Generalitat de Catalunya
Departament de Salut

Government of Catalonia
Ministry of Health

Health System Catalonia

Partnerships, Contracting and Business approaches for new care models

Integration, cooperation and performance of the Catalan Health Systems

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Pla de Salut de Catalunya 2016-2020

Agència de Qualitat i Avaluació Sanitàries de Catalunya

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Context

Devolution process to Autonomous Communities

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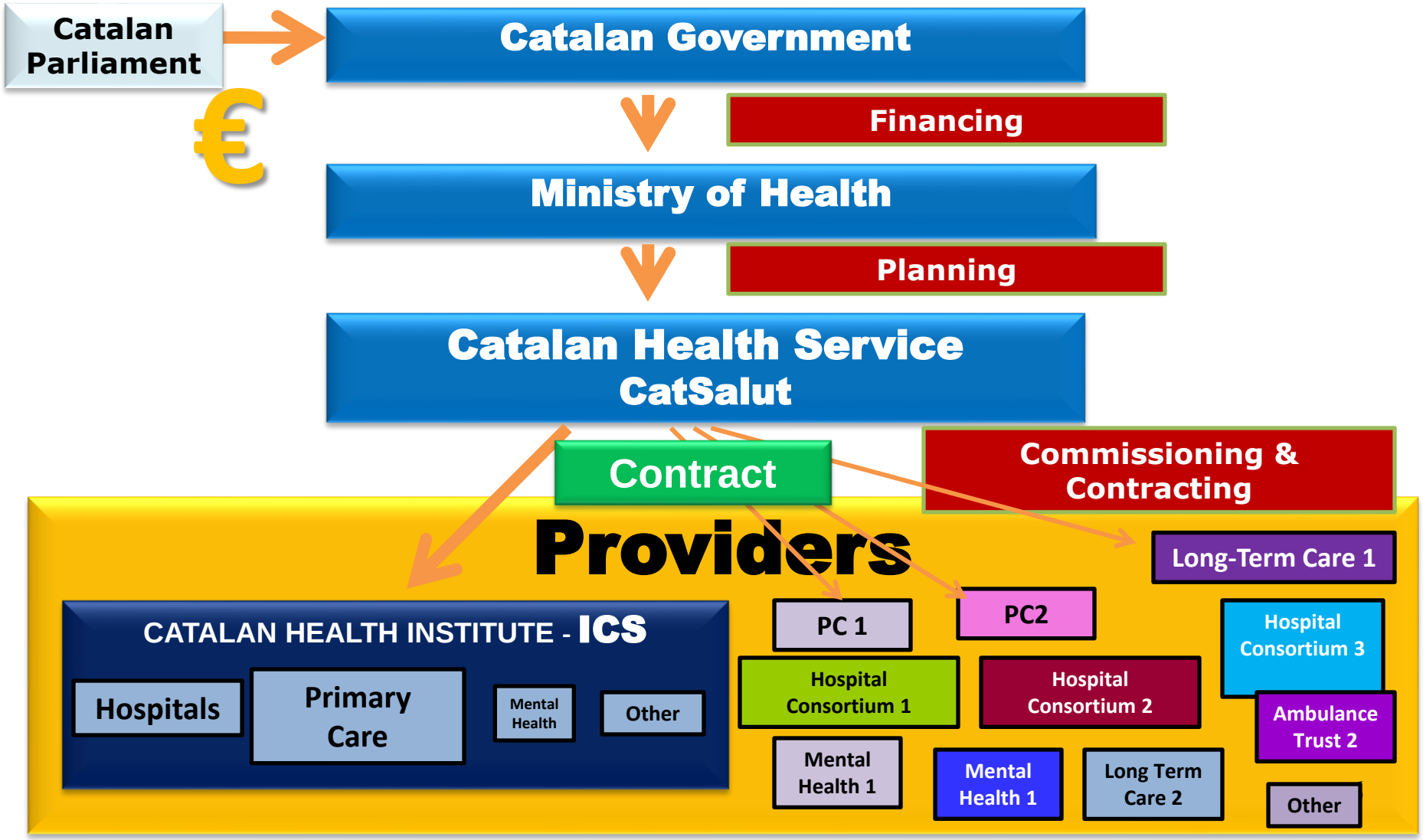
Health System Decentralization

Central Government	▪ Basic legislation and coordination ▪ Minimum package funded through NHS ▪ Pharmaceutical policy ▪ International health policy ▪ Educational requirements
Autonomous Government CATALONIA	▪ **Subsidiary legislation** ▪ **Organizational structure of the Health System** ▪ **Accreditation and Planning** ▪ **Purchasing and Service Provision** ▪ **Public Health** ▪ **Quality evaluation / Agency for Quality**

Overview and key figures of the Catalan healthcare system

- **National Health Service – NHS based system**
- **Universal coverage** and free access at the point of use
- Funded by **taxes**
- Spending **9.1%** of Catalan GDP
- **Co-payment in pharmaceutical products** (free for pensioners and people with certain conditions)
- **Multi-provider system publicly funded**
- Relationship between **Catalan Health Service** and **providers contractually full accounted** (health objectives, activity, economic amount, rate (pricing), invoicing system, evaluation system).
- Providers have the **duty to share information** with both **Public Insurance** (Catalan Health Service) and **other providers. Interoperability must be guaranteed**

