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The search for low-cost integrated healthcare

The Alzira model – from the region of Valencia

The NHS European Office

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NHS European Office
Rue Marie Thérèse, 21, B-1000 Brussels
Tel 0032 (0)2 227 6440 Fax 0032 (0)2 227 6441
european.office@nhsconfed.org
www.nhsconfed.org/europe

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Executive summary

The challenges facing the Spanish healthcare system mirror those currently concerning the English NHS: an ageing population, rising costs, and increasing demand. Such challenges have propelled managers, clinicians and policy-makers to look further afield for innovative models that deliver efficient and effective healthcare.

The Alzira model, from the Valencia region of Spain, is a pioneering approach to the provision of healthcare through public-private partnership and was subject to an NHS Confederation study visit in March 2011, designed by leading UK and European policy experts. Under this model, the private contractor receives a fixed annual sum per local inhabitant (capitation) from the regional government for the duration of the contract and in return must offer free, universal access to its range of health services.

Implemented in 1999, the Alzira model was originally designed for secondary care only, but the model was extended to cover primary care in 2003. Full integration of healthcare provision hinged on aligning clinical and business directorates and the use of technology across all services. A shared patient record between GPs and specialists is a key ingredient of the model, which relies on a rigorous management culture that expects compliance with procedures and guidelines, uses staff incentives and has a strong performance management system.

This paper reviews the model, in particular from the UK perspective. While many aspects of the model do look attractive, participants on the study visit felt there were some obstacles and issues to be taken into account when considering its replicability into the local NHS context. These obstacles are discussed later in the paper.

It was clear that without the inclusion and clinical integration of primary care into the wider system, this model is unlikely to operate successfully. The importance of clinical integration, supported by incentives, information systems, clear goals and effective management, is key.

However, would it be worth adapting some of its underpinning principles and applying them to the UK context?

Introduction

Like many other health systems, the NHS in England is experiencing unprecedented funding challenges. These pressures are forcing managers, clinicians and policy-makers to look further afield for innovative models that deliver efficient and effective healthcare.

This report identifies one particular model, originating from the region of Valencia, Spain, which purports to be a pioneering approach to the provision of integrated healthcare through public-private partnership.

The Alzira model, a mixed management model, was the subject of an NHS Confederation study visit in March 2011, led by Nigel Edwards, then director of policy and acting chief executive of the NHS Confederation. The purpose of the visit was to see first-hand its evolution, the integration of clinical and business models, its documented outcomes and the political, economic and societal impact on healthcare in Spain. This paper is a report from that visit, and examines the aims and components of the model in light of the current challenges facing the NHS in England.[1]

The study visit

The study visit to Valencia was jointly organised by the NHS Confederation and the NHS European Office, which has well-established links with senior policy and healthcare colleagues from across the EU. Participants included senior healthcare professionals, managers and policy experts from ten different countries across Europe, ensuring a mixture of roles, interests and experiences. The delegation consisted of 28 participants, of whom 15 were from a range of NHS organisations.

The two-day programme was designed by leading UK and European policy experts. These included: Nigel Edwards, then director of policy and acting chief executive of the NHS Confederation; Stephen Wright, Executive Director of the European Centre for Health Assets and Architecture; and Dr Antonio Durán, Director of Tecnicas de Salud, the leading Spanish healthcare industry consultancy.

> 'I found it a very useful visit. I believe it is vital we exploit the contacts within Europe.'
> **Chief executive, NHS trust**

The programme included site visits to two hospitals (Hospital de la Ribera and Hospital de Manises). Participants heard from senior representatives of regional government, the operating company which holds the contract, clinical and managerial employees and policy leads.

> 'As a private sector organisation, this is and will continue to be invaluable information for our use in developing an approach to delivering services to NHS commissioners.'
> **Chairman, UK independent sector healthcare company**

For more information on the visit itself, or to find out about future opportunities to learn from good practice elsewhere in Europe, please visit www.nhsconfed.org/europe or contact michael.wood@nhsconfed.org

> 'The Alzira model is a good example of integrated care, cooperation between public administration and private entrepreneurship and providing healthcare at low cost, which all are current questions in Finland.'
> **Finance director, joint municipal authority, Finland**

Background

The region of Valencia

The region of Valencia is located on Spain's eastern coast and has a population of around five million. The regional health ministry has a budget of approximately €4 billion, around 40 per cent of the region's total budget. It employs around 50,000 people and runs more than 1,000 health facilities.

