European Commission

Health system performance assessment – Integrated Care Assessment (20157303 HSPA)

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Spain

Population size (thousands): 46,448 (State of Health in the EU, Spain, 2017)[1]

Population density: 92.5 inhabitants / km^2 (Eurostat, 2015)[2]

Life expectancy: 83 years (State of Health in the EU, Spain, 2017)

Fertility rate: 1.3 births / woman (State of Health in the EU, Spain, 2017)

Mortality rate: 9.1 deaths / 1,000 people (Central Intelligence Agency, 2017)[3]

Total health expenditure: 9.2% (State of Health in the EU, Spain, 2017)

Health financing: government schemes (65%), compulsory contributory health insurance schemes and compulsory medical saving accounts (4.8%), voluntary health insurance schemes (5.2%), financing schemes of non-profit institutions serving households (0.4%), household out-of-pocket payments (24.7%) (Eurostat, 2015)[4]

Top causes of death: circulatory diseases, malignant neoplasms, and respiratory diseases (State of Health in the EU, Spain, 2017)

The Spanish healthcare system

The Spanish Health System, Sistema Nacional de Salud (SNS), has near-universal coverage (with 99.1% of the population covered), is almost fully funded from taxes, and operates predominantly within the public sector. Provision is free of charge at the point of delivery, with the exception of pharmaceuticals prescribed to people aged under 65, which entail co-payment of 40% of the retail price (European Commission, 2017k). The national Ministry of Health and Social Policy (MSPS) is vested with a limited extent of powers due to the de-centralised nature of the health system. It has authority over pharmaceutical legislation and is the guarantor of the equitable functioning of health services across the country – thus being responsible for coordinating the SNS through the 17 regional health systems (European Commission, 2017k).

The 17 regional health administrations (ACs) are responsible for regional health legislation, health insurance, health services planning, management and provision, and public health; local authorities (i.e. in provinces and municipalities) are responsible for sanitation and collaboration in health services provision as well as in direct management of 'residual' public health and community services. Primary care is entirely public and is run by multidisciplinary teams made up by GPs, paediatricians, nurses, social workers and, occasionally, physiotherapists and dentists (European Commission, 2017k).

Integrated care policies

The *Strategy for Addressing Chronicity in the National Health System* of 2012, highlighted in the Council of the European Union's *Reflection process: Towards modern, responsive and sustainable health system* (Council of the European Union, 2013a) promotes integration of care at the structural and organisational level in Spain (National Health System, Spain, 2012). Nevertheless, integrated care has been adopted in several but not all regions, where healthcare coordination still seems to predominate over integration in the health setting (Jiminez-Martin and Vilaplana Prieto, 2012).

Catalonia and the Basque Country lead in terms of the number of initiatives and population coverage. The experiences in the two regions have taken different approaches. In Catalonia, a split between purchaser and provider was promoted; organisations known as integrated healthcare organisations (IHO), (organizaciones sanitarias integradas (OSI) in

[1] https://ec.europa.eu/health/sites/health/files/state/docs/chp_es_english.pdf

[2] Population data, Eurostat http://ec.europa.eu/eurostat/tgm/table.do?tab=table&init=1&language=en&pcode=tps00003&plugin=1

[3] https://www.cia.gov/library/publications/the-world-factbook/fields/2066.html

[4] http://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=hlth_sha11_hf&lang=en

Spanish), have been slowly created to manage the provision of the healthcare continuum. IHOs have been evolving over the years and, despite some common characteristics, it is possible to differentiate the organisations by their basic features such as breadth and depth of service integration along the care continuum, the emphasis on formal instruments or on coordination mechanisms, and the forms of relationship between the entities that make up the IHO. In addition to this evolution of the service model, the Chronicity Prevention and Care Programme set up by the Health Plan for Catalonia 2011–2015 has been used as an opportunity to create a new integrated care model in Catalonia (Contel et al., 2015). In the Basque Country, in addition to the establishment of IHOs, other integrated care initiatives (e.g. projects and programmes) have been developed to improve the care of chronic diseases (Vazquez et al., 2012). In addition to Catalonia and the Basque Country, other numerous experiences of integration of care are emerging in other Spanish regions, such as Galicia, Andalusia and Madrid.

