The Effects of Contracts on Health Policy: The Case of Primary Health Care in Spain

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Abstract

In this paper we consider the relationship between contractualism and primary health care policy. The methodology includes interviews with the main actors (managers and health care professionals) and analysis of the contract documents. Based on the author’s PhD dissertation, the paper will examine how politicians use contracts to pass on health policy priorities to primary health care centres. We will also explore the results and contradictions of this process with the aim of finding out the effects of contractualism on health policy.

1. Introduction

Contractualism or the use of internal contracts between different parts of the public sector has been considered the main element of New Public Management (NPM) (Lane, 2005). Different terms have been coined to reflect the extension of the phenomena such as new contractualism (Boston, 1998), contractual state (Kirkpatrick and Martinez Lucio, 1996) or government by contract (Lascoumes and Le Gales, 2007).

Contractualism involves replacing input-based control or ex ante control by result-based or ex post control (Sulle, 2010). Ex ante control consists of regulations and rules that force agencies to seek prior approval before they take action, whereas ex post control consists of different interrelated elements such as: setting performance goals, the use of indicators to make goals measurable, the presence of performance monitoring or the presence of a system of rewards and sanctions.

Contractualism is often accompanied by other features of the NPM doctrines such as the decentralization of responsibilities to managers and subordinate units. But there are some tensions between contractualism and decentralization. The price for more autonomy and discretionary power is sharper performance accountability based on contracts (Sulle, 2010). Contractual arrangements have been considered a device to reinforce the power of political leaders against bureaucracy through more centralization and control (Christensen and Laegreid, 2001).

In this article we analyse the use of internal contracts in primary health centres in the Spanish public sector. We will show how contracts exhibit these contradictory features. Central government presented contracts to staff as an instrument that would give centres more autonomy. In practice, contractual arrangements have produced greater central control. The government used contracts as a mechanism to pass on health priorities to primary health centres, especially the attempt to reduce pharmaceutical expenditure.

We focus our research in a central department, National Institute of Health (Instituto Nacional de Salud, Insalud). The period studied covered the years during which Insalud made use of internal contracts, 1993-2001.
Insalud managed the Social Security Healthcare network from 1978 to 2002. This network is the most important one as it represents 85% of public health expenditure. Between 1978 and 2002, Insalud was the highest health care management authority in the country, although hierarchically subordinated to the ministry of health.

Between 1981 and 2002 the management of the Social Security Health network was transferred sequentially from Insalud to the 17 regional governments. Between 1981 and 1994 seven regions assumed total control over the health system: Catalonia, Andalucia, Basque Country, Valencia, Navarra, Galicia and Canary Islands. The health care system of the remaining 10 regions (Aragon, Asturias, Balearic Islands, Cantabria, Castilla-La Mancha, Castilla-León, Extremadura, Madrid, Murcia and La Rioja) was managed by Insalud during the period of study (1993-2001). In 2002 these responsibilities were transferred to the regional governments.

Several reasons justify the relevance of studying the experience of Insalud. During the period analysed, it is the biggest health service in Spain as it managed the health care of 39% of Spanish population and the same amount of national public health expenditure. Secondly, given the extension of the coverage, Insalud has had a diffusing role in the use of contracts. The dynamics of contracts have probably meant a process of organizational learning from which the regional governments have started to work once they assumed the health competencies. Therefore the experience of Insalud with internal contracts may help understand the subsequent use of contracts by regional governments. Nowadays the ten regions managed previously by Insalud make use of internal contracts (Carnicero et al., 2011).

The methodology is based in the analysis of documents and in 33 in-depth interviews. Two main variables were taken into account to select interviewees: professional group (doctors, nurses or administrative staff) and managerial responsibilities from the different organizational and professional levels. Out of the 33 people interviewed, 26 of them had managerial responsibilities. The strong presence of managers is justified by the central role that NPM assigned to them but also because, due to their organizational position, they know the problems that reform programmes designed by the top administrations encountered when they are implemented in lower level units (Floyd y Wooldridge, 1997).

The paper starts reviewing the main aspects in the design of contracts. It follows with the analysis of the problems and contradictions that came out in the process of implementation. Finally, we include some concluding remarks.

2. Main features in the design of contracts

In this section we will deal with two key aspects of contracts. The first one is the levels at which contractualism takes place. The other aspect is the economic targets of contracts.

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1 In a broader research we have analysed the contents of contracts in aspects such as pharmaceutical spending, performance indicators, interorganizational relationships and incentives (Morillo Balado, 2009).
2.1. Levels of contractualism

Performance contracts in the Spanish primary health care take place in three different interrelated levels. The first level is the contract-programme agreed annually between central government (Insalud) and the primary care area managers. These managers are responsible for organizing primary care in a health area, which is an administrative territorial division that covers a population of between 200,000 and 250,000 inhabitants.

The second level of contractualism takes place annually between the above mentioned managers and the coordinators of the primary care centres, in what were originally called contracts of decentralization. Primary care centres cover a population of between 5,000 and 25,000 inhabitants and their coordinators report to the primary care area manager. In the contracts of decentralization health authorities try to adapt the targets of the contract-programme to each centre. This level of contractualism involves the delegation of some responsibilities to primary care centres such as line managers being able to recruit temporary staff or assign pay incentives.

