing, enforcing and monitoring 'hard' contracts. By contrast, in the world of politics transactions are mediated through relations of public authority - that is, they are not voluntary but compulsory -, and transactions costs derive from agreeing 'soft' contracts, where commitments and contingency are seldom specified in detail. The commitment problem of legislators, the costs derived from the

actual legislative process (vagueness as opposed to refinement of legislation), from participation rights for social actors in the structure of government, from implementation monitoring, and from uncertainty and risk assignment to private actors, are all explanatory variables characterising the governance structure actually implemented.

For example, for a situation in which investments are highly asset-specific and transactions recurrent, transactions costs economics predicts a unified governance structure. Unified governance involves forward or backward integration of purchasers and providers into a hierarchical or vertical mode of organisation, so as to economise on the costs derived from negotiating and monitoring long-term contracts which are complex because they cannot completely cover all contingencies associated with uncertainty and opportunism (Williamson, 1985). The health care sector is characterised by highly asset-specific investments, by recurrent transactions between financing authorities (purchasers) and providers, and by market failures such as uncertainty and information asymmetry leading to moral hazard, adverse selection, supply-induced demand and opportunism. But NPM does not postulate a unified governance structure for the sector, but instead the creation of hybrid forms of governance - namely, quasi-markets.

Quasi-markets involve a comprehensive development of the NPM components of incentivisation, disaggregation and competition and are close to the hybrid forms of governance defined by transactions costs economics: trilateral governance supported by neo-classical contracting, and bilateral governance supported by relational contracting. Theoretically, the former is most efficient when investments are either mixed or idiosyncratic (namely, medium or highly specific) and when transactions are occasional. Bilateral governance is supposed to be more efficient when the asset-specificity of investments is mixed and transactions are recurrent. The shift from the soft contracting involved in unified governance arrangements to the hard contracting involved in these hybrid forms of governance is central to the development of quasi-markets. The main argument for this line of reform is the need to break the lock-in situation which commonly affects unified/hierarchical forms of health systems. Hierarchical integration has had the unintended effect of intensifying asset specificity, without eradicating the opportunism, uncertainty and information asymmetry inherent in health care (Perrow, 1986). Thus the aim of the NPM reforms is to break these lock-in effects by making contractual relations explicit and binding, and by introducing

incentives to induce providers to improve efficiency and prevent opportunistic behaviour.

The governance structure actually implemented in the Catalan health care reforms turned out to be hybrid, that is, something pitched between a unified and a market governance structure. Although these NPM reforms involved a deviation from theory, because highly asset-specific investments no longer determined the choice of a unified governance structure in a situation of recurrent transactions, they did fit theory in the choice of the contractual law which supports the new hybrid governance form. That is, the contractual law chosen was not the neo-classical contracting required for occasional transactions (trilateral governance), but the relational contracting defined as the theoretically most efficient regime when transactions are recurrent (bilateral governance). Relational contracting means that adaptation between contracting parts rests on bilateral negotiations for mutual interest, and on mutual resource dependence.

In the Catalan case, structural disaggregation of functionally defined roles (financing, purchaser, provider, consumer) was clarified for different organisations and actors. And hard contracts started to make principal-agent relations explicit for some actors, and continued to do so for other actors, on the assumption that each part has and will press for its own interests, which may or may not coincide with the other's. At the same time, though, these hard contracts were acknowledged to be incomplete for the coverage of all contingencies. As a result, extra-contractual financing sources were used, which were subjected to bilateral negotiations between the purchasing health authority and each provider. This relational contracting is the basis of a process of co-ordination and adaptation between mutually dependent parties. Despite being a monopsonistic purchaser, the health authority needs the services of all the providers of the Hospital Network of Public Utilisation. And these providers have in turn come to fully depend on the contracts with the health authority for their survival.

The enacting coalition's commitment to the persistence of the heterogeneous and mostly privately managed provision network coincided with the preferences of the main interests groups. The governing coalition was concerned with the transactions costs derived from uncertainty and risk assignment to providers, and with the costs associated to the principal-agent relations derived from controlling implementation. All these factors conditioned the governance structure actually implemented. In essence, *these concerns are incompatible with central NPM postulates*, such as competition,

contestable quasi-markets and its ultimate economic consequences. In a situation of mutual resource dependence, contracts have become bridging strategies between purchaser and providers, and boundary setting instruments for the health administration itself (Pfeffer, Salancik, 1978). On the one hand, the purchaser formally controls the whole incentive and financing system - including, therefore, elements of hierarchical contracting (Stinchcombe, 1985). The effective use it has made of these powers has in some cases raised criticisms about the blurring of boundaries between the health administration and providers. On the other hand, providers have not only kept their managerial and organisational autonomy, but they have also ensured the commitment of the health authority to their economic survival as effectively almost 'quasi-public' bodies.

Thus, relational contracting is the basis of the new hybrid, bilateral governance structure of the Catalan health care system. However, the fact that these contracts are financed through the public budget, and that both parliament and the courts are entitled to supervise the use of public money, means that this governance structure could be defined as formally trilateral - in the sense that third-parties exist which are entitled to make binding decisions on the operation of the system. All this confirms the theoretical prediction that in a hybrid form of governance both incentive intensity and administrative controls have a semi-strong role as instruments, and that both autonomous adaptation and co-ordination become semi-strong performance attributes (Williamson, 1991).

