Primary Healthcare and Community Health Innovation Plan

Strategic and Operational Aspects

Generalitat de Catalunya
Departament de Salut

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Note: male and female pronouns are used in this document to refer to both men and women, and the use of one gender or the other reflects common usage of this terminology

Health is the way of living that is independent, charitable and joyful.

10th Congress of Catalan-speaking Physicians and Biologists
Perpignan, 1976

Introduction

The Catalan healthcare model provides universal healthcare. Over time, some of its characteristics have differentiated it and made it unique. These include: the proximity of services to the general public; the participation of civil society and the municipalism in many health institutes; the tradition of mutual insurance schemes; and the wide range of services that are provided.

Catalonia has a quality healthcare system that is well thought of by the public. Its results in the areas of health and quality of life are among the best in developed countries. In recent years, the Government of Catalonia has made a considerable effort in plans for the budget, investments, general planning and healthcare, to maintain the high levels of public satisfaction and healthcare quality.

However, the Catalan health system now faces a series of challenges. In response, mid- and long-term sustainability must be ensured in terms of quality and equity. Some of the main factors to take into consideration are the following: the wide variety of changing variables, such as the constant increase in demand and the rapid and continuous technological and pharmacological innovation; the need to coordinate incentives for professionals; the need for lifelong learning; the ageing population; immigration; population movements away from large cities to the surrounding areas; demographic growth; and the growing need to allocate sufficient financial resources to healthcare.

There is a strong political will to maintain the quality and equity of the Catalan health service. This is the driving force behind the need to establish the bases of a social and political agreement for its modernization. The commitment to reform is inevitably linked to the desire to run a health system that is based on the collaboration of all the agents that are involved; embraces a range of public policies; is transparent and centred on people, their families and communities; is focused on excellence; is equitable in terms of individuals and regions; and is committed to the professionals who are the main assets of the system.

We must move towards a new concept of health and healthcare that is based on the values of personal autonomy, community networks, solidarity, equity and recognition of the diversity of health determinants. Public health should be at the heart of this concept, to promote and protect health and to prevent disease. The model of healthcare provision should boost quality, efficiency and transparency by means of cooperation and the synergies of working in a regional network. The model's basic premises should be to establish primary healthcare and community health as the main pillars of comprehensive, integrated, equitable and excellent care.

The Primary Healthcare and Community Health Innovation Plan (PIAPiSC) should be considered another element in the context of change and modernization that is already underway. This reform is needed in all of the health and social care services that are offered to the public.

Since its foundation, the main features of the Catalan health system have been specificity and dynamism. In the 1980s, the first Health, Social Health

and Public Healthcare Map was drawn up, primary healthcare reform began and the General Law on Health was approved. In the 1990s, the Law on Healthcare Organization in Catalonia (LOSC) was approved, the Catalan Health Service (CatSalut) was created and the financing, commissioning and provision of healthcare services were separated. Furthermore, in this decade, a robust process of health planning began (the healthcare plans) and networks for public hospitalisation, social care and mental healthcare were established. In 1990, the Women's Healthcare Programme was set up as a support structure for primary healthcare teams. In 2004, the name of this programme was changed to sexual and reproductive health departments.

In 2002, a pilot test began on the regional allocation of resources, to expand the healthcare continuum and maintain the system's sustainability.

Healthcare planning has been given a major boost since the change of government in 2004. New strategic planning instruments have been created on the basis of increased knowledge of Catalonia, its regions, health, inequality, and the operation and performance of the health system (with information gathered in the Catalan health survey, various records of healthcare activity, monitoring access to services, an analysis of supply and demand, and service satisfaction surveys). The main instruments are the new 2101 Catalan Health Plan; the new Health, Social Health and Public Healthcare Map; the master plans and the strategic plans for the reorganization of services.