Contracts in the first and second level include a budget, targets, a system to monitor the contract and pay incentives linked to the accomplishment of the contract. The only penalty for failure to achieve objectives is the withdrawal of financial incentives, whose amount, nevertheless, is always marginal to the bulk of remuneration (Garcia et al., 2010)

There is a third level of contractualism in which primary care centres sign every year an agreement with hospitals under which they set up common objectives to overcome the traditional lack of coordination between primary and specialized health care. Whereas the other two levels of performance contracts are agreed between organizations with a hierarchical relationship, the contract between primary and specialized care takes place between two independent organizations. This contract does not include a budget nor financial incentives.

2.2. Economic targets in contracts

The budget has been a central element of the contractual arrangements. In six out of the nine years in which central government use contracts, one of the two requirements for accomplishing the contract was not to spend more than was initially assigned. From 2000 this requirement became less rigid in the second level of contractualism, the contract of decentralization, but nevertheless there were still sanctions for primary care centres that did not stay within the expenditure limits.

An important item in primary health expenditure is the share of pharmaceuticals, which represents 61% of the total expenditure for that health level. Its evolution in the period 1994-2001 shows that its share increased every year whereas the other two headings remained the same (maintenance) or decreased (personnel). The tight relationship between the accomplishment of the contract and the expenditure on pharmaceuticals can be appreciated by analysing the evolution of the amount devoted to this item. The year in which this amount was bigger, most of the primary health centres managed to accomplish the economic objectives of contracts.
Another key aspect in the accomplishment of the economic objectives of contracts is the margin of manoeuvre that primary health centres have to influence the different elements of expenditure. Contracts for primary health centres include expenditure for three items: personnel, maintenance, and pharmaceutical care. Out of these aspects, employees can only have an impact on the amount devoted to replace sick colleagues and to pharmaceuticals. In the first case, the amount that centres received were already very stringent, hence they did not have much chance to make an impact on that. Regarding expenditure on pharmaceuticals, the government has had problems to influence the prescribing patterns of doctors as this is a medical decision. Nevertheless, the government has developed indicators to evaluate whether doctors were prescribing the most cost effective formulas. Primary care area managers have also linked the financial incentives of contracts to promote cost effective prescriptions.

3. Main issues in the implementation of contracts

In this section we will deal with the main topics that came out during the field work. Although contracts have some merits, their implementation has encountered a series of problems such as the centralization of decisions and the weakness of performance indicators. Contracts have also been affected by the stringent budgets and have not had much success in improving the coordination between health care levels.

3.1. Contractualism and improvements in health policy

In primary health care contracts present the following merits: standardization of targets and working methods, more clear objectives, more transparency, and some benefits related to the process of decentralization of decisions.

The homogenization of objectives and working methods is due to the establishment of common objectives to all primary care centres. This homogeneity contrasts with the variety of practices that existed previously.

A related merit of contracts is that they have brought more clarification to the targets of the different units. Contracts make explicit what should be done during the year, with what quality standards and with how much money. This was mentioned by central government officials and by primary care area managers, those that manage a group of primary health centres in a geographical area.

Contracts introduce greater transparency in the tasks performed by staff as they make results more visible. Two opposite discourses appear in relations to this greater visibility. On the one hand, some employees are in favour of showing the work that it is being done. One reason that justifies this greater transparency is the fear of the private sector assuming their tasks. On the other hand, more transparency is considered a threat to professional autonomy and a sign of distrust by public administration to the professionalism of health care staff.

Finally, the process of decentralization that was introduced with the contractual arrangements has meant some positive developments. First, for primary care area managers, the signature of a contract with the individual health centres leads to larger compromises by staff in the accomplishment of targets. Health area manager consider that the establishment of a formal written agreement puts more trustworthiness to the
arrangements. Also the process of negotiation makes targets more enforceable than if they were imposed. Second, line managers in primary care centres agree to the delegation of tasks related to the recruitment of temporary staff that cover short leaves and to the more discretionary power they now have in that process. Before the geographical managerial structures used to hire temporary staff following a set up procedure whereas now line managers can choose from a pool of candidates who had previously worked for them.

3.2. Contractualism and the centralization of decisions

One of the most serious problems of contracts is that targets are set up by central governments health authorities. Primary care managers, line managers and staff have very little capacity for influencing that process. The lack of employees’ participation in setting up targets is also a problem in the British executive agencies (Trosa, 1997) and is considered the biggest challenge of French contracts (Grapinet, 1999).

A highly criticized feature is that all primary care centres have to achieve the same health targets. They all have to cover the same health problems, regardless of the demand they face and the type of population they cover. This means that contracts very often ask centres to accomplish tasks that are irrelevant for that geographical area. This criticism was made by the main professional groups (doctors and nurses) and by the different organizational levels (primary care area managers, line managers and employees).