In sum, while the new economics of organisation does define useful concepts and variables for explaining choices about governance structures, it fails to predict central features of such choices in the public sector. The very concept of 'economising' on transactions costs is not fully suitable for the political domain. Rather, adequately 'facing' or 'dealing with' transactions costs, as suggested by Horn (1995), better captures the idea that legislators' decisions on institutional choices are driven by whatever their commitment problems are. Solving such problems may require managing greater transactions costs in a way which is favourable to legislators' political objectives, instead of economising on transactions costs for society as a whole. The reason is that political transactions are not defined in economic, voluntary exchange terms. Instead, public officials and interest groups reason and pursue strategies which need a political explanation, that is, a theory that integrates the organisational and political/public authority dimensions of the process

of institutional choice. The main implication of this political rationale is that the institutional choices aimed at overcoming particular commitment problems may be incompatible with associated reform programmes, such as that postulated by the market-led NPM discourse.

What are now seen as recurrent inconsistencies between a NPM discourse advocating competition-led quasi-markets and new forms of governmental intervention, have to a large extent their origin in in-built tensions of this governance form: how to make compatible political control and planning on the one hand, with managerial freedom and competition on the other hand. In addition, both the market failures inherent in health care and health insurance and the kind of transactions involved partly explain the divergences between the market-led NPM discourse and the actual operation of quasi-markets. In short, the emergence of actual relational markets does not represent a clear theoretical puzzle, but rather a relative theoretical reassurance.

NPM as a new governance structure for the public sector is still an evolving reform trend. Different reform sequences and variable emphasis on the introduction of NPM components in different countries are not only traceable to particular sets of exogenous and endogenous factors in each case, but also to different solutions given to the emergence of those recurrent tensions. In essence, both problems and solutions are concerned with the allocation of decision rights about the rationalisation of resources in society. And the most important challenge any governance structure of the public sector has to meet is to gain legitimacy - that is, the trust of citizens - for the performance of that function.

Appendix 1

Data appendix

Table A.1. Structure of public health expenditure in Spain, 1982-95 (in percentages).

Year	Primary health care and pharmacy	Specialised health care	Other expenditure+
1982	40.7	54.8	4.5
1983	40.2	55.2	4.6
1984	40.4	54.8	4.8
1985	39.6	55.5	4.9
1986	37.9	57.1	5.0
1987	37.0	60.0	3.0
1988	37.0	60.0	3.0
1989	35.6	61.0	3.4
1990	32.8	62.7	4.5
1994*	33.2	61.7	5.1
1995*	34.8	60.0	5.2

+:Health care provision for seamen; health research; researcher training programs and general services administration.

Sources: CAENS, 1991:18; *:Guillén and Cabiedes (1998:189) cited from Oficina de Economía de la Salud, 1994:5.

Table A.2. Population coverage by the Spanish public health care system.

Years	Population covered (hundred thousands)	% of Coverage
1945	5,912	22.1
1952	8,767	30.9
1960	13,292	43.3
1964	16,066	50.6
1967	18,200	55.5
1970	21,374	63.8
1971	23,952	70.0
1973	28,020	80.3
1978	30,000	81.8
1982	32,170	84.5
1983	33,067	86.4
1984	35,876	93.2
1985	36,930	95.4
1986	36,974	96.1
1987	37,348	96.0
1988	38,052	96.3
1989	38,433	96.1
1990	39,453	98.0
1991	38,789	99.8

Source: Freire, 1993:85-6 (based on data from reports by the INP and the INSALUD).

Table A.3. Health expenditure in Spain as a percentage of GDP.

Year	Public	Non public	Total	Public/Total
1965	1.3	1.3	2.6	51.0
1970	2.4	1.3	3.7	65.5
1975	3.8	1.1	4.9	77.3
1980	4.5	1.1	5.7	80.0
1981	4.6	1.2	5.8	78.7
1982	4.7	1.2	5.9	79.4
1983	5.1	0.9	6.0	84.5
1984	4.7	1.1	5.8	81.6
1985	4.6	1.1	5.7	80.8
1986	4.4	1.2	5.6	79.0
1987	4.5	1.2	5.7	78.3
1988	4.9	1.1	6.0	82.2
1989	5.1	1.3	6.6	80.5
1990*	5.4	1.5	6.9	78.7
1991	5.5	1.2	6.7	82.3
1992+	6.0	1.5	7.5	80.5
1994*	5.7	1.6	7.3	78.6
1995*	5.9	1.7	7.6	78.2

Source: OECD (1994:72-73); *C.Gest. (1997:26), +:(OECD:1994b)

Table A.4. Financing sources of INSALUD's budget: state contributions *versus* Social Security contributions, 1989-96 (in percentages).

Year	State	Social Security	Others
1986	23.8	74.3	1.9
1987	24.7	69.9	5.4
1988	25.2	69.6	5.2
1989	70.1	27.2	2.7
1990	68.8	27.2	4.0
1991	67.8	27.2	5.0
1992	69.0	27.2	3.8
1993	68.8	28.0	3.2
1994	70.2	27.1	2.7
1995	77.3	20.4	2.3
1996	82.8	15.1	2.1
1997	91.9	6.0	2.1

Source: C.Gest (1997:26).