In recent years, the healthcare model has been focused on strengthening the healthcare authority and governing role of the Ministry; supporting public health (a new law); guaranteeing transparency and accountability (with the establishment of a Results Centre and the future Agency for Information, Assessment and Quality (AIAQ)); shared governance with the municipalities (with the creation of regional health authorities (GTS)); and public participation (with the creation of sectoral advisory councils and GTS health councils). CatSalut guarantees that the entire population has access to all the services and provisions that make up the portfolio of public healthcare. This institute is also responsible for reinforcing the mechanisms of tendering and commissioning services, which are governed by criteria of transparency, quality, clinical safety, healthcare continuity, efficiency, public satisfaction and professional motivation.

The health sector is being strengthened in a new process of decentralization and population-based allocation. Regional health authorities (GTS) have been created, which include a Commission for Healthcare-Providing Entities and a Council for Public Participation (governance, provision and participation).

We are committed to a new healthcare model with a regional organization (regions and GTS) based on networks and on fostering the leadership of public health professionals and physicians, whose experiences are gathered. The region becomes a place for cooperation in the search for quality, efficiency and satisfaction, through the coordinated work of healthcare providers and the sharing of professional teams.

The new healthcare model involves the incorporation of systems of work that are based on agreements and collaboration between institutions and professionals. This should promote the mutual recognition of areas of activity and combine the value of the various actors. To attain this, clinical leadership must be fostered in the region. CatSalut must encourage alliances between providers on the basis of the process and the continuity

of healthcare in a framework of tenders and population-based financing that extends throughout the territory.

To ensure the success of the process of innovation and modernization of primary healthcare (PHC) and community health (CH), we must facilitate the task of the healthcare professionals. Within the organizations, professionals must be able to manage their own time, increase their professionalism, and share risks. Furthermore, incentives should be promoted. In other words, professionals should have the degree of autonomy that is needed to bring the Catalan health system together in a network, and to ensure that the healthcare providers meet the objectives of sustainability and quality.

The Innovation Plan that is presented here is a key component of these innovative dynamics. Consequently, it is no surprise that its proposals have a direct impact not only on primary healthcare, but also, above all, on the entire healthcare system. The options and strategies proposed in this Plan represent a step towards the coherence of the healthcare model promoted by the Ministry of Health. The aim of this Plan is to provide a better response to the public's new health requirements; to increase the satisfaction of healthcare professionals; a Plan committed to the quality of Catalan institutions and the sustainability of the healthcare system, both in terms of quality and equity; and to make progress in the balance between the available budget and spending.

Marina Geli i Fàbrega
Minister for Health

1. Executive summary

The Primary Healthcare and Community Health Innovation Plan (PIAPiSC) is the result of the development of the Catalan healthcare system and the constant need to adapt to a changing environment, in order to offer the best possible response to the public's health problems. Hence, the aim of the Plan's proposals for strategic and operational areas (some of which have arisen in other regions) is to gradually facilitate the modernization of primary healthcare services. This is a project for the short, medium and long term.

The current situation

In general, the organizational model of primary healthcare is uniform and inflexible. This limits the ability to respond to demand and leads to the marked dissatisfaction of most healthcare professionals, as a result of many factors.

Despite the progress that has been made, there is still a lack of coordination and mutual distrust between primary healthcare and other levels of care.

Additional factors include the increasing demand, the growing bureaucratization and the lack of professionals in the labour market. Furthermore, the current system of compensation or budget appropriation, which has a strong structural component, does not consider the levels of problem solving or foster coordination that is focused on the healthcare continuum. In this context, research is also limited.

The current primary healthcare model has been strongly influenced by the existence of the Catalan Institute of Health, which provides most of the primary healthcare in Catalonia. This institute comes under the Catalan Government's regulations and has been highly centralized and organized into divisions to date.

The challenges

According to the recommendations of the Minister for Health's Advisory Council in 2004, the main challenges faced by Catalan primary healthcare, after twenty-five years of reform, are to increase the autonomy of the centres, expand the healthcare continuum, increase the problem-solving capacity, strengthen the leadership and competences of nurses, expand the competences of general practice staff and improve coordination with the public health sector.

