

Conference

**Improving primary care in Europe and the US:
Towards patient-centered, proactive and coordinated systems of care**

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**Country Case Study Spain:
Primary care in Catalonia**

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1 Summary

The definition, development and organization of primary care services are acceptably homogenous across Spain. Under a decentralized National Health System scheme, primary care is the main entry point to access public health services and is underpinned by Alma Ata's attributes (accessibility, continuity, longitudinality, quality and efficiency) and includes preventive and curative care, promotion and health education.

A total of 15 to 20% of health care expenditure is allocated to finance primary care services. The main form of contracting is through retrospective budget with the exception of the Catalan contracting system introduced in the mid 90s, which is mainly based in adjusted capitation and includes a variable part upon goal fulfilment. Health professionals practicing in primary care are paid basically by salary either in a civil servant type of contract or a private labour contract, a professional bureaucracy in Mintzberg terms.

Primary care is organized in teams of practice that include general physicians (GP), paediatricians, dentists, nurse and social care practitioners, nursing aids and administrative staff. As part of primary care but distinct from this team composition are a set of support services such as women health, rehabilitation, radiology and some medical specialties that visit in primary care centers.

Even though patients value primary care services as outstanding, the main drivers for reform in primary care are coming from professional dissatisfaction with the current model. The shortage of some professions such as GPs, paediatricians and to some extent qualified nurses, jointly with demographic and epidemiologic pressures resulting from immigration and ageing are pressures to reform primary care. These are too the challenges for those that are responsible for managing primary care.

This report presents the situation of primary care in Spain through the case of Catalonia as it was the first community in managing devolved health competences and as it represents the edge from an innovation point of view.

2 Macro level

The decentralization of the Spanish Health System into regional autonomies started in 1981 and was finished in 2002. Table 1 shows the main characteristics of the Spanish health system whereas table 2 shows the competencies of both the central and the autonomous government.

Table 1. Characteristics of the Spanish national healthcare system

Health system characteristics
<ul style="list-style-type: none"> • Funded by taxes • Decentralized to regional autonomies • Universal coverage • Free access • Very wide range of publicly covered services • Co-payments for pharmaceutical products • Services provided mainly in public facilities • Sustainability and funding system under discussion

Table 2. Health system decentralization

	Competencies
Central Government	<ul style="list-style-type: none"> • Basic legislation and coordination • Financing • Minimum package funded through NHS • Pharmaceutical policy • International health policy • Educational requirements
Autonomous Government	<ul style="list-style-type: none"> • Subsidiary legislation • Public health • System's organizational structure • Accreditation and planning • Purchasing and service provision
Local Government	<ul style="list-style-type: none"> • Public health: inspections, hygiene

Catalonia was the first autonomous community in Spain to take on healthcare responsibilities in 1981. The existing network of public and private providers served as a basis to create a health system which splits the financing and provision functions. In this model, the Department of Health sets up the health policy and draws up the health plan. The *Servei Català de la Salut* (Catsalut), a public entity de-concentrated into Health Regions, purchases healthcare services from autonomous providers with diverse ownership: consortia, public enterprises, municipal and private foundations) and from

the *Institut Català de la Salut* (ICS), the main public provider of health services, that directly depends on the autonomous government and is financed by a global budget.

The population of Catalonia is about 7.200.000. The life expectancy is 80 years. The department of health represents 32.5% of the total autonomous budget. We spend 50% of our budget on hospital services, 21.5% on drugs, 16.5% on primary health care services, 3% in convalescence and long-term care, and slightly less than 3% on mental health services. The per capita public expenditure in 2006 was 1119€ the forecast is to achieve 1500€ in 2011. Table 3 shows selected health care data.