Table A.5. Distribution of investments in the Catalan health sector, 1982-95 (in percentages over total investment in health).

	1982			1983			1984		
	Primary care	Hospital care	Other*	Primary care	Hospital care	Other*	Primary care	Hospital care	Other*
Real investment	8.3	56.6	35.0	19.2	79.9	0.8	34.9	64.5	0.6
Capital transfers	-	-	-	-	-	-	-	-	-
TOTAL (100)	*8.3*	*56.6*	*35.0*	*19.2*	*79.9*	*0.8*	*34.9*	*64.5*	*0.6*
Total investment**	6,979,760,000			4,824,000,000			3,593,100,000		
INDEX+	100			69.1			51.5		

*Includes: urgent investments programs for infrastructure and equipment, prices review and other.
**In pesetas
+Indexed 100 in 1982.

	1985			1986			1987		
	Primary care	Hospital care	Gral. Admin.	Primary care	Hospital care	Gral. Admin.	Primary care	Hospital care	Gral. Admin.
Real investment	35.3	64.3	0.5	26.3	63.8	9.9	35.5	57.8	6.6
Capital transfers	-	-	-	-	-	-	-	-	-
TOTAL (100)	*35.3*	*64.3*	*0.5*	*26.3*	*63.8*	*9.9*	*35.5*	*57.8*	*6.6*
Total investment**	7,186,200,000			3,300,000,000			7,187,000,000		
INDEX+	103.0			43.3			103.0		

	1988			1989			1990		
	Primary care	Hospital care	Gral. Admin.	Primary care	Hospital care	Gral. Admin.	Primary care	Hospital care	Gral. Admin.
Real investment	36.2	60.6	3.2	35.8	54.2	6.0	33.4	53.1	5.9
Capital transfers	-	-	-	4.0++			2.6	5.0	-
TOTAL (100)	*36.2*	*60.6*	*3.2*	*37.8*	*56.2*	*6.0*	*36.0*	*58.1*	*5.9*
Total investment**	10,578,000,000			11,370,000,000			15,150,000,000		
INDEX+	151.6			163.0			217.1		

++To public enterprises and other public entities, without specifying whether they belong to primary or hospital care.

	1991			1992			1993		
	Primary care	Hospital care	Gral. Admin.	Primary care	Hospital care	Gral. Admin.	Primary care	Hospital care	Gral. Admin.
Real investment	-	-	0.0	17.8	18.1	0.9	16.3	20.1	13.1
Capital transfers	-	-	0.0	-	-	-	-	-	0.0
to CHI***	23.8	40.5	1.1	6.2	28.5	0.5	3.3	14.3	0.6
to non-CHI providers	12.1	22.5	-	8.8	19.2	-	9.1	23.2	-
TOTAL (100)	*35.9*	*63.0*	*1.1*	*32.8*	*65.8*	*1.4*	*28.7*	*57.6*	*13.7*
Total investment**	18,197,999,000			21,313,999,000			24,808,264,000		
INDEX+	260.7			305.4			355.4		

	1994			1995		
	Primary care	Hospital care	Gral. Admin.	Primary care	Hospital care	Gral. Admin.
Real investment	17.2	25.1	16.2	19.4	30.6	15.5
Capital transfers	-	-	0.0	-	-	0.0
to CHI***	2.4	6.6	0.6	2.4	4.9	0.4
to non-CHI providers	7.6	24.3	-	4.3	22.5	-
TOTAL (100)	*27.2*	*56.0*	*16.8*	*26.1*	*58.0*	*15.9*
Total investment**	20,818,142,000			21,448,500,000		
INDEX+	298.3			307.3		

**In pesetas.
*** Spent as real investment by the CHI on its own providers.

NB: Real and capital investments were a share of the budget of the DG of Social Security Health Services between 1982 and 1983, of the Catalan Health Institute's budget between 1984 and 1990, and of the Catalan Health Service's budget from 1991.

Source: Own elaboration based on DEF (1982, 1983, 1984, 1985, 1986, 1987, 1988, 1989, 1990, 1991, 1992, 1993, 1994, 1995).

Table A.6. Budget share spent on contracts with non-CHI providers in Catalonia, 1982-95 (in percentages over the total budget of the DHSS of the Catalan government and over the total budget of the corresponding health authority within the DHSS).

	1982		1983		1984	
	DHSS	DG of SS Health Services	DHSS	DG of SS Health Services	DHSS	Catalan Health Institute
TOTAL	*27.7*	*31.4*	*30.2*	*34.4*	*30.1*	*34.0*

NB: The budgets for the years between 1982 and 1984 do not specify the distribution of the contracting expenditure among primary and hospital care.

	1985		1986		1987	
	DHSS	Catalan Health Institute	DHSS	Catalan Health Institute	DHSS	Catalan Health Institute
Primary care	5.4	6.1	5.9	6.7	6.2	7.0
Hospital care	18.3	21.0	19.0	21.9	19.0	21.6
Other*	5.0	5.7	3.3	3.8	3.7	4.2
Current transfers**	0.6	0.6	0.3	0.4	0.7	0.7
TOTAL	*29.3*	*33.4*	*28.5*	*32.8*	*29.6*	*33.5*

*Specialists services and other, in 1989 it includes specialist services, haemodialysis and other.
**To families and non-profit institutions (one-off regulatory payments, prostheses, vehicles for handicapped patients, and other).