Due to the validity of these challenges, the Catalan Ministry of Health approved—among other initiatives and through the Board of Directors of the Catalan Health Service-—the creation of the Primary Healthcare and Community Health Innovation Plan on 27 March 2007.

This Innovation Plan promotes primary healthcare as a core element of the heath system, due to its role as the first specialised level of healthcare for the public and as a repository in the healthcare continuum of the promotion, prevention, healthcare and rehabilitation activities undertaken in other areas and levels of the health service by the healthcare institutions and professionals in a specific regional framework.

The PIAPiSC addresses the following main challenges:

- Demand and appropriate use of services.

• The accessibility of primary healthcare.

• The healthcare continuum, through the organization of healthcare into a network rather than in divisions.

• The consideration that general practitioners, paediatricians and nurses are the first point of contact for the public.

• Flexible organization of primary healthcare, with a focus on demand, accessibility and problem solving.

• Professional development in the organizations that provide primary healthcare.

• Appropriate financing and compensation of services.

• The problem-solving capacity, quality and safety of primary healthcare in the framework of the portfolio of primary healthcare services.

• Research as a recognized activity.

• Undergraduate and postgraduate education.

The aim is to improve the care of patients through planning and the joint, integrated operation of the various healthcare levels in the region. To achieve this, primary healthcare innovation is tackled in three main areas:

• People (the public and the professionals who work in the institutions).

• Resources (providers of primary healthcare and community health services and of the public healthcare network).

• The main instruments that support the Plan.

The main objectives

Primary healthcare is the cornerstone of the healthcare system. Hence, the aim of this document is to foster innovation in this area and in the entire system.

The following objectives are proposed in the Plan:

1. Objectives to increase participation:

• Boost the group participation of the health councils in the regional health authorities (GTS).

• Use information and communication technology (ICT) for individual participation.

• Develop the Expert Patient Programme to boost the commitment to solidarity.

2. Objectives to improve accessibility:

• Determine the portfolio of primary healthcare services and access to them.

• Promote all of the professionals in the primary healthcare team as the first point of contact for the public.

• Ensure that patients have access to their clinical records.

• Guarantee that the public has same-day face-to-face or virtual access to healthcare provided by their healthcare team or their healthcare professionals.

• Guarantee a gradual reduction in the time it takes to access tests and specialist consultants, when the consultations are defined as a priority by the family and community health services and the specialized support services.

3. Objectives to improve service provision, professionals and providers in relation to:

• The portfolio of services.

• The institutional providers.

• Professionals and the organization of work.

• The assessment of results.

With respect to the portfolio of services:

• Create a portfolio of healthcare services that is focused on meeting health needs from the moment of the first contact. Within reasonable limits, these services should fulfil the following functions: treatment, health promotion, rehabilitation and those related to a basic level of community health.

With respect to the institutional providers and the professionals:

• In the framework of a population-based model of budget appropriation, take into account a system of compensation that makes it possible to develop the Plan in accordance with the available budget.

• Regulate instruments to increase the independent management of primary healthcare providers, facilitate their operational links with other healthcare levels, and foster knowledge exchange with consultants.

• Establish the performance of primary healthcare by means of indicators that help to attain the objectives of accessibility and problem-solving capacity within the bounds of the contract with the Catalan Health Service.

• The proximity of the health centre to the community is an added value. In the operational management, there should be a balance among the allocated facilities, staff and budget; the volume of healthcare, including seasonal fluctuations; the urban or rural location; and the specialized services that are offered to the community.

With respect to professionals and by means of agreements with providers:

• Increase the autonomy and responsibilities of the professionals who are the first point of contact so that they can organize themselves and ensure accessibility.
• Foster the clinical leadership of the healthcare team.

• Promote the deployment of all of the competences of the professionals, particularly those of the nurses.

• Reduce bureaucratic requirements.

• Promote and foster the role of the professionals who are the first point of contact as guarantors of the healthcare continuum.

