Health planning in Spain

Planeamento de saúde em Espanha

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Resumo

O sistema de saúde espanhol (SNHS) foi definido por lei em 1986. Existem muitos estudos bem documentados sobre como os seus traços essenciais (universalidade, acessibilidade, descentralização, redes públicas de saúde integradas, financiamento público e privado, financiado por impostos, seguros, copagamentos, etc.) têm evoluído desde então.
Este artigo explica como as estruturas e funções do SNHS estão profundamente descentralizados e como a recente crise económica mudou esse cenário, com o planeamento em saúde centralizado essencialmente no Ministério das Finanças e quase unicamente com fundamento em considerações de controlo do *deficit* financeiro.

Palavras Chave:
Espanha, planeamento em saúde, descentralização, crise económica.

Abstract

The Spanish National Health System (SNHS) was legally defined in 1986. There are many well documented studies on how its basic traits (universality, accessibility, decentralization, integrated public health networks, public and private provision, financed by taxes, social premiums and copayments, etc.) have evolved since then.
This paper explains how the SNHS facilities and functions are deeply decentralized and how the recent economic crisis has changed this picture, with central health planning basically located into the Ministry of Finance and mainly guided by deficit control considerations.

Key Words:
Spain, health planning, decentralization, economic crisis.

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Introduction

In 1986, the General Health Act (GHA) defined the Spanish National Health System (SNHS). There are many well documented studies on how its basic traits (universality; accessibility; primary health care based; quality and integrality; decentralization; integrated public health networks; public and private provision; financed by taxes, social premiums and copayments) have evolved since then [1, 2].
From 2002 onwards, with the exception of Ceuta and Melilla, the 17 Spanish regions (*Comunidades Autónomas*) are fully competent to plan, organize and manage the publicly financed health services of their territory. The GHA created a coordination body, the *"Consejo Interterritorial del Sistema Nacional de Salud*" (CI) where the Minister of Health and the other 17 regional ministers meet and discuss common issues. This body meets in plenary 3-4 times a year, has several permanent technical commissions and working groups, and its agreements are usually reached by consensus [3].
Articles 75, 76 and 77 of the GHA mandated the elaboration of an "Integrated Health Plan" as a single, consolidated document including the central and regional health priorities and plans, as well as the resources for implementing them. The "Integrated Health Plan" had to be discussed and approved by the CI. But this "Integrated Plan" was never elaborated.
At the same time, regions have produced, and in most cases revised and updated, Regional Health Plans. Regions are happy to use Health Plans to synthesize health situation and needs, setting formal strategies (being very exhaustive in scope and scarcely selective in priorities), and pointing out interventions and indicators. Nevertheless, there is no evidence that this displaying function goes much further than "inspirational planning", being marginal to the real processes of resource allocation or setting hard objectives to the healthcare centres and services.

For priority setting Regions use three sort of tools: a) health Plans, that inspire general health objectives but do not link well to the other two; b) contractual management among the Regional healthcare service and the health centres, basically focused on effectiveness, safety, productivity and efficiency, good performance and control of waiting times; and, c) annual budgets, that follow a different and timely decoupled path: they are input oriented (personnel, running costs, external contracts, investments, etc.), and split funds to centres and headings with very little relation to the health care outputs or outcomes.
In conclusion, in Spain today you may found 17 Regional Health plans but no a comprehensive Spanish one.

It worth to note that, once it was completed the devolution of SNHS services to all the 17 Regions in 2002, and after "Cohesion and Quality Act" was passed in 2003, the "old" General Directorate for Health Planning of the Ministry of Health (MoH) was split into a DG for Quality of Care, and another one for "Cohesion and High Inspectorate" of the SNHS.
Nevertheless, when consensus is reached within the CI on a particular subject, it can result in special Health Plan being approved. This has been the case for the preventive measures in relation to high temperature (every year since 2005), tuberculosis prevention and control (2007, reviewed in 2013), and poliomyelitis eradication (2013).
In conclusion, generally speaking, all Regions have full powers for health planning, including territorial distribution of health facilities (public and private), though they usually inform the MoH when relevant changes are introduced.
There are six notable exceptions to health powers of the Regions: a) health protection controls in the national borders (a MoH exclusive responsibility); b) drugs and pharmaceuticals register and prices, an area that the GHA assigned almost exclusively to MoH; c) AIDS prevention, control and treatment (a MoH central Plan is in charge from the beginning of the epidemic), d) organ transplantation, which is a centralized organization since the 80's (*"Organización Nacional de Transplantes"*), e) the post-graduate health education system (a MoH responsibility but with important presence of the Regions), and f) the nomination of "Centres of reference" for some illness and/or procedures (this process is shared by the MoH and the Regions through a CI's particular commission)