Table 3. Healthcare data (2006)

Total beds available:	4.9 (per 1,000 inhabitants)
Beds in Acute Care:	2.3 approx. (per 1,000 inhabitants)
Medical Doctors:	4.7 (per 1,000 inhabitants)
Per capita expenditure:	1,118.69 Euros / inhabitant
Discharges	123.5 (per 1,000 inhabitant)

2.1 Primary healthcare organisation

Primary health care is citizens' first level of access to the health care system. Primary health care services are available at the primary health care center (CAP), where teams of health professionals work (physicians, nurses, paediatricians, dentists and social workers). Primary health care pursues to integrate preventive and curative health, rehabilitation and community health promotion in a balanced manner. If a patient requires medical attention outside the regular opening hours of its CAP, s/he should go to the nearest continuous attention center (CAC). CA centers provide primary health care 24 hours a day. Patients can request a home visit by calling their CAP or the telephone 061 if their health is such that they cannot get to their CAP. When patients want to make an appointment they can call by phone to the CAP or they can schedule visits over the internet. For those patients with invalidating chronic diseases home visits are regularly appointed by health care teams.

The specific feature of the Catalan Health System (Catsalut) is its great diversity of suppliers and providers in the several lines of healthcare provision. In primary care, the *Institut Català de la Salut* (ICS) is the most important supplier (80% of the total) while the remaining suppliers are non-profit organisations. Thirteen primary care centers (PCC) out of the 354 health areas are owned by a private firm created by doctors who work within the health areas. Of the 61 acute care hospitals of the Catalan Health System, only eight belong to the ICS; ownership of the rest being distributed between public companies, municipal authorities, and non-profit organisations.

2.2 Contracting process

The remit of the Catalunya is to regulate the relationship between the healthcare administration and the suppliers. This relationship is composed of a series of contracts between the different lines of service (inpatient care, ambulatory care and emergency care) and each one of the suppliers. Although not strictly necessary, the formalisation of different performance-related contract programs is agreed with ICS according to the same framework as the rest of the healthcare network so as to establish bases for comparison of effectiveness and quality. For the rest of suppliers, the contract with the Catalunya is via a system of service purchasing, but with the peculiarity that the type of agreement is different within each line of service.

Currently, the contracting-out of primary care is based on a capitation-based budget allocation adjusted for factors such as age, gender, population, geographical dispersion, and proxy indicators of the income level of the area. 5% of the total budget is related to the achievement of health goals such as, in the main, the promotion of health and the prevention of disease (table 4).

Table 4. Primary health care in Catalonia: types of providers, contracting conditions and services covered

Types of providers:	<ul style="list-style-type: none"> • Institut Català de la Salut (ICS) • Other providers: <ul style="list-style-type: none"> - EBAS (Entitat de Base-Asociativa (Private, for-profit enterprises run by a team of doctors and nurses who care for a defined population) - Integrated providers - Independent providers
Contracting conditions:	<ul style="list-style-type: none"> • All providers sign the contract objectives • Resource allocation to ICS is really through the budget set in the parliament • Resource allocation to other providers depends on the contract
Services covered:	<ul style="list-style-type: none"> • General medicine, paediatrics, nursing & care to the elderly • Dental care • Health Promotion and Prevention • Community healthcare • Training & research • First level emergency care
Payment mechanisms:	<ul style="list-style-type: none"> • 95 % fixed, paid monthly and 5 % variable subject to objectives' attainment paid at the end of the year.

The purchase of hospital-based services is based on the activity of the different lines of care and which are, essentially, three: inpatient care, ambulatory care and emergency care. Hence, for inpatients, for example, the Catalunya pays the hospital an amount for each patient on discharge based on patient case-mix of Diagnostically Related Group (DRGs) and structure (by applying a relative structure index). In outpatient care and emergency care lines of activity, the payment is based on activity and according to the structural level of the hospital which is defined ad hoc.

2.3 Policies to promote better cooperation and coordination between providers

Two strategies at the macro level are being implemented to foster better coordination and cooperation between providers of health and social care. The first is related to funding of services and a new system of *population-based purchasing* is already in place in many areas of the country. The second is related to administrative organisation: we are promoting health territorial governments with the objective to create a *stable collaboration body* among the Regional Government (Department of Health and the Department of Social Welfare) and Municipalities.

The current purchasing system has positive elements. There seems to have been a considerable increase in cost-consciousness. There appears to be also a wide agreement that splitting the purchaser role from that of the provider has proved to be broadly successful and should remain in some form. At the very least, the contracting process probably has forced some greater clarity into the interchange between the Catalan Health Service and providers as to what should be provided, for whom, to what standard, and at what price.