• Ensure that professional activity is integrated with all levels of the public healthcare network (XSUP) in the GTS region.

The main instruments to support the plan

Legislative:

• Law 15/1990 of 9 July on Healthcare Organization in Catalonia (LOSC).

• Law 8/2007 of 30 July of the Catalan Institute of Health.

• Law 44/2003 of 21 November on the Organisation of Healthcare Professions.

• Bill of the Law on Public Health.

Administrative and organizational:

• The regional health authorities (GTS).

• CatSalut and its organization.

• The basic health areas (ABS) and primary healthcare centres, the providers and the professionals.

• The public healthcare network.

• The Health, Social Health and Public Healthcare Map, the Healthcare Plan, the master plans and the strategic plans for the reorganization of services.

Instrumental:

• Information and communication technology (ICT):
clinical reports in primary care, shared clinical reports and e-prescriptions.

• Population-based financing.

• Hiring services.

• The Results Centre and the Agency for Information, Assessment and Quality (AIAQ).

• Health portal.

Other instruments to be developed in the future:

• Guidelines for the accreditation of primary healthcare.

• The Communication Plan for the PIAPiSC.

• The Implementation and Development Plan for the PIAPiSC.

• Indicators and the factors of accessibility and problem-solving capacity(future agreement).

• Assessment of the Innovation Plan.

• Plan steering committees.

• The Innovation Plan as one of the Ministry of Health's programmes of interest.

2. Rationale

The Primary Healthcare and Community Health Innovation Plan falls within the framework of the processes of change that are required in all the public healthcare and social care services. Although the Plan is not in a central position in the healthcare system, it is another component of these innovative dynamics. Consequently, it is not surprising that its proposals have a direct impact on the rest of the healthcare services and areas in Catalonia.

The profound need to address changes in the entire Catalan health system and in primary healthcare and community care in particular, is due to the following factors, among others: the increasing public expectations and demands; the new technological requirements and other factors such as the ageing population and the increase in dependency; the changes in the classic model of family structure; the rapid increase in population due to immigration from other countries, with the associated need to incorporate new cultural models, values and beliefs; the increasing incidence of behaviour related to unhealthy lifestyles, particularly in the young population (smoking, alcoholism, sedentary lifestyles, etc.); and the greater prevalence of mental health problems in all age groups. The existing division of the health system into levels has facilitated the sectoral organization of services and professionals. However, new, more integrated approaches are required to help to **improve the quality** of care for the public. The current model and its limitations require this change.

The Primary Healthcare and Community Health Innovation Plan was drawn up in response to the new needs and demands of the **public**. This led to the design of new policies and strategies **for the future**, to bring the health services into line with the changing needs. This Plan addresses the short, medium and long term.

In this general framework, the strategic objectives of the Plan with respect to planning and service provision in primary healthcare should be focused on:

• Introducing a new way of providing services, so that they are more accessible and effective. Professionals and providers should be fully involved in this change.

• Knowledge sharing among professionals and the development of their competences.

• Ensuring that the various levels and areas of healthcare are more closely interrelated. In particular, family and community primary healthcare should be more closely linked to the three levels of specialized healthcare in the network.

• Improving problem-solving capacity by sharing, cooperating and working in a **network** with all of the areas of services provided in the region.

In the design of this Plan, sufficient consideration has been given to the goals that have already been attained in the health sector to date, for example:

• The high level of knowledge on the population and the community environment as a result of almost twenty-five years of applying the primary healthcare reform.

• The good level of knowledge of health results generated by professionals in primary healthcare teams (the design of indicators of healthcare quality).

• The satisfaction of the users, which demonstrate the population's confidence in the public health system, its providers and its professionals.

• All of the actions to improve the system that are included and described in the Health, Social Health and Public Healthcare Map, and in the various master plans and strategic plans for the reorganization of services that are underway.