Figure 1. Map of Valencia region

According to the Spanish 1986 General Health Service Act, each region of Spain is divided into health areas (or departments) which are responsible for the management of facilities, benefits and health service programmes within their territory. Valencia has 24 such areas.

Prior to 1999, health department 11 in the Valencia region – also called the Ribera department – was one of the few without a local hospital, despite a political commitment to build a hospital dating back to 1982.

The demand for local hospital provision, coupled with new legislative powers to involve the private sector in the delivery of healthcare, compelled the regional government to tender for a new public hospital that would provide all district hospital services for the population of their area.

The Spanish national health service and its recent evolution

The 1986 General Health Service Act in Spain established a national health system with 17 autonomous health services. The main principles of the system were:

- universal coverage
- public financing through taxation
- integration of existing health service networks
- political devolution to the autonomous regions
- a new model of primary care with multi-disciplinary teams based in health centres.

While the Ministry of Health and Social Policy in Madrid defines the national legislative framework for the Spanish national health service, each region is required to compile detailed health maps setting out the services that will be provided to its population. Regions have flexibility to raise additional funds for healthcare provision through regional taxation.

Since the late 1980s, a combination of limited budgetary resources and increased public demand, along with criticism that the Spanish national health system lacked efficiency, flexibility and clinical engagement, has forced Spanish health managers and policy-makers to look for new, more efficient management

services that would provide optimum quality at the lowest possible cost. The 1991 Abril Martorell Report – named after the man who headed a commission to evaluate and make recommendations to the health sector – reiterated these challenges facing the national health system and set out alternatives to improve its maintenance and viability. The report introduced concepts such as separating the financing, purchasing and provision of health services, and sought to establish a new legislative basis for the involvement of the private sector in the delivery of healthcare, as long as it remained free and universal.

This new legislative base was enacted in 1994 and 1997, paving the way for the Alzira model and other forms of self-managed hospitals across Spain to evolve.

‘The Abril Martorell Report introduced concepts such as separating the financing, purchasing and provision of health services, and sought to establish a new legislative basis for the involvement of the private sector in the delivery of healthcare, as long as it remained free and universal.’

The Alzira model

In looking for improved managment arrangements, a number of new models of healthcare emerged in Spain under the decentralised Spanish health system.[2]

The Alzira model is a public-private partnership model which takes its name from the town in Valencia where the first Spanish public hospital (Hospital de La Ribera), managed under what is referred to as an administrative concession, was built in 1999. This pioneering model is based on four fundamental pillars: public ownership; public control; public financing; and private management.

Key principles of the Alzira model

- A single, integrated provider with responsibility for almost all care provided to the population – the diagnosis-related group (DRG) tariff is only used to make payments for patients treated outside the network.
- Integrated working between primary and secondary care, with primary care doctors being an integral part of the system. The incentives for primary care doctors and for the other parts of the system are aligned to ensure that work is carried out in the most appropriate place.
- Systematised clinical work linked to strong incentives for clinical staff to follow the pathways and operating procedures.
- A unified information system and good links to external data. This reduces transaction costs and ensures that clinical decision-making is always informed by reference to the patient's full history and prescriptions. This, and the use of a common pathway, also reduces the risks of duplication. The system also allows for detailed management of clinical processes and accountability for individual clinicians.
- Professional management with delegated responsibility, including for profit and loss.
- Using networks to provide diagnostic support rather than replicating these in each site.
- External performance management on outcomes but not on the details of processes, inputs and periodic procurement.

Developing the model

The development of the Alzira model took place over two stages. Originally, it was only envisaged that the model would cover the delivery of care at Hospital de La Ribera, but soon after the start of the project, for various financial and other reasons, the decision was made to extend the contract to cover primary as well as secondary care. A fresh approach was designed with the overall health needs of the population in mind, partly to avoid problems with cost shifting between primary and secondary care.

