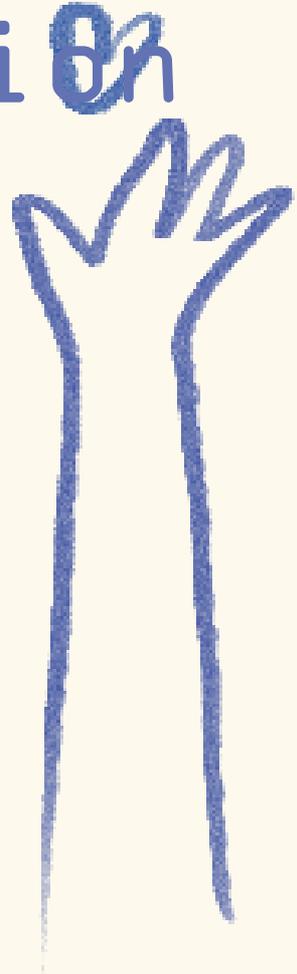




Adapting Primary Care to the current needs of the population in Spain



Final Report Executive Summary

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AARC - Consortium

The project is funded by the European Union via the Technical Support Instrument and implemented by NTT Data, in cooperation with the European Commission's Directorate General for Structural Reform Support (DG REFORM).

Abbreviations

AB	Advisory Board
AEC	Community Nursing Association (<i>Asociación Enfermería Comunitaria</i>)
AEEP	Spanish Association of Paediatric Nursing (<i>Asociación Española de Enfermería Pediátrica</i>)
AEF-APySC	Spanish Association of Physiotherapy in Primary Health Care and Community Health (<i>Asociación Española Fisioterapia en Atención Primaria y Salud Comunitaria</i>)
AEPAP	Spanish Association of Primary Care Paediatrics (<i>Asociación Española de Pediatría de Atención Primaria</i>)
AEPCP	Spanish Association of Clinical Psychology and Psychopathology (<i>Asociación Española Psicología Clínica y Psicopatología</i>)
AGP	General Alliance of Patients (<i>Alianza General de Pacientes</i>)
EKSOTE	South Karelia Health and Social Care District
FAECAP	Federation of Associations of Community and Primary Care Nursing (<i>Federación de Asociaciones Enfermería Comunitaria y Atención Primaria</i>)
FAME	Federation of Midwives Associations of Spain (<i>Federación de Asociaciones Matronas de España</i>)
FEP	Spanish Patient Forum (<i>Foro Español de Pacientes</i>)
GDP	Gross Domestic Product
ICT	Information and Communications Technology
INGESA	National Institute of Health Management (<i>Instituto Nacional de Gestión Sanitaria</i>)
KoM	Kick-off meeting
KPIs	Key Performance indicator
MoH	Spanish Ministry of Health
NHS	National Health System
OWG	Operational Working Group
PC	Primary Care
PM	Project manager
POP	Patient Organisations Platform (<i>Plataforma Organizaciones Pacientes</i>)
RD	Royal Decree
RSWG	Regional Stakeholders Working Groups
SC	Steering Committee
SCETSS	Spanish Scientific Society of Social Health Work (<i>Sociedad Científica Española de Trabajo Social Sanitario</i>)
SEDAP	Spanish Society of Primary Care Managers (<i>Sociedad Española de Directivos de Atención Primaria</i>)
SEMERGEN	Spanish Society of Primary Care Physicians (<i>Sociedad Española Médicos Atención Primaria</i>)
SEMFC	Spanish Society of Family and Community Medicine (<i>Sociedad Española Medicina Familiar y Comunitaria</i>)
SEMG	Spanish Society of General and Family Physicians (<i>Sociedad Española Médicos Generales y de Familia</i>)
SEPEAP	Spanish Society of out-of-hospital and Primary Care Paediatrics (<i>Sociedad Española de Pediatría Extrahospitalaria y Atención Primaria</i>)



Table of contents

1	Introduction.....	1
2	Analysis of the current situation of Primary Care in Spain.....	4
3	Case study on Primary Care reforms.....	12
4	Recommendations and Operational Plan for adapting Primary Care to the current needs of the population in Spain.....	17
5	Conclusions and next steps.....	23
6	Annexes.....	24
	Annex I: Case Study Sheets.....	25
	Annex II: Members of the Working Groups	42

1. Introduction

The European Commission has supported the **Directorate General for Public Health from the Ministry of Health of Spain** (MoH) in developing Recommendations on criteria, governance models and requirements to promote equity in access to high-quality Primary Care (PC) services through the project 'Adapting Primary Care to the current needs of the population in Spain'. The project, funded by the European Union through the [Technical Support Instrument](#), has been technically developed by **NTT Data** in close collaboration with the Subdirectorate General for Quality of Care of the Directorate General of Public Health from the MoH and with the European Commission's Directorate-General for Structural Reform Support (**DG REFORM**).

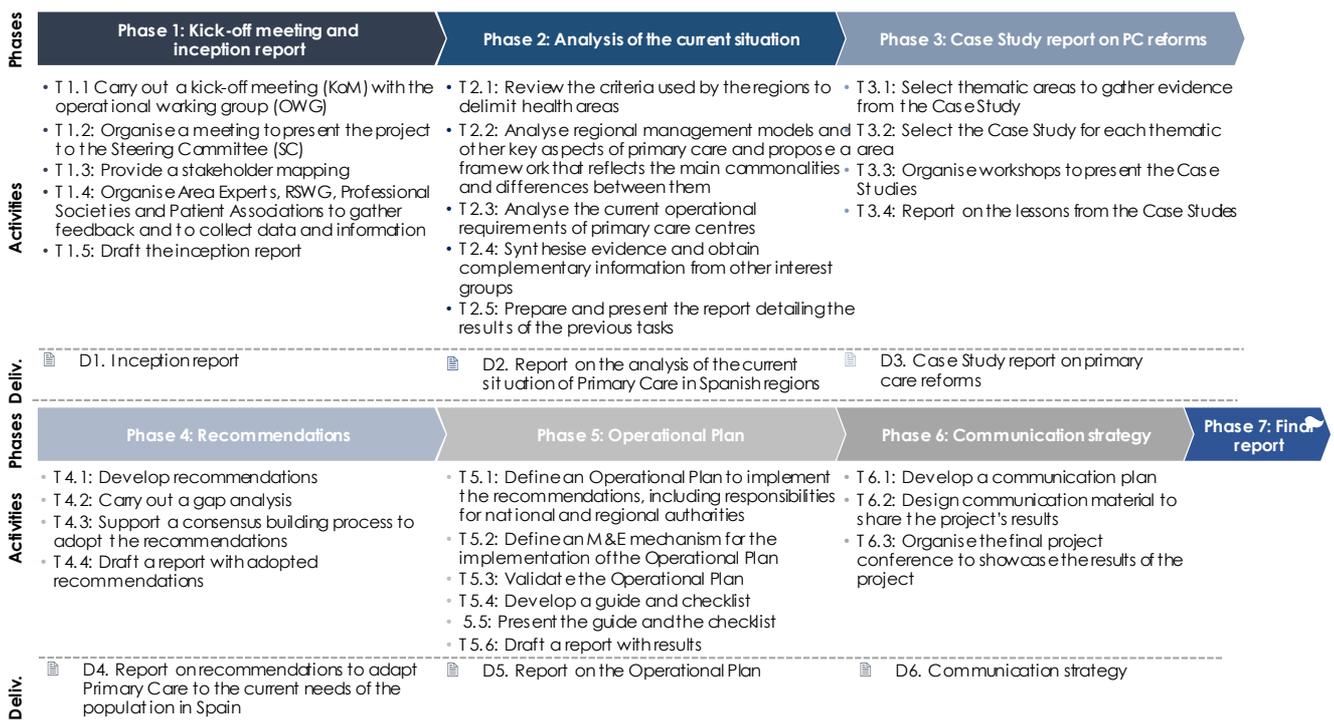
The Technical Support Instrument helps member states to recover from social and economic effects of the COVID-19 pandemic, to improve the quality of public services and to reinforce sustainable and inclusive economic growth. This project arises from the need to strengthen Primary Care in Spain, improve the National Health System sustainability and reduce health inequities.

The expected result is to provide tools that allow the National Health System to adapt PC services to the specific needs, such areas with hard-to-fill positions among others. Regarding the expected impact, endorsed recommendations should contribute, over the long-term, towards improving access and ensuring equity and quality of PC services through all regions.

This 20-month project was carried out through a participatory consensus process involving all Health Regions and a consultative process was carried out with Professional Societies and Patient Associations. It also involved experts and an Advisory Board. The methodology used included individual interviews, Delphi questionnaires, presentation and discussion meetings and online surveys.

The project consisted of 7 phases:

