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The Governance of Prevention in Spain

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Background

The Spanish Constitution of 1978 significantly modified the Spanish political and institutional system, promoting a progressive devolution to the Autonomous Communities (AC), which was completed in 2002. The ACs have several competencies, including health, concurrently with the State.[1] In 1986, with the approval of the General Health Law, a National Health System (NHS) was introduced as a coordinated set of health services from the Central Government Administration and the Autonomous Communities that integrates all healthcare functions and benefits for which public authorities are responsible. Under constitutional provisions and their respective autonomy statutes, all the ACs assumed some responsibilities regarding healthcare. Each AC has its own Health Service (*Servicio de Salud*), which is the administrative and management body responsible for all health centres, services and facilities in its region, provincial administrations, town councils, and any other intra-regional administrations.

The Central Government retains responsibility for healthcare management in the cities with autonomy statutes – Ceuta and Melilla – through the National Health Management Institute (INGESA). The Interterritorial Council of the National Health System is responsible for coordination, cooperation and liaison among the public health administrations operated by the Government and the ACs. Its purpose is to promote the cohesion of the National Health System. It is made up of the Minister of Health, Social Services and Equality and the Regional Ministers from the Autonomous Communities.

Health competencies are divided as follows:

- **State administration**: coordination of health, international health, drug policies, INGESA management.
- **Autonomous Communities**: health planning, public health, health services management.
- **Local corporations**: environmental health and cooperation with the management of public services.

The Spanish National Health Service (NHS) is financed by general taxes and provides universal and uniform healthcare coverage, requiring no patient cost-sharing.

The services offered by the National Health System to citizens include preventive, diagnostic, therapeutic, rehabilitative, health promotion and maintenance activities. Regulation of the actions to enable exercise of the right to health protection have been implemented over time through the following acts: General Health Act (1986), Act on the Cohesion and Quality of the National Health System (2003), Act on Guarantees and Rational Use of Medicines (2006), Public Health Act (2011) and Royal Decree-Law on Emergency Measures for the Sustainability of the National Health System and Improvement of Quality and Safety (2012).

The Spanish healthcare system developed from a Bismarckian to a Beveridge model in the 20th century, through the General Healthcare Law of 1986 (HGL, 14/1986, 25 April). During recent decades, the Spanish healthcare system has become universal, with free access to healthcare for the entire population, financed through a progressive tax system, and as such, separate from the social security system. This also includes the integration of different health service networks and political devolution to the Autonomous Communities.[2]

The Spanish National Health Service stands out among European countries because of its specific focus on widespread implementation of primary care**.** Primary care in Spain has been playing a significant role since the early 1980s, when a major transformation of the healthcare system took place, along with the political reorganisation of the State into the Autonomous Communities. The devolution process in the health sector occurred at different stages within the 17 ACs, and this has resulted in different models of care under the umbrella of an NHS common for Spain as a whole.[3] The most frequent model consists of two separate executive organisations, one for primary and one for specialist care (outpatient and hospitals). When the reforms began, in 1978, the primary care structure in Spain was basic and involved a limited national network of *consultorios* (doctors' offices). The typical consultation generally lasted only around one minute, and general practitioners limited their role mostly to rushed requests for basic laboratory tests and chest x-rays, drug prescriptions, and referrals to specialists. General practitioners and nurses working in primary care had neither the time nor the mandate to engage in health promotion or disease prevention activities. The managers of the Spanish NHS set a goal of providing a primary care centre within a fifteen-minute radius of any place of residence. To allow the provision of such services, the specialism of family and community medicine was created in 1978, with the aim of promoting comprehensive healthcare, including disease prevention and health promotion. The creation of family medicine as a medical specialism contributed to higher standards and a distinctive professional identity for primary care physicians in Spain. From 1986, intensive strategies of institutional reform and capacity building were introduced to build a primary

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care structure that could meet the aims of comprehensive care. This included the creation of highly qualified, multidisciplinary primary care teams, backed by a sophisticated workforce and professional development programmes, process redesign, decentralised service provision, and a progressively stronger information and communication system.[4]

In 1988, the Spanish Society of Family and Community Medicine (semFYC in Spanish) launched the first Preventive Activities and Health Promotion Programme (*Programa de Actividades Preventivas y de Promocion de la Salud - PAPPS*) to promote the implementation of preventive and health promotion services in primary healthcare. This was one of the first experiences in health promotion and disease prevention in primary care and its recommendations have been adopted throughout Spain.[5]

However, the rapid expansion of primary care in the 1980s and 1990s exceeded the ability of the Spanish organisation for graduate education in family and community medicine to provide adequate numbers of trainees. Spain had only 50 general practitioners per 100,000 inhabitants in 1991 – one of the lowest ratios in the European Union. Efforts have been made to address these primary care workforce deficiencies. After some initially slow progress, the number grew rapidly to 100 general practitioners per 100,000 inhabitants by 2008.[6] As in many other Western countries, there remain concerns about future deficits in numbers of primary care physicians.

Organisational Structure and Delivery of Prevention

The Spanish National Health System is structured into two healthcare levels: primary care and specialist care, in which there is an inverse relationship between accessibility and technological complexity.