	1988		1989		1990	
	DHSS	Catalan Health Institute	DHSS	Catalan Health Institute	DHSS	Catalan Health Institute
Primary care	7.1	8.0	0.4	0.4	5.5	5.6
Hospital care	17.7	20.1	27.3	28.2	29.2	29.7
Other*	3.5	3.9	4.4	4.6	-	-
Current transfers**	0.5	0.6	0.1	0.1	-	-
TOTAL	*25.8*	*32.6*	*32.4*	*33.5*	*34.7*	*35.3*

	1991		1992		1993	
	DHSS	Catalan Health Service	DHSS	Catalan Health Service	DHSS	Catalan Health Service
Primary care	5.5	5.6	5.3	5.4	5.5	5.5
Hospital care	31.2	31.3	31.8	32.1	30.8	30.9
TOTAL	*36.7*	*36.9*	*37.1*	*37.5*	*36.3*	*36.4*

	1994		1995	
	DHSS	Catalan Health Service	DHSS	Catalan Health Service
Primary care	5.6	5.5	5.7	5.7
Hospital care	32.4	32.2	33.8	33.5
TOTAL	*37.0*	*37.7*	*39.5*	*39.2*

Source: Own elaboration based on DEF (1982, 1983, 1984, 1985, 1986, 1987, 1988, 1989, 1990, 1991, 1992, 1993, 1994, 1995).

Table A.7. Difference between Basic Care Unit (BCU) cost and tariff* for different hospital sizes and contract levels in Catalonia, 1993.

Size (nº of beds)	Cost/BCU	Most frequent tariffs		% of BCU cost covered by BCU tariff
>800	45,320	C	29,480	0.65
401-800	29,870	B/C	25,060	0.84
201-400	29,320	B	22,190	0.76
101-200	26,350	B	22,190	0.84
		A/B	19,490	0.74
51-100	20,720	A/B	19,490	0.94
		A	16,410	0.79
<50	20,430	A/B	19,490	0.95
		A	16,410	0.80

*In pesetas.

Source: Ramis *et al.* (1997:26), based on *Enquesta d'Establiments Sanitaris en Règim d'Internat*, elaborated by the DHSS of the Catalan government.

Table A.8. Unions electoral results in the health sector, 1987-90.

Unions	1987 CHI %	1990 Catalan Health Institute (CHI) representatives elected	%	1990 HNPU non-CHI providers (common collective agreement) representatives elected	%	1990 HNPU non-CHI providers (individual enterprise agreements) representatives elected	%
CEMSATSE	38	84	37.7	17	6.6	28	14.0
CC.OO	34	70	31.4	138	53.7	100	50.0
UGT	8	26	11.7	24	9.3	31	15.5
USTECATAC		22	9.9	0	0.0	16	8.0
USO	2	7	3.1	46	17.9	19	9.5
Other**	1	14	6.9	3	1.2	6	3.0
Non-affiliated	15			29	11.3	0	
Total	*100*	*223*	*100*	*257*	*100*	*200*	*100*

Unions	1990 Private providers representatives elected	%	1990 Psychiatric providers representatives elected	%	1990 Elderly residences representatives elected	%
CEMSATSE	3	0.8				
CC.OO	186	50.1	26	65.0	31	57.4
UGT	131	35.3	14	35.0	19	35.2
USTECATAC						
USO	16	4.3				
Other**	7	1.9				
Non-affiliated	28	7.5			4	7.4
Total	*371*	*100*	*40*	*100*	*54*	*100*

**The unions included in this category are not specified in this internal report, which does point out that none of them reached the level of ten per cent of the elected representatives and, therefore, cannot be considered as being among the 'most representative unions in the health sector'.

NB: In 1990 there were 30,000 workers in the CHI, 7,000 in the members of the HNPU with the same HNPU collective agreement, 11,000 in the rest of members of the HNPU -which have their own enterprise collective agreements-, 5,900 in the private sector, 500 in the psychiatric providers, and 540 in the providers for elderly people care. In the CHI only those having a statutory, civil service-like contract -namely 93 per cent of its workers- were entitled to vote. In the rest of the HNPU and in the private sector these electoral results are the aggregation of the results of two different electoral colleges: on the one hand, medical staff, nurses and administrative personnel, and on the other hand, nurse assistants and non-health personnel. The number of representatives each electoral college may elect is proportional to the number of workers in each college.

Source: CC.OO. (1991) based on the certificates of elections of the Department of Labour of the Catalan government.

Table A.9. Unions electoral results in the health sector, 1994-97/8*.