Some recent developments

In 2005, in order to strengthen the MoH′s role within the SNHS, a **"Quality Plan for the NHS"** was elaborated. The Plan included strategies, actions and goals for: a) health promotion and protection, b) foster equity in health, including gender equity, c) planning of human resources, d) promoting good practices and clinical excellence, e) e-health and electronic records, f) strengthening health information systems.
The Plan, which was not compulsory voluntary for the Regions, was revised and updated in 2010 and it was financed with 50M € a year for five years [4].
The MoH, being an the driving actor of the Quality Plan, in coordination with *Regions*, *professional associations* and *patients,* produced a number of **Health Strategies** dealing with *prevalent diseases* (cardiovascular, cancer, normal delivery, diabetes, neuro-degerative

disorders, chronic kidney failure, stroke, rare diseases, etc.) and other *relevant health problems* (mental health, sexual and reproductive health, chronicity).
Each Health Strategy included a revision of the "state of the art", a number of goals, actions, time-frame and indicators. They were discussed and approved in the CI. All of them but one (chronicity) was approved before 2011 and, unfortunately, since then they **have not been reviewed or updated.**
Also, as a part of the Quality Plan, the MoH published three **prospective studies on medical manpower** (2006, 2008, 2010), and another one on **nurses supply and demand** (2010)**.** These studies were intended to predict the balance/disbalance between the number and distribution of specialists and their estimated needs in the long run (2025) on a multi-parametrical basis. They were very useful to negotiate with Ministry of Education and Universities the number annual intake of students into Medicine and Nursery Schools. Unfortunately, after 2012 this effort **was discontinued**.
An area of MoH that has been clearly improved during the last ten years is Health Information Systems. Today health decision makers, other stakeholders, health professionals and the public have access to a great number of good quality, frequently updated repository of health information on many different aspects of the SNHS. An official report summarizing and analyzing this information is published every year [5]. Additionally, other relevant reports on several SNHS aspects are published regularly [6].
Therefore, it can be said that there is a clear **misbalance** between the amount and quality of health information available and MoH's institutional capacity for health planning at a national scale.
Apart from the legal distribution of responsibilities, there are at least three reasons for that: a) a lack political will ("avoiding conflicts" is a deeply rooted tradition); b) no funds to attract the Regions into sharing plans and strategies (both the funding of the Quality Plan and a so-called Cohesion Fund were suppressed in 2012 as part of central "austerity measures"); c) the intra government redistribution of power caused by the economic crisis (today the Ministry of Finance decides on every economic aspect of the SNHS, from the copayments for drugs, to the annual percentage of personnel replacement in hospitals and health centers).

Current situation

Six years of public health spending cuts (the per capita health spending decreased a 12% between 2009 and 2014) have had a notable impact on NHS, basically in terms of:

a) Universality (the Royal Decree 16/2012 amended the GHL and re-established the public health coverage as a benefit of the Social Security System, excluding to irregular migrants among others) [7]
b) Equity (private health expenditure was above 30% of total health expenditure in 2014 and 2015, for the first time since the SNHS was created) [8]
c) Health personnel (a lack of 25.000 health professionals between 2011 and 2015)
d) Co-payments for pharmaceuticals (that were increased, affecting the accessibility for some disadvantage groups even though the effort of some Regions to minimize it) [9]
e) Waiting lists (from 459.885 to 549.424 patients from 2011 to 2015, with a 22% of increase of the average waiting times)
f) Increasing differences among Regions (in 2015 the difference between País Vasco -1.548 € per capita- and Andalucía -1.004€ per capita- was 544 €); in global terms this difference increased a 5,1% since 2010 [10].
All this happened in a context of scandals linked to important corruption cases and a semi-bankruptcy of financial system the that forced to a EU not declared intervention with an estimated cost of about 69.700M €, a figure notably similar to the SNHS annual budget [11].
This strategy was, by no means, inescapable; on the contrary, it was the result of a conservative approach to challenges of the SNHS. Other strategies to cope with the economic crisis, which would had dealt dealing with some structural SNHS problems while preserving its fundamental traits, were proposed [12] but ignored by the Government.
Worse than that, the last macro-economic horizon sent to Brussels by the Government persists in the same way, with additional reductions (from 5,95% of GDP *expected* for 2016 to a *projected* 5,74 for 2019) of public health spending [13].
That in spite of the above, people´s opinion on NHS remain still relatively high it is probably due to the high esteem of the Spaniards for the NHS, and to the hard work of health professionals, as the recently appointed new Health Minister, Ms. Monserrat, has recognized [14].
As a consequence, the health debate in Spain is now mainly centered on issues like:

- Financing (could the SNHS survive a new wave of the budgetary adjustments? Is it possible to recover an adequate and a more territorially fair level of financing? How a relevant cohesion fund could be re-introduced?)
- Good governance (both at Central and Regional levels), including more transparency, better mechanisms to select and control health managers and improving social and professional engagement) [15].
- The need of a new NHS General Act that takes into

account changes and developments since 1986, re-establishes *de jure* universality, and updates and clarifies the prolific legislation on health matters and the SNHS issued during the last 30 years. On this matter, the issue of giving more power to the CI is periodically raised, though it not may be acceptable for some Regions.

