Health Policy xxx (2019) xxx–xxx

Contents lists available at ScienceDirect

Health Policy

journal homepage: www.elsevier.com/locate/healthpol

Health Reform Monitor

Public-private partnerships in the Spanish National Health System: The reversion of the Alzira model☆

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ARTICLE INFO

Article history:
Received 22 April 2018
Received in revised form
20 December 2018
Accepted 28 January 2019

Keywords:
Public-private partnership (PPP)
Administrative concession
Alzira's model
Policy reform

ABSTRACT

In the statutory Spanish National Health System (SNHS), the role of public provision is prominent. Nonetheless, since the inception of the SNHS, Regional Health Authorities have also purchased hospital care from private not-for-profit or for-profit providers, usually complementing public provision. Over the years, the autonomous community of Valencia has championed the use of Public Private Partnerships (PPP) in the form of administrative concessions (AC) awarded to private providers. In the La Ribera Health Department, which includes Alzira, the company Ribera Salud held the concession to provide hospital and primary care to the registered population since 1999 - and this became known as the Alzira model. In April 2018, when the administrative concession was expected to be renewed, Valencia's Health Authority decided to terminate the concession and to revert to direct public provision. While most stakeholders - and in particular the left-wing regional government - were in favour of reverting to public provision, advocates of the Alzira model argued that it was superior in terms of productivity, per capita expenditure and quality. The termination of the Alzira model led to further regulatory changes enacted in the Law for Health 8/2018, which clearly states that public provision is the preferred model of service delivery and new (tighter) requirements are defined for any future PPPs aiming to settle in the autonomous community of Valencia. This paper describes the process and provides background information to understand the underlying reasons of this policy development.

1. Purpose of the policy

After decades of Alzira's Model, the emblematic public private partnership (PPP) incepted in 1999 in the autonomous community of Valencia, the current Regional Government decided to reverse the administrative concession (AC) and took on the direct management of the hospital and primary care services provided by 'Ribera Salud', the company who held the AC, and whose capital was owned by the Bank of Sabadell (50%) and Centene Corporation (50%).

The reversion of the Alzira's model (moving from an AC to the original direct public provision) started the 1st of April of 2018, allegedly 'to increase the efficiency and sustainability of the Alzira services', while reinvesting the private revenues obtained by the PPP as a consequence of the administrative concession, and with a view to further develop primary care and home care services.

This policy development might not only have affected the 250,000 lives living in the corresponding health care area (namely, department of La Ribera) but also, eventually, up to other 655,000 inhabitants living in other four health care areas served by 'Ribera Salud' under the same PPP scheme.

2. Political and economical background

In the statutory Spanish National Health System (SNHS), where responsibilities on health care planning, purchasing and provision were fully devolved to the autonomous communities in the early 2000's, the role of public provision is prominent, both in hospital care (more than a 77% of the services are provided in public institutions) and primary care (primary care providers, with few exceptions, are owned by public institutions). Nonetheless, since the inception of the SNHS [1], regional Departments of Health (i.e., the health authority and purchasing body at regional level) have also been purchasing hospital care from private not-for-profit or

☆ Open Access for this article is made possible by a collaboration between Health Policy and The European Observatory on Health Systems and Policies.

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https://doi.org/10.1016/j.healthpol.2019.01.012

Table 1
The chronology of the health policy processes.

Policy measure	Year	Description
National Law on new legal mechanisms for care provision within the National Health System	1997	The law 15/1997, expanded the type of legal mechanisms for care provision, enabling the development, among others, of public private partnerships (PPP)
Regional legislation enacting PPP development	1997	The Autonomous Community of Valencia issued regional legislation mirroring the law 15/1997
Inception of the Alzira PPP	1999	An administrative concession was signed between the Health Authority in the autonomous community of Valencia and a temporary joint venture company composed of RiberaSalud and the insurance group ADESLAS
Alzira's contract extension	2003	Primary care services were included in the basket of benefits provided by RiberaSalud
Regional elections	2015	A new government in office run the autonomous community – following an electoral commitment, the new health authority started the process for the discontinuation of the administrative concession.
Reversion of the PPP	2018, March	The 31 st of March, the administrative concession was finalised, and the Valencian Health Authority reset direct public provision.
Regional parliament approval of a new Law for Health	2018, April	This new Law updated the former 2014 Law for Health. Regarding PPP, the law includes some provisions to reduce the risk of monopoly or dominant positions if eventual new PPPs will set up and provides short-term legal solutions to the labour conditions endured by those health professionals working for administrative concessions.