The current system for purchasing of services does, nevertheless, have its critics. It does not encourage co-ordination or collaboration between suppliers. The diversity of payment systems occasionally causes conflicts of interest between suppliers. For instance, a program that induces improvements in the capabilities of the primary care sector would result, almost by definition, in income reduction of the secondary and tertiary care reference hospitals because of a potential reduction in hospital-based activity. Conversely, less control in primary care of patients with chronic disease would result in greater activity in the hospital-based inpatient care.

Furthermore in the early nineties the focus was on competition. There certainly was a degree of competition, particularly for the provision of elective surgery or new services and in conurbations with a concentration of hospitals. However, in many parts of the country, particularly outside the networks of urban communities, Catalunya had little choice among alternative providers. Moreover, although providers had certain freedoms of action concerning pay, skill-mix, and service delivery, they had to conform to central guidelines concerning pricing and investment. Health authorities increasingly moved toward negotiating long-term agreements with their providers, using the purchasing process to plan the configuration of local services.

Most patients can choose their own general practitioner (although few do), but no one could change his or her health authority, and in turn choose their hospital, except by moving. As a consequence, the opportunities for competition between them are highly restricted. Further, many hospital (or trust) incomes are heavily dependent on their local health authority. Hence, authorities cannot switch providers easily without destabilizing them. Also, because both central and local politicians are acutely sensitive to the political costs if a local hospital were to close, authorities often are instructed by the central government to bail out hospital in financial difficulties.

A *new system of population-based purchasing* is being implemented which attempts to pre-empt these situations by placing the emphasis on achieving cooperation and coordination of health providers. Catsalut started in 2001 a pilot test of a capitation payment system to contract integrated healthcare in five areas of Catalonia. The general objective was to improve healthcare equity, continuity and efficiency through the promotion of territorial alliances among providers.

Catsalut purchased a range of health services for a geographically defined population from the providers in the territory that in exchange received a capitation payment – Catalonia per person expenditure adjusted by a correcting factor (variables of need). The formula used allowed purchaser and providers to share the risk for expenditures on prescribing, ambulance services, and hospital care outside the territory (high technology) in order to lessen the capitation payment risks. All providers and the purchaser signed a co-operation agreement in which providers accepted to hold responsibility jointly for a percentage of deviation on the items previously mentioned.

The manner in which government regulatory and administrative functions are structured and devolved can help eliminate program complexities, streamline eligibility and access, and better manage system resources. In this area we are promoting health territorial governments: the objective is to create a *stable collaboration body* among Regional Government (Department of Health and the Department of Social Welfare) and Municipalities. The legal status will be a consortium.

2.4 Evaluation

Catsalut as a purchaser evaluates each year the health objectives contained in the health contracts in all primary health care teams. Depending on the level achieved by the health team they obtain the 5% of the budget related to these objectives. Furthermore external evaluations embracing structure, process and outcomes of different types of providers (ICS, other non-profit organizations and EBAs) have been performed, the last in 2006. The results of these evaluations are benchmarked among providers but are not publicly disclosed to the citizens.

Every three years Catsalut evaluates the satisfaction of the citizens with the services received. These results are publicly disclosed to the citizens. Table 5 shows the results in the year 2007.

Table 5. User satisfaction survey results (2007)

Question	Primary care	Hospital care	Long term care
Have you received understanding explanations?	92.3%	93.1%	83.4%
Has the time devoted to attend you been sufficient?	86.8%	88.0%	78.5%
Do you trust the person treating you?	91.3%	97.4%	95.3%
Have you been given contradictory information?	95.4%	96.9%	97.5%
Did you receive a proper attention from the physician?	94.1%	96.5%	91.5%
Did you receive a proper attention from the nurse?	91.9%	96.2%	97.3%
Did they listen to what you wanted to say?	89.1%	92.8%	84.1%
Could you express your opinion?	87.5%	91.3%	83.3%
Global satisfaction degree	7.7 ± 1.7	8.6 ± 1.6	8.3 ± 1.8
Would you come back to this centre /hospital?	86.3%	91.8%	78.4%

Source: CatSalut 2007

3 Meso level

3.1 The community

Primary care services are delivered through primary care teams (PCTs), the basic unit of provision. PCT are composed of general physicians, paediatricians, dentists (offering a limited benefit basket), nurses, social workers and allied health professionals. Still considered primary care but beyond PCT certain specialties provide services in primary care settings in coordination with the community hospital, although they do not collaborate with the community.