Figure 1: Project phases, activities and deliverables

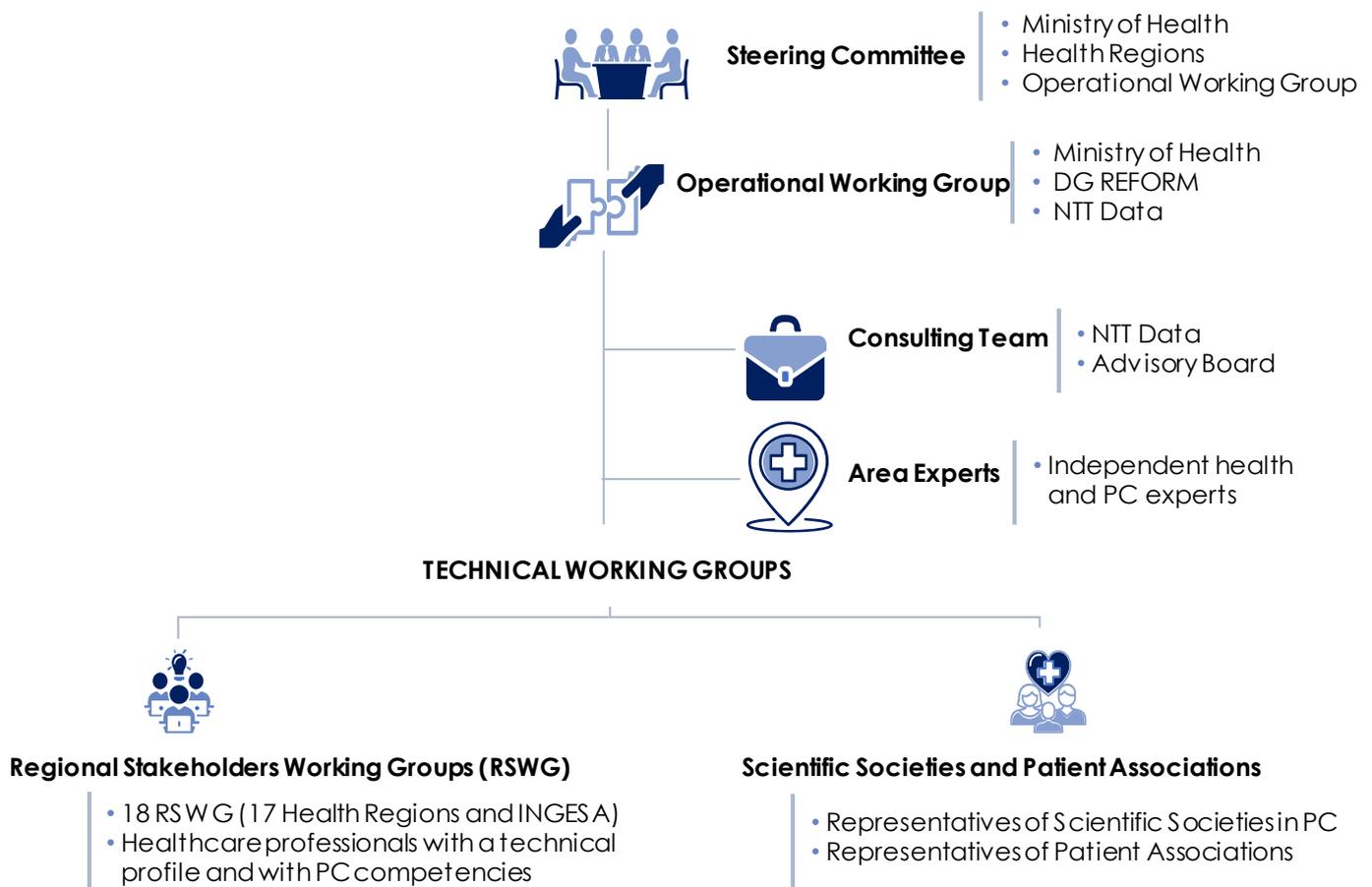


The work carried out resulted in the following products:

- Detailed analysis of the current situation of Primary Care in each Health Region in the following areas: 1) Planning; 2) Management and Organisation ; 3) Human Resources; 4) Financing; and 5) Infrastructure and Equipment (Phase 2 results).
- Case Studies of reforms carried out in Primary Care in other countries (Phase 3 results).
- Recommendations to adapt Primary Care to the needs of the population in each area of analysis (Phase 4 results).
- Detailed Operational Plan to implement the recommendations as well as their monitoring, with tools to facilitate their implementation (Phase 5 results)

Different Working Groups participated in this project, including fieldwork, data collection, participation in workshops and meetings, consensus agreement on Recommendations and the Operational Plan, and drafting and reviewing the documents.

Figure 2: Working Groups involved in the Project



The Working Groups functions are described below:

- **Steering Committee (SC):** Deliberate and adopt agreements on any issues submitted for its consideration by the Operational Working Group (OWG).
- **Operational Working Group (OWG):** Responsible for the operational and strategic monitoring of the project, as well as for reviewing and validating the project deliverables.
- **Advisory Board (AB):** Responsible for advising the NTT Data team.
- **Area Experts:** Provide strategical support in the project, to consultations requested by the project team; participate in the Case Study workshops and make the first proposal of Recommendations and Operational Plan.
- **Regional Stakeholders Working Groups (RSWG):** Responsible for providing their opinion and knowledge as well as complementary information on the current situation of PC in their Health region, as well as for defining the Recommendations and the Operational Plan.
- **Scientific Societies and Patient Associations:** Responsible for providing their opinion, expert view and complementary information on the current situation of PC and during the Recommendation phases.

The project focused on 5 areas of analysis:



1. **Planning:** Criteria for defining healthcare system and basic health zones for healthcare provision; national and regional policies and regulations; differences between urban and rural areas.
2. **Management and Organisation:** Management models; differences between rural and urban areas; coordination models between levels of healthcare; coordination models between health and social care providers.
3. **Human Resources:** Human resources policies; cooperation models between professionals; composition of Primary Care teams; staffing ratios.
4. **Financing:** Share of the regional health budget devoted to Primary Care; financing needs.
5. **Infrastructure and Equipment:** Availability of medical equipment; information and communications technology (ICT); quality of infrastructures (consultation rooms, etc.); maintenance, renovation or building plans for Primary Care centres.

2. Analysis of the current situation of Primary Care in Spain

2.1 Objectives

The objectives of Phase 2 are:

- To provide the Ministry of Health with a comprehensive analysis of the current PC organisation in all Health Regions, including the strengths and weaknesses of the different models.
- To carry out an analysis of the criteria used by the Health Regions to define the boundaries of the geographical areas for service provision as well as the PC regional management models, infrastructure and equipment.
- To assess the extent to which the 1986 General Health Law (“*Ley General de Sanidad 1986*”) and the provisions of Royal Decree (RD) 137/1984 and RD 1575/1993 influence the criteria adopted by the Health Regions and affect the healthcare system’s capacity to ensure access to services.
- To assess differences and challenges to PC organisation in urban and rural areas and for specific populations, such as the elderly.

2.2 Methodology

Desk research

1



The aim of the desk research was to obtain quantitative and qualitative information on the 5 areas of analysis in order to discover the current situation of Primary Care provision in Spain.

The desk research was carried out in two stages: (1) literature research; (2) data collection and synthesis.

Data sources and documents developed during the desk research

Sources searched	Type of documents developed
Regional and national health laws and regulations	Database containing the quantitative information gathered
Publically available databases	Technical data sheets on Health Regions
Information provided by RSWG	

2



Semi-structured interviews with the RSWG

The main objective of the semi-structured interviews was to obtain complementary information to the desk research, thereby broadening knowledge while obtaining the opinion of the RSWG about the current situation of PC in Spain. Their views on the current situation of PC within their Health Regions were also collected. Additionally, respondents validated and proposed issues to be appraised in the online surveys to be conducted amongst healthcare professionals with PC management competencies.

3 Online survey (I) amongst healthcare professionals with PC management competencies

An online survey (survey I) was conducted amongst healthcare professionals with PC management responsibilities within the Health Regions.

The aim of the online survey was to complement the information obtained from the semi-structured interviews with the RSWG to delve into aspects related with usual practice, organisation and currently available resources. It was also possible to learn about the challenges and opportunities that PC faces. The questions of the online survey were grouped according to the 5 areas of analysis of the project. Responses were aggregated and completely anonymised so they could not be traced back to the individual respondent.

4 Online survey (II) amongst healthcare professionals from the main PC Scientific Societies and amongst members of the most representative Patient Associations

The aim of this online survey was to discover the perception of PC Scientific Societies and of Patient Associations on the current status of Primary Care. As in online survey I, questions were grouped according to the 5 areas of analysis of the project, and responses were aggregated and completely anonymised so they could not be traced back to the individual respondent.

2.3 Results

2.3.1 Planning

The 1986 General Health Law ("*Ley General de Sanidad 1986*") establishes the essential criteria that define the healthcare system and basic health zones and include geographic, socioeconomic, demographic, labour, epidemiological, cultural, climatological factors as well as the type and amount of communication channels and resources, and the healthcare facilities available. RD 137/1984, of 11th January 1984, establishes that the criteria for delimiting the Health Zones are demographic, geographical and social together with the size of the population to be cared for within each zone (between 5,000 and 25,000 inhabitants whether in rural or urban areas).

The members of the interviewed RSWG highlighted the strengths of the criteria of current laws and regulations. Major strengths include adequate design to fulfill their purpose; the accessibility and equity in access they allow; their transparency for both professionals and citizens; the territorial delimitation and the proximity to the target population that the criteria guarantee.

Participants of some Health Regions felt that the criteria of current legislations and regulations should be reviewed. There are some Health Regions that already apply other criteria not included in current regulations, such as criteria related to the areas with hard-to-fill positions, seasonal (summer) patients' commute and interprovincial collaborations to allocate resources for adequate healthcare provision. As a result, some regions are currently reviewing the criteria and defining the healthcare map while one of them is already working on its modification.

According to the interviews conducted with RSWG members, population ageing and dispersion, the increase of the incidence of chronic diseases and of mental health-related problems, the shortage of professionals, the technological gap and the lack of coordination between the different levels of care are challenges faced by the Health Regions. RSWG members believe that it is **necessary to incorporate more dynamic criteria than those currently in place.**

Challenges faced by the Health Regions, according to the RSWG



Population ageing



Distribution of the population



Chronic diseases



Mental health



Shortage of professionals



Technology gap



Coordination between levels of care

Additionally, healthcare professionals with management competencies in PC taking part in the online surveys, the members of the Scientific Societies and of Patient Associations agreed with the RSWG participants on the fact that the **existing criteria are not suitable to respond to the current needs of the Spanish population.**

Some Health Regions stated that it is necessary to consider the dispersion of the population, areas with hard-to-fill positions, and to give more importance to the social determinants of health and to health inequalities.

2.3.2 Management and Organisation

Completed in 2002, the decentralisation of healthcare provision has allowed and fostered the development of new models for the Management and Organisation of Healthcare Centres and Services in the Health Regions within a common general framework.

Most Health Regions follow a **direct public health management model**, apart from Catalonia (and, to a lesser extent, the Region of Valencia "Comunidad Valenciana"), where services are provided by both Public Administration and private providers). According to the participants from the Health Regions, the strengths of the direct public health management model are **accessibility, equal access to healthcare services and health promotion**. An aspect to be improved includes the **rigidity and slowness** of administrative processes. The main advantage of the mixed management model lies in the diversity.

From an organizational point of view, there are **3 management models**:

1

Single management model

in which Primary Care is managed by a single body and independent from Hospital Care (as in *Cantabria* and *Madrid*).

2

Shared management model (also called Integrated Care Management) in which Primary Care and Hospital Care are managed by the same body. This model exists in *Andalucía, Aragón, Principado de Asturias, Comunidad Valenciana, Extremadura, Galicia, Región de Murcia, País Vasco* and *La Rioja*.

3

Mixed management model

in which two types of management models coexist in the Health Regions but models vary depending on the Health Area (rest of Health Regions).

Strengths and areas of improvement in PC management models according to RSWG participants

Technical representatives of the Health Regional stated that **single management model** allows for a better response to the needs of the healthcare professionals and for better budget management compared to other models. However, health budget distribution is often imbalanced, with the largest share most frequently allocated to Hospital Care.



Likewise, technical representatives of the Health Regions stated as a strengths of the **shared management model** the functional integration of all public healthcare resources that enables the provision of joined solutions, continuity of care and improved efficiency. Regarding the areas of improvement, in this model, the position of Primary Care is reduced in importance and less visible than Hospital Care. Additionally, financing is of greater importance in Hospital Care than in Primary Care.



Challenges in the Management and Organisation of PC over the next 2 to 5 years

Most healthcare **professionals with management competencies in PC** from rural areas identified as most challenging the management of the available resources to guarantee equal access to PC services. On the contrary, healthcare **professionals with management competencies in PC** from urban areas gave the highest importance to professional recruitment and retention and to having greater self-management capacity and autonomy.