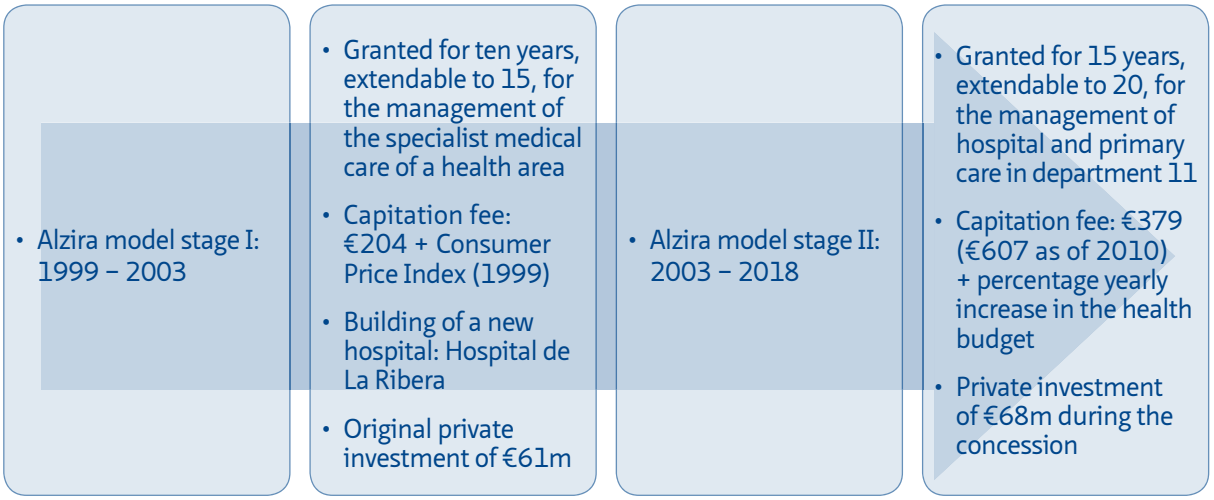
The new organisational model was initiated in 2003, with the existing private contractor assuming responsibility for delivering healthcare in both primary and secondary settings. The capitation budget for the population, which was already being used, was extended accordingly, with most of the associated risks transferred.

The resulting administrative concession contract was the first of its kind, differing from previous public-private partnerships by taking responsibility for a population's full-service healthcare provision.

The Hospital de La Ribera is a 300-bed hospital, offering a comprehensive range of services. There are 260 single rooms, 22 ICU beds, ten psychiatric beds and 13 surgery rooms. It also runs 40 public primary care health centres.[3]

'The administrative concession contract was the first of its kind.'

Figure 2. The two stages of the model



Source: Ribera Salud

Benefits of the model at a glance

Ribera Salud, the health management holding company running the Alzira model, has cited the following benefits of the model.

For patients:

- a higher level of privacy and comfort, resulting in more personalised treatment
- greater accessibility and a quicker response time
- a choice of hospital and doctor
- technology at the service of the surgeon.

For professionals:

- stable employment with an innovative payment system
- opportunities for development and for pursuing a professional career
- opportunities for teaching and research
- working in an environment with a strong commitment to technology.

For regional government:

- public management at a lower than average and relatively predictable cost
- investments paid for by the concessionaire during the management period
- capitated payment with financial risk transfer
- innovation in management technologies and systems
- contribution of complementary human resources.

The capitation system

One of the novel aspects of this model is the payment by capitation system, which applies to all the hospitals operating under this model across the region of Valencia. An annual public expenditure budget is assigned by the region to each area health department, according to population and the range of services provided. A comparison of the cost per inhabitant in the region of Valencia and the areas covered by the model (in Euros) is shown in Figure 3. This budget does not include the cost of some services, such as extra hospital pharmaceutical prescriptions, prostheses, oxygen therapy and medical transport services.

The principles behind the capitation system are:

- the private contractor receives a fixed annual sum per inhabitant for the duration of the contract
- the annual fee rises in successive years in line with the region's public health budget increase[4]
- in return, the company runs the health department and must offer universal access to its wide range of services
- the annual fee has to cover all the expenses needed to provide the service, including amortisations, payroll, consumables and utilities
- annual cost for the Valencia community and La Ribera management is fixed (subject to inflation) and can be forecast with reasonable precision.