In addition to the Strategy for Addressing Chronicity in the National Health System mentioned above, a total of seven strategies and one policy related to integrated care can be found in Spain, all at the regional level and including the Basque Country, Murcia, Andalusia and Valencia regions. Three strategies were of particular interest in this context given their population-level scope: Population Intervention Plans[5] and the Chronicity Strategy,[6] both in the Basque Country; and the Strategy for Chronic Care in Valencia Region (Barbarella et al., 2015), both focusing on a regional-level integration of health and social care with the purpose of improving the quality of chronic care and tackling multi-morbidity.

Implementation of integrated care in Spain: initiatives in Asturia

- Patients School of Asturias is an initiative developed to promote the self-management of citizens with a chronic disease. It takes as a basis for its implementation the Chronic Care Model, strongly linked with the concept of Patient Schools. The model commenced in February 2017.[7]
- In 2016, the Principality of Asturias was a finalist for the Outstanding ICT Achievement Award – Europe. Information is shared in real time between all hospitals and primary care centres. Secondly, telemedicine and videoconferencing will be used to provide care at home. Thirdly, through networked medicine, population screening programmes will be implemented thus centralising clinical decision making.[8]

Assessment of the maturity of the health system

Maturity Model – Spain (Asturias)	
Readiness to Change to enable more Integrated Care	
Self-assessment	1- Compelling need is recognised, but there is no clear vision or strategic plan

[5] A detailed description of this strategy can be found at https://www.nivel.nl/sites/default/files/bestanden/Rapport-CHRODIS.pdf

[6] A detailed description of this strategy can be found at http://cronicidad.blog.euskadi.net

[7] A detailed description of this strategy can be found at https://ec.europa.eu/eip/ageing/commitments-tracker/b3/develop-chronic-disease-self-mangement-programme-cdsmp-chronic-disease_en

[8] A detailed description of this strategy can be found at http://www.investinasturias.es/en/salud-en/

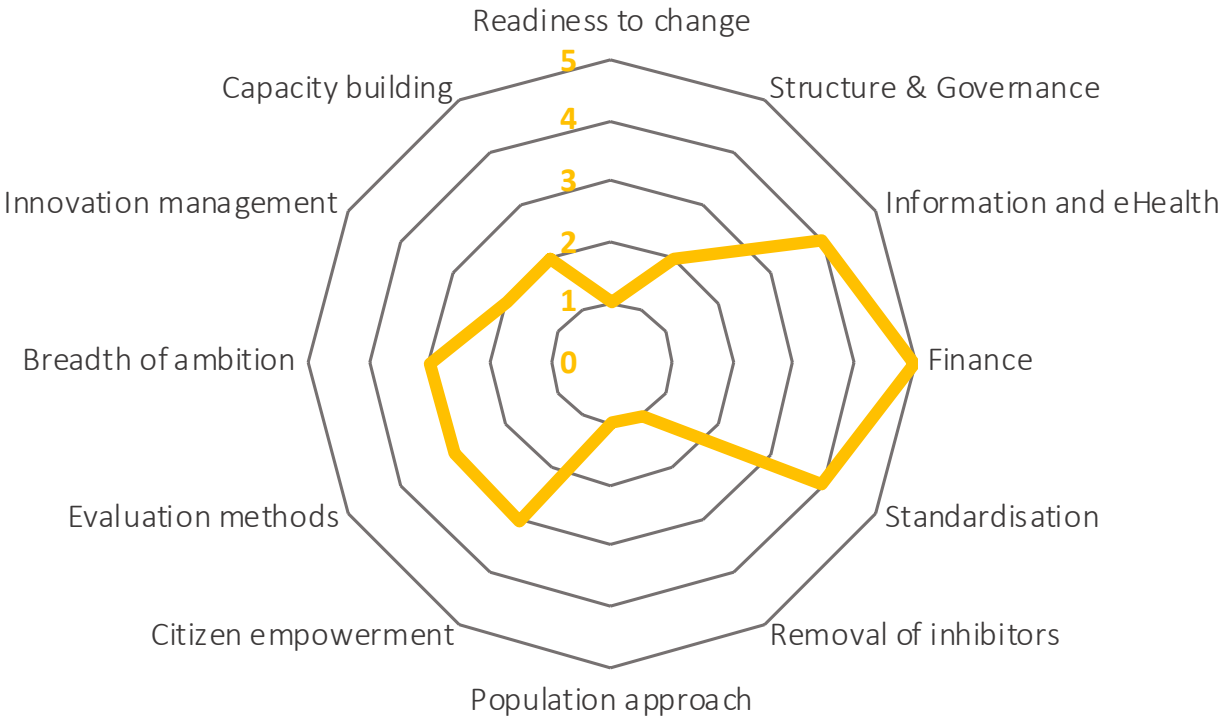
Justification	A great need for change is recognised but there is no strategic plan as such, at least not in a document. Also, there is not a very clear shared vision.
Structure & Governance	
Self-assessment	2 – Formation of task forces, alliances and other informal ways of collaborating
Justification	There are multidisciplinary workgroups, especially across collaboration from health (managed at regional level) and social care services (managed at municipal level). There are supporting documents for this at national level, but not at regional level in Asturias. Some elements of level 3.
Information & eHealth Services	
Self-assessment	4 – Mandated or funded use of regional / national eHealth infrastructure across the healthcare system
Justification	Patients and healthcare professionals have access to a unique electronic health record; however, it is not integrated with social services. There is a commission working across health and social care (comisiones socio-sanitarias) in the region of Asturias to further develop ICT in this field. There are no strategic plans at the moment, however; most of the progress and discussions relate to the operational / practical level.
Finance & Funding	
Self-assessment	5 – Secure multi-year budget, accessible to all stakeholders, to enable further service development
Justification	Inclined to rank it as a 5, but not with confidence. Funding streams do not seem to be directly aimed at integrating care, but rather to develop the region (e.g. ICT and standardisation funding streams).
Standardisation & Simplification	
Self-assessment	4 – A unified set of agreed standards to be used for system implementations specified in procurement documents; many shared procurements of new systems; consolidated data centres and shared services widely deployed
Justification	There is a very well-defined set of standards across the health sector, but the social sector has not yet been integrated.
Removal of Inhibitors	
Self-assessment	1 – Awareness of inhibitors but no systematic approach to their management is in place
Justification	Rather than big barriers to integrating care, there are small inhibitors along the way and continuous work to overcome them. On the social care side, the biggest inhibitor is a cultural one – health professionals are not fully aware of, or are not used to considering, the social needs of their patients and what they can do to offer them social support in addition to health support. Another important inhibitor in the social field is the dispersion of services – social care provision is too fragmented and provided in different places (municipalities with different types and level of services). Both of these inhibitors are seen as equally important.
Population Approach	
Self-assessment	1 – A population risk approach is applied to integrated care services but not yet systematically or to the full population
Justification	Population risk stratification is not used in a systematic way.
Citizen Empowerment	
Self-assessment	3 – Citizens are consulted on integrated care services and have access to health information and health data
Justification	This question should be ranked as between 2 and 3. It would be a 3 but there is no systematic approach. Patients have the power to steer several aspects of their care provision and have access to their records
Evaluation Methods	