Catalan Healthcare System



The Catalan Health System

Overview and Key figures

Population 7,508,106

63
Hospitals

49
Mental health centers

370
Primary Care Teams

72
Long Term care centers

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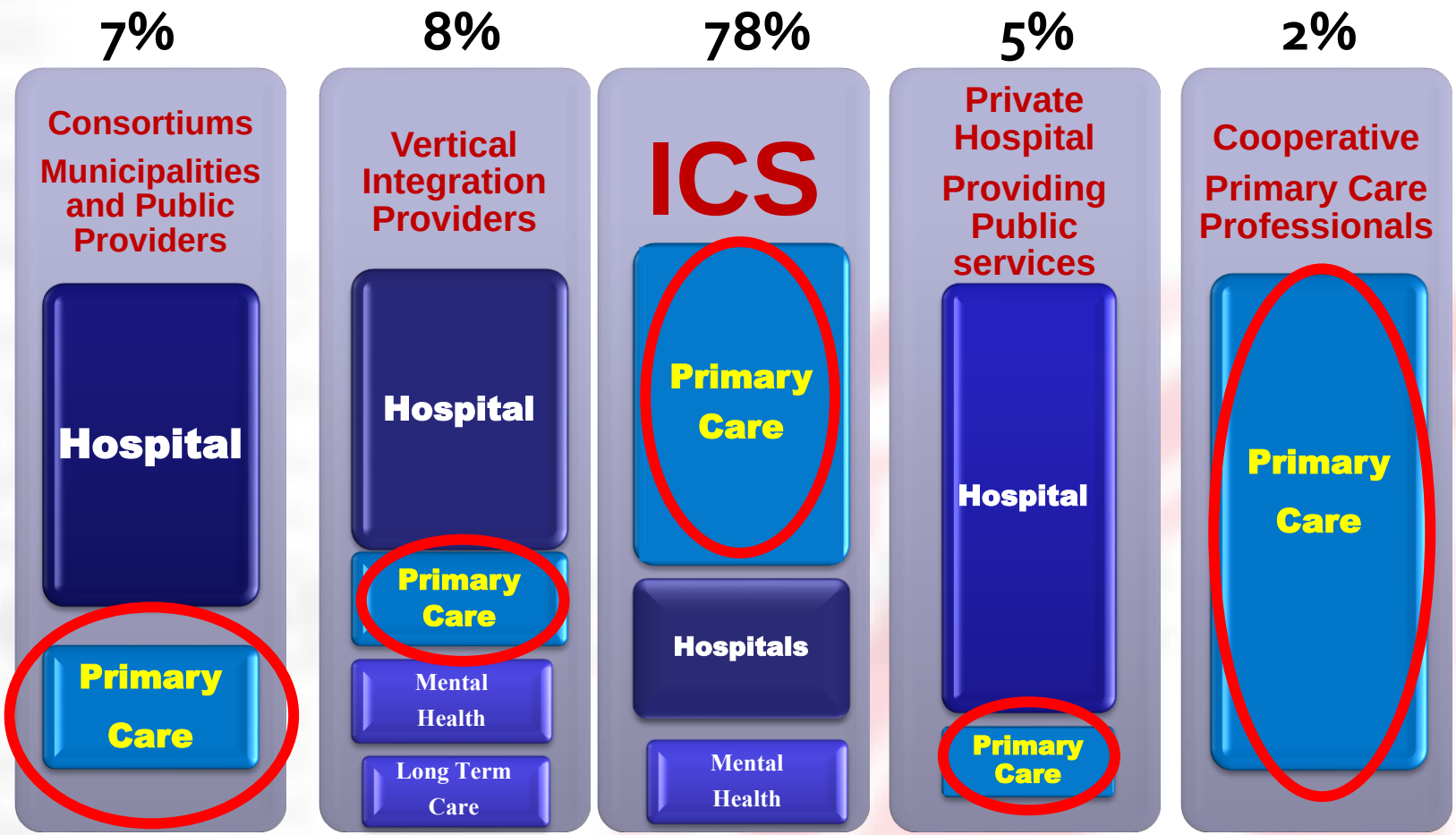
Catalan Healthcare System Healthcare Providers at Primary Care