Unions	1994-1997 Catalan Health Institute(CHI) representatives elected	%	1994-1997 HNPU non-CHI providers (common collective agreement) representatives elected	%	1994-1998 HNPU non-CHI providers (individual enterprise agreements) representatives elected	%
CEMSATSE	134	42.8				
CEMSAT			3	0.7		
SATSE			55	12.1		
AMIC			8	1.7		
APF			8	1.7		
CC.OO	75	24	171	37.5	87	46.8
UGT	37	11.8	79	17.3	39	21.0
USTECATAC	31	9.9				
CTSC			48	10.5		
SAE	9	2.9	3	0.7		
CGT	8	2.6	4	0.9		
CSIF	8	2.6				
USO	4	1.3	44	9.6		
CTC	3	1.0				
SAC	2	0.6				
APAIL	2	0.6				
SPAS	0	0.0				
INDEP			12	2.6		
SMC			12	2.6		
API			9	2.0		
Non-Affiliated					7	3.7
Other					**53	**28.5
Total	*313*	*100*	*456*	*100*	*186*	*100*

Unions	1994-1997 Private providers representatives elected	%	1994-1998 Psychiatric*** providers representatives elected	%
CEMSATSE				
CC.OO	182	50.7	33	70.2
UGT	95	26.5	14	29.8
USTECATAC				
USO	10	2.8		
Other	38	10.6		
Non-affiliated	34	9.5		
Total	*359*	*100*	*47*	*100*

*The union elections follow a dynamic time pattern as they are not held at the same point in time in all providers. The data shown in this table represent the results obtained by the different unions in the health sector as accumulated between 1994 and 1997.
**This category 'Others' involve some associations standing for election within AMIC and others in 1998, but which have not been classified into AMIC in this report.
NB: The membership of the HNPU varies over the years as new providers sign contracts with the Catalan Health Service on a regular basis and are included in the HNPU by decree.
Source: CC.OO. (1998) based on the certificates of elections of the Department of Labour of the Catalan government.

Table A.10. Budget structure of the Department of Health and Social Security of the Catalan government, 1990 (in percentages over the total DHSS's budget)*.

	Cabinet of the *Conseller*	DG of Health Organisation and Planning	DG of Economic Resources of the Health System	DG of Public Health	**Catalan Health Institute (CHI)**	Total % of total budget
Core Budget						
Personnel	0.4	0.1	0.03	1.2	-	1.7
Purchase of goods and services	0.1	0.1	0.00	0.06	-	0.3
Total Core Budget	*0.5*	*0.2*	*0.03*	*1.3*	-	*2.0*
Bureau Budget						
Investments	0.05	0.00	-	0.2	-	0.07
Capital transfers to private agents	-	-	-	-	-	-
Current transfers to private agents	0.03	-	-	-	-	0.03
Financial assets	0.00	-	-	-	-	0.00
Total Bureau Budget	*0.03*	0.00	-	0.2	-	*0.2*
Programme Budget						
Current transfers to public agents	0.06	-	-	-	**92.4**	92.5
Capital transfers to public agents	0.00	-	-	-	**4.6**	4.6
Total Programme Budget	*0.06*	-	-	-	*97.0*	*97.1*
Superprogramme Budget						
Total SP Budget	-	-	-	-	-	-

*All calculations are based on the initial budgetary appropriation (332,195 million pesetas).

Source: Own elaboration based on DEF (1990) and Dunleavy (1991).

Table A.11. Budget structure of the Department of Health and Social Security of the Catalan government, 1995 (in percentages over the DHSS's total budget)*.

	Cabinet of the *Conseller*	DG of Resources of the Health System	DG of Public Health	Territorial Delegations	**Catalan Health Service (CHS)**	Total % of total budget
Core Budget						
Personnel	1.1	-	-	-	-	1.1
Purchase of goods and services	0.1	0.1	0.00	0.03	-	0.2
Total Core Budget	*1.1*	*0.1*	*0.00*	*0.03*	-	*1.3*
Bureau Budget						
Investments	0.02	-	0.1	0.00	-	0.1
Current transfers to private agents	0.03	0.02	0.00	-	-	0.1
Capital transfers to private agents	0.04	-	-	-	-	0.04
Financial assets	0.00	-	-	-	-	0.00
Total Bureau Budget	*0.1*	*0.02*	*0.1*	*0.00*	-	*0.2*
Programme Budget						
Current transfers to public agents	0.1	0.00	0.00	-	**94.6**	94.7
Capital transfers to public agents	0.00	-	0.00	-	**4.1**	4.1
Total Programme Budget	*0.1*	*0.00*	*0.00*	-	***98.7***	*98.8*
Superprogramme Budget						
Total SP Budget	-	-	-	-	-	-

*All calculations are based on the initial budgetary appropriation (541,294 million pesetas).

Source: Own elaboration based on DEF (1995) and Dunleavy (1991).

Table A.12. Budget structure of the Catalan Health Institute pre-LOHC, 1990 (in percentages over the total CHI's budget)*.