Primary care is the most accessible healthcare level for the general population, as it makes basic healthcare services available within a 15-minute radius from any place of residence. Primary care is in a better position to evaluate the overall health status of the individual and to decide when to act and what measures should be taken in each specific situation. The multidisciplinary primary care team provides a wide range of services with a focus on prevention and promotion of health, acute and chronic care, homecare and community care activities. The team is made up of physicians, who are family and community medicine specialists, paediatricians, nurses, auxiliary nurses, social workers, dentists and administrative staff. The team works closely with midwives, gynaecologists, public health professionals, pharmacists, radiologists, physiotherapists and laboratories.[3] The core of the team is composed of Basic Practice Units (BPUs), which are made up of a physician and a nurse. Primary care physicians, as a professional group, have specific responsibilities for preventive health or anticipatory care for adults and children. Each nurse can work either at one or at more BPU, and each BPU covers a population group of between 1,500 and 2,500. The basic prevention services portfolio is established in Law No 16/2003 of 28 May 2003 on the cohesion and quality of the National Health System, and in Royal Decree No 1030/2006 of 15 September 2006. The portfolio guarantees citizens' rights to the same services regardless of Autonomous Community and provider identity.[7] The national Ministry of Health and Social Policy (MSPS) has authority over certain strategic areas, such as pharmaceutical legislation, and guarantees the equitable functioning of health services across the country.

The most senior body for NHS coordination is the *Consejo Interterritorial del Sistema Nacional de Salud* (CISNS), comprising the 17 regional Ministers of Health and chaired by the national Minister. Decisions of the CISNS must be made by consensus and, as they affect matters that have been transferred, they can only take the form of recommendations. Responsibility for public health was devolved to all 17 ACs long before other health-related competencies were transferred. The ACs have undergone a reorganisation of decentralised services, and several inspectorates responsible for health issues that were previously dispersed among different sectors (health, agriculture, industry, environment, etc.) and different administrations (municipalities, provisional offices, etc.) have been integrated. In terms of programmes targeted at the population, the MSPS is responsible for intersectoral programmes, such as monitoring and surveillance of the environmental determinants of health (such as evaluation, authorisation and registry of chemicals, enforcing the European regulation on chemical agents, ERCHA) and integral programmes such as the national AIDS/HIV prevention plan and occupational health initiatives. In addition, the MSPS has the mandate from the CISNS to perform a coordinating and overseeing role over public health policies in the ACs.[8]

Public health services form part of the Spanish NHS benefits package. The common health benefits package defines public health services as the set of initiatives organised by public administrations to preserve, protect and promote the health of the population through collective or social intervention. The definition prescribes the public health structures of the administrations and Spanish NHS primary healthcare infrastructures as the preferred vehicle for providing integral public health services. In fact, the primary healthcare common benefits package (as defined in Royal Decree No 1030/2006) includes those public health programmes focused on the individual. Therefore, the bulk of preventive medicine and health promotion is integrated with primary healthcare and carried out by family doctors and nurses as part of their normal activity subject the responsibility of regional health authorities. There is often a network of public health technicians distributed in each of the basic healthcare areas, building up the managerial structure of regional health services. These individuals oversee processing of the epidemiological information for the area and support the monitoring of public health programmes in place. The approach taken in defining common public health services involves two types of services. One refers to public health policy-making as a service to the population covered that includes:

- design, implementation and evaluation of health policies for protection against health risks, prevention of diseases and injuries, and health promotion;
- exercise of authority to ensure enforcement of the regulations imposed to support those policies;
- epidemiological information and surveillance systems with a dual purpose: sustained monitoring of and reporting on the population's health status and emergent health problems, and quick response to detected health threats and epidemics, providing an emergency response to public health alarms and crises.

The second type refers to programmes targeted directly at the population. Two kinds are defined in the common benefits package for public health services:

- *intersectoral programmes:* public health services intended to impact lifestyles and other environmental health determinants considered to be risk factors. Examples of these programmes are protection and promotion of health in the workplace, environmental health (quality of water, air, animal-transmitted infections, sanitation), food safety regulation and surveillance, control and surveillance of

risks derived from international movement of commodities and passengers (borders, airports, seaports, national and international transport);
- *integral programmes*: tailored for different life stages, interventions targeted at transmissible and non-transmissible diseases, injuries and accidents or programmes aimed at population groups with special needs.

Financing of Prevention Services

Public expenditure on healthcare is relatively low. Although in 2010, Spain spent 9.6% of GDP on healthcare, 26% of this was from private sources (6% private insurance and the remaining 20% paid by individuals) and 74% was public, with the latter equivalent to 7.0% of GDP, compared to an average of 7.6% in the European Union. Total health expenditure decreased in 2015 to 9.1% (public expenditure 6.3%) of GDP, or $3,153 per capita.[9]

As in many other OECD (Organisation for Economic Co-operation and Development) countries, the reduction in health spending in Spain in recent years is linked partly to a reduction in pharmaceutical expenditure, which fell by more than 6% in real terms in 2011. Spain has introduced a series of measures to reduce spending on pharmaceuticals, including a general rebate applicable for all medicines prescribed by NHS physicians in 2010, and mandated price reductions for generics and an increase in copayments in 2012. The share of the generic market also doubled in Spain between 2008 and 2012, reaching 18% of the total pharmaceutical market in value (40% in volume).