for-profit providers, generally acting as subsidiary agents (usually, to reduce waiting lists, both for diagnostic testing and surgical procedures, or as part of early discharge programs) [2]. In the late 1990s, new legislation, issued in the Spanish parliament and approved with the vote of conservatives and social-democrats, expanded the type of legal mechanisms for care provision, with a view to better differentiate between the purchasing and the provision roles, in order to increase social efficiency; in turn, mirror regulation in some autonomous communities enacted the development of PPP at regional level [3].

Some regional Health Authorities were strongly supportive to those alternative provision mechanisms, whose governance rules completely differed from the general scheme. So, in the late 1990s, two new provision mechanisms were incepted: 1) primary care 'limited partnerships' (in Catalan, *Entitats de Base Associativa or* EBAs) that still provide care to a registered population according to a contract with the Health Department (i.e. resembling to a certain extent the Clinical Commissioning Groups in the UK National Health Service); and, 2) the PPP, specifically, administrative concessions that provide hospital and primary care to a registered population, namely the population who lives in a health care area (*N.B.:* the health care areas are the basic managerial structure for the delivery of hospital and primary care services in the SNHS what, in practical terms, results in an administrative distribution of the population). While EBAs have been confined to Catalonia and no more have been set up since then, AC experienced some expansion over the last two decades, particularly between 2007 and 2011, under the assumption that AC were able to provide care services more efficiently than providers run under public administration rules [1].

Over the years, the AC of Valencia has championed the use of this kind of PPP, with five health care areas serving the whole resident population of La Ribera (Alzira), Manises, Denia, Elche-Vinalopó, y Torrevieja, representing the 18.7% of the population in the region, almost 900 thousand lives.

3. Health policy processes

Table 1 summarizes the policy process that ended up with the formal discontinuation of the Alzira's administrative concession. There are a variety of underlying factors that could explain the decision of discontinuation. To some extent, the decision of reversion built on an increasing social pressure in favour of public services and against (so said) 'health care privatization', and its translation into electoral commitments of the current parties co-running (or supporting) the regional government. Although relevant, the civil mobilization in a society where the role of third-party for-profit players is a matter of controversy, the partisan arguments, or the concurrent deep financial and economic crisis [4] were not the leading underlying causes of the reversion, but the numerous concerns about the governance and financial achievements of Alzira. Thus, some strong arguments posed by main actors were: a) the absence of real competition in the administrative concession, as just one group presented an offer for 5 out of the 6 bidding processes in Valencia, and just for-profit companies applied [5]; b) the dubious role of regional savings banks and its collusion with political stakeholders [6]; c) the high potential of the regulatory capture observed by external agents [7]; d) the difficulties of a proper contract design and the high transaction costs associated to its effective oversight; and, e) the inappropriate incentives of the concession contract, so that patients' transfers from public providers to the Alzira's hospital were not paid at marginal costs but at average costs, eventually transferring extra-funds from the public sector to the AC [8].

Once the new regional government vowed the reversion of the Alzira's model in 2015, tensions between the Health Authority and 'RiberaSalud' increased. On the one hand, for the company, the reversion implied not only the termination of the contract, but also the loss of a substantive amount of annual revenues (there are no public figures). On the other hand, the basis for liquidation was a matter of dispute; so, the annual per capita (in 2017 the contract amounted for 190 M€ or €777 per capita) [9], had been augmented with additional quantities aimed at covering the cost of patients' referrals from other health care areas; the latest update of the annual liquidations recognized, until 2012, a controversial Health Department's payment obligation of 12 M€ for this concept [10]. Finally, the Company's fear that Alzira's reversion could anticipate the cancellation of the remaining AC in the autonomous community of Valencia, most of them run by the same company, was also a matter of uneasiness. Consequently, the disputes translated into different legal actions against the termination of the contract.