At the community level, PCT collaborate with social services provided by municipalities, patient associations and public health practitioners. Some municipalities have developed special health programmes to encourage exercise, smoking cessation and diet. The Department of Health has also launched some health programmes in coordination with municipalities in this direction. It's worth to particularly mention the "Health and School Programme" designed to detect early-stage mental health disorders in children and "Health and Sports Programme" which address health problems by means of sport prescription and use municipal sport settings.

Regarding to public health and community health integration, a significant initiative in Barcelona started in 2003 under the name of AUPA, that stands for "united action for Health", and which involves 27 PCT. Its main lines of action address prevention for frail elders, healthy habits promotion and psychological care. This project has been selected by the TUFH Network (WHO and WONCA) as one of twelve demonstrative projects on the field of integration of public health and primary care.

4. Micro level

4.1 Self-management support

Self-care promotion is implicit in the primary care benefit basket as prevention and health education are functions of PCT. The burden of these services is carried by nurse practitioners, although there are still developments to be done to reach a widespread self management level.

Pioneering patient involvement in the care process, programs such as “expert patients” have blossomed during the last two years. It consists of group education of patients with a specific chronic disease (e.g. cardiac insufficiency) by qualified nurses and sometimes even expert patients.

Another worthy experience is the Centre for Chronic Disease Follow-up that functions as a reverse call-center where a team of nurses do a telephone follow-up and education process to previously identified chronic patients.

Upon satisfaction surveys, the perceived quality of patient-doctor relationship is rated at 95 out of 100 both for doctors and nurses. Despite this high level of user satisfaction, patients are passively involved in the treatment process as the demand for services exceeds the capacity to deliver consultations with enough time to communicate and to commit patients with their care. Average consultation time is around 8 minutes, while doctors consider a minimum of 10 minutes to deliver a quality service.

With the advent of health information on the internet, doctors realise a better informed patient, particularly in those aged under 50. This phenomenon is bringing a slow and progressive cultural change in the patient-doctor relationship.

4.2 Decision support

Primary care teams frequently use clinical guidelines developed by medical societies (Spanish and Catalan Society of Family and Community Medicine) and groups of experts at ICS. Some of them are evidence-based and with reference to Cochrane Collaboration guidelines.

Guidelines are now available in the EHR suite to facilitate access to them from the clinical station. Connected with EHR there is so far a stand-alone application to trigger alerts when some dangerous association is detected in the prescription pattern. Development of decision support tools under EHR is a wide improvement area to be explored.

In Catalonia, Continuous Medical Education (CME) is defined through education committees composed by scientific societies, provider groups and hosted and chaired by the Institute for Health Studies (IES), an autonomous entity linked to the Department of Health, committed to professional development.

CME is mainly provided by the same parties, societies, providers and IES.

Recently, with the introduction of the career escalator, CME is considered a compulsory part of the reward scheme and there is much focus from providers to facilitate its access to health professionals.

4.3 Clinical information systems

Patient registries are up rather for planning than for managing care. Databases like nosocomial infections and obligatory declaration diseases are developed and maintained by public health institutions.

Closer to management purposes, EHR data mining processes are carried out by primary care providers to feed scorecards and to develop research.

EHRs are only doctor oriented and are the clinical station where doctors and nurses edit health information (diagnosis, treatments, consultations, ancillary services and drugs prescription). Its introduction back in the late 90s did not find resistance from health professionals; on the contrary, it was well welcomed as it supposed the modernization of clinical practice. It also meant the progressive disappearance of old paper registries and more space for administrative work.

So far, patients do not enjoy the benefits of EHR and they can only do some administrative work through the internet.