	Corporate Centre	Specialised care	Primary care	Health Professionals Training	Total % of total budget
Core Budget					
Personnel	1.6	15.3	15.9	0.9	33.7
Purchase of goods and services	0.8	6.6	1.4	0.02	8.8
Total Core Budget	*2.4*	*21.9*	*17.3*	*0.1*	*42.5*
Bureau Budget					
Contracts with non-CHI providers	-	29.7	5.6	-	35.3
Investments	0.3	2.5	1.5	-	4.3
Capital transfers to private agents	-	-	0.06	-	0.06
Current transfers to private agents	0.00	0.5	16.3**	-	16.8
Redemptions	0.00	0.2	0.06		0.3
Financial assets	0.03	-	-	-	0.03
Total Bureau Budget	*0.3*	*32.9*	*23.5*	-	*56.7*
Programme Budget					
Capital transfers to public agents	-	0.2	0.06	-	0.3
Current transferst ot public agents	0.02	-	0.4	-	0.4
Total Programme Budget	*0.02*	*0.2*	*0.5*	-	*0.7*
Superprogramme Budget					
Total SP Budget	-	-	-	-	-

*All calculations are based on the initial budgetary appropriation (326,888 million pesetas).

**94 per cent of this amount is transferred to pharmacies in payment for 60 per cent of the price of pharmaceuticals bought by patients on medical prescription (patients pay 40 per cent of the price).

Income sources of the CHI's budget:

Transfers from the DHSS:	98.5 %
Service provision:	1.2 %
Heritage income:	0.3 %
Financial assets:	0.03 %

Source: Own elaboration based on DEF (1990) and Dunleavy (1991).

Table A.13. Budget structure of the Catalan Health Institute as a provider, 1995 (in percentages over the CHI's total budget)*.

	Corporate Centre	Specialised care	Primary care	Health Professionals Training	Total % of total budget
Core Budget					
Personnel	2.3	34.1	39.6	2.5	78.5
Purchase of goods and services	0.6	15.2	4.7	-	20.5
Total Core Budget	*2.9*	*49.3*	*44.3*	*2.5*	*99.0*
Bureau Budget					
Investments	0.05	0.5	0.3	-	0.9
Financial assets	0.1	-	-	-	0.1
Current transfers to private providers	0.00	-	-	-	0.00
Total Bureau Budget	*0.2*	*0.5*	*0.3*	*-*	*1.0*
Programme Budget					
Total Programme Budget	-	-	-	-	-
Superprogramme Budget					
Total SP Budget	-	-	-	-	-

*All calculations are based on the initial budgetary appropriation.

Income sources of the CHI's total budget (203,444 million pesetas):

Transfers from the CHS: 97 %
Provision of health services: 2.9 %
Financial assets: 0.1 %

Source: Own elaboration based on DEF (1995) and Dunleavy (1991)

Table A.14. Budget structure of the Catalan Health Service as the financing and purchasing agency, 1995 (in percentages over the CHS's total budget)*.

	Corporate Centre	Specialised care	Primary care	**Catalan Health Institute (CHI)**	Total % of total budget
Core Budget					
Personnel	0.6	-	-	-	0.6
Purchase of goods and services	0.8	-	-	-	0.8
Total Core Budget	*1.4*	-	-	-	*1.4*
Bureau Budget					
Contracts with non-CHI providers	-	33.5	5.7	-	39.2
Investments	0.6	1.2	0.8	-	2.6
Current transfers to private agents	0.04	0.00	19.0	-	19.0
Capital transfers to private agents	0.00	0.6	0.00	-	0.6
Financial assets	0.00	0.04	0.02	-	0.06
Total Bureau Budget	*0.6*	*35.3*	*25.5*	-	*61.4*
Programme Budget					
Current transfers to public agents	0.04	0.3	0.2	**35.8**	36.3
Capital transfers to public agents	0.00	0.3	0.2	**0.3**	0.8
Total Programme Budget	*0.04*	*0.6*	*0.4*	***36.1***	*37.1*
Superprogramme Budget					
Total SP Budget	-	-	-	-	-

*All calculations are based on the initial budgetary appropriation.
**: 96 per cent of this amount is transferred to pharmacies in payment for 60 per cent of the price of pharmaceuticals bought by patients on medical prescription (patients pay 40 per cent of the price).

Income sources of the CHS's total budget (546,053 million pesetas):

Transfers from the DHSS:	97.6 %
Provincial administrations:	1.4 %
Financial assets:	0.00%
for patients' displacements:	1.0 %

Source: Own elaboration based on DEF (1995) and Dunleavy (1991).

Appendix 2

Methodology

The choice of the reforms of the Catalan public health sector from the early eighties to the mid-nineties is based on the criterion of 'information-rich case' (Patton, 1990:181). On the one hand, this case is part of an international trend of public sector reforms which has generated a considerable volume of publications. So far, though, the Catalan case had not been the object of analysis from a political science perspective. On the other hand, it has the added-value of including structural and contingent variables which theories of institutional choice seldom integrate - namely, the territorial organisation of the state, the distribution of political power between different levels of government as a result of democratic elections and a complex distribution of complementary resources among a heterogeneous policy elite.

The methodology used in this research combines qualitative and quantitative approaches in the analysis of data from both primary and secondary sources. The primary sources used here include thirty-eight in-depth and semi-structured interviews with key informants, non-published internal reports from major organisations and an annual survey of all health providers carried out by the Department of Health and Social Security of the Catalan government[149]. The secondary sources include official publications, relevant academic journals and books on the subject and newspapers.