This retrospective evaluation also requires a new approach, both from and towards the **healthcare professions**. The professionals who are the first point of direct contact with the population (primary healthcare doctors and nurses and paediatricians) and medical receptionists are the core of the healthcare team and promote a comprehensive, biopsychosocial approach to care, by establishing long-term relationships with their clients that give them a unique view of the healthcare services provided to the public.

As a group and through their work in teams and in networks, the healthcare professionals are jointly responsible for providing comprehensive healthcare for the region's population. They contribute the added value and specificity of their skills.

In addition, the role of the **medical receptionists in primary care** needs to be re-evaluated. Such professionals must be able to standardize the service and also personalize it on each contact. More importantly, they must be able to add value to the organization in each of their activities and increase the range of tasks that they perform.

It is important to accept the need for changes, to bring them about and to strengthen the positive elements of the existing model, attained during the process of primary healthcare reform that began in the mid-1980s. It is essential not only to improve, but also to innovate. To achieve this, profound changes must be made in the current paradigms of primary healthcare and in the healthcare system. Such changes should enable us to make sufficient progress in a flexible way and with mid and long-term perspectives.

Innovative changes in primary healthcare and community health are only possible in the framework of transformation of the entire healthcare system. As indicated above, decisive political will is required to attain this goal. This political will must be strong and constant and applied to the way that the services operate, in the context of the activities of the service providers and professionals and in the improvement that the public and all patients should be able to perceive.

The Innovation Plan aims to meet these new challenges, which can be related to the needs and expectations of the general public that have arisen recently and that take priority. A large body of evidence shows that when primary healthcare with a community approach is established as a key element in the healthcare system, it has a clear and direct impact on improvements in the population's health and in the rationalization of spending, which contributes to ensuring the sustainability of the system.

In this Innovation Plan, we have defined some strategic focal points for implementing innovative actions that are aimed at:

• Focusing the healthcare system on the needs of the population and promoting the joint responsibility of individuals for their healthcare.

• Promoting further changes in the management of primary healthcare and community health services, including the use of new technologies, increased autonomy of centre management and greater quality of care for the public.

• Introducing new services that have proven benefits into the primary healthcare and community health service portfolio.

• Promoting individual, lifelong professional development.

• Strengthening the role of professionals in the decision-making processes.

• Resizing health centres so that they provide integrated healthcare.

• Attaining a model of heath care in a network that enables the functional integration of services that are centred on the public.

• contributing to defining new criteria for financing, commissioning, hiring and assessment that foster the functional integration of the services and professionals that come under the various healthcare providers in the region.

3. Analysis of the situation

Conceptually, the primary healthcare reform (hereafter, the RAP) was based on the 1978 International Conference on Primary Health Care in Alma-Ata. It then developed at varying rates in the different autonomous regions of Spain over the course of more than twenty-five years. Today, some people (although very few in reality) are still treated by doctors and nurses who work according to the guidelines of the model prior to the RAP.

The reform process, which began in the 1980s, was based on a change in the conceptual focus of professionals' capacity for action and in the organization of work in primary healthcare teams (EAP). The reform increased dedication to work and—more importantly—the problem-solving capacity of the professionals who form part of the system.

In this context, professionals in the healthcare system, particularly those who work in primary healthcare and community care, needed new approaches and proposals in several areas, including undergraduate and postgraduate training, lifelong professional development and professional careers.

In this section of the document we use some numerical data to describe the context, actions and main trends of the Catalan healthcare system in recent years, with particular reference to primary healthcare and community health.

3.1. The current model

Since the beginning of the 1990s, a mixed healthcare model has been developed in Catalonia that separates service provision from planning, commissioning and assessment. The management methods that may be contracted by CatSalut are varied and include services established by the main provider (the Catalan Institute of Health, (ICS)); consortiums; foundations; mutual insurance companies, which usually manage hospital services and primary care (as does the ICS); and association-based entities (EBA), which only manage primary healthcare teams.

The major contribution of the ICS to primary healthcare services often leads to confusion between situations linked to the process of reforming the ICS and the processes needed to modify primary healthcare. Hence, the adaptation of the ICS during the development of the Plan is a key success factor.