'The 2003 revision of the administrative concession sought to ensure that profits were shared between contractor and community.'

Ensuring financial stability

The 2003 revision of the administrative concession sought to ensure that profits were shared between contractor and community. Under this revision, the hospital retained profits of up to 7.5 per cent of turnover, with profits exceeding this limit being returned to the local government. This was a means of ensuring financial sustainability for both parties.

Under the model, if patients are treated in hospitals outside the area, the Hospital de La Ribera assumes 100 per cent of the cost, based on the relevant tariff. In contrast, public hospitals in other parts of the Valencia region not using this model do not lose money if their patients go elsewhere. However, as a disincentive to the hospital for using its capacity to treat patients from elsewhere, in such cases the hospital is only reimbursed 80 per cent of the cost (priced per diagnosis-related group (DRG)) per patient.

Figure 3. Capitation costs

	2006	2007	2008	2009	2010
Cost per inhabitant for the wider region of Valencia	€659.53	€731.11	€780.96	€811.74	€824.64
Annual fee paid to the contractor per inhabitant	€494.72	€535.39	€571.90	€597.64	€607.14
Difference	**25%**	**27%**	**27%**	**26%**	**26%**

Source: Ribera Salud

The transfer of risk

The particular public-private partnership in this administrative concession model operates as follows.

The construction phase

At this initial stage, investment needs are very high, for hospital development at least. Therefore, the budget of the regional administration is relieved of this initial cash outflow. The private bidder usually opts for a turn-key construction contract. Any deviations in the construction project are the responsibility of the bidder (the primary 'Special Purpose Vehicle' contractor). Once the concession period expires, the hospital is returned to the regional administration as it will then be their property.

