

# “There is no better professional motivation than being one’s own master”

Doctor Francisco Carreño is currently president of Lavinia, Sociedad Cooperativa, and of Asistencia Sanitaria Interprovincial, SA (ASISA). President of the Espriu Foundation between 1998 and 2000, he was the first European president, between 1996 and 2000, of the International Health Co-operative Organisation (IHCO).

## **In what healthcare context would you situate the work of Lavinia, the physicians’ co-operative that you preside?**

In that of a permanent and progressive individual and collective concern for improving quality of life and defence capabilities against illness. Health protection is today a recognised right of all citizens in contemporary democratic societies. In the 20th century employment, infrastructure, environmental and education policies were the vehicle which facilitated raising the average standard of living in western societies and as a direct consequence, these policies also raised the level of health in our populations, who today live much longer and in general, in much greater comfort. The development of healthcare systems aimed at attending the population as a whole has become a basic instrument of States for the undertaking of healthcare activities directed at fighting illnesses. To achieve this, the proportion of gross domestic product represented by expenditure on healthcare has more than doubled in the last 30 years in the majority of industrialised countries. But this positive development of healthcare systems has revealed an apparent paradox, introducing future uncertainties.

It would seem reasonable to think that with a bigger and better level of community health, such as that attained in the western world, would come a correspondingly lower level of necessary expenditure on healthcare. But experience has shown us quite the

contrary: a higher standard of living and social and economic development has been accompanied by a considerable increase in budgets destined to cover healthcare needs.

## **How would you explain this paradox?**

Because development produces modifications in the patterns of illness, sometimes radically. Illnesses that are widespread among us nowadays were highly infrequent 100 years ago. Causes of death today are very different from those of the last century because most people in those days did not reach a sufficient age to develop these ailments, nor did they live in an environment like we have now. Furthermore, the possibilities are constantly increasing of applying technological innovations, to extremes that were unimaginable only a few decades ago, to learn about and treat illnesses. We can now make many more people survive more often and longer, and doing so involves using the best means to guarantee more years of life of an improved quality. This is the characteristic demand of the better informed and thus, in relation to their health, more demanding societies, and it unfailingly costs more money.

## **What challenges are presented by this evolution in healthcare systems and society?**

The main challenge is how to confront this steady rise in healthcare expenditure, because we know that, in general, use of the services increases with age. The over-65s tend to use the health service between three and six



Archivo

times more than the population as a whole. Given that the total number of elderly persons is rising drastically, the costs of utilisation will increase proportionately. Although we also know today that the prime factor in these cost increases is related to the influence of scientific progress and advances in the industries involved in the development of medical practice.

**How can the growing necessities of quality healthcare be confronted in the long term?**

This is the crux of the issue and obliges us to analyse the organisational effectiveness of current healthcare systems. This includes aspects relative to the different sources of financing and provision; the dimension and geographical distribution of infrastructures; the incentives or disincentives offered by suppliers and so on. Such analysis must be done making the degree of user-satisfaction the backbone of reforms. This depends, fundamentally, on the facility of access or waiting time to obtain the required treatment, and on the user's personal and obviously subjective perception of the treatment received, which tends to be directly proportionate to levels of freedom to choose and depth of relationship with the professionals who attend to the patient.

The majority of western healthcare systems share some basic, fundamental objectives, which may be summarised in four: one, to guarantee an adequate level of compulsory healthcare provision, financed from public funds; two, to achieve equality of access to the services for all citizens; three, to maintain growth in costs at a reasonable percentage with respect to the country's productive capabilities; and four, to attempt microeconomic efficiency, translated into acceptable results and patient satisfaction, at the lowest possible cost.

**Are there any common tendencies in the design of policies that will allow these objectives to be reached?**

Although the structure of health systems in different countries is diverse, there are some common features in the reforms being carried out. In general, health policies have been directed at finding ways of making public spending budgets and their use more effective. Successive reforms have been applied, starting in the 80s, and as the problems became more complex new revisions were needed throughout the 90s. In countries with a tradition of health services directly financed and managed by the public sector there is a tendency to separate the functions of purchase and provision of services, in order to introduce more public/private competition. Publicly owned supply companies have to compete with private firms for the provision of healthcare. They must be profitable and verify the quality of their results. An attempt is also being made to



Josep M. Ferré

guarantee patients greater freedom of choice, to reduce bureaucracy and encourage the more adequate use of services. In countries where the healthcare service has evolved with less direct public intervention, at the market's discretion, reforms have used the extension of compulsory universal coverage as a mechanism of market regulation and cost containment. To this end they have introduced demands for the fulfilment of agreements (health plans) at a known budget to private insurance companies interested in collaborating. All reforms coincide in considering mixed models as the most ideal, with differing levels of relationship between the public and private sectors. This enables policy-makers to attempt to use the advantages of the market to improve microeconomic effectiveness and to moderate its inconveniences by introducing regulatory criteria established by the Administration, in defence of the general interest of the population. In all cases, in addition to general healthcare policy concentrations, various methods have been introduced to influence the quality and effectiveness of procedures and results in the healthcare sector.