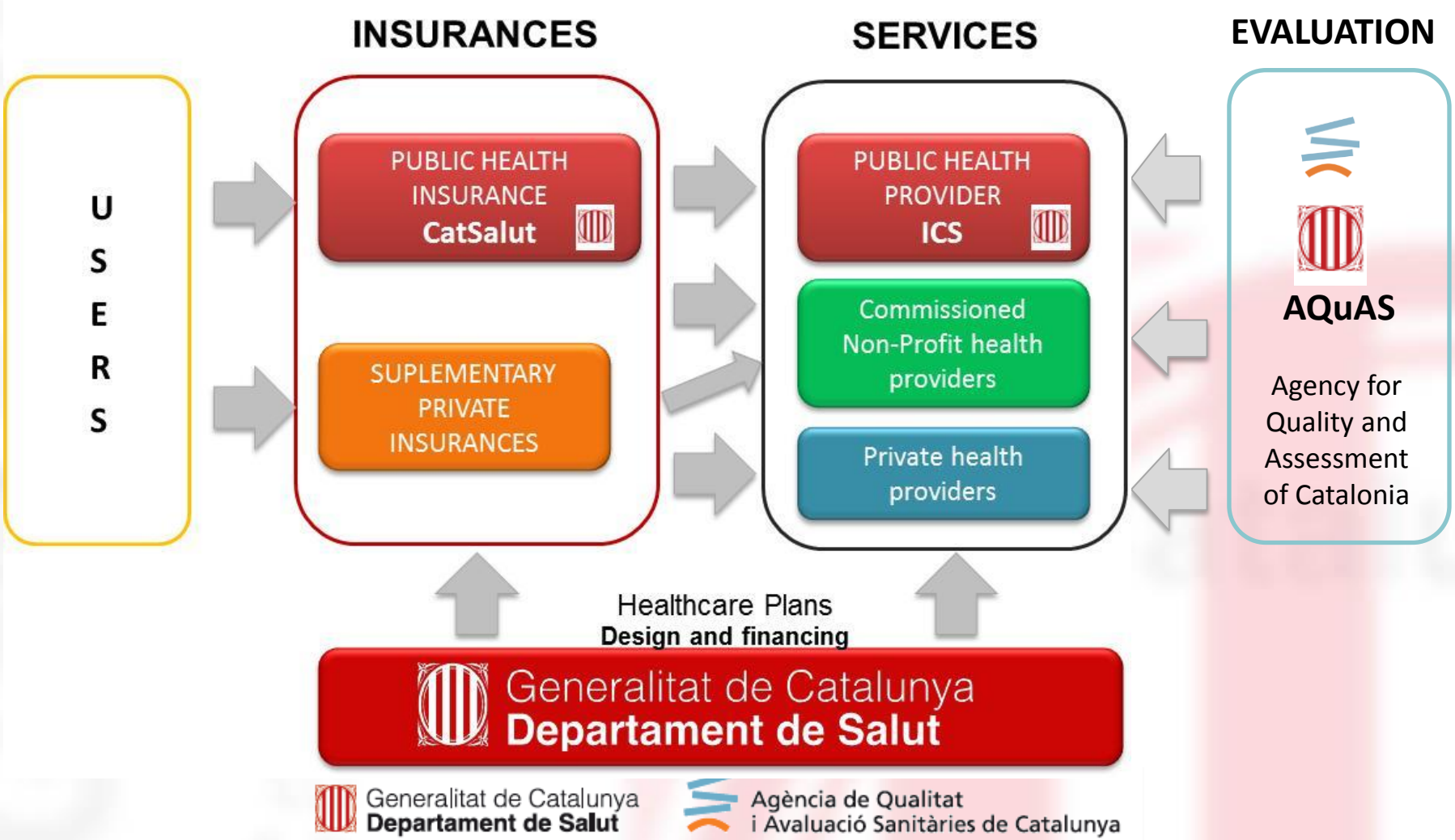
The Catalan Health Care System

NHS based System

Purchaser-Provider Split

Universal coverage & free

Access Equity



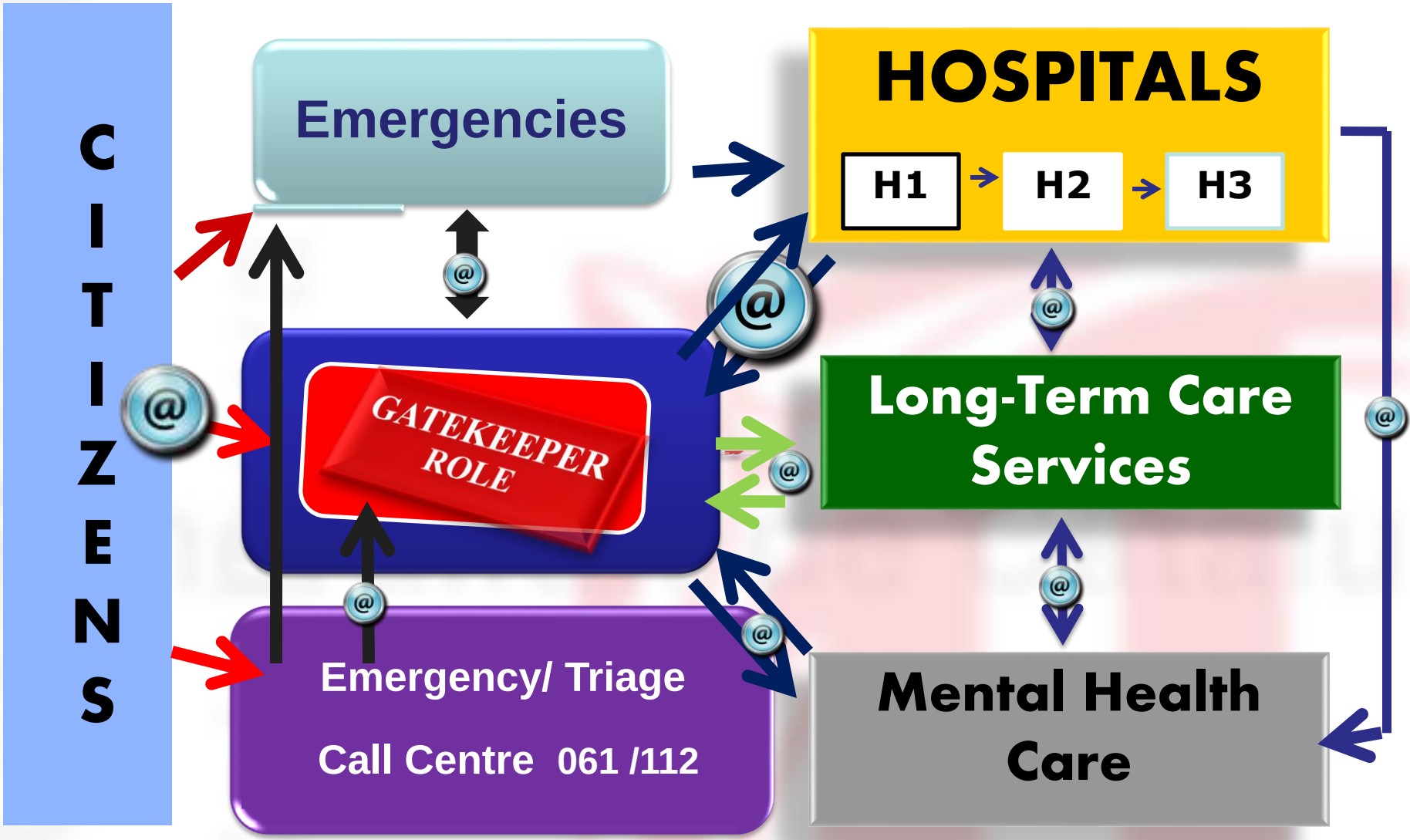
How healthcare Information is organized

The challenge is to relate and analyze all the information that is constantly being generated to obtain more value for the Catalan health system