As a matter of fact, there is no so much eagerness for central health planning as for sharing the good (and bad?) practices taking place at regional level, with an information-action approach [16].

Conclusions

Health planning is an elusive term that may have different meanings: program planning, planning as decisions about resources allocation, planning as coordination of efforts, planning as the elaboration and implementation of a "Plan", etc. [17].

Spain has an almost federal organization of the State and, accordingly, the SNHS facilities and functions are deeply decentralized with very few exceptions. For years, the central Government had no other option to keep the system aligned that using some few additional funds, and the relatively weak CI coordination mechanisms.

Therefore, there is no a single "Spanish" Health Plan but 17 Regional Plans, even though Health Information Systems are relatively well developed and a lot of reliable health information is periodically published and discussed. Health Plans do exist in the Regions but their practical impact on the Regional Health Services activity and performance is doubtful.

The recent economic crisis has changed this picture, with the Ministry of Finance entering decisively into "health planning", solely guided by financial considerations, an approach that hampered the capacity of SNHS to respond to people health needs.

As the conservative government that took office at the end of 2016 has no parliamentary majority, political negotiations and agreements are to be required. A number of recent official statements suggest a certain relief on public social spending may occur to be compensated with some taxes increase. How consistent this "new approach" will be and how it will affect SNHS 2017 budget is still uncertain[1].

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1 -At the moment of writing these lines a political agreement between central and regional Governments to redisigned the entire financing system to Regions was reached. This new system (replacing to former one that expires in 2014 will be operative at the end 2017 and it will fundamentally affect health, education and social regional services

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Planeamento de saúde na Alemanha

Princípios fundamentais: descentralização, subsidiariedade, corporativismo

Health planning in Germany
Fundamental principles: decentralisation, subsidiarity, corporatism

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Resumo

O planeamento de saúde na Alemanha está amplamente determinada pela estrutura corporativista e descentralizado do seu sistema da saúde. Desde o início, o Estado terceirizou funções centrais de decisão e direção a órgãos de caráter público sem fins de lucro que representam os compradores e os prestadores de saúde, ou seja os seguros sociais obrigatórios de doença e hospitais, médicos da atenção ambulatória e colégios médicos. Estes organismos atuam segundo alguns princípios fundamentais como solidariedade, paridade, subsidiariedade e autogoverno, isto é trata-se de órgãos autónomos de afiliação obrigatória e autoadministrados. Enquanto o Governo define o marco legal, a direção operativa do sistema e a concretização das regulações ficam a cargo da auto-governança. As associações têm o mandato legal de participar ativamente no planeamento e na direção do sistema. O órgão não governamental máximo e mais influente do sistema de saúde alemão é a Comissão Conjunta Federal composta por igual quantidade de representantes das caixas sociais e dos provedores. A comissão estipula as regras comuns a todos os níveis de cuidados médicos, orientações para a garantia da qualidade e orientações processuais para o planeamento; acima de tudo é responsável pelo pacote de benefícios do seguro social obrigatório de doença. Se por um lado o corporativismo assegura um alto nível de participação e legitimidade, por outro dificulta a implementação de políticas baseadas na evidência que estejam de acordo com as prioridades sanitárias.

Palavras Chave:
Cuidados de saúde, planeamento em saúde, segurança social, seguros de saúde, Alemanha.

Abstract

Health planning in Germany is largely determined by the corporatist and decentralised structure of the healthcare system. From the very beginning, the State has outsourced central decision-making and management functions to public, non-profit bodies representing purchasers and providers, i. e. compulsory social health insurance schemes and hospitals, outpatient care physicians and medical colleges. These organisations operate according to fundamental principles such as solidarity, parity, subsidiarity and self-government, that is they are autonomous and self-governed bodies with mandatory affiliation. While the government defines the legal framework, the system of self-governance is responsible for the operational steering of the healthcare system and the implementation of regulations. Corporatist associations have the legal mandate to actively participate in the planning and guidance of the system. The highest and most influential non-governmental body in the German health system is the Joint Federal Commission consisting of equal numbers of representatives from social insurance funds and providers organisations. The commission stipulates common rules for all levels of medical care, quality assurance guidelines and procedural guidelines for planning; over all is responsible for the benefits package of the social health insurance schemes. While corporatism ensures a high level of participation and legitimacy, it also hampers the implementation of evidence-based policy measures according to health priorities.

Key Words:
Health care, health planning, social security, health insurance, Germany.