A final milestone in this policy process, concurrent with the termination of the PPP, was the publication of the Law for Health 8/2018, where the regional parliament (namely, *Corts Valencianes*) approved some provisions issuing an unequivocal preference for the use of public governance when it comes to the protection of health and the provision of healthcare services [11].

3.1. Stakeholders' position

When it comes to stakeholders' positions (Fig. 1), they generally showed to be supportive with the reform, in particular the Regional Health Authority, and the left-wing parties backing the

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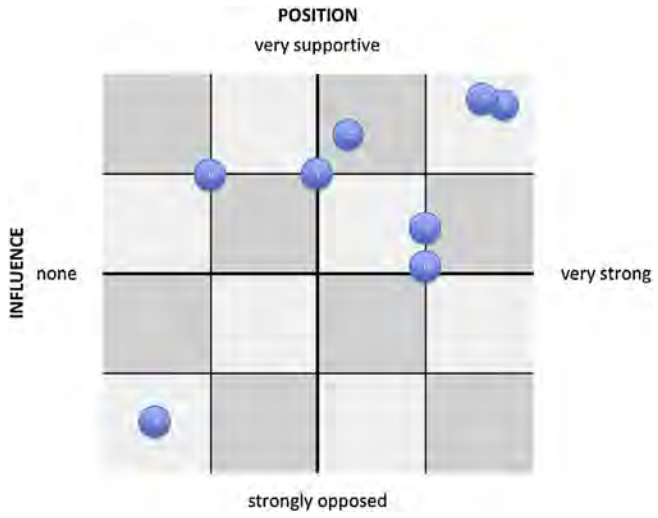

Fig. 1. Stakeholders' position and influential capacity.
Legend 1: Regional Health Authority / 2: Associations in defence of public services / 3: Health professionals / 4: Trade Unions / 5: 'RiberaSalud' / 6: Conservative Party / 7: Left-wing parties supporting the regional government / 8: National Market Regulator.

government. In turn, 'RiberaSalud' and its shareholders were clearly opposing, although their influential capacity, otherwise limited as the concession was actually coming to an end, was diminished because of the successive resolutions by the Courts of Justice. On the other hand, the conservative party (once the strongest advocate of PPPs in the autonomous community and currently opposition party), although opposing, focused on encouraging non-binding motions in those municipalities run under its rule, aiming to preserve La Ribera hospital achievements (e.g., high quality, efficiency and being a reference site). Interestingly, trade unions, that had a limited influence in the decision process, were currently playing a more relevant role while the workforce labour conditions were being revised and the new contract mechanisms put in place. In turn, health professionals in Alzira's premises, passive actors during the process, were getting more –although limited- influential capacity, as their working conditions were currently subject of negotiation. On the contrary, professional and civil groups, who had a critical role prompting the reform beneath the common motto for the defence of the public services, although still supportive, have now a more neutral position as the policy development was eventually implemented.

4. Content of the reform

This policy development did not substantially modify the scope, depth and breadth of the population coverage; nonetheless, the regional government declared its interest in increasing primary care benefits, allocating specific funds to develop home care services and increasing capital investments in high-technology.

Certainly, the new policy rather focused on a change in the governance model of the Alzira's hospital and primary care services (La Ribera Healthcare Area), transforming the private governance model, managed by a for-profit company, into a public management model run under public regulatory prescriptions. However, although the reversion of the AC hardly entailed the termination of the contract between 'RiberaSalud' and the Health Authority of Valencia (contract that, otherwise, had to be renewed -or cancelled- the 31 st of March), new regulation was issued to establish the requirements for new PPPs to settle in the autonomous community. As aforementioned, the Law for Health 8/2018, a general law aiming to update the 2014 Law for Health on prevention and protection, issued some specific articles to avoid monopoly or dominant positions as those seen in the case under debate. In particular, the legal text established, for individuals or entities interested in providing services within the public system of Valencia, a maximum amount of shares or participations (up to a 40%) in the companies benefitted from a public contract. In addition, and with the view to fill in an existing legal gap, the Law also framed how to revise the workforce labour conditions and contract schemes present in the Valencian administrative concessions, whose first application was actually the personnel serving in Alzira before the contract termination. According to this legal text, the Alzira's personnel had to be maintained assuming its original labour conditions under the Spanish labour private legislation; however, this scheme is expected to apply whilst professionals continue serving the institution; once those positions turn vacant (e.g., after retirement), the new regulation provides that they should be transformed into public positions, and covered with public servants throughout the public mechanisms foreseen for any other public provider in the Region [11].