- Universal health care card **with unique personal identifier**, operating since 2002.
- It has to be used in **all health contacts**.
- This allows us to easily **link** all datasets.

Unique personal identifier code

Catalan Healthcare System
Citizens' Pathways. Gatekeeping based



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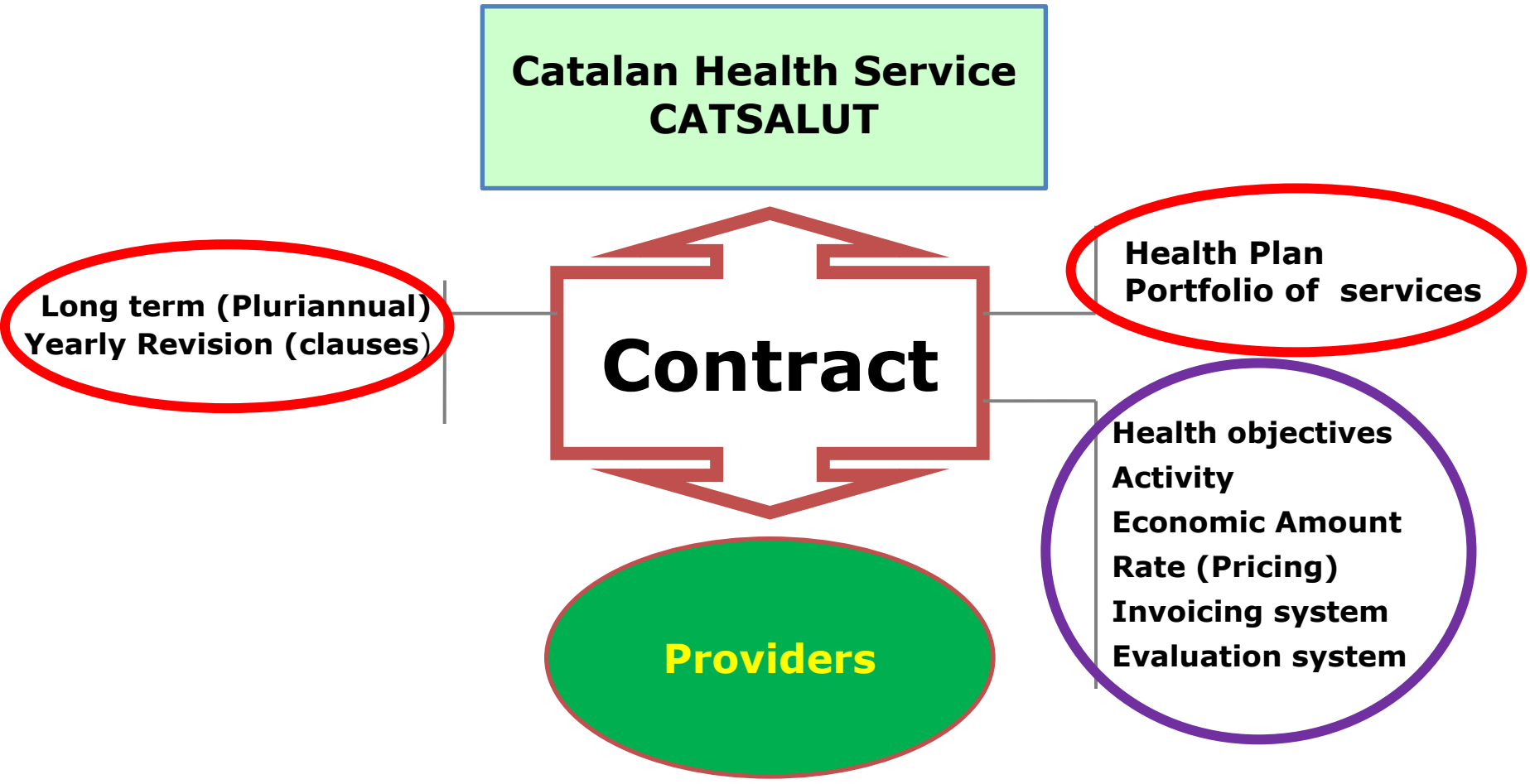
New contracting and health service procurement system