Currently, primary healthcare provides personal healthcare and prevention services. The original concept of the primary healthcare reform (RAP) had a clear community focus and was closely related to interaction with other public service sectors. However, this concept has not been developed fully to date.

The professionals in the primary healthcare teams respond to the demands of the public and either resolve the problem or refer the patient to other levels of the system. However, when a case it referred, there is frequently no follow-up in primary healthcare. Hence, it is important to act

in a more proactive and integrated way with the other community care resources. Indeed, there are an increasing number of examples of coordination with resources in the areas of mental health, urgent care or other specializations. However, it is also true that in various situations, primary healthcare and its professionals do not assume overall responsibility for care in certain processes.

Many patients with chronic diseases who are admitted to hospital for a worsening condition are subsequently treated in outpatient departments and only return to the health centre to request sick notes and prescriptions. In addition, healthcare for dependents is a new field that requires an increasingly close interaction with the Ministry of Social Action and Citizenship.

In general, coordination with public health services is lacking. When it does exist, it is generally focused on carrying out procedures such as the declaration of diseases.
There is still significant room for improvement in one vital area: the organization of services and the structure of the facilities that are available in each region must be adapted to the region's characteristics. The aim is to increase the links with the surroundings, as this provides an opportunity to improve the service that is provided to the public and to promote the verticality and continuity of healthcare.
The analysis of various primary care management models in Catalonia has revealed the importance of giving centres and healthcare teams a greater degree of autonomy in their management, whilst maintaining the cohesion of the system. Among other aspects, this increases the professionals' motivation, satisfaction and their perception of proximity to decision-making that affects them. In addition, the analysis also indicated that autonomous teams are more efficient in their management of human resources, complementary tests and referrals to other specialists; have a greater impact on prescription policies; and patients have shorter waiting times for care in their centres.

Diversification in the provision of primary healthcare services. Organizations that provide primary healthcare teams (31/12/2008)

Providers		Number of EAP		% out of the total EAP	
Public	ICS	324	280	90.3	78.0
	others (agreement)		44		12.3
Private participation	EBA (competition)	35	12	9.7	3.3
	Others (competition)		23		6.4
			359		

Source: the Catalan Health Service's primary care database

An analysis undertaken by the Institute of Health Studies (IES) on behalf of CatSalut (2005) showed non-statistically significant differences between the models of primary healthcare management in most of the aspects considered (clinical practice, coordination and accessibility).

The differences that were found in organizational aspects, the involvement of professionals and the management of pharmaceutical services indicate that a policy of benchmarking could be of use for the entire primary healthcare sector.

3.1.1. The organization of services in Catalonia

Many healthcare systems in developed countries are organized into two levels of care: clinical and community healthcare; and more complex clinical healthcare with more technological requirements. This differentiation does not justify the lack of coordination between the levels and the insufficient continuity in healthcare. It is important to boost mechanisms that integrate the operation of the different levels and areas of the services, in order to facilitate public and patient access to healthcare and social care resources.
Various Spanish (Puertollano) and international (England, USA, Portugal, etc.) initiatives are working on the current challenge of healthcare systems: to integrate healthcare in order to meet needs related to the ageing population and the increased prevalence of chronic diseases. The starting point is the integration of clinical medicine and services that are focused on improving patients' experiences in the way diseases are handled, the clinical results and the efficiency.