**What procedures have been used to try to achieve this?**

On the offer side, that is to say with the suppliers and services, the requirements to be covered have been delimited, creating technical-professional selection procedures for the incorporation of new technologies and introducing incentives for quality programmes and compliance with quotations. On the demand side, that is

the user, dissuasive procedures have been introduced to prevent the unnecessary use of services. With the exception of Canada, all OECD countries employ some type of co-payment system (payment directly from the user's pocket) when services, both in-house and extra-hospital, are used, in addition to the methods established for payment of pharmaceutical products.

**What is happening in Spain?**

In Spain we have a public healthcare system with universal coverage which is financed from general taxes and attends patients directly through its own wide-ranging network. The National Health System is made up of the health services of those autonomous communities where responsibility has been transferred and by the Spanish health service Insalud in the rest. From the very beginning, with approval of the general law on health, the system's financial difficulties have been the topic of discussion. Cosmetic surgery to heal its debts has been varied and continuous. Looking towards the future, the incidence of

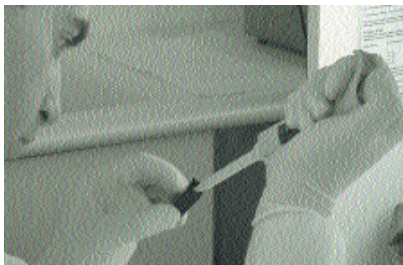
maximum possible performance from the existing ones makes no sense. Decentralising super-specialised healthcare units which are only justifiable on the basis of the volume of cases to be attended to geographical areas whose population cannot generate the necessary number of incidences is ruinous for the general well being of the nation. Not using with the greatest possible intensity the underlying potential in terms of provision of services represented by the experience of economic agents specialised in healthcare management, as is the case of the insurance companies operating in Spain, is a mistake. Maintaining the present rate of new-physician training is absurd.

**What functions can the private insurance sector develop?**

I have already mentioned that at an international level we are trying to achieve a change in the behaviour of the private insurance sector towards greater commitment to equality. It should cover compulsory services without

excluding risk groups, with pre-established economic conditions and rigour in the guarantee of quality of service. This experience already exists in Spain, accredited by decades of service to the very same public healthcare sector. Here, nearly two million people have a

*In Spain, physicians immediately saw the insurance business as an instrument to freely practice their profession.*



Charles Roche

previously mentioned factors will maintain the tension of rising costs and will force the adoption of alternative measures aimed at finding new sources of income. We also have the organisational problems deriving from over-sizing which are well known to all: overcrowding, dehumanisation, excessive bureaucracy and delays. The citizen's perception will continue to show dissatisfaction with the system while his or her degree of freedom within that system will remain constricted.

**What should we do?**

The measures to be taken involve, in my experience, the better use of resources, all resources both public and private, in confronting the problems and working towards a situation of greater balance between the two. It is evidently necessary to co-ordinate planning criteria, as much between local authorities as between these and the private sector, using such positive and negative incentives as may be available. The creation of new healthcare infrastructures, always costly, without first obtaining the

model of healthcare provision financed from public funds which is organised in a way somewhat distinct from the general rule. It corresponds to those who come from the system covering public servants' mutual benefit societies. This system has enabled the mutual societies to organise compulsory healthcare provision for their affiliates by means of agreements, either with the public system itself or with the private sector as the supplier, through health insurance entities that act, in this case, as guarantors and managers of the provision of services. The agreement establishes conditions, as much to avoid any form of risk selection as to guarantee that effective access is granted with no shortcomings in the attention received. Each public servant may, in turn, choose individually, freely and annually from among the entities taking part in the agreement system the centre in which he or she prefers to receive treatment, which will be equivalent to that dispensed in the public sector. For the last 20 years, more than 85% of people with the right to choose have opted for the non-public sector. **F**