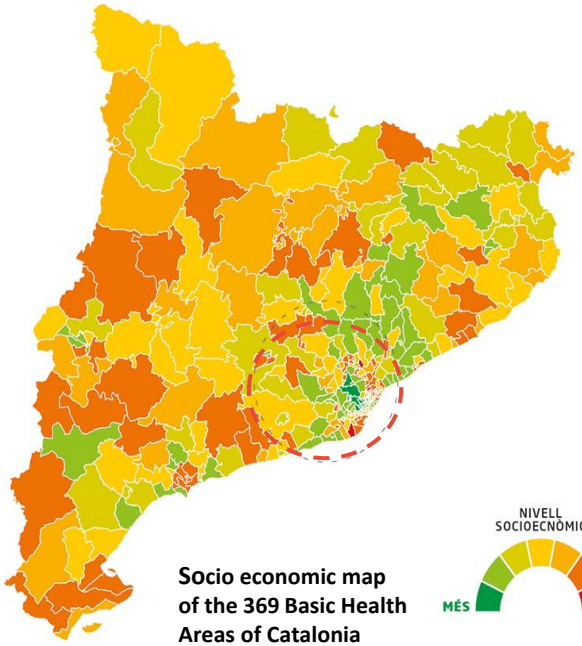
Contract of health services



Socio economic distribution at the Basic Healthcare Area level

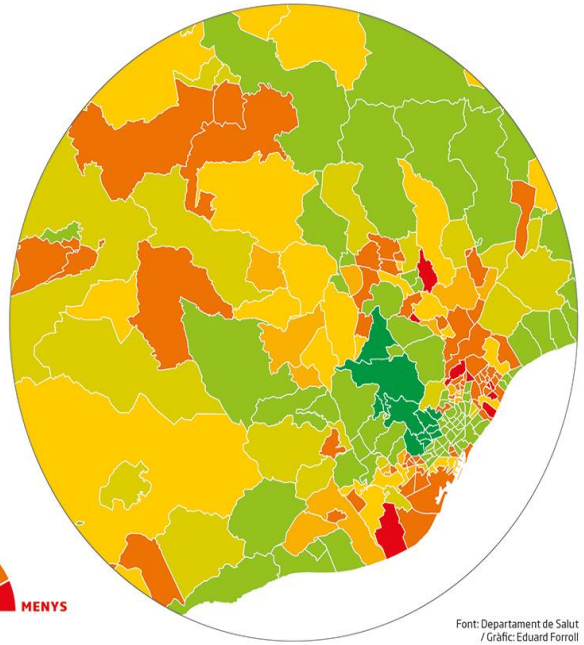
7 Health Regions (*Health Boards*)

369 Basic Healthcare Areas



Socio economic map of the 369 Basic Health Areas of Catalonia

Barcelona Metropolitan Area



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Payment to professionals

Hospital :

Salary + variable (bonus) (related to objectives and results)

PC (Primary Health Centre Professionals):

Salaried

Common Base

Capitation

Indexed by population characteristics conferred (age, rurality, dispersion, socio-economic, etc.).

Bonus related to health outcomes

Health Plan for Catalonia 2016-2020

Health across all policies

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COMMITMENT & PARTICIPATION

1 Persons, their health and Health System

2 Healthcare professionals involvement

HEALTH QUALITY

3 Public Health

4 Accessibility & Performance

5 Drugs & Pharmaceutical Policy

6 Integrated & Chronic Care

7 Health Research & Innovation

GOOD GOVERNANCE

8 Excellence & Safety

9 Outcomes Evaluation & Transparency

10 Digital Health

11 Territorial Integration

HEALTH ACROSS ALL POLICIES

12 Cross-ministerial and cross-sectoral policies

PRIORITY AREAS & STRATEGIC PROJECTS

- Vulnerable infants & teenagers
- Elderly & people with disabilities
- Mental Health
- Minority Diseases
- Communicable Diseases
- Osteo-articular System
- Respiratory System
- Vascular System
- Cancer

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Persons, their health and Health System

Public Health

Integrated & Chronic Care

Accessibility & Performance

Outcomes Evaluation & Transparency

Person Centred

Drugs & Pharmaceutical Policy

Healthcare professionals involvement

Cross-ministerial & cross-sectoral policies

Territorial integration

Digital Health

Health Research & Innovation

Excellence & Safety

Health Plan
for Catalonia 2016–2020

Pla de Salut
de Catalunya 2016-2020

The Catalan Health Service

1. To develop the Catalan Health Service functions directly through the bodies or organisms that are relevant or could be created for this purpose, if necessary.
2. **To establish integrated or joint agreements, conventions, concerts or management formulas with public or private bodies.**
3. **To create partnerships** of a public nature with **public or private non-profit bodies**, concurrent with common interests, which may be equipped with instrumental bodies, if necessary.
4. To create or participate in any other bodies as permitted by law, as well as appropriate management and execution of services or activities.