The members of the **Scientific Societies** surveyed considered most challenging the provision of PC with greater decision-making capacity and the improvement of coordination between Primary Care and Hospital Care - a challenge also highlighted by the **Patient Associations**.

Regarding the **organisation of PC and social care**, the participants from the Health Regions highlighted the need for continuing to work on on improving coordination and on strengthening plans and initiatives fostered by the COVID-19 pandemic.



2.3.3 Human Resources

There is a structural problem at a Human Resources level which needs to be corrected in order to respond to emerging health care challenges. The 2022-2023 Primary and Community Care Action Plan approved by the NHS Interterritorial Council established as objective number 2 to "Increase the number of professionals, guarantee their availability and improve working conditions so as to enable accessibility, longitudinal care, stability, attract talent and consequently reduce temporary work". This objective has 11 actions directly related to Human Resources.

Health Regions, Scientific Societies and Patient Associations considered that a higher number of professionals is necessary to provide PC. As a result, **plans and initiatives focused on improving contract conditions and on providing professional incentives have been developed.**



In addition to Family and Community Medicine, Paediatrics and Nursing professionals, more than 40% of the healthcare professionals with management competencies in PC interviewed believed that other profiles, such as Clinical Psychologists, Physiotherapists and Midwives are needed to provide the services included in the National Healthcare Basket of Services (48%, 47% and 46%, respectively).

In rural areas, the most demanded profiles are also Family Physicians and Nurses. In urban areas, respondents agreed that there is a lack of Family Physicians. Physiotherapists are the second most demanded profiles, followed by Clinical Psychologists and Paediatricians.

75% of the surveyed healthcare professionals who have management competencies in PC were of the opinion that there are obstacles for recruiting, attracting and retaining PC professionals.

Some of the main obstacles mentioned were lack of professionals willing to work in PC and unsatisfactory working conditions. In the coming years, a high number of PC professionals will retire, and it is considered necessary to increase the number of **training positions for physicians** in the specialty of Family and Community Medicine. It is also considered important to promote the role of Family and Community Nursing. This is a challenge that participants from the Health Regions and from the Scientific Societies similarly emphasized.

It is of **utmost importance to cover job vacancies in rural areas and in underserved areas with hard-to-fill positions.** According to the interviews carried out, these areas are not very attractive for new recruits and some Health Regions are implementing specific human resources policies such as guaranteeing that young professionals have access and participate in the selection processes to cover permanent contract positions in rural areas, making working hours more flexible to facilitate work-life balance or providing greater economic incentives.

2.3.4 Financing

Public healthcare expenditure is 7.5% of the GDP in Spain (2020), with a regional variation that ranges between 6.2% and 9.7% depending on the territories. The national average percentage spent on PC as a proportion of total healthcare expenditure is 14.3%. There are regions with differences of up to 7 points between the maximum and minimum values (17.5% compared to 10.7%).

PC budgets can be estimated for the provision of PC only or can be integrated into the budgets for other levels of healthcare provision. Two types of budget coexist in the different Health Regions:



There is a general agreement among the interviewed healthcare professionals who have management competencies in PC (72%), Scientific Societies (96%) and Patient Associations on the **insufficient allocation of PC budgets** to offer good quality service, accessibility, equity and sustainability.

Almost all participants of the Health Regions stated that they have set objectives for increasing (or at least maintaining) the annual funding allocated to PC; this is considered a necessary action to position PC as the backbone of the healthcare system.

The criteria for determining the budget for PC are:

- (1) historical expenditure;
- (2) needs and priorities defined by the competent budgeting bodies.

It is important to highlight that this criteria differentiation is not exclusive. Both groups of criteria can be applied to establish the budgets for each Health Region.

According to the opinion of the surveyed healthcare professionals who have management competencies in PC, the Scientific Societies and the Patient Associations, **the priorities for financing PC over the next 2 to 5 years are:**



Human Resources



Acquisition and/or renewal of medical equipment



Investment in ICT/digitalisation



Creation and/or adaptation of physical spaces

In addition, the representatives of Patient Associations indicated that a **healthcare approach to chronicity, chronic disease care and new models for healthcare delivery** should be financing priorities.

2.3.5 Infrastructure and Equipment

National regulations set the general basis for authorising the implementation of healthcare centres and services (RD 1277/2003 of 10th October 2003). Likewise, regional regulations set the technical requirements that all Primary Care centres must accomplish locally.

Two thirds of the participants from the Health Regions stated that **maintenance plans** to preserve the infrastructure of local centres and clinics are in place. These maintenance plans are **updated with a variable frequency** (either annual, multi-annual, or not established) depending on the Health Region considered.

In general, the participants from the Health Regions considered that the internal infrastructures in PC centres allow the delivery of PC services contemplated in the National Healthcare Basket of Services. However, representatives from most of the territories (14 out of 18) considered that **adaptations are necessary** to meet present and future challenges. Some of these adaptations are already anticipated in the new basket of services to be implemented.

Equipment needs are established according to:

- (1) requests from centres to replace equipment obsolescence;
- (2) territorial strategies to respond to changes in the Healthcare Basket of Services set by the Health Region.

The main criteria applied for equipment renewal are 4:

- 1 age;
- 2 equipment damage or loss;
- 3 obsolescence;
- 4 decisions to include new features and functionalities.

Both healthcare professionals who have management competencies in PC and the representatives of Scientific Societies agreed on the **overall poor condition of the infrastructure of Primary Care centres**.



Most territories (16 out of 18) have an **established equipment renewal plan**, with the frequency of renewal varying according to the territory.



Not all the Health Regions report having **maintenance plans for Primary Care equipment** (approximately half); however, most territories (17 out of 18) do have an inventory of equipment.



Regarding **the technological equipment of PC centres**, RSWG participants reported that it is in good condition. The technological equipment has been recently renewed, or renewal has been planned or annual replacements due to declared obsolescence take place regularly.

However, there is disparity of opinions: 56% of healthcare professionals who have management competencies in PC and 72% of the members of the PC Scientific Societies believe that **the technological equipment of PC centres** is not in a good condition. This view is in line with the opinion of the Patient Associations' representatives.



The development and implementation of **PC information systems**, understood as the integration of the electronic health records amongst levels of care varies depending on the territory:

- (1) A single Electronic Health Record shared among the different levels of healthcare.
- (2) An Electronic Health Records restricted to PC.



With the exception of Ceuta and Melilla, all the territories reported having a **digital portal** dedicated to patients.

All Health Regions' participants felt that the available equipment and the Healthcare Basket of Services are coherent. The few exceptions reflect the need for some further adaptations in the future.

According to the opinion of the surveyed professionals, **the resources on infrastructure and equipment that will be needed over the next 2 to 5 years** are (ordered from the most to the least important) (1) creation and/or adaptation of physical spaces (51%); (2) investment in ICT resources for the PC centres (41%); (3) acquisition and/or renewal of medical equipment (41%); (4) investment in ICT resources for the national healthcare system (26%).



3 Case study on Primary Care reforms

3.1 Objectives

The objectives of Phase 3 are:

- To acquire knowledge and experiences from other countries, mainly European, to improve Primary Care within the healthcare system.
- To select aspects and draw conclusions that are sufficiently complete, applicable, and detailed to help with developing recommendations for improving PC in Spain.

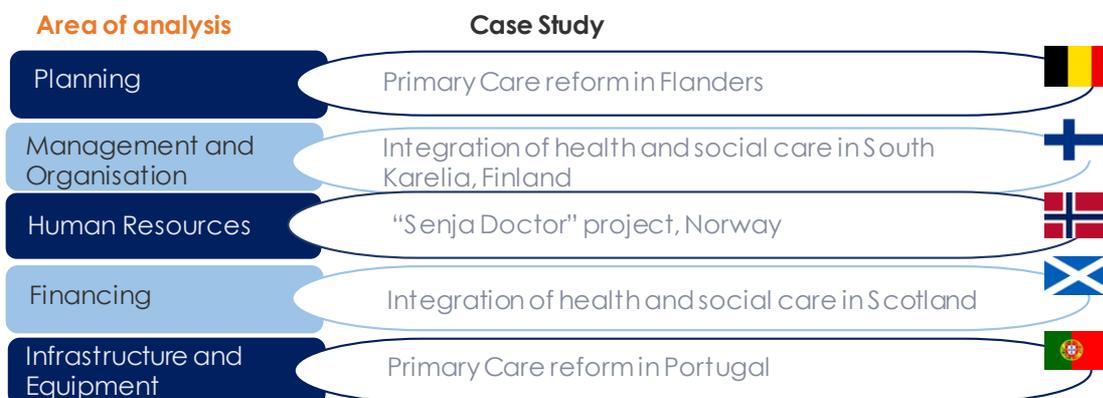
3.2 Methodology

Study phase 3 methodology had 2 stages:

Selection of case studies

1 The significant characteristics for the bibliographic selection of the case studies were PC reforms related to the 5 areas of analysis considered in the project, PC reforms carried out in other countries of the European Union, countries with healthcare systems similar to the Spanish healthcare system and countries with a similar administrative organisation to Spain (decentralised). Area experts and the Advisory Board contributed to complementing the bibliography (articles, reports, etc.). A total of 112 bibliographic references on Primary Care reforms were reviewed. The OWG selected 9 (between 1 and 3 for each area of analysis of the project). For each case study, a case study sheet was generated. Ministry of Health representatives selected one case study per area to discuss its potential transferability in online workshop sessions with members of the RSWG and representatives from Professional Societies and Patient Associations. For the selection of each Case Study to be discussed in the online workshops, aspects such as transferability, applicability, usefulness, relevance, adequacy, innovation, impact, equity, accessibility, and continuity of care were taken into account.

Figure 3. Selected Case Studies for the online workshops



Annex I shows the detailed Case Study Sheets selected to be discussed in the online workshops (n=5).

2 Online workshops on the case studies



Participants at the online workshop I were members of the RSWG and at the online workshop II were representatives of Professional Societies and Patient Associations. Both sessions were attended by the Operational Working Group, Area Experts, Advisory Board members and international experts involved in the selected reforms / with deep knowledge of them. Each online workshop was divided into 5 sessions, one section for each area of analysis. To make the online workshops more dynamic, the Case Studies to be discussed and a questionnaire to encourage reflection were sent to all participants in advance.