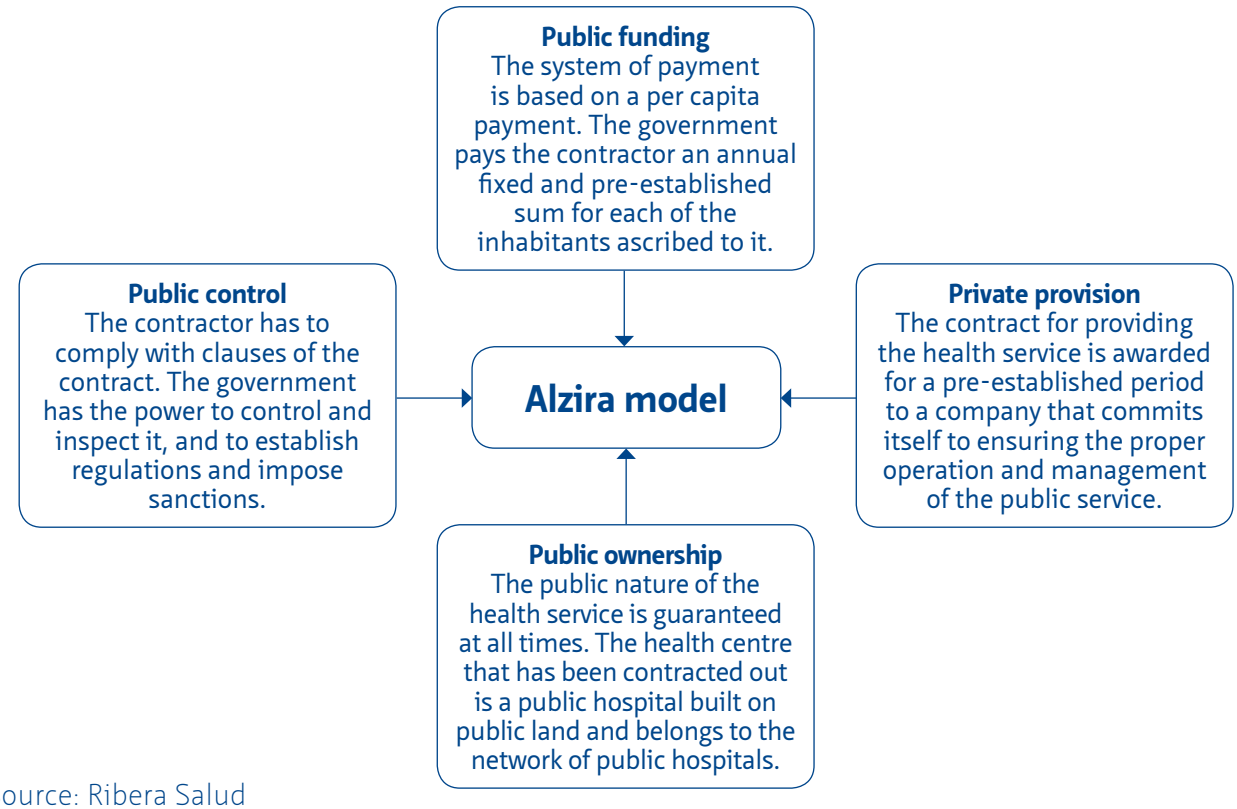
Investment in equipment

The bidder will undertake investment in all necessary medical and non-medical equipment. The investment plan has to be approved by the regional administration at the initial phase and then again every five years. Once the concession period expires, the equipment also becomes the property of the regional administration.

Cost of providing health services

The cost of providing health services to the population is lower for the regional administration under this concession scheme. For example, in the region of Valencia, the costs per inhabitant, paid by the local authority to

Figure 4. The keys of the model



Source: Ribera Salud

the contractor, are reduced by around 25 per cent from the costs per inhabitant prior to the concession contract. They are also lower than comparable areas within the region, and across Spain more generally.

'The cost of providing health services to the population is lower for the regional administration under this concession scheme.'

Growing the model across Valencia and beyond

While the Hospital de La Ribera was the first public hospital to use this model, over 20 per cent of the Valencia region is now covered by similar contracts, with the model also used in an area of Madrid. Within the model, all the hospitals are managed by the Ribera Salud Group, the health management holding, and are shown in Figure 5.

Figure 5. Hospitals of the Ribera Salud Group

	No. of beds	Population allocated *	Investment **
Hospital Universitario de La Ribera	300	250,000	€140m
Hospital de Torrevieja	264	180,000	€ 90m
Hospital de Denia	222	160,000	€ 97m
Hospital de Manises	220	200,000	€ 137m
Hospital de Vinalopó	212	150,000	€ 146m
Hospital de Torrejón	250	140,000	€ 130m
TOTAL	**1,468**	**1,080,000**	**€ 740m**

* According to the Population Information System (SIP)
** Investment planned for the 15 years of the franchise except Torrejón (initial investment)

Source: Ribera Salud

Vertical integration – aligning the clinical and business models

Extending the first-stage model to cover primary care alongside secondary care, while delivering improved functions and medical processes, presented a real challenge. Crucial to this development was the need to embed a new patient-centred corporate culture across the model.

The clinical directorate at work

Hospital doctors and many GPs working within the Alzira model are employed by the operating company rather than the public sector or civil service as is usual in Spain's public hospitals. They are salaried employees within a clinical directorate, organised by clinical coordinators who manage outpatient and inpatient activities, on-call duties, holidays and operating lists. The coordinators are also responsible for arranging the support services necessary to achieve the clinical and non-clinical objectives determined by each medical director. Together with the medical director, the coordinators represent the doctors' interests to the hospital board. The Hospital de La Ribera has a continuing medical education programme, overseen by a medical training commission.

Medical salaries have both fixed and variable components. For hospital doctors, the fixed component amounts to 80 per cent and the variable component to 20 per cent, while for GPs the split is 90 per cent to 10 per cent. The variable part of the earnings relates to on-call payments and incentives, a number of which concern access targets. Incentives (which are in the range of €6,000 to €24,000 per year) are negotiated with the medical coordinator and linked to specified and quantified goals. Salaries are negotiated between the hospital's medical board and trade unions. In Spain, public sector wages for physicians vary according to region.

'The private salaries negotiated within the Alzira model tend to be above the Spanish average for public sector health wages.'

The private salaries negotiated within the Alzira model tend to be above the Spanish average for public sector health wages, when both the fixed and variable components are taken into account.

Facilitating the integration

New working methods were implemented during the second stage of the administrative concession to facilitate the necessary integration of primary care services. These are outlined below.

Medical link

A consultant physician is attached to each health centre, working with the same patients as the GP. This link is designed to implement clinical guidelines with the local GPs, resolve medical problems in the health centre, and reduce the number of inappropriate hospital referrals.