Self-assessment	3 – Some integrated care initiatives and services are evaluated as part of a systematic approach
Justification	Use several process and outcome indicators but evaluation methods are not used in a completely systematic way.
Breadth of Ambition	
Self-assessment	3 – Integration between care levels (e.g. between primary and secondary care)
Justification	Level 3 represents the current stage of development in the integration of care journey but with the ambition to achieve level 4 in the near future, incorporation of social care services in a more seamless and generalised way. Currently it works for dependent patients, as this area is managed at regional level rather than local level
Innovation Management	
Self-assessment	2 – Innovations are captured and there are some mechanisms in place to encourage knowledge transfer
Justification	Use of discussion groups for information sharing. There are some training courses available, some of them online. Asturias is an EIPonAHA reference site.
Capacity Building	
Self-assessment	2 – Cooperation on capacity building for integrated care is growing across the region
Justification	Initiatives are now emerging on this area. Nowadays we can confidently say that the number of resources for integrating care in the region is increasing.

There are no clear policies specifically aimed at setting guidelines for integrated care implementation, which is considered to hinder its progression in the region. Moreover, there is no political consensus or a shared vision toward implementation of integrated care. This was reflected in the Maturity Model Assessment, particularly in the Readiness to Change and Removal of Inhibitors assessment dimensions, which were rated as 1 (i.e. *Compelling need is recognised, but no clear vision or strategic plan* and *Awareness of inhibitors but no systematic approach to their management is in place,* respectively).

However, even with these constraints in place, there has been considerable progress in implementing integrated care in the Asturias region from a 'bottom-up' perspective, particularly with regard to the integration of health and social care. In this respect, one of the challenges faced in the region is that healthcare is managed at the regional level and social care at the municipal level, although a collaboration framework across the two dimensions is starting to emerge. From a healthcare perspective only, the system is integrated with unique electronic health records and shared pathways, but there are still areas of improvement such as citizen engagement, evaluation, innovation management and capacity building.

Spain | Asturias



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