The sessions in each area started with a presentation of the details of the case studies by the international experts, followed by questions from the audience and finally they focused on a discussion about transferability and alternatives that are being implemented in the regions in relation to the analysed aspects of the case study structured as follows:

- **Relevant aspects** of the reform that may be interesting to transfer to Spanish PC. Participants voted on the aspects of reforms they found most important to be considered for transferability. They had 3 votes and could distribute them as they deemed appropriate.
- **Transferability** of prioritised aspects of interest. The most voted relevant aspects were debated in order to assess: the added value of aspects of the reform, the possible transferability to the Spanish case (facilitators and barriers) and alternatives. After each discussion, a vote was made via Zoom to assess the impact, in terms of benefits, that this aspect would have on Spanish PC, and the effort in terms of resources that would be required to implement each aspect in Spain (none, low, high, very high).
- **Impact - effort matrix.** The results from voting were represented in a "Quick-Wins" matrix. The results were weighted, and the values were normalised on a scale from 0 to 10, with 0 being no value and 10 being the highest possible value.
- **Conclusions.** The invited member from the Advisory Board for each Case Study was responsible for summarizing the main conclusions obtained during the session.

The main aspects of the Case Studies highlighted by members of the RSWG and representatives of Professional Societies and Patient Associations, and presented and discussed in the online workshops, are shown below.

International Experts – Case studies discussed during the online workshops

Area	Country	Name	Position
Planning	Belgium	Thomas Boeckx	Primary Care Physician. Flanders Agency of Health and Care
Management and Organisation	Finland	Merja Tepponen	Medicine PhD and Director of development of the South Karelia Health and Social Care District (EKSOTE)
Human Resources	Norway	Jorunn Nygaard	Family Physician, University of Bergen. Karsten Kehlet, National Center of Rural Medicine, University of Tromsø
Financing	Scotland	Sarah Reed	Senior Fellow at Nuffield Trust
Infrastructure and Equipment	Portugal	Luis Pisco	Family Physician. President of the Regional Health Administration of Lisbon and Tagus Valley

3.3 Results

3.3.1 Planning

Primary Care reform in Flanders



The reform of PC in Flanders was selected because of its interest for **reorganising and planning** the healthcare system, establishing **organisational levels**. Beyond the new criteria followed to delimit the new areas, the assigned functions for each organisational level were also considered of great interest. Moreover, this reform was particularly relevant because it focused on person-centred care.

The members of the RSWG indicated that the most relevant aspects were: (1) **social and healthcare coordination with a common management body**; (2) support for advancing **ICT** implementation. Representatives of Professional Societies and Patient Associations indicated that the most relevant aspects of the Flemish reform were: (1) reinforcement of **patients self-care capacity**; (2) **continuity of care** for people with complex and/or long-term care needs by coordinating healthcare and non-healthcare sectors, and with the participation of informal caregivers. Both groups emphasised the complexity of establishing joint information systems and sharing resources between health and social care.

Representatives of the Professional Societies and Patient Associations focused the debate on aspects related to the training of professionals and patients, and on the continuity of care, while the members of the RSWG addressed aspects related to the complexity of implementing integrated care with new ICTs while avoiding inequity.

3.3.2 Management and Organisation

Integration of health and social care in South Karelia, Finland



The South Karelia Case Study was selected because of its innovation in implementing comprehensive **home-based healthcare** for the ageing population in this region of Finland. The initiative is supported by the creation of a **single patient information system**.

Both online workshops considered (1) the **integration of health and social care** and (2) the **digital integration of services**, the two most relevant aspects of the reform. Both working groups agreed that the equity and **single-patient approach** are added values for the Spanish healthcare system. However, major limitations in Spain include the separation of regional care settings with different electronic records, a lack of interoperability, restrictive laws, the need to redistribute competences and digital gaps..

Some relevant aspects highlighted by the representatives of the Professional Societies and Patient Associations were not priorities for the members of the RSWG. Such priorities included providing greater autonomy to the municipalities, establishing medicines dispensation centers in rural areas or establishing financial support based on patients' needs.

3.3.3 Human Resources

"Senja Doctor" project, Norway



The "Senja Doctor" project in Norway was selected as a case study due to its **successful results** for healthcare professionals, policy makers and administration authorities. The reform succeeded in **reducing professional turnover** and in strengthening the **sense of professional belonging** to the healthcare system.

Both online workshops covered similar issues, focusing mainly on the need to establish specific incentives for professionals working in hard-to-fill positions/areas: (1) recognition of **travelling hours as working time**; (2) **reduction of the patient per professional ratio**; (3) measures to **balance work and family life**; (4) increased **research opportunities** for professionals filling these hard-to-fill positions.

The members of the RSWG also addressed organisational aspects, such as the figure of an "official centre" or "host", the collaborative model for municipalities and the network created to support professionals.

Regarding the potential transferability of these aspects, while the RSWG members recognised organisational aspects, PC teams composition and facilitators predisposition, the representatives of the Professional Societies and Patient Associations mentioned the efforts already made by the Health Regions as facilitators.

Both groups highlighted two limiting aspects in Spain: (1) the rigidity of Human Resources policies, which makes it difficult for the Health Regions to adapt quickly for changing needs; (2) the current and especially future lack of available healthcare professionals.

3.3.4 Financing

Integration of health and
social care in Scotland



The Scottish reform is particularly relevant because of the **association of the health and social care budgets**. The integrated authority bodies, made up of local authorities and healthcare boards, manage a single budget.

Both working groups indicated four relevant aspects: (1) the **integration of PC with social care services**; (2) the **association of budgets**; (3) the orientation towards the provision of **health care in the community**; (4) the importance of defining **valid and reliable KPIs**. However, the representatives of the Professional Societies and Patient Associations highlighted the importance of multidisciplinary teams while the members of the RSWG mentioned the legal and structural aspects to be taken into account.

The members of the RSWG identified the current social and healthcare interactions that resulted from the pandemic as facilitators of the implementation of this measure, and they stated the need for maintaining that. The representatives of the Professional Societies and Patient Associations found the lack of non-pharmacological therapies, the need for education in prevention, the need for changes in the governance model and the lack of political willingness to carry out a reform directed towards integration as limiting factors in Spain.

3.3.5 Infrastructure and Equipment

Primary Care reform in Portugal



The reform of PC in Portugal was selected because of the complete digitalisation of the healthcare services that was carried out. This reform allowed for a universal operating system that enables **integrated care** and the **monitoring of the teams' productivity, accessibility and quality of care**.

The most relevant aspects identified by both groups of participants were similar: (1) **modernisation/renewal of infrastructure and ICT**; (2) **monitoring and evaluation of teams through KPIs**; and (3) **interoperability** of information systems at national level. Although similar workforce capacity issues, such as incentives and motivation, were addressed in both online workshops, the representatives of the Professional Societies and Patient Associations focused the discussion on the assessment of professionals and the RSWG members mentioned the rigidity of the current regulations.

In relation to other aspects addressed, RSWG members focused the rest of the discussion on KPIs and the representatives of Professional Societies and Patient Associations discussed in depth the interoperability of information systems at the national level.



4. Recommendations and Operational Plan for adapting Primary Care to the current needs of the population in Spain

4.1 Objectives

The objective of Phase 4 was:

- To formulate recommendations on key aspects identified in the deliverables of "Analysis of the Current Situation of Primary Care in Spain" and "Case Studies on Primary Care Reforms" to establish new criteria and requirements to improve the management of Primary Care within the NHS in Spain.

The objectives of phase 5 were:

- To define specific measures to be developed in the field of Primary Care to comply with the established recommendations by defining an Operational Plan, a mechanism for monitoring and evaluating its implementation, and a Guide with an overview of available funds to facilitate the development of the recommendations and the Operational Plan.
- To encourage participation and agreements amongst the RSWG and other stakeholders involved in the development of the Operational Plan.
- To allow the Health Regions to prioritise actions and to estimate the necessary resources.

4.2 Methodology

- 1** **Formulation of preliminary recommendations/ Operational Plan in the following steps:**
- Drafting by the Area Experts and the project team of a initial proposal of the recommendations (Phase 4) and the specific actions to accomplish the recommendations and KPIs (Phase 5).
 - Holding of a working sessions with the Area Experts to discuss recommendations (Phase 4) and review/comment on the preliminary actions and KPIs (Phase 5) as well as on their contributions.
 - Reformulation of preliminary recommendations / Operational Plan by the project team.
 - Recommendations were modified for the following reasons: i) Recommendations addressing similar aspects were unified; ii) recommendations that did not meet the defined criteria or were out of the project's scope were discarded. Additional recommendations on relevant aspects were included. The project team compiled a total of 68 recommendations from the Area Experts, and after modifications based on the reasons described above, the final list included 19 recommendations.
 - Reformulation by the project team of the preliminary actions and KPIs to incorporate the contributions of the Area Experts.
 - Presentation of preliminary recommendations / Operational Plan to the RSWG.

2 Online consensus surveys administered to the RSWG (Phases 4 and 5), Professional Societies and Patient Associations (Phase 4)



Applying the Delphi methodology, two consecutive questionnaires were sent in each phase. Recommendations (Phase 4) and actions and indicators (Phase 5) in questionnaires 2 were reformulated taking into account the responses obtained in questionnaire 1 and they were ordered based on the established prioritisation scheme .

3 Workshop with the RSWG



Two workshops were held, one in each phase, with the RSWG in which Area Experts also participated. The objectives of the sessions were: 1) To discuss the recommendations/actions and indicators with no agreement in terms of online consensus (Delphi consultation) among the RSWG (Phases 4 and 5); 2) To discuss and assess the nuances suggested by Professional Societies and Patient Associations (Phase 4).

- There was disagreement in only one recommendation.
- There was disagreement in two actions of the Operational Plan.

4 Validation by ministerial departments of the Spanish Ministry of Health with competencies in PC of the recommendations (Phase 4) and the actions and indicators (Phase 5) agreed by the RSWG to align them with all other projects on Primary and Community Care currently under development by the Ministry of Health.



All the recommendations and actions of the Operational Plan were validated, some contents were reformulated.