The sampling criteria for the collection of the data used in this study has been qualitative, purposive, theory-driven and guided by the research questions formulated (Miles; Huberman, 1994:27). The analysis of the role of the policy elites in terms of advocacy coalitions required not only the collection of non-published internal reports by both institutional and non-institutional actors, but also the realisation of face-to-face interviews (Sabatiers; Jenkins-Smith, 1993). The

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[149] This survey title is *Estadística d'Establiments Sanitaris en Règim d'Internat*, and has been carried out by the Service of Information and Studies of the Direction General of Health Resources of the DHSS of the Catalan government. Although the survey stated to be conducted in 1983, the data available only covers from 1985 to date.

selection of interviewees was based both on purposive and snowball sampling, with the aim to contact at least two representatives of each collective actor defined as relevant within the health policy domain (see Chapter 3 and Appendix 3). The interviews conducted combined features of the semi-structured and in-depth types, and were recorded and transcribed. They intended to cover a small sample of key informants, nested in their context and studied in depth when they showed the initiative to expand their answers. In all cases, though, interviews were initially designed as semi-structured and covered the following themes:

What they understood by 'Catalan model' of health care,

Whether they thought there might have been other 'feasible' alternatives (both in political and economic terms),

How they perceived their role in the policy-making process within the Catalan health system from the early eighties to date,

How they perceived other relevant actors' role in the policy-making process within the Catalan health system over the same period,

How they perceived their relations with these and other relevant actors,

How they perceived their interests to have been affected by the evolution of the Catalan health system from the early eighties,

What views and beliefs they had about the Catalan health system.

The need to identify the arguments of the different Catalan political parties when deciding on a new institutional design for the health authority in 1990 required analysing official publications, such as the transcripts of parliamentary debates leading to the passage of the new legislation (see Chapter 4). The analysis of these documents was driven by the transactions costs concepts defined by Horn (1995). The different arguments defended by each party were classified into Horn's analytical categories by associating the meaning of the indigenous wording to sensitising concepts which bear a direct identification with those defined by the theory (Patton, 1990:390-1). This is a process of inductive abstraction. The indigenous wording in which the main arguments of political parties were expressed were classified into two different levels of sensitising concepts:

1. at a more concrete level: the legal nature of the health authority, its managerial autonomy and independence from the executive, participation rights for political and social actors, providers' functional attachment to as against integration into the health authority, the role of local administrations, and the policy tools available to the health authority;

2. at a more abstract level into which the concepts above were classified: margin of discretion of the health authority, participation rights, and providers autonomy. This classification turned out to be meaningful, resilient and directly related to Horn's model.

Finally, the analysis of the actual operation of the new governance structure formulated for the health sector required both qualitative and quantitative data. The former was taken mainly from interviews and from the contracts prototypes. The latter was taken from the annual budget of the main public agencies of the health authority and from the annual survey conducted by the DHSS. In Chapter 5, the analysis of the budget structure of key public agencies was shaped by the analytical categories defined by Dunleavy's (1991) bureau-shaping model. The objective was to assess the extent to which their roles had actually been re-defined in accordance with the new governance structure formulated. In Chapter 6, the budget share spent on investment and contracts by the health authority, the distribution of resources and workload among different providers as shown in an annual survey carried out by the DHSS, and interviews were analysed to clarify the actual operation of the governance structure of the Catalan health system. The analytical construct that guided this analysis were Williamson's (1985) combined types of governance form and contract law.

The use of these different types of data from different sources has allowed triangulation of the evidence obtained from them (Patton, 1990:267). Thus, for example, the discourse prevailing among the policy elite, as reflected in official publications, internal reports and interviews, was that the 1990 reform had introduced the purchaser/provider split within the health authority or administration. However, neither the formal and actual distribution of competencies nor the analysis of the budget structure of the relevant public agencies confirmed an effective implementation of these roles. In sum, the purposive selection of these quantitative and qualitative data was guided by the analytical variables defined in the theoretical framework. The aim was to empirically test whether the nature of the relations between specific variables as established by the theory held in this particular case study. That is, this research did not attempt to describe a particular state of affairs and its preceding evolution in the Catalan health reforms, but to understand why this particular state of affairs prevailed over other possible ones.

Appendix 3

List of key informants intervewed

Expert interviewees recorded, posts and date of interview:

Mr. Simó Aliana, former high official of the Department of Health and Social Security (DHSS) of the Catalan government, former Catalan Health Institute (CHI) hospital manager, and present director of the Public Administration School of Catalonia (23/10/96).

Mr. Miquel Argenté, Head of the Area of Economic Resources of the Catalan Health Service's (CHS) corporate centre (13/11/96).

Ms. Roser Artal, Head of the Payment Systems Unit of the Health Area of the CHS's corporate centre (4/12/96).

Mr. Joan Josep Artells, member of the Abril Commission (1991) and Health Economist of the Cabinet Economía y Salud, S.L. (15/4/96).

Mr. Jaume Aubia, Doctor, Vice-President of the Official Medical College of Barcelona (COMB) (17/4/96).

Mr. Juan José Avendaño, Doctor, Medical Director of the Primary Care Centre Barceloneta (4/11/96).

Mr. Ricard Bosch, Manager of the HNPU-member Health Consortium of Barcelona (30/10/96).

Mr. Miquel Bruguera, Doctor, President of the COMB (20/10/97).