Last but not least, the termination of the contract implied a substantial change in the purchasing mechanisms between the Health Authority and the Department of La Ribera. Thus, the usual annual negotiation of a per-capita amount covering all hospital and primary care services between the Health Authority and the Company, turned into a lump-sum budgeting mechanism to be negotiated between the Health Authority and the, from now on, Alzira's public provider, as in any other health care area in the Region.

5. Expected outcomes

Interestingly, the same arguments were made public by the health authority in 1999 to implement the Alzira's model, namely, 'a PPP will spend less money and more efficiently while providing services with higher quality', were alleged at that time to underpin the political decision of reversion. However, the scarce literature on whether PPP outperforms its public-tenured providers (or the other way round) is consistently inconclusive about the superiority of either alternative [12]. In the Spanish context, four studies have reliably compared Alzira with other SNHS providers. The first study, using 2009 and 2010 data, analysed the differences in costs and efficiency between the 5 aforementioned PPP and the remaining 19 hospitals in the autonomous community of Valencia; authors found that AC were performing better than average, although they did not rank the best in the sample [13]. The second one, focusing on three out of these AC, sought to compare those with the universe of hospitals in Catalonia (where a greater diversity of governance models coexist), using data from 2012 to 2015; authors found no differences in terms of clinical or economic indicators [14]. The third one compared all the integrated providers in Valencia showing that the differences observed in the number of primary care visits and urgent hospital contacts in chronic complex patients were irrespective of the model of governance [6]. In the last one, the largest and most comprehensive study, Alzira's performance was compared with all its potential peers in the SNHS, using 26 performance indicators covering low value care, potentially avoidable hospitalizations, hospital case-fatalities, and technical efficiency and expenditure. In this study, Alzira did not generally outperform those public-tenured providers, although in some areas of care its developments were outstanding [15]. Consequently, the existing evidence would not indubitably favour the political decision (nor the AC continuation), nor allow predictions about the future consequences of either decision.

Conspicuously, professional and civil associations in defence of public services, those supporting the reform, saw the reversion as an end itself (rather than a mean) so that, the contract termination was already assumed as a successful policy.

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6. Overall assessment of the policy

The numerous administrative and financial doubts on Alzira's governance, in the context of a deep financial and economic crisis with a sharp reduction of public spending on healthcare, enabled the alignment of part of the civil society, professionals, and left-wing parties enabling, almost 20 years later, a policy development aiming to reset direct public management in such an emblematic PPP.

Some months after the reversion, a public debate on what should be the role of the public-private mix in a fully devolved SNHS (where less than a 6% of the national GDP represents the public expenditure in health) is yet to occur. Instead of lingering on a Manichean debate on whether public is better than private (or the other way round) the discussion should be built on how regional health authorities should assure effective access to high-quality care while they guarantee that the services purchased are worth the money (i.e., purchasing services that maximize the overall benefit), ensure that the governance of the public services is respectful with social values (e.g., building on a wide social agreement about the role of for-profit entities) and implement the monitoring mechanisms to assess the actual impact of the implementation of public policies. The consequence of not having such a debate might be the reversion of the reversion of the Alzira's model in a few years, when a new political majority leads the regional government of Valencia, turning inevitably back to the starting point.

Funding

This paper has been partially funded by the Instituto de Salud Carlos III through the Research Network on Health Services Research (REDISSEC) grant RD16/0001/0007

Acknowledgments

The authors would like to acknowledge the collaboration of the Atlas VPM research group (http://www.atlasvpm.org) and data authorities who allowed us to access the data used in this study.

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