Integrated primary care centres

These seek to enlarge the scope of some of the health centres, with onsite x-ray services, accident and emergency departments, and medical specialist outpatient clinics. The aim is to bring medical services closer to patients.

Integrated medical care pathways

These attempt to streamline the management of health problems, from prevention through to palliative care, including acute care, rehabilitation and chronic care.

The role of technology

From the outset, the hospitals using the Alzira model identified the innovative use of information and communications technology (ICT) as an essential tool for effective integration of services. Hospital de La Ribera was the first public hospital in Spain with a fully integrated, computerised medical history system, including nursing and medical notes, test results and imaging. The principles shaping the use of technology were that:

- IT should be global, integrating all the activities of the hospital, and should be designed with full integration in mind, based on health standards
- doctors should be able to access data from any location within the health area. By linking the hospital's IT system to that of the local government health department, doctors can access data for patients from any other health area directly from the hospital
- technology should support the medical care received by patients, improving its quality and speed. For example, digital screens in the hospitals highlight all departmental waiting times
- economic and financial data should be fully integrated within the healthcare system.

'A free access policy was implemented to attract patients to the Hospital de La Ribera, given that management must pay when patients in the health department are treated elsewhere.'

The patient's perspective

Although the patient follows the contract, under the Alzira model they are free to go elsewhere to receive healthcare. Its hospitals are therefore incentivised to maintain high standards in order to inspire loyalty in patients and also place a large focus on disease prevention and health promotion. A free access policy was implemented to attract patients to the Hospital de La Ribera, given that management must pay when patients in the health department are treated elsewhere.

What the policy offered

- free access to medical specialties, without – initially at least – any gatekeeping function by primary care, in order to achieve patient loyalty
- a choice of medical specialists and hospitals
- a wide range of outpatient and elective surgery time slots – from 08:00 to 21:00 (most Spanish public hospitals do not provide clinical services after 15:00)
- short waiting times (less than two weeks) in its outpatient department, less than 90 days' wait for elective surgery, and an efficient accident and emergency department.

This policy also attracted patients from other health departments with longer waiting lists, with the cost of their care being charged to the respective local government, subject to the 80 per cent cap. After seven years of free access to specialist care, the system was changed to restore the role of GPs as gatekeepers to hospital care, although – perhaps surprisingly – there has been no major change in demand levels.

Outcomes

According to the terms of the administrative concession, the hospitals using the Alzira model have to meet a series of targets set by the Valencia government and listed in annual management agreements. These targets cover a wide range of quality and safety objectives, including: process indicators (for example, waiting times and clinical activity); clinical outcomes (including immunisation and mortality rates); and patient experience (such as satisfaction and involvement in care, and the number of complaints handled on time).

Making a difference

When compared to the non-Ribera Salud hospitals in the Valencia region, the results achieved by those using the Alzira model are impressive, as can be seen in Figure 6.

'Satisfaction surveys indicate that it has been effective at retaining patients and absenteeism among staff is well below the national and regional average.'

The model is also viewed favourably by patients and staff. Satisfaction surveys indicate that it has been effective at retaining patients, a key prerequisite of the model. Similarly, absenteeism among staff at the La Ribera hospital is less than 2.5 per cent, well below the national and regional average.

Figure 6. Activity results, Ribera Salud hospitals vs. other hospitals in Valencia region

Example indicators	Ribera Salud hospitals	Valencia region hospitals
External consultation delay	25 days	51 days
Average surgery delay	34 days	60–90 days
CAT delay	12 days	90–120 days
MRI delay	15 days	90–120 days
Readmission within three days (per 1,000 discharges)	4.05	6.1
Patients' satisfaction (0 to 10)	9.1	7.2
Electronic case history use (hospital)	100%	20%
Major day surgery	56%	43%
Outpatient surgery rate	79%	52%
Caesarean rate	22%	25%
Average hospital stay	4.5 days	5.8 days
Minor emergency	9%	20%
Emergency waiting time	Less than 60 minutes	131 minutes
Emergency response time	4 hours	No measure

Source: Ribera Salud

The future of the model – a third stage?