5 Development of a Guide with an overview of available funds and a self-evaluation Checklist to facilitate in the Health Regions the execution of all recommendations and the Operational Plan. Two working sessions with the RSWG to present and train them in the use of the Guidelines and the Checklist



4.3 Results

The specific actions for each Recommendation are listed below:

	Recommendations	Actions
Transversal to the 5 areas		
1	<p>To strengthen innovation and strategic orientation to analyse, evaluate, and propose improvements in the Primary and Community Care model through the Executive Office for the Strategic Framework of Primary and Community Care (<i>Oficina Ejecutiva del Marco Estratégico de Atención Primaria y Comunitaria</i>).</p>	<p>A 1.1 To develop the procedure for identifying and selecting innovative practices in Primary and Community Care in the National Health System.</p> <p>A 1.2 To create a Communication Plan for the actions on the identification of innovative practices developed by the Executive Office of the Strategic Framework of Primary and Community Care.</p> <p>A 1.3 To promote the development of innovative practices (at the regional and/or local level).</p>
1. Planning		
2	<p>To enhance territorial planning with evidence-based data.</p>	<p>A 2.1 To identify the relevant factors for territorial planning and the diverse sources of information on each Health Region's reality, as well as to define assessment and update models for continuous improvement.</p>
3	<p>To systematise the process of updating healthcare management in order to adapt it to territorial and population variability as well as to changes that may arise from exceptional circumstances, such as health emergencies.</p>	<p>A 3.1 To define the processes and mechanisms for monitoring, updating, assessing and improving the health map based on data-based evidence.</p>
4	<p>To define the criteria for designating areas with hard-to-fill positions.</p>	<p>A 4.1 To identify areas with hard-to-fill positions in each Health Region according to the minimum criteria defined by the Human Resources Commission of the National Health System and to determine if complementary criteria are needed to tackle regional realities, including, for instance, areas/positions that may have not been previously considered.</p> <p>A 4.2 To conduct the necessary regulatory changes to adapt territorial planning to the updated maps to include undeserved areas with hard-to-fill positions.</p> <p>A 4.3 To develop a specific territorial planning model to meet the needs of the least populated rural areas ("empty Spain").</p>

Recommendations	Actions
2. Management and Organisation	
<p>5 To define a model of health and social co-governance at the National Health System level, including socio-sanitary care plans at the regional level with a community-based, holistic approach.</p>	<p>A 5.1 To define: 1) the profiles of people requiring integrated health and social care; 2) the lines of action, health and social care processes, and interventions; and 3) the resources needed to provide integrated health and social care, and to identify the available resources.</p> <p>A 5.2 To identify the stakeholders as well as the objectives and the coordination mechanisms for a co-governance model integrating the provision of services and the resources of the health and social care systems.</p> <p>A 5.3 To detail a roadmap for the implementation of the co-governance model that should flexibly adapt to the organisation of each health region.</p> <p>A 5.4 To define a Minimum Data Set at the national level for joint health and social care management.</p>
<p>6 To enhance collaboration between Primary and Community Care teams, social services, and local agents to implement community health programs.</p>	<p>A 6.1 To identify and promote existing actions and processes conducted by health and social care professionals and other players working in the community.</p> <p>A 6.2 To identify the community players involved at the basic health zone level and existing communication channels.</p> <p>A 6.3 To establish communication channels and protocols for joint actions among relevant players involved in community care.</p> <p>A 6.4: To monitor and evaluate the community healthcare strategy.</p> <p>A 6.5 To define a methodology to involve professional societies and community care associations in all phases of the development of the community's healthcare strategy..</p>
<p>7 To get the community involved in decision-making bodies on healthcare policies.</p>	<p>A 7.1 To identify existing participation mechanisms and communication channels among decision-making bodies and agents in the community and, if necessary, to create adequate channels.</p> <p>A 7.2 To establish a specific regulatory framework at the regional level to integrate community participation in healthcare policy decision-making.</p>
<p>8 To review and, if necessary, update the content and methodology of annual management plans that develop the clinical management competencies of professionals and autonomy of resource management.</p>	<p>A 8.1 To define and agree on a common assessment model for annual management plans at the regional level.</p> <p>A 8.2 To update the annual management plans based on the previously defined methodology.</p>

Recommendations		Actions
3. Human Resources		
9	To develop planning and professional management strategies that meet the needs and demands of each basic health zone.	A 9.1 To implement the model to calculate human resources needs in Primary Care based on the 2022-2023 Primary and Community Care Action Plan.
10	To establish a regional and national human resources supply strategy to ensure service provision in areas with hard-to-fill positions.	A 10.1 To develop an agreed strategy for covering, implementing and assessing difficult-to-cover areas with hard-to-fill positions at the regional level.
11	To identify competencies and roles among different categories of Primary Care professionals.	<p>A 11.1 To adapt the regional reality to the competency map developed in the National Health System Human Resources Commission.</p> <p>A 11.2 To develop a competency management model based on the defined map for healthcare and non-healthcare professionals, and on the continuous evaluation mechanisms.</p>
12	To create (or reinforce) recruitment and retention plans for the Primary Care professionals.	<p>A 12.1 To agree on and include additional measures to those defined in the 2022-2023 Primary and Community Care Action Plan for attracting and retaining professionals.</p> <p>A 12.2 To maintain the planned retention actions included in the 2022-2023 Primary and Community Care Action Plan.</p> <p>A 12.3 To maintain the planned recruitment actions included in the 2022-2023 Primary and Community Care Action Plan.</p>
13	To redefine professional development and career paths to adapt them to current needs.	<p>A 13.1 To define a professional career model common to the entire National Health System.</p> <p>A 13.2 To adapt the common National Health System framework in terms of professional development to the real needs of Health Regions.</p>
4. Financing		
14	To strengthen public spending on Primary Care in terms of the public health spending.	<p>A 14.1 To agree on a minimum criteria in the Interterritorial Council of the National Health System to make the Primary Care budget's growth conditional to part of the nominal growth of total health spending.</p> <p>A 14.2 To align Primary Care budgeting to all strategies in planning and managing as well as human resources, infrastructure, and equipment provision and organisation.</p> <p>A 14.3 To include managerial contract analyses for the efficient allocation of available resources.</p> <p>A 14.4 To promote the adoption of efficient healthcare interventions in Primary Care.</p>

Recommendations	Actions
5. Infrastructure and Equipment	
<p>15 15.</p> <p>To share information between different care levels (Primary and Hospital Care) and among different regions to guarantee clinical information transfer within and outside territories.</p>	<p>A 15.1 To expand and improve the integration and interoperability of digital health record services.</p> <p>A 15.2 To advance the integration of essential data and its expansion, if necessary, within the entire National Healthcare System, preferably adopting clinical data sharing models with open standards.</p> <p>A 15.3 To extend the participation of Primary Care Services throughout the national territory in the dissemination of European Union Patient Summary reports.</p>
<p>16 16.</p> <p>To design, adapt, and implement technological platforms run by Primary and Community Care services to provide health and social care to chronically ill patients and dependent inhabitants.</p>	<p>A 16.1 To identify the necessary tools and technological platforms to support healthcare provision in coordination with social care services, including remote care to chronically ill patients and dependent individuals, described in the common basket of Primary Care services.</p> <p>A 16.2 To develop roadmaps to complement health and social care for chronically ill patients, including the development, adaptation and/or acquisition of digital tools.</p>
<p>17 17.</p> <p>To enhance the digital transformation of rural areas to strengthen healthcare coverage in areas with hard-to-fill positions.</p>	<p>A 17.1 To develop, adapt and/or implement digital solutions that streamline and optimize health care, addressing inequities due to access and digital deficiencies.</p> <p>A 17.2 To extend virtual referral Primary Care -Hospital Care (PC-HC) schemes with access to complementary labs and medical imagery as needed.</p>
<p>18 18.</p> <p>To evaluate and review, if necessary, new forms and types of non-face-to-face care.</p>	<p>A 18.1 To prioritise the evaluation of virtual (remote) healthcare by the Spanish Ministry of Health and the Health Regions.</p> <p>A 18.2 To evaluate, at the regional level, the need to complement the virtual (remote) service types included in the updated Common basket of Primary Care Services.</p>
<p>19 19.</p> <p>To prioritise the review and adaptation of available building infrastructure (healthcare centres, clinics).</p>	<p>A 19.1 To establish regional investment plans with specific funding for the renovation of the infrastructure and the equipment included in the Primary Care basket of Services</p> <p>A 19.2 To systematise the maintenance processes at Primary Care centres.</p>

5 Conclusions and next steps

From the evidence reviewed in this report, it is possible to draw the following conclusions:

- It is necessary to incorporate more dynamic criteria for the definition of healthcare areas and basic health zones. These criteria should consider the dispersion of the population, areas with hard-to-fill positions, and place more importance on the social determinants of health and health inequalities.
- Regarding the coordination of PC and social care, it has been highlighted the need for continuing working on improving coordination and on strengthening plans and initiatives fostered by the COVID-19 pandemic.
- There is a consensus between Health Regions, Professional Societies, Patient Associations and Experts that a higher number of professionals is needed to provide PC. As a result, plans and initiatives focused on improving contract conditions and on providing professional incentives must keep developing.
- There is general agreement among the interviewed healthcare professionals who have management competencies in PC, Scientific Societies and Patient Associations on the insufficient allocation of PC budgets to offer good quality service, accessibility, equity and sustainability.
- The resources in terms of infrastructure and equipment that will be needed over the next 2 to 5 years are: creation and/or adaptation of physical spaces, investment in ICT resources for the PC centres, acquisition and/or renewal of medical equipment, investment in ICT resources for the national healthcare system.

The Operational Plan will help the Health Regions in implementing Recommendations that have been defined to adapt Primary Care to the current needs of the population in Spain. It is expected that the Ministry of Health and the Health Regions collaborate to ensure the implementation of the Operational Plan.

In line with this, The Ministry of Health will reflect on implementing the following actions:

- Based on the results obtained from the evaluation of the 2022-2023 Primary and Community Care Action Plan, the Health Regions and the MoH will identify actions already implemented that need continuity through the Operational Plan and actions not executed that need to be implemented and promoted.
- Prioritize, based on a consensus process with the autonomous communities, the actions included in the Operational Plan to be developed in the mid term, according to agreed criteria.
- Develop a monitoring and evaluation manual of the recommendations implementation that will include the development of the proposed indicators of the Operational Plan.
- Recognize improvement strategies on Primary Care environment that are being developed on the NHS related to governance models, planning and management and promote the identification, sharing and dissemination of the good practices.
- Publication on the MoH website and other official channels the final reports and executive summaries of the project.
- Share with the Europe WHO the results of the project as a source of information and as complement of the Case Studies that are currently developing on Spanish Primary Care.
- Disseminate project results in order to search for synergies with the institutional committees of the Strategic Framework for Primary and Community Care and the Strategy for the Chronicity Approach.



Annexes



Annex I: Case Study Sheets

Sources of information

The variables included in the Case Study factsheets and the data sources are shown below, including hyperlinks to the original sources.