Principal changes – Fix item

Division	Until present	New
Regional assignment	Population Assignment	→ Regional Assignment
Primary Care (assignment)	Assignment per structure	→ Morbidity-based assignment
Primary Care (resolution)	--	→ Budget for referrals to Specialised level
Hospital Care	Discharge	→ Discharge
	Outpatient services	→ O.S. assigned to Hospital & PC
	A&E payment per case and Hospital level	→ A&E payment per triage + complexity
Highly complex hospital care	Payment per discharge	→ Payment per process
Social & Health Care	Stay (medium-term stay)	→ Discharge (medium-term stay)
Variable portion	Primary: 5% and 15% Hospitals: 0.05% Social & Health Care: 3%	→ 5% of total care division, except training

Regional assignment (Health Board)

Current model

- Assigned on the basis of population per age groups and adjusted according to MBDS and pharmacy consumption (correction factor)

New model

- Regional assignment excludes highly specialised care, educational training and Health Department Special Interest Programmes (PEIDS)
- Population stratification (9 levels of diseases and 44 categories depending on severity)
- All available databases are used to stratify (MBDS, billing, etc.) and are classified according to Clinical Risk Group (CRG). CRG indicates average costs for each category

Primary Care

Existing model

- Resources are allocated on a **structural basis** according to the reference population (physicians per nº of residents, etc.) regardless of qualitative considerations (e.g. morbidity, etc.)
- Bonuses are available for professionals joining the structure

New model

- The new decree provides for allocating resources based on the **needs of the population** served by each Basic Healthcare Area.
- The variables that adjust population data are: **morbidity, age structure, socioeconomic status and dispersion**.
- To adjust morbidity, the **population is stratified based** on Primary Care Minimum Basic Data Set (MBDS) and pharmacy consumption. **This is adjusted per CRG (9 levels and 44 categories)**
- A budget is assigned to the **hospital Outpatient Service** which is the resolution level of Primary Care.

Performance-related pay - variable item

- **Performance-related pay** represents a % of overall economic compensation. This payment is fixed according to the achievement of established objectives.

- The objectives of performance-related pay are essentially associated with the **strategic axes of the Catalan Health Plan** (especially care for chronicity and the system's capacity for resolution), and must focus on stimulating the improvement of service provision, quality and efficiency.

- These objectives must consider **information systems** and **other aspects of health care**: accessibility, resolution, coordination/integration, efficiency, safety and satisfaction.

- **Performance-related pay** should essentially target incentivising the achievement of **regional objectives** and on **specific objectives per division of care and/or supplying unit**.

New payment system
Regional population-based assignment: adjustment variables

Clinical Related Group categories

9 • Individuals with intensive health needs (‘Catastrophic Conditions’)

8 • Persons with complex neoplasia

7 • Persons with dominant chronic diseases (3 or more organ system)

6 • Persons with significant chronic diseases (multiple organ system)

5 • Persons with a significant chronic disease (single dominant or moderate chronic disease)

4 • Persons with minor chronic disease

3 • Persons with minor chronic disease (single minor chronic disease)

2 • Persons with acute disorder (History of significant acute disease)

1 • Persons who are healthy (includes non-useers)

Patient Complexity Profiling - Stratification

HC3 Història clínica compartida de Catalunya

Shared Medical Record –
Patient complexity profiling

Complex Chronic Patient

MACA: Advanced Chronic Disease

- HC3 stratification with Clinical Risk Groups (CRGs)
- Publish label/mark in HC3
- Label visible on all screens

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Extra Slides

New payment system
Regional population-based assignment: adjustment variables

Baseline CRG status category excluding those assigned hierarchically to each person, starting by reviewing criteria for highest category (elevated health requirements) and working down as far as the condition which defines complex criteria.

GROUP	DESCRIPTION & EXAMPLES
Group 9 **Individuals with intensive healthcare needs** ("Catastrophic Conditions")	Includes long-term dependence on medical technology, (**i.e. dialysis, respirator, total parenteral nutrition)** as well as chronic diseases which condition patients' life or which dominates the necessary medical care **(e.g., persistent vegetative state, cystic fibrosis, AIDS, history of heart transplant)**.
Group 8 **Persons with complex neoplasia** ("Dominant and Metastatic Malignancies")	A malignant neoplastic disease that dominates the required medical care **(e.g. malignant brain tumour)** or a non-dominant malignant neoplasm which has metastasized **(e.g. malignant neoplasm of prostate with secondary neoplasm)**.
Group 7 **Persons with dominant chronic diseases** ("Dominant Chronic Disease in Three or More Organ Systems")	Dominant chronic disease in three or more organ systems **(e.g. combined COPD, congestive heart failure and diabetes mellitus).**
Group 6 **Persons with significant chronic diseases** ("Significant Chronic Disease in Multiple Organ Systems")	Significant chronic disease in multiple organ systems, as such there are two or more primary chronic diseases, one of which is dominant (see examples above) or moderate (e.g., asthma, HBP, obesity).
Group 5 **Persons with a significant chronic disease** ("Single Dominant or Moderate Chronic Disease")	Single dominant or moderate chronic disease **(see examples above)**
Group 4 **Persons with minor chronic disease** ("Minor Chronic Disease in Multiple Organ Systems")	Minor chronic disease **(e.g.: chronic bronchitis, ventricular septal defect or hyperlipidaemia)** in two or more organ systems.
Group 3 **Persons with minor chronic disease** ("Single Minor Chronic Disease")	Single dominant or moderate chronic disease **(see examples above)**
Group 2 **Persons with acute disorder** ("History of Significant Acute Disease")	Present in the last six months after one or more significant acute episode categories **(e.g. pneumonia or open fracture of the humerus)** or an episode of procedure without chronic diseases **(e.g. electrocardiogram**).
Group 1 **Persons who are healthy (includes non-users)** ("Healthy")	Identified by the absence of chronic disease, procedures, or significant acute diagnosis **(e.g. compatible with having flu or broken fracture of the humerus and with pregnancy and childbirth)**. This category also includes significant "truncated" episodes (presence of a single chronic diagnosis in primary care).