Because of the existence of multiple providers, each one using its own EHR, health data integration has become a health policy concern and the Shared Health Record project has emerged three years ago. Currently, there is a limited connection between providers' health data. In some territories, this situation is well solved through a common health information system (e.g. SISO in Osona)

5. Further aspects

There are two specific particularities in the Catalan primary care system that differs from neighbour health systems. At first, the presence of paediatricians as part of the primary care team, working together with GPs and being the first point of access for children below the age of 14. This means that primary care paediatricians do not practice as consultants and that GPs do not visit children as a norm. Although, the shortage of paediatricians in some areas, particularly non-urban ones, has meant that GPs start to visit children and refer patients to paediatric specialists in the second care level. This attribute is also present in the rest of Spain's primary care.

The second feature is the multi-provider primary care system, different even from Spain, which was introduced in the 90s when competition drove health policy reforms. Multi-provision was a matter of fact in the hospital sector inherited from the health system before Social Security was introduced.

Modern primary care in Catalonia was settled through the Primary Care Reform in 1983. After nearly 25 years of walking, the reform effects are vanishing and a new re-orientation is taking place in the shape of the "Primary Care Innovation Plan" initiated by the current Ministry of Health. The driving forces of this new system design are patient-centeredness and health care integration through Primary Care Network Services that include community health, primary and social care and public health.

6. Key findings from the country case study

Main barriers to improving primary care in your country:

- Poor service orientation
- Financing and management constraints
- Limited professional involvement (civil servants)
- Weak coordination with specialty care
- Continuous and urgent care (afterhours care delivered in primary care settings)

Main success factors for improving primary care that derive from your analysis of your country's primary care system.

- Teamwork
- Central policy planning
- Fair competition among providers through the establishment of internal markets created by the split of purchasing (CatSalut) and provision (Providers)
- Consciousness of a second wave reform

References

Framework models

The Advanced Medical Home: A patient-centered, physician-guided model of health care. Policy Monograph of American College of Physicians. January 22, 2006

J E Epping-Jordan, S D Pruitt, R Bengoa, E H Wagner. *Improving the quality of health care for chronic conditions.* Qual Saf Health Care 2004;13:299–305

Primary care

Rico A, Saltman R, Boema W. *Organizational Restructuring in European Health Systems: The Role of Primary Care.* Social Policy & Administration 2003; 37(6): 592-608

Rico A, Saltman R, Boema W. *Primary care in the driver's seat? Organizational reforms in European primary care.* Open University Press 2006

Conrad DA, Shortell SM. *Integrated health systems: promise and performance.* Frontiers in Health Services Management 1996; 13 (1):3-40

Hofmarcher M, Oxley H, Rusticelli E. *Improved health system performance through better care coordination.* OECD Health Working Paper No. 30 December 2007

Lakhani M, Baker M, Field S. *The future direction of general practice. A roadmap.* Royal College of General Practitioners. London, 2007

Ministerio de Sanidad y Consumo. *Proyecto AP21. Estrategias para la Atención Primaria del siglo XXI.* Madrid: Ministerio de Sanidad y Consumo; 2006.

Spanish case study

SNS Spanish National Health System. Ministerio de Sanidad y Consumo 2006.

Minué Lorenzo S, de Manuel Keenoy E, Solas Gaspar O. *Situación actual y futuro de la atención primaria.* En Informe SESPAS 2002.

Catalan case study

Magdalena Bundó, Jordi Delàs, Montserrat Gavagnach, Pere Nolasc Acarin i Miquel Torres. *Relació entre l'atenció primària i l'hospitalaria. Situació actual i propostes de millora.* Consell Català d' Especialitats en Ciències de la Salut 2007

Pla d'Innovació d'Atenció Primària i Salut Comunitària. Propostes per a la innovació. Document base, Desembre 2007

Fundació Avedis Donabedian. *Estudi sobre l'activitat, l'organització i la gestió dels equips d'atenció primària*. Barcelona: FAD; 2001.

Institut d'Estudis de la Salut. *Avaluació de l'AP en funció dels sistemes de provisió*. Barcelona: IES; 2008 (in print)