Population characteristics and health information

Variable	Year	Source
Population size (no of people)	2021	The World Bank
Percentage of population aged 65 and over (%)	2021	The World Bank
Life expectancy at birth (years)	2019	Global Health Observatory, WHO
Healthy life expectancy at age 60 (years)	2019	Global Health Observatory, WHO
Overall mortality (no death/100.000 inhabitants)	2019	World Population Review
Self-perceived health (proportion of people with perceived good or very good health)	2021	Eurostat
Tobacco consumption (daily smokers, percentage in population aged 15 years and older)	2019	Global Health Observatory, WHO
Alcohol consumption (litres per capita in population aged 15 years and over)	2019	Global Health Observatory, WHO
Obesity (percentage of adults aged 18 and over with a BMI greater than or equal to 30 kg/m ²)	2016	Global Health Observatory, WHO

Health System organisation and Primary Health Care characteristics

Variable	Year	Source
Mode of healthcare service provision: public or private	2023	World Population Review
Organisational model for Primary Care (Groups of physicians/groups of physicians and other professionals, individual practice, etc.)	2019	Health care systems in the European Union countries, Spanish Ministry of Health
Primary care as a filter for access to other specialists: yes/no (exemptions)	2019	Health care systems in the European Union countries, Spanish Ministry of Health
Co-payment for PC use: by assistance or by any procedure	2019	Health care systems in the European Union countries, Spanish Ministry of Health
Health expenditure as a share of GDP (%)	2020	Global Health Observatory, WHO

1. Primary Care reform in Flanders, Belgium

Area of analysis	Planning
Case study	Primary Care Reform in Flanders
Country and region	Belgium, Flandes



General features

<u>Population characteristics and health information</u>	Spain	Belgium
Population size (n of people)	47,415,750	11,592,950
Percentage of population aged 65 and over (%)	20	19
Life expectancy at birth (years)	83.2	81.4
Healthy life expectancy at age 60 (years)	19.2	18.17
Overall mortality (n of deaths/100.000 inhabitants)	950	980
Self-perceived health (proportion of people with perceived good or very good health)	71.2	76.4
Tobacco consumption (daily smokers, percentage in population aged 15 years and older)	27.7	23.4
Alcohol consumption (litres per capita in population aged 15 years and over)	12.7	10.8
Obesity (percentage of adults aged 18 and over with a BMI greater than or equal to 30 kg/m2)	23.8	22.1

<u>Healthcare System characteristics and Primary Care organisation</u>	Spain	Belgium
Mode of healthcare service provision: public or private	<i>Public</i>	<i>Private</i>
Primary Care organisational model: (groups of doctors/groups of doctors and other professionals, individual practice, etc.)	<i>Doctor groups and other professionals</i>	<i>Individual practice</i>
Primary care as a filter for access to other specialists: yes/no (exemptions)	<i>Yes</i>	<i>No</i>
Co-payment for PC use: by assistance or by any procedure	<i>No</i>	<i>No</i>
Health expenditure as a share of GDP (%)	10.71	11.06

Case study description

Background and justification

Being a region of Belgium, Flanders has had one of the strongest health systems in Europe for several years. It is also a member of the Regions for Health Network (RHN), which operates within the WHO at the European level. In 2014, a redistribution of functions from the federal/central level to the Flanders region took place within the "Sixth Belgian State Reform". It also included other regions. This measure aimed at creating Primary Care (PC) services offering high quality wherever applicable to all people in need of care, as well as to informal caretakers. The reasons behind Flanders' Primary Care reform are similar to those that are currently driving Spanish needs:

- ✧ Demographic and epidemiological changes
- ✧ Technical evolution
- ✧ New information and communication technologies that enable changes in care patterns, support home care, assist in the decision-making process and quality of care.
- ✧ Increased concern about the gap between the health and social care sectors, and within the healthcare system, and what could help to narrow that gap.

In response to these challenges, the Flemish region initiated a reform of Primary Care based on the measures and objectives listed below.

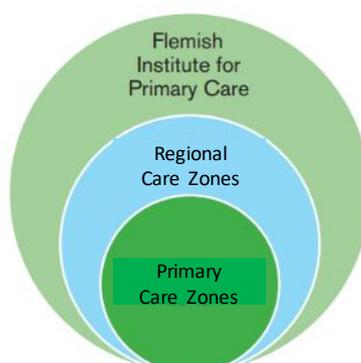
Description of implemented measures

Main objectives:

- ✧ Strengthening and simplifying Primary Care.
- ✧ To establish a solid basis of integrated care by creating mechanisms to support the integration of Primary Care and Social Services overtime.
- ✧ Strengthening welfare initiatives, social care, and health care.
- ✧ Addressing the weaknesses of the Flemish Primary Care system.
- ✧ Reconfiguration and rearrangement of Primary Care areas with the aim of improving coordination and planning.

Regarding the last point, 3 levels were developed: Primary Care Zones, Regional Care Zones and the Flemish Institute for Primary Care.

The new support structure in the Flemish health system



From top to bottom:

1. Primary Care Zones (PCZs)

PCZ are new structures that provide the basis for effective integrated care and services in each location. The aim was for **the boundaries of each to be agreed locally**, with each serving **a community of 75,000 to 125,000 inhabitants**. In 2019, the 60 zones were agreed: 59 in Flanders and 1 in Brussels.

The main responsibilities of the areas were initially to support multidisciplinary and cross-cutting collaboration at the practice level, with further roles being acquired as they matured.

By mid-2020, their functions were:

- ✧ To align the organisation and provision of high-quality care and support.
- ✧ To support local social policy.
- ✧ To promote specific professional associations.
- ✧ To support Primary Care professionals and to reinforce the organisation of multi- and inter-disciplinary collaboration.
- ✧ To cooperate on Flemish health objectives in terms of prevention and to propose their own objectives.

Over time, it is expected that they will assume many other tasks, such as how to address bottlenecks, **develop planning** and support ICT developments. One role will be to create **an integrated approach to equity**. PCZs will provide a capacity still underdeveloped in the Flemish system: a local approach to service development and problem solving. PCZs will assess the specific needs of their population and identify what response is needed.

Each PCZ is led by a care council consisting of four groups of representatives from the local authorities, the health sector, the welfare sector and people with care and support needs, each of which is equally represented by a maximum of 24 members.

The PCZs gradually incorporated personnel from other previously created structures to help support local coordination and development: Primary Care collaborations, integrated home care services, and local multidisciplinary networks for chronic conditions. Funding for these groups ceased in July 2020 and economic resources went directly to the PCZs..

The existence of PCZs does not limit patients' freedom of choice: they are still able to freely choose professional services within or outside of the PCZ in which they reside.

Primary care zones (highlighted in colour) and regional care zones (numbered)



2. Regional Care Zones (RCZs)

The PCZs are grouped into Regional Care Zones (RCZ), and these are in turn governed by a Regional Care Platform (RCP). RCZs are expected **to cover a population of 350,000 to 400,000 inhabitants.**

RCP functions:

- ✧ Creating a coordinated set of services at a broader population level (where the PCZ population is too small) for issues such as palliative care, dementia, mental health, and prevention; existing personnel and budgets will be absorbed by the new structure.
- ✧ Working to strengthen the connections between hospitals, specialized care, and Primary Care to ensure continuity of care and the development of a strategic regional care plan.

Given that hospitals serve a larger population than the average PCZ, it is intended for, when possible, the RCZ to coincide with the areas of the developing hospital network.

The implementation of Primary Care reform coincided with a reform of the hospital sector in Belgium. Hospitals in Belgium are funded by the federal government (except for infrastructure). The last few decades have seen hospital mergers in Flanders. A new policy now requires hospitals to join a hospital network to increase efficiency in the sector. The aim is for hospitals to work closely together and complement each other. All hospitals must offer basic medical care, and only some hospitals offer specialised care. The network coordinates the organisation, so that patients who need specialised care are referred to the appropriate hospital. The goal is to have a maximum of 14 networks.

The main objective of the reform is the transition of Primary towards **comprehensive and integrated care focused on people:**

- ✧ Ensuring adequate Primary Care capacity and continuity of care by coordinating care for people with complex and/or long-term care needs, with the involvement of both health and non-health sectors and the participation of informal caregivers as key actors in care.
- ✧ Emphasizing the importance of health in all policies to achieve health and well-being, focusing on the social gradient of health and vulnerable groups to promote a mindset shift towards integrated, person-centred and multidisciplinary care, and equipping healthcare personnel with the necessary knowledge and competencies through training to place Primary Care at the centre.
- ✧ The reform aims to develop information and communication technologies to reinforce digitalisation as a significant catalyst for change and a resource to improve collaboration in Primary Care.
- ✧ Focus on citizens, through a social map, to better guide interventions, and structure the policy and service development process to include them (including patients).

A key characteristic/activity of the reform **is to put the person at the centre** and to focus on the person.

The goal is **to protect and improve the individual autonomy of the patient.** To strengthen the individual's ability to **self-manage**, the reforms seek to improve health literacy by enhancing relevant sources of information, knowledge, and skills. It is also important to gather information on the patient's perception of the disease and care. Additionally, in order to achieve the above, Flanders is implementing the following measures:

- ✧ To include health and wellness competencies in school curricula.
- ✧ To develop a tool to help patients with long-term problems formulate their life and care goals.

To accomplish the objectives, it is essential to pay attention to informal caregivers. In Flanders, informal care is provided voluntarily by people with a social or family bond to the person in need of care. These individuals may face their own difficulties, and the Flanders reform proposes recognizing informal caregivers as actors in the care process which may also require professional support. A plan is being implemented to support this group, addressing the issue of social recognition, relationships with professionals and the special position of young caregivers.

Results and impact

The reform is currently ongoing, but it is expected to be completed by 2025. It considers digitalisation as an important catalyst for change and a tool for better collaboration.

The implementation of the reform is based on 6 main components: 1) **putting the person at the centre**; 2) integrating all aspects of the reform; 3) continuing with the digitalization of the care process; 4) providing greater support to local care providers through structural innovation; 5) integrating health and social services; and 6) aligning with other sources.

Justification for selecting the case study

Reorganisation and planning of health areas. Beyond the new criteria followed for delimiting the new zones, the functions assigned to each organisational level are considered of great interest. Furthermore, this case is considered particularly relevant because it is focused **on people-centred care**.

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2. Integration of health and social care in South Karelia, Finland

Area of analysis	Management and Organisation	
Case study	Integration of health and social care in South Karelia, Finland	
Country and region	South Karelia, Finland	
General features		

Population characteristics and health information

	Spain	Finland
Population size (n of people)	47,415,750	5,541,020
Percentage of population aged 65 and over (%)	20	23
Life expectancy at birth (years)	83.2	81.6
Healthy life expectancy at age 60 (years)	19.2	18.46
Overall mortality (n of deaths/100.000 inhabitants)	950	1.010
Self-perceived health (proportion of people with perceived good or very good health)	71.2	70.1
Tobacco consumption (daily smokers, percentage in population aged 15 years and older)	27.7	21.6
Alcohol consumption (litres per capita in population aged 15 years and over)	12.7	10.7
Obesity (percentage of adults aged 18 and over with a BMI greater than or equal to 30 kg/m ²)	23.8	22.2

Healthcare System characteristics and Primary Care organisation

	Spain	Finland
Mode of healthcare service provision: public or private	<i>Public</i>	<i>Public</i>
Primary Care organisational model: (groups of doctors/groups of doctors and other professionals, individual practice, etc.)	<i>Doctor groups and other professionals</i>	<i>Doctor groups and other professionals</i>
Primary care as a filter for access to other specialists: yes/no (exemptions)	Yes	Yes
Co-payment for PC use: by assistance or by any procedure	No	Yes
Health expenditure as a share of GDP (%)	9.13	9.61

Case study description

Background and justification

In Finland, Primary Care and Hospital Care are managed separately. There are two models of Primary Care management: 1) Primary Care centres, and 2) health and social care centres depending on the municipality. Hospital care is provided to citizens through 21 Hospital Care districts maintained by 360 municipalities. One of these districts has changed its model and integrated all health and social care into one single management area.