In order to be able to assign common goals, central government designed a performance indicator, *cartera de servicios*, service list. This indicator contains the health activities that every year centres have to cover. It is the main instrument that centres use to measure their health care performance and it comprises a quantitative and a qualitative element. The qualitative part includes a number of features designed to guarantee the quality of care. The quantitative part gives information about the number of individuals that should be assessed in relation to certain medical conditions. The accomplishment of the quantitative element for a list of health activities is the second requirement for considering a contract accomplished. The first one being not spending more than the budget initially assigned.

Primary health care area managers spoke about a lack of motivation among health staff created by the introduction of the service list. Previously primary care centres and area managers agreed their own target according to the characteristics of the populations they cover. This lack of motivation is seen as a serious problem in the working environment of centres and in their day to day management.

3.3. Problems with performance indicators

Apart from the centralization process that the introduction of the service list meant, this indicator presents other problems. First of all, the data used for setting up targets is based in average figures for general populations; hence health professionals complain that they do not reflect the characteristics of population in lower geographical levels.

Secondly, the service list does not take into account all medical practice, as it only measures 25% of the whole activity. Service list is mainly focus on prevention activities.
and chronic conditions, but not so much on the problems for which patients go to the doctor daily. The lack of sensitivity of the service list to these latest problems increases in those centres that cover large populations as in those cases doctors devote more time to ordinary health problems.

The weakness of the service list as a performance indicator was expressed not only by the staff at primary health centre, but also by central government officials. A top civil servant defined the service list as an “institutional priority of what should be covered”, but not as an instrument that allows to measure what is really being done. The same interviewee spoke about their ignorance of the health problems that centres deal with, due to the weaknesses of performance indicators (“all that is not included in the service list, we know nothing”).

3.4 The effects of the stringent budgets

Stringent budgets have had an effect in the decentralization of responsibilities to primary health centres and in the targets related to pharmaceutical care.

First of all, as mentioned before, the possibility line managers have to recruit short term staff is considered one of the merit of the contractual arrangements. In practice, this autonomy has been curtailed by the stringent budgets. The money available for this matter has not been enough to replace employees’ time off. The result has been more workload for primary health care centres.

Members of primary care centres complain that the initial expectations regarding the decentralization of responsibilities in the contract model has not been realized. Real decentralization would be not only to be able to recruit employees but also decide how many days the centre needs to hire new staff. Given the lack of funding, line managers view the decentralization of responsibilities in the area of recruitment as a burden. They think that in the current economic context the delegation of this issue from the primary care area managers to health centres is a source of conflict.

In addition to the effects on the delegation of responsibilities, the second problem of contracts related to the economic context is that the amount devoted to pharmaceutical care is not enough. This was reported by medical interviewees from the different organizational levels.

In a more general level, other professional groups complain that the discourse around the Welfare State crisis has made savings an obsession. Other issues more related to health care as a public service, such the consideration of pharmaceuticals not so much as expenditure but as another health service have been given up. Some interviewed expressed the view that the pressure on doctors not to spend on pharmaceuticals was having a negative impact on health care quality.

3.5. Contractualism and interorganizational relationships

Interorganizational coordination has been considered a way to improve the efficacy of public services (Nylen, 2007). This concept assumes that public professional are going to cooperate between them and that competition between public organizations will be
replaced by collaboration (Diamond, 2006). In this context, contracts can make collaboration between different organizations easier because they mean a formalization of targets (Nylen, 2007).

The relationship between independent organizations are particularly relevant in health care, especially in a model like the Spanish one, in which primary health care filters the access of patients to specialized care. Furthermore, the traditional rivalry between the two levels of care have rendered the initiatives to improve continuity of care hard to implemente (García et al., 2010)

Spanish health authorities have used the contracts to try improving the collaboration between primary and specialized care. But it is precisely in this voluntary search of agreement where primary health doctors situate the problem. It is not a relationship between equals; specialized doctors have more power and define the rules of the game. This complaint is in line with one of the criticism made to the concept of partnership: it minimizes power fighting and conflict (Diamond, 2006).

4. Conclusions

The economic context in which contracts have been introduced have had a great influence in their implementation. Contracts were designed to make pharmaceuticals expenditure a key component, to the extent that some interviewees consider that the contention of this budget was the main objectives of contractual arrangements. For most of the period of study contracts were only accomplished when expenditure was within the limits. Given the share of pharmaceuticals on total expenditure, central government has been able to determine through the assignment of funds the likelihood of contract accomplishment. At macro level the funds devoted to pharmaceuticals were considered too tight by interviewees, although at micro level some improvements could be achieved in the prescription of more cost effective formulas.

The second requirement to consider contracts accomplished, health activity, shows how the implementation of a certain performance indicator has meant greater centralization. But it is not so much greater centralization that is considered a problem, but the prominence that central health authorities give to an indicator unable to properly measure health activity.

But contracts also have some merits. They have introduced more transparency and more clear objectives. Hence contracts can be helpful instruments to improve public sector management. The problem seems to be the use that government has made of them. Contracts have been too focused on achieving health policy priorities in a short period of time.
References