The Spanish NHS provides several health services for all citizens regardless of income level with almost universal coverage (almost 99.5% of the population). According to the most recent information available in 2005, 95% of the population was served by the Spanish NHS and there were only slight differences recorded between ACs, while 5.1% of the population is protected by the special systems mentioned above. The remaining 0.5% of the population is represented by self-employed people with high earnings who opt for private health insurance.

In recent decades, private healthcare has increased in importance in Spain. It plays an important role as a complement to the NHS health services in terms of specific services that are not covered by the public system (e.g.: dental health services). They are an alternative for obtaining faster access to specialised outpatient healthcare and/or for receiving more personalised care.[10]

Since 2010, private payments have increased from around 25% to 30% of total healthcare expenditures. In 2015, 70% of the total healthcare expenditure originated from public sources, and 30% came from private funds. This is one of the highest private share expenditures in Europe. Private out-of-pocket spending has also been increasing, reaching 78% in 2015 and is expected to continue rising gradually.

Public healthcare expenditure is funded through compulsory social security contributions from employees and employers, income taxes, state grants, and compulsory insurance contributions. Public funding is collected centrally and allocated to those Autonomous Communities that have their health services centrally managed. Private financing stems from out-of-pocket charges for private care, private health insurance and prescription charges (less than 50% of the price of medicines). Private insurance accounts for approximately 5.5% of healthcare financing.

Regional and local authorities finance (in part) most types of providers from primary to tertiary, in both the public and private sector, and fully lend financial means to regional Health Services.

When the 17 ACs in 2002 became totally accountable for health service planning and organisation, they also achieved the associated autonomy in terms of expenditure and revenue raising (especially after the 2009 revision). This is mostly based on transfers from the Central Government (94%) related to population size and age, and approximately 6% stems from State and social security budgets.

The introduction and implementation of the DRGs happened at different times and with different strategies in the regions. The financing of capital costs is not included in the DRG system. For recent years, DRG tariffs have decreased by 10% on average each year.

The transformation of primary care has required investments of one-sixth to one-seventh of total public spending on health. Although there is dynamic private medicine in other sectors in Spain – consisting of specialists, hospitals, and other providers – primary healthcare is largely publicly funded. Public spending on primary health services nearly tripled between 1988 and 2003, from 2.1 billion euros to 5.9 billion euros. Despite the extensive and expanding nature of primary healthcare in Spain, public health spending on primary care as a percentage of total public expenditures on health has decreased, from 17.0 percent in 1986 to 14.3 percent in 2003. Meanwhile, spending on hospital and specialised services has remained above 40% of total spending.[4] Hospital and specialist services represent 54.0% of public healthcare expenditure, followed by pharmaceutical benefits (19.8%), and primary care services (15.7%). Public health services, with 1.4% of expenditure, show an apparently small proportion, because the activities associated with public health, prevention and promotion are carried out basically through the primary care network and are not accounted for specifically.[7]

The Spanish remuneration system for primary care professionals shows features that are distinctive in the European landscape. All members of the multidisciplinary team are State employees – except for the private primary care team in Catalonia – and receive a fixed salary with the addition of a variable capitation (approximately 15% of the total), which takes into consideration the nature of the population, its density and the percentage of the population aged over 65 years. In Catalonia, a further adjustment is made based on the socioeconomic conditions of the area served (García-Armesto, et al. 2010).

The employment contract includes the implementation of training activities, healthcare and home care (an average of 1,500 patients for each doctor) conducted in teams, research, teaching and community prevention programmes (Fernández del Rio, 2008).

Primary care physicians have a relatively low status and pay compared to European standards. A study conducted in 2004 on payment levels for primary care physicians in seven European and five English-speaking Western countries reported that Spanish remuneration levels were substantially lower. Additionally, Spanish general practitioners earn less than their specialist counterparts.[4]

The Prevention Service Workforce

The primary care network is entirely public and most of the providers are salaried professionals within the public sector with the few exceptions described (private providers are contracted out to provide primary healthcare under different formulas in Valencia and Catalonia). Primary healthcare centres are served by a multidisciplinary team composed of family doctors, paediatricians, nurses and social workers.

Unlike many European countries, university departments in family medicine do not exist in Spain. The specialisation is cov-

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ered in Family and Community Medicine Teaching Units, which are responsible for coordinating the postgraduate and specialisation four-year programme of the speciality in family and community medicine. On the other hand, the multidisciplinary team, with the support of scientific societies and primary care research Institutes, has resulted in an excellent platform for research and continuous medical education, compensating for the absence of the associated university departments.[3]

Conclusions and Perspectives

There are several barriers for the development of primary care in Spain. Budgets have not increased over the last few years, hospitals still find it difficult to shift to community-based capitation, and an integrated care perspective is not a priority.

The current economic downturn should be taken as an opportunity to accelerate the innovative formulae in order to coordinate and integrate care.[3]

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