Description of implemented measures

In 2010, a new model integrating social and health care was implemented in this region, the South Karelia Health and Social Services District (known by its acronym in Finnish, Eksote). Its objectives are:

- ✧ Integration of Hospital Care, Primary Care and Social Services.
- ✧ Improving balance of Hospital and Primary Care.
- ✧ Improving financial, strategic and investment co-ordination.
- ✧ Common use and recruitment of staff and sharing of resources across levels of care.
- ✧ Strengthening the decision-making power of municipalities.
- ✧ Creating out-of-hospital services and self-employment.
- ✧ Additionally, in the future, added value will come from the data, being commonly analysed and used, as well as from the application of artificial intelligence, robotics, etc.

For this purpose, the model relied on digital services, creating a single patient information system based on shared knowledge and online services, such as tele-consultations.

The teams in the centres are multidisciplinary and include professionals from medicine, nursing and social work who work in cooperation with different health and social care providers.

Results and impact

The main implementations were:

- ✧ **Home-based rehabilitation.** This has meant a major strategic shift from centre-based models to home-based models, allowing for personalised patient care and shorter hospital stays. Compared to the traditional model, the care cost has decreased by 33%.
- ✧ **Emergency care using mobile units.** They can carry out tests, assess the patient and, if necessary, contact the physician. This has led to a decongestion of ambulances and emergency units and a 30% decrease of expenditure since its implementation in 2014 (€3m).
- ✧ **Mobile units for patients in rural areas,** as well as the implementation of 50 smart medicine dispensers at patients' homes. This has allowed for better patient care and more immediate follow-up.



Justification for selecting the case study

Similarities between the Finnish healthcare system (universal coverage, Beveridgian health system) and the Spanish healthcare system. The model was implemented in 2010; its impact is consolidated and measurable. It is an innovative model that promotes accessibility and equity within the healthcare system for citizens. The results show that its sustainability and efficiency are better when compared to the previous model.

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3. 'Senja Doctor' Project, Norway

Area of analysis	Human Resources
Case study	"Senja Doctor" Project from Norway
Country and region	Senja, Norway
General features	



Population characteristics and health information

	Spain	Norway
Population size (n of people)	47,415,750	5,408,320
Percentage of population aged 65 and over (%)	20	18
Life expectancy at birth (years)	83.2	82.6
Healthy life expectancy at age 60 (years)	19.2	18.46
Overall mortality (n of deaths/100.000 inhabitants)	950	790
Self-perceived health (proportion of people with perceived good or very good health)	71.2	74.7 ¹
Tobacco consumption (daily smokers, percentage in population aged 15 years and older)	27.7	16.2
Alcohol consumption (litres per capita in population aged 15 years and over)	12.7	7.1
Obesity (percentage of adults aged 18 and over with a BMI greater than or equal to 30 kg/m ²)	23.8	23.1

Healthcare System characteristics and Primary Care organisation

	Spain	Norway
Mode of healthcare service provision: public or private	<i>Public</i>	<i>ND</i>
Primary Care organisational model: (groups of doctors/groups of doctors and other professionals, individual practice, etc.)	<i>Doctor groups and other professionals</i>	<i>ND</i>
Primary care as a filter for access to other specialists: yes/no (exemptions)	<i>Yes</i>	<i>ND</i>
Co-payment for PC use: by assistance or by any procedure	<i>No</i>	<i>ND</i>
Health expenditure as a share of GDP (%)	9.13	11.42

Case study description

Background and justification

Over the last decades, the problem of recruiting and retaining family physicians in the Senja region (Norway's second largest island) has worsened. This problem is due to the geographical and socio-demographic characteristics of the region. The causes are: cold climate, limited jobs opportunities other than fishing, municipal jobs, remoteness from hospitals (3-4 hours by car), high workload and long on-call hours for family physicians, professional isolation, high degree of temporality (short term contracts), difficulties in finding jobs for partners/relatives and a sparsely populated territory, mostly with an ageing population.

Description of measures implementation

The "Senja Doctor" project started in 2007 and consisted of the development of a collaborative model amongst the Primary Care (PC) services of the four municipalities of Senja (island of Norway), establishing an inter-municipal Primary Care service. In this way, the municipality of Lenvik was assigned responsibility for the daily operation of the services ("host centre"). Additionally, a new PC centre was established near Finnsnes with a team of 4 family physicians, 2 training physicians, nursing and administrative staff. New work shifts were implemented. Physicians and staff are both responsible for tending to the main medical offices 5 days a week. Local medical consultations and medical visits to remote homes of the elderly take place 2 days a week. A new emergency unit was established covering 18,000 inhabitants in its area of influence (4 + 2 municipalities).

As incentives for staff recruitment and retention, the following aspects were reinforced: creation of improved professional networks in the territory, consideration of driving hours to remote areas as working hours, decrease in workload by reducing patient allocation for each family physician, reduction of salary uncertainty by establishing fixed salaries, decrease in on-call workload to improve the work and family life balance (from twice a week to twice a month), increased focus on continued medical education (educational programmes for medical students, training physicians and physicians) and increased opportunities to participate in research projects (3 months per year per doctor).

Results and impact

The "Senja Doctor" project has resulted in an enhanced continuity of Primary Care for the population of Senja.

- **Turnover of physicians:** Over the course of 11 years (from 1998 to 2009), 100 physicians left their job. From 2009 (to 2015), 9 general practitioners were employed on a regular contract. This represents a significant reduction in the turnover rate. While there is still a need for substitutes, this is quite moderate. This is mainly due to the employment rights of those already employed, such as maternity leaves and educational activities. At the end of 2013, all job positions were occupied by physicians who expressed their intention to continue.
- From the point of view of Primary Care professionals, and from the information generated in a focus group session, young physicians currently employed in Senjalegen unanimously stated that they would not have sought positions in this rural area if the current working conditions had not been in place. Getting a job in a small municipality without special working conditions was not an option for them. Reasons for their attitudes may be: 1) the project gives them the possibility to live in central parts of the city, which increases the possibility for their partners to get a job; 2) they may also highly value their belonging to a professional network in which they can find guidance and discuss complicated cases.

Authorities and governmental representatives are satisfied overall with the outcome of the process.



Justification for selecting the case study

Interesting experience for the continuation of Primary Care.

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4. Health and social care integration – Scotland

Area of analysis	Financing
Case study	Health and social care integration in Scotland
Country and region	Scotland, United Kingdom



General features

Population characteristics and health information

	Spain	United Kingdom
Population size (n of people)	47,415,750	67,326,570
Percentage of population aged 65 and over (%)	20	19
Life expectancy at birth (years)	83.2	81.4
Healthy life expectancy at age 60 (years)	19.2	18.25
Overall mortality (n of deaths/100.000 inhabitants)	950	950
Self-perceived health (proportion of people with perceived good or very good health)	71.2	74.7
Tobacco consumption (daily smokers, percentage in population aged 15 years and older)	27.7	15.4
Alcohol consumption (litres per capita in population aged 15 years and over)	12.7	11.4
Obesity (percentage of adults aged 18 and over with a BMI greater than or equal to 30 kg/m ²)	23.8	27.8

Healthcare System characteristics and Primary Care organisation

	Spain	United Kingdom
Mode of healthcare service provision: public or private	<i>Public</i>	<i>Private</i>
Primary Care organisational model: (groups of doctors/groups of doctors and other professionals, individual practice, etc.)	<i>Doctor groups and other professionals</i>	<i>Doctor groups and other professionals</i>
Primary care as a filter for access to other specialists: yes/no (exemptions)	Yes	Yes
Co-payment for PC use: by assistance or by any procedure	No	No
Health expenditure as a share of GDP (%)	9.13	11.98

Case study description

Background and justification

To reduce access inequalities to health care and to increase the emphasis on prevention, Scotland made proposals to promote the coordination of healthcare and social service activities, involving the Scottish Healthcare system and local authorities.

In 2002, the Community Health and Care Act allowed for the transfer of competencies between local authorities and the healthcare system. In 2004, a reform requiring healthcare boards to set up community healthcare partnerships was implemented.

Description of implemented measures

The Public Bodies (Joint Working) (Scotland) Act 2014 creates 31 integration authorities, legal associations for health and social care that commission the services to local authorities and healthcare councils in a coordinated way.

The association of 32 local authorities and 14 healthcare councils within the healthcare system makes up the 31 integration authorities. Each integration authority covers 2 to 6 healthcare councils, but the same healthcare councils is included in more than one integration authority.

The integration authorities also have representatives from various professional groups, social care providers, social care users and voluntary caretaker. They are responsible for managing £8.5 billion, 70% of which comes from the national health system and 30% from local authorities.

Results and impact

- ✧ Healthy life expectancy at age 65 has improved for men.
- ✧ Access to employment for people with chronic or long-term illnesses has improved.
- ✧ Mortality from treatable conditions has also improved.
- ✧ Spending on social care remained stable while spending on healthcare increased, but less when compared to other UK countries.

Justification for selecting the case study

Scotland has a model similar to the Spanish model (Beveridge). This reform is based on a 2014 law that has been implemented since 2016. Its impact can be evaluated. This reform also shows an increase in access and equity within the healthcare system.

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5. Primary Care reform in Portugal

Area of analysis	Infrastructure and equipment	
Case study	Primary Care reform in Portugal	
Country and region	Portugal	
General features		

Population characteristics and health information

	Spain	Portugal
Population size (n of people)	47,415,750	10,325,150
Percentage of population aged 65 and over (%)	20	23
Life expectancy at birth (years)	83.2	81.6
Healthy life expectancy at age 60 (years)	19.2	18.65
Overall mortality (n of deaths/100.000 inhabitants)	950	1.110
Self-perceived health (proportion of people with perceived good or very good health)	71.2	58.2
Tobacco consumption (daily smokers, percentage in population aged 15 years and older)	27.7	25.4
Alcohol consumption (litres per capita in population aged 15 years and over)	12.7	12.1
Obesity (percentage of adults aged 18 and over with a BMI greater than or equal to 30 kg/m2)	23.8	20.8

Healthcare System characteristics and Primary Care organisation

	Spain	Portugal
Mode of healthcare service provision: public or private	<i>Public</i>	<i>Private</i>
Primary Care organisational model: (groups of doctors/groups of doctors and other professionals, individual practice, etc.)	<i>Doctor groups and other professionals</i>	<i>Doctor groups and other professionals</i>
Primary care as a filter for access to other specialists: yes/no (exemptions)	Yes	Yes
Co-payment for PC use: by assistance or by any procedure	No	Yes
Health expenditure as a share of GDP (%)	9.13	10.55

Case study description

Background and justification

In 2005, an ambitious reform of Primary Care was launched in Portugal in response to the need to provide quality healthcare to citizens, improve patient and professional satisfaction and increase accessibility to healthcare. The reform is considered modern and innovative due to its technological assets and the replacement of the traditional hierarchical model by a more horizontal one. Investment in IT was key to monitoring health improvement indicators.