3.1.2 The views of the public, professionals and the managers

In 2007, the Ministry of Health commissioned the *Estudi de les visions de ciutadans, professionals i gestors sobre l'atenció sanitària a Cata*lunya [Study on Public, Professional and Managerial Views of Healthcare in Catalonia]. This study on opinions of the health system in general and primary healthcare services in particular was based on surveys carried out for the Health, Social Health and Public Healthcare Map of Catalonia. The conclusions include the need to take the maximum advantage of the independent decision-making ability of the professionals in the healthcare teams and to increase the multidisciplinarity of all activities, through greater integration of the services and resources available in the community sector. The study highlights the need to strengthen the development of nursing skills, to reconsider the roles of auxiliary nurses and other professionals, and to promote community health interventions. In the field of management, the Map is in agreement with the Innovation Plan as it states that self-management methods should be boosted within the system of public provision. Finally, in the fields of home care and urgent care, there is a clear commitment to primary care playing a major central, managerial role, as described in this Innovation Plan.
Some of the public views that were gathered in the study included the following:

- A demand for clear, comprehensible information on their state of health, the healthcare process and the organization of services.

- The healthcare pathways are often too complex and are not explained well.

- A lack of listening skills in professionals and the system.

- Processes take too long, and there is a difference between the time of the users and the time of the system.

- There is a lack of coordination between networks and professionals, and members of the public systematically use emergency services as an alternative to other services.

• The public claimed their right to information, to be treated well, to disagree, to be treated without discrimination, to be respected, to receive care that is well adapted to their specific characteristics, etc. The study also revealed that people increasingly play an active role in the decisions that are taken that affect their health.

Among the specific demands identified in the study, the public propose that the primary care network should be improved to revitalize the health service in general.

Some points that were gathered on the professionals' opinions are listed below:

• The following are essential: interaction with users, willingness to meet demand, provide care and listen.

• The time available for each consultation must be increased, to focus on the healthcare rather than on technological activity.

• Ageing and immigration are putting extra pressure on daily practice.

• The expectations of hospital healthcare in relation to the functioning of primary healthcare, as well as a lack of knowledge about the real conditions in which primary healthcare is provided, lead to a lack of coordination between these two healthcare areas. The lack of coordination between the various levels and networks in the system has an impact on the users.

• Pressure on healthcare services creates tension between professional practice and demand, and has an impact on teamwork.

• The provisional nature of positions and staff turnover causes dysfunction.

• The criteria for evaluating the system and the professionals are different, and include (mainly) quantitative criteria, as well as qualitative criteria (which tend to be related to professional practice).

Points in the study on the opinions of managers of health services include the following:

• The management model should again consider that the users are the priority and the system should be adapted to the new needs and future trends.

• Coordination is central to the healthcare system, particularly in the organization of services and professional practice.

• Problems associated with a lack of coordination are related to the large number of users and carers who have to deal with an extremely high number of different professionals and with the loss of contact and control that is experienced in primary care when users enter the hospital network.

The results showed a tendency to overmedicate. Opinions of this trend varied according to the group of interviewees.

The healthcare users do not consider that the problem of overmedication exists. Professionals attribute overmedication to the demands of users and consider that this problem has a great impact on their work. Managers stress that the increase in the demands of users is a serious problem for the system.

In the 2006 satisfaction survey of the population covered by CatSalut, three results stand out: 33.7% of the interviewees considered that the organization of care in the health centre was unsatisfactory; 88.9% would return to the same health centre to be treated; and 93% had a high degree of confidence in the primary healthcare professionals.

3.1.3. The context of work and professional development

The doctors and nurses in the healthcare teams and the other professionals involved in primary healthcare and community care carry out their tasks using a method of organizing work that existed prior to the reform that began in the 1980s. The inertia that is common in highly administrative systems has led to uniform dedication being given priority over adaptation to needs and the search for diverse solutions to problems in the working environment. Currently, the organization of work in most of the primary healthcare centres (CAP) does not foster autonomy in the design of each professional's work schedule. The establishment of morning and afternoon shifts has led, in many cases, to the division of the health team into two organizations that are almost independent.

Great improvements could be made in the comfort of the work place and opportunities to personalize it for the public and for the professionals. In addition, decisive action needs to be taken on the excessive bureaucratization of healthcare processes, which continues to take up a significant proportion of the professionals' working hours. Neither new information and communication technology nor the organization of work have been able to effectively resolve this problem.