The challenges facing the Spanish healthcare system largely mirror those currently concerning the English NHS: an ageing population, rising costs, and increasing demand. Issues that will affect the evolution of the model are examined below.

Leading through the political uncertainty

By passing responsibility for healthcare delivery to autonomous regions, the Spanish government affirmed the link between local political decision-making and the Spanish health service. The Alzira model originated in a region notable for the electoral success of the conservative Popular Party, which has long supported a more diverse provision of public services. Other political parties have publicly opposed such changes in provision and the Alzira model itself, although it is unclear what would happen if there was a change of local government, given the duration of the administrative concession's contract. It should also be noted that the severe economic situation facing Spain and its health service could lead to funding cuts following the recent election of a new government.

A revision to the contract model

Given Spain's ageing population, one possible change to the model involves the integration of social care into the capitation sum, which would presumably alter the funding model significantly. This evolution of integration could represent another pioneering model for funding the health and social care services of the 21st century.

The composition of funders

While the levels of government payment for the levels of healthcare provision are clearly laid down, there are challenges for the holding company responsible for managing this model. Recent changes to the legal framework of the Cajas de Ahorro (local banks) have restricted the financial support Spain's social banks can provide, and pushed Ribera Salud to look for potential new partners.

Using patients as the driver

Given the importance of patient loyalty to this model, it is important that local citizens understand its evolution. Ribera Salud says it will be ensuring the local population is kept informed as the model adapts, including on its changing processes, the health outcomes it achieves, and the associated costs involved. This places significant emphasis on fully involving patients in governance and decision-making processes, and educating them to take responsibility for their own care.

Virtual, not just vertical, integration

Ribera Salud have been looking for some time at ways of making the organisation more virtual and less structural, by capitalising on their innovative use of ICT. They aim to offer a complete service portfolio in situ to patients in conjunction with other non-concession suppliers.

Moving from staff mix to skill mix

A new professional leadership approach, building on and reshaping Ribera Salud's corporate culture, would re-evaluate the skill mix across clinical and non-clinical staff, with an emphasis on clinical governance. There will also be more focus on sharing risks with the medical staff, through incentive schemes and the purchasing of services.

'Given the importance of patient loyalty to this model, it is important that local citizens understand its evolution. This places significant emphasis on fully involving patients in governance and decision-making processes, and educating them to take responsibility for their own care.'

Can the model work in the UK?

Nigel Edwards, who led the study visit, has provided his policy insight into whether the model could work in the UK. He argues that while many aspects of the model certainly look attractive when viewed from a UK perspective, there are some obstacles and issues to be taken into account. These are discussed below.

A different approach for commissioners

The Alzira model requires commissioners to take quite a different approach to their role. In this model, the commissioner confines the contract to the specification of outcome measures and only a small number of process measures. The formal powers of the commissioner to direct the provider in detail are much more limited than is the case in the UK. This might be an issue in the NHS, where the habit of using the contract to direct providers on not just what to do but how to do it, is ingrained.

Potential for regulatory capture

Study visit participants were concerned that to a certain extent the representatives of the Valencia community administration were very close to the concession holders, which could reduce the effectiveness of the oversight they were providing (regulatory capture). We also had the strong impression that the detail of the contractual relationship was rather more negotiable than UK public administration may be comfortable with. This has some positive aspects, and the concession holders clearly had a lot of flexibility in being able to adapt their services. The way that UK public-private partnership contract law works tends to require all small changes to be made as contract variations – the Spanish model seems less rigid.

'Without the inclusion of primary care and its clinical, managerial and cultural integration into the wider system, this model is unlikely to operate successfully. The information systems are central to this model and it is difficult to see how it could operate without them.'

Nature of the UK General Medical Services contract

Because Spanish GPs are employees, it has been much easier to incorporate them into an integrated clinical model. In the UK model, the fact is that some tasks which the wider delivery system might undertake are embedded in the Quality and Outcomes Framework or are part of core general practice. This means either a difficult, if not impossible, negotiation or effectively paying twice for this type of care: once to the practice and again to the new service.