Socio economic index indicator

Criteria: selection of variables used in deprivation index and other variables associated to health inequalities in which primary care has a mitigation effect

- % of unemployed population (inactive population also included)
- % manual labourers
- % people with insuficient level of studies completed
- Income level
- % People from low income country origine
- % elderly people living alone
- Premature mortality rate (<75 yr old)
- Avoidabe hospitalisation rate for diseases co-related to deprivation

Primary care compensation

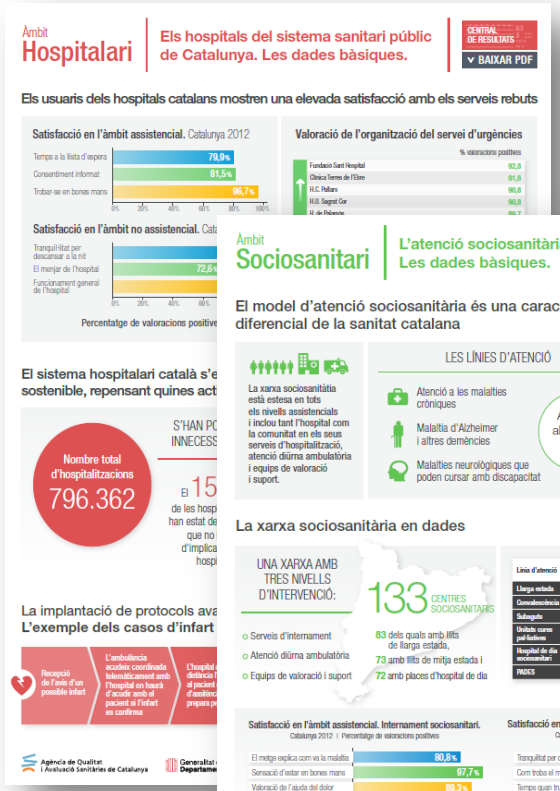
Activity associated with specialised care: Outpatient services

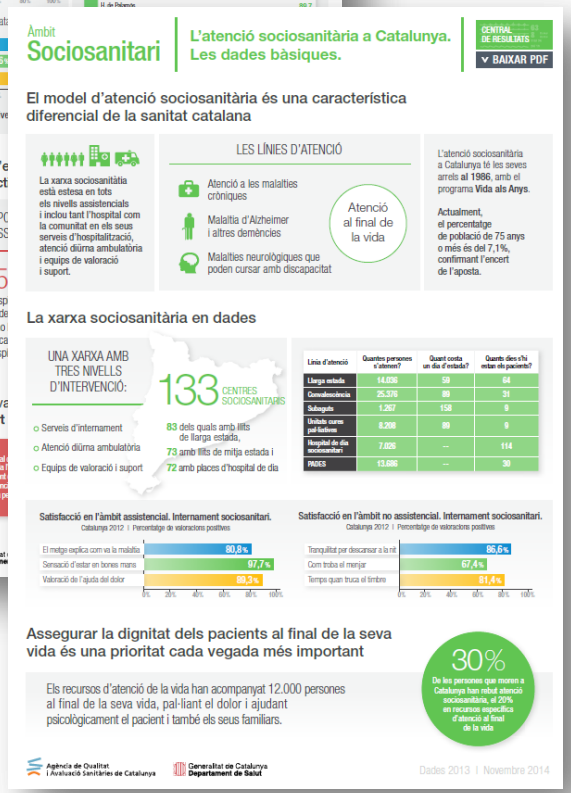
- Total Funding
  - By way of hospital contract (standard activity of each centre)
  - By way of activity contracted through PC (PC support activity)
- Transition from payment per volume of activity to pay-per-performance. Aspects for payment referencing:
  - Complementation of information system
  - Indirect results indicators
    - Variation in number of emergency cases dealt with in hospital
    - Variation in number of emergency admissions vs programmed per speciality
    - Variation in number of emergency readmissions
    - Increase in volume of patients dealt with in hospitals outside area
  - Indicators of perceived quality: i.e. Satisfaction surveys
  - Waiting time