Mr. Xavier Casas, member of the Party of the Catalan Socialists (PSC), local councillor for Public Health of the Barcelona's Local Council, President of the HNPU-member Municipal Institute of Health Care (IMAS) of Barcelona's Local Council, and Vice-President of the CHS's Health Region of 'Barcelona City' (20/11/96).

Mr. Joan Castillejo, Head of Primary Health Care of the Health Area of the CHS's corporate centre (22/7/96).

Mr. Jordi Codina, Director of the Parc Taulí Foundation of the HNPU-member Consortium of the Parc Taulí of Sabadell (10/4/95). Present Director of the Foundation Unió of the Catalan Union of Hospitals (UCH).

Mr. Jordi Colomer, Manager of the HNPU-member Health Consortium of Mataró (4/11/96).

Ms. Mònica Corominas, Doctor, Head of the Planning and Management Control Unit of the CHI (9/9/96).

Mr. Josep Cuervo, Manager of the CHI hospital Vall d'Hebró (12/4/96).

Mr. Ramon Espasa, Doctor, former *Conseller* of the Department of Health and Health Care of the provisional Catalan Government (1977-1980), and doctor at the CHI hospital of Bellvitge (20/1/98).

Mr. Antoni Garcia Prat, former high official of the former Direction General of Health Care of the DHSS (1981-1983), where it was responsible for contracts with hospitals and primary care, Administrator of the Hospital Clínic (1983-1986), Manager of the CHI's Health Area of Barcelona City (1987-1990), and present Manager of the Foundation Josep Carreras (10/11/97).

Mr. José Andrés Gorricho, Director of the Hospital Section of the CHI (19/11/96).

Mr. Josep Mª Grego, Doctor, Director of the Primay Health Care Section of Mútua de Terrassa, most of whose providers are HNPU-members (8/11/96).

Mr. Manuel Guerrero, Lawyer, President of the insurance company ARESA, and Vice-president of the insurance employers' association UNESPA (25/11/97).

Ms. Elvira Guilera, former Director General of the Direction General of Health Care of the DHSS of the Catalan government (1981-83) and director of the private consulting cabinet CODEH (19/11/96).

Mr. Manuel Jovells, Manager of the CHI (12/4/95).

Mr. Albert Ledesma, Doctor, former CHI primary care doctor, Director of the professionals self-managed Centre of Primary Care Vic S.L. (Primary Care Centre del Remei) (19/10/96).

Mr. Carles Manté, former Director of the Hospital of Mataró in the late seventies, Health Councillor in the Local Council of Mataró (1979-1985), Director General of the Hospital Consortium of Catalonia (CHC) from 1985 (20/1/98).

Ms. Esperança Martí, collaborator of the former Direction General of Health Care of the DHSS of the Catalan government (1981-83), President of the UCH and manager of the private hospital Institut d'Urologia, Nefrologia and Andrologia (IUNA) linked to the Fundació Puigvert, member of the CHS's Directive Council (6/11/96).

Mr. Patricio Martínez, President of the Spanish Confederation of Medical Unions (CESM -CEM/SATSE coalition with a nurses' union in Catalonia), member of the CHS's Directive Council (5/11/96).

Ms. Victòria Martorell, Doctor, Health Director of the Primary Care Centre Badalona Gestió Assistencial S.L., dependent on the HNPU-member Hospital Municipal de Badalona (14/11/96).

Mr. Ramon Massaguer, former Manager of the CHI and Director of the CHS (12/7/95).

Mr. Pere Monràs, Manager of the HNPU-member Hospital Consortium of the Parc Taulí in Sabadell (24/10/96).

Mr. Francesc Moreu, Manager of the CHS's Health Region 'Centre' (4/4/95). Present manager of the CHC's enterprise Consultoria i Gestió S.A.

Mr. Albert Oriol-Bosch, Director of the Institute for Health Studies of the DHSS of the Catalan government (4/4/96).

Mr. Adolf Rodés, Internal Auditor of the Municipal Institute of Health Care (IMAS), member of the Health Consortium of Barcelona, which is itself a HNPU-member (21/10/96).

Mr. Manel Santaló, Director of the Primary Health Care Division of the CHI (24/7/96).

Mr. Ramon Serna, Nurse at the CHI Hospital of Girona and representative of the Catalan public sector union CATAC in this hospital's workers' commitee (18/3/98).

Mr. Joan Sintes, Manager of the CHS's Health Region 'Barcelona City' (25/7/95).

Mr. Pere Torrabadella, Doctor, Manager of the Catalan Association of Health Centres (ACES), member of the CHS's Directive Council (11/3/98).

Mr. Xavier Trias, former Director of the CHI (1984-88), former *Conseller* (counterpart of a Minister in the Spanish central government) of the DHSS of the Catalan government (1988-95), and present *Conseller* of the Presidency Department of the Catalan government (22/10/96).

Mr. Antoni Tuà, Head of the Health Policy Area of the Catalan branch of the trade union CC.OO, member of the CHS's Directive Council (30/10/96).

Mr. Miquel Turner, Administrative Secretary at the HNPU-member Hospital of Mataró and representative of the CTS health union in this hospital's workers' commitee (18/3/98).

Mr. Josep Mª Via, former Secretary General of the CHI, former Director of the Health Area of the CHS' corporate centre, and Director of the International Division of the CHC (18/11/96).

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