Description of implemented measures

In Portugal, Family Health Units (FHU) based on multidisciplinary teams that operate in healthcare centres placed in new or renovated buildings and managed by the state were created between 2006 and 2016. Primary Care support services (administrative, IT, etc.) were reorganised, services were fully computerised and most clinical practice support resources (e.g. paper records) were replaced by electronic options. The reform proposed a new model of clinical governance in the FHU based on a system of knowledge, skills, and competencies acquired by healthcare teams to favour individualised care, seeking to improve the quality of care.

Investment in the Information System was key to this reform. With the development of interoperability and individual electronic patient health records, it was possible to track team work and indicators monthly. Also, it became easier to facilitate the coordination and communication of professionals' activities while consolidating the contractual care model.

Between 2016 and 2019, a renewal of the primary IT systems was carried out ("Operation Megabyte") in which computers were distributed to all FHUs. This "operation" also included the improvement of the information systems in place - PEM (Electronic Medical Prescription Platform), SClínico (platform common to all healthcare professionals to record patients' medical history) and SINUS (national information system aimed at supervising Primary Care administrative processes)- seeking to standardise information handling and sharing as well as clinical records between different healthcare systems. These systems allowed for standardising practices and information collection at the national level which enabled multidisciplinary support for patients and improved the effectiveness and efficiency of healthcare professionals' performance. The "Portal BI CSP", a nationwide platform for clinical and health governance that contributes to continuous improvement and transparency in Primary Care throughout the country, was also created.

Results and impact

- ✧ Better efficiency, accessibility, patient and professional satisfaction and better quality.
- ✧ Interoperability between systems.
- ✧ Integrated health care providing quality care to patients.



Justification for selecting the case study

This model addressed the reform of Primary Care, including the complete computerisation of healthcare services. It improved information systems to secure universal operating systems and enable integrated healthcare. Analysis of patients' registries, allowing for the monitoring of productivity, accessibility and quality of care. Information on patient outcomes can be offered to individuals..

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Annex II: Members of the Working Groups

Members of the Operating Working Group (OWG)

Organisation	Name and Surname	Position
European Commission	María Isabel Farfán	Policy Officer
Ministry of Health, Subdirectorate-General for Quality of Care (Subdirección General Calidad Asistencial)	Yolanda Agra	General deputy
	Rocío Fernández	Area manager
	Julio Heras-Mosteiro	Senior technician
	Paloma Calleja	Senior technician
	Lourdes Álvarez	Senior technician
NTT Data	Anna Forment	Team leader/Senior expert 1
	Liliana Eduarda Ramalho	Senior expert 2
	Almudena Nake	Project Manager (PM)
	Jordi Gol	Junior expert 1
	Arana Uzcudun	Junior expert 2
	Covadonga Casas	Junior expert 3

Area Experts

Name and surname	Position	Areas of Analysis
Amando Martín Zurro	Director of the Continuing Medical Education Programme in Primary Care	Planning
Pilar Astier Peña	Family Doctor of the semFYC. Coordinator of the semFYC Patient Safety Working Group.	Planning
Siro Lleras Muñoz	Independent advisor on strategic planning projects for health centres and hospitals. Former Head of Service assistance and social health coordination of Castilla y León	Management and Organisation
Esteban de Manuel Keenoy	Former Director of the Kronikgune Health Services Research Institute	Human Resources
José María Abellán Perpiñán	Professor at the University of Murcia in the Department of Applied Economics.	Financing
Juan Olivia Moreno	Professor, Department of Economic Analysis, University of Castilla-La Mancha	Financing
Josep Vidal Alaball	Research Coordinator at IDIAPG01	Infrastructure and equipment

Members of the Advisory Board (AB)

Name and surname	Position	Project's position
Toni Dedeu	Senior consultant at the WHO European centre for PC	Senior Expert 3
Luis Pisco	President of the Regional Health Administration of Lisbon y Tagus Valley	Senior Expert 4
Nigel Edwards	Chief Executive, Nuffield Trust	Senior Expert 5
Jordi Varela	Clinical Management Professor (ESADE) and specialised consultant on clinical management	Senior Expert 6

Steering Committee is represented by:

- Members of the following Departments from the Ministry of Health: General Directorate Public Health (Dirección General de Salud Pública); General Subdirectorate General for Quality of Care (Subdirección General de Calidad Asistencial); General Subdirectorate of Portfolio of NHS Services and Compensation Funds (Subdirección General de Cartera de Servicios del NHS y Fondos de Compensación); General Directorate of Professional Organization (Dirección General de Ordenación Profesional); General Directorate of Digital Health and Information Systems for the NHS (Dirección General Salud Digital y Sistemas de Información para el NHS); Sub-directorate General Health Information (Subdirección General de Información Sanitaria).
- Members of all Health Regions (Directors of the Regional Health Services)
- Members of the Operating Working Group

Members of the Regional Stakeholders Working Groups (RSWG)*

Autonomous community	Name and surname	Position
Andalusia	Sebastián Tomero Patricio	Operational Planning Technician. Health Management Subdirection
Aragón	Javier Marzo Arana	Head of Primary Care
Asturias (Principado de)	Óscar Suárez Álvarez	Assistance and Care Coordination. Directorate of Health Care and Evaluation. Health Service of the Principality of Asturias
Islas Baleares	Patricia Lorente Montalvo	Specialist in Family and Community Medicine. Quality Office of the Health Service of the Balearic Islands (IBSALUT)
Canarias		
Cantabria	Teresa Ugarte Miota	Managing Director of PC of the Cantabria Health Service
	Cristina Manzanares Anaiz	Deputy Medical Director of the Primary Health Care Management of the Cantabrian Health Service
Castilla y León	María Ángeles Guzmán Fernández	Head of the Primary Care and Continuity of Care Department
	María Yolanda Manchón Díez	Primary Care and Continuity of Care Service Technician
Castilla-La Mancha	Jesús López Díaz	Advisor to the SESCAM Welfare Directorate
	Francisco Vicente Herranz Catalán	Deputy Medical Director of G.A.I. Alcázar de San Juan
	María Ángeles Martín Octavio	General Director of Primary Care of the Castilla-La Mancha Health Service
Catalonia		
Valencian Community	Enrique Soler Bahilo	Assistant General Manager of the Integrated Assistance Activity
Extremadura	Asunción Campos Cangas	Deputy Director of Primary Health Care of the Extremadura Health Service
Galicia	Francisco Jesús Repesas Carrera	Head of Health Planning Service. Department of Health. Xunta de Galicia
Madrid (Comunidad de)	Cristina Jiménez Domínguez	Technician of the Primary Care Assistance Management Department
Murcia (Región de)	José Manuel Pérez Fernández	Technician D.G. Health Care
Navarre (Comunidad Foral de)	Óscar Lecea Juárez	Head of Clinical Management and Continuity of Care Support Service
Basque Country	Susana Martín Benavides	Deputy Director for the Coordination of Primary Care
La Rioja	Noemi Marauri Corcuera	Director of Nursing of Primary Care Management
INGESA (Ceuta and Melilla)		

*The names and positions of those participants who have authorised the publication of their data are included in the table

Members of the Professional Societies and Patient Associations Working Group*

Professional Society / Patient Association	Name of the Professional Society or Patient Associations	Name and surname
Patient Association	General Alliance of Patients, AGP – (<i>Alianza General de Pacientes</i>)	José Luis Baquero Úbeda
Patient Association	Patient Organisations Platform, POP – (<i>Plataforma Organizaciones Pacientes</i>)	Carina Escobar Manero Paula Echeverría
Patient Association	Spanish Patient Forum, FEP – (<i>Foro Español de Pacientes</i>)	Andoni Lorenzo Garamendia
Professional Society	Community Nursing Association, AEC – (<i>Asociación Enfermería Comunitaria</i>)	José Ramón Martínez-Riera
Professional Society	Federation of Associations of Community and Primary Care Nursing, FAECAP – (<i>Federación de Asociaciones Enfermería Comunitaria y Atención Primaria</i>)	Sagrario Celada Pérez
Professional Society	Federation of Midwives Associations of Spain, FAME – (<i>Federación de Asociaciones Matronas de España</i>)	Daniel Morillas Gujarro
Professional Society	Spanish Association of Clinical Psychology and Psychopathology, AEPCP – (<i>Asociación Española Psicología Clínica y Psicopatología</i>)	Carmen Carió Rodríguez
Professional Society	Spanish Association of Pediatric Nursing, AEEP – (<i>Asociación Española de Enfermería Pediátrica</i>)	Isabel María Morales Gil
Professional Society	Spanish Association of Physiotherapy in Primary Health Care and Community Health, AEF-APySC – (<i>Asociación Española Fisioterapia en Atención Primaria y Salud Comunitaria</i>)	Montserrat Ingles Novell Fernando Ramos Gómez
Professional Society	Spanish Association of Primary Care Pediatrics, AEPAP – (<i>Asociación Española de Pediatría de Atención Primaria</i>)	Pedro Gorrotxategui Gorrotxategui
Professional Society	Spanish Scientific Society of Social Health Work, SCETSS – (<i>Sociedad Científica Española de Trabajo Social Sanitario</i>)	
Professional Society	Spanish Society of Family and Community Medicine, SEMFyC – (<i>Sociedad Española Medicina Familiar y Comunitaria</i>)	Asensio López Santiago
Professional Society	Spanish Society of General and Family Physicians, SEMG – (<i>Sociedad Española Médicos Generales y de Familia</i>)	Francisco José Sáez Martínez
Professional Society	Spanish Society of out-of-hospital and Primary Care Pediatrics, SEPEAP – (<i>Sociedad Española de Pediatría Extrahospitalaria y Atención Primaria</i>)	Javier Pellegrini Belinchón y María del Carmen Sánchez Jiménez
Professional Society	Spanish Society of Primary Care Managers, SEDAP – (<i>Sociedad Española de Directivos de Atención Primaria</i>)	Cristina Ibarrola Guillén
Professional Society	Spanish Society of Primary Care Physicians, SEMERGEN – (<i>Sociedad Española Médicos Atención Primaria</i>)	Rafael Manuel Micó Pérez

*The names and positions of those participants who have authorised the publication of their data are included in the table