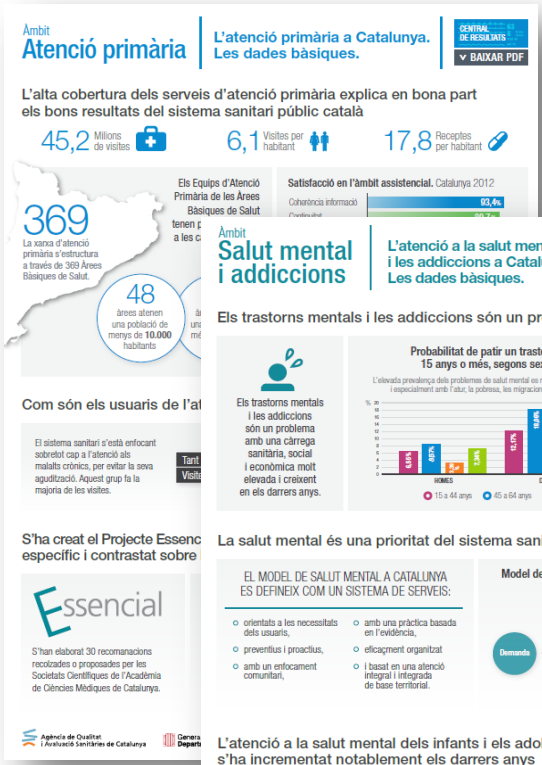
Discharge: per structure level (1)

- A cost per unit was defined corresponding to the structure level assigned to each hospital
- The structure levels established are the following:
  - Level 1: complementary hospital services
  - Level 2: basic general hospital type A
  - Level 3: basic general hospital type B
  - Level 4: reference hospital type A
  - Level 5: reference hospital type B
  - Level 6: highly complex hospital services
  - Level 7: specialist hospital

Infographics for citizens







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Value based public procurement

The Catalan experience

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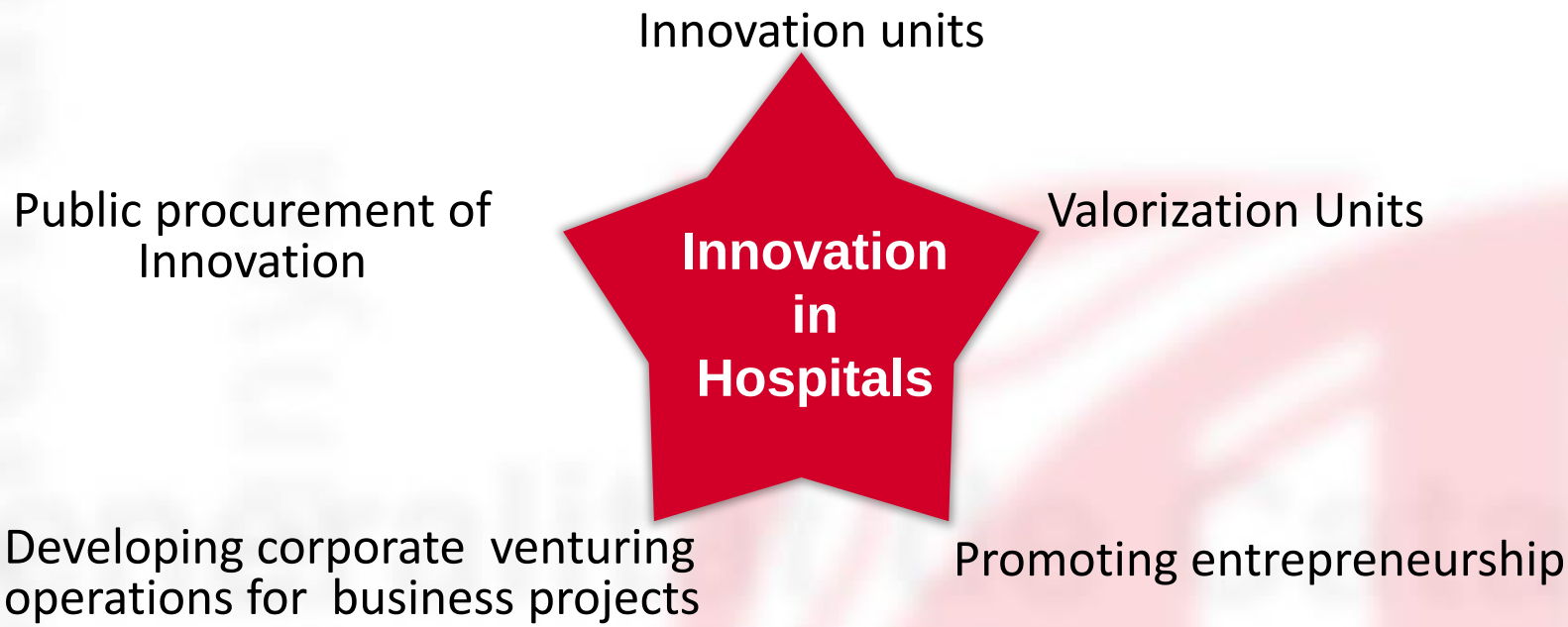
What is the problem ?

Innovate Public Services is a need for Public Administrations **to address the growing demand with limited budgets.**

How did we engage clinicians?

Through the **Program to promote innovation in Hospitals**



Key learnings

Innovative procurement is a **Co-creation process** requiring a **Cultural Change**

New approach

Provider – Procurer interaction

Preserving procurement principles of equity, transparency and confidentiality

Life cycle approach

Multidimensional procurement **Team**

Open specification of tender:

Define the Needs and Boundaries instead of Requirements

Payment based on results

Procurers - clarify which are the expected outputs and outcomes

Providers will procure outcomes instead of solutions!

New activities

Open Market Consultation

Is an essential part of the Co-creation process

Business model approach, functional analysis of Needs

Outcome-based service specifications

*with **clear built** in key performance indicators (**KPIs**), data collection and output measurement!*