Challenging the provider landscape

A further feature that might be a problem in an NHS setting is the extent to which the model is likely to squeeze out all other providers. Social enterprises, charitable providers and other niche services could easily find themselves fatally squeezed by this model. In a UK setting, the model would probably need to be challenged to offer a range of suppliers for a number of areas where choice is important. For example, the budget holding organisation could be mandated to offer a range of competing services in areas where different styles of service are required or where performance is poor and higher levels of choice are required.

Study visit insights

The conclusion from our visit is very clear: without the inclusion of primary care and its clinical, managerial and cultural integration into the wider system, this model is unlikely to operate successfully. The information systems are central to this model and it is difficult to see how it could operate without them.

The lower cost of operation between the concessions and the other areas of Valencia (and Spain) is striking and it seems reasonable to suppose that some of this comes from integration and the emphasis that capitation puts on cost-effective management and early intervention for some conditions, and more conservative treatment for others.

The use of information, better organisation and more rigorous management of care and staff must also play a role. As with systems of this sort in the USA (health management organisations) there may also be a confounder that this approach to practising medicine, and the culture of accountability and use of pathways, may attract certain types of staff who also contribute to improved performance. There is also a possibility that the usage in Alzira was lower before the hospital was built due to the impact of distance on access, and that some of this habit of lower hospital use has persisted.

Disentangling these effects is difficult and means there are risks that these benefits may be hard to replicate without great care applied to the framework. The lack of a legacy of a large, expensive and unsuitable estate is also undoubtedly a significant advantage.

'The importance of clinical integration, supported by incentives, information systems, clear goals and effective management, is key.'

Experience shows that many claims that services are integrated are based only on structural measures. They do not consider the importance of integrating systems, processes and culture, and often clinical care and the internal arrangements of organisations claiming to be integrated are silo-based and fragmented, with few behaviours evidencing integration. The Alzira model did not seem to have this problem at first sight, although further investigation is needed to confirm this.

The outcome measures quoted are impressive but only cover a narrow aspect of the performance of the system. A more rigorous investigation is needed across a wider range of indicators.

It would be worth some of the principles that underpin this model being adapted to the UK context. The importance of clinical integration, supported by incentives, information systems, clear goals and effective management, is key. Structural integration has undoubtedly been important in supporting the model but it is only one part of a complex mix of measures which have developed over time. Time is key; these are difficult models to create and significant change management projects.

Nigel Edwards was the director of policy and acting chief executive of the NHS Confederation at the time of the study visit.

References

1. The programme for the visit and the presentations given can be accessed on the NHS European Office website **www.nhsconfed.org/europe**
2. There are five different models of self-governed hospitals in Spain, including the Alzira-style administrative concession. These include public healthcare companies (public law entities), public healthcare foundations (state-owned), foundation hospitals and consortiums. More information on these can be found in the recent European Observatory on Health Systems and Policies publication, *Governing public hospitals*, edited by Richard B. Saltman, Antonio Durán and Hans F. W. Dubois.
3. Hospital de La Ribera: **www.hospital-ribera.com/english/index.htm**
4. In the original first phase (hospital-only) of the model, indexation was by Consumer Price Index (CPI). This presumably left the contractor too vulnerable to excessive healthcare cost rises. In the second phase, indexation was connected instead to the annual increase in the Valencia Region's health budget.

Further information

NHS Confederation (2006), *Building integrated care: Lessons from the UK and elsewhere.*

NHS Confederation (2010), *Where next for health and social care integration?*

NHS Partners Network (2011), *A positive partnership – the independent sector and the NHS.*

NHS Confederation (2011), *Remote control: The patient-practitioner relationship in a digital age.*

All are available at **www.nhsconfed.org/publications**

The search for low-cost integrated healthcare

This paper examines a pioneering approach to the provision of integrated healthcare through public-private partnership; the Alzira model from the region of Valencia, Spain. The model was the subject of an NHS Confederation study visit in March 2011 to see first-hand its evolution, integration of clinical and business models, documented outcomes, and political, economic and societal impact on healthcare in Spain. This paper is a report from that visit, and examines the aims and components of the model in light of the current challenges facing the NHS in England.

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NHS European Office

Rue Marie Thérèse, 21, B-1000 Brussels
Tel 0032 (0)2 227 6440 Fax 0032 (0)2 227 6441
european.office@nhsconfed.org
www.nhsconfed.org/europe