The processes of continuous professional development for individuals and the professional career have become confused and there have been no improvements in motivation, incentive schemes or the recognition of excellence in the task that is undertaken, either in the centres, the teams or from an individual perspective, despite labour actions and management policies. An improvement in the quality of life of professionals and the required work-life balance have not, to date, been satisfactorily attained in the complexity of the healthcare. This factor is partially responsible for the lack of primary care and hospital professionals.

The process of primary healthcare reform (RAP) has been highly focused on the structure (primary healthcare centres) and organization of work (the primary healthcare team). However, it has partially neglected the individual perspective of the professionals, who consider that neither they nor their relationship with the patients have been given sufficient consideration. The patients do not always perceive that the primary healthcare professionals are their first point of contact and the managers of their health problems.

The type of management that exists in primary care is still too focused on managing resources and not cantered on leadership in the areas of healthcare, teaching and research. Primary healthcare physicians are committed to innovation and change within their organizations and aim to motivate and train professionals, through the delegation of power and the adoption of responsibilities. They want to have the same access as hospital physicians to certain positions of prestige and responsibility, by means of transparent application processes.

A review of management models in the human resources departments of the various providers would enable the standardization of hiring methods and part-time or full-time contracts. These aspects still require more

attention in the Catalan health system, despite the possibilities provided by the legislation.
The assessment of core, specific, interdisciplinary and shared competences is not the main mechanism of staff recruitment, despite the state of the professional job market. The healthcare organizations should be motivated in all of these aspects, in order to focus continuous learning activities in the framework of continuous professional development.

3.1.4. The structures

The Catalan network of health centres covers the entire region, with guarantees of accessibility and geographic coverage. According to a study on the accessibility of health services in Catalonia,[1] 98.0% of the population have a primary healthcare centre (CAP) at less than 10 km, with an average distance for all population centres of 7.2 km and an average weighted distance per population of 1 km. In terms of travel time, 96.8% of the population are less than 10 minutes from a CAP. If local surgeries are included in the model, only 0.05% of the population are over 10 km from the closest health centre and only 0.35% are more than 10 minutes away.

The development of the process of primary healthcare reform that began in the 1980s has revealed quantitative and functional gaps in the infrastructures. This is particularly true of primary health centres, which require significant changes to incorporate satisfactorily some of the modifications that have been introduced into the system.

[1] Health Care, Social Care and Public Health Map (Volume II), 2009. Ministry of Health, Government of Catalonia (p 110).

The main problems with health centres are related to functional aspects and the lack of space, which affects the reception area for users, the consulting rooms, and rooms for work or meetings. In addition to these shortcomings, other problems are related to accessibility in terms of telephone, telecommunication and computer connections with other centres in the system, signs (inside and outside) and the lack of privacy in some areas, such as the reception and the information desk.

It is essential to improve the maintenance of equipment, the comfort of the general furnishings, the clinical instruments and the infrastructure of the centre's general services. Frequently, the location and structure of a centre are such that it is difficult to extend the building or adapt it to house new services and activities.

In the case of other community centres, structural and organizational modifications as well as improvements in equipment need to be undertaken to ensure that the full range of services can be offered.

From the start of the healthcare reform to the present, the distribution of basic health areas (ABS) according to the volume of the population has varied widely. There has been a notable increase in ABS that have more than 25,000 inhabitants: from 19% initially to 33% in 2008.

Distribution of ABS according to the assigned population

≥5,000	21,001-25,000
5,001-10,000	25,001-30,000
10,001-15,000	>30,000
15,001-20,000	

Source: Health, Social Health and Public Healthcare Map, Ministry of Health, Government of Catalonia, 2008

3.1.5. Financing and criteria for allocating resources

There is a contradiction between a discourse that constantly stresses the central, vital role that primary care must play in the health system and the allocation of the resources that are needed to make this a reality. This has led to a certain level of disillusionment and confusion among professionals and providers regarding the general situation of primary care and its role in particular.

The financing been insufficient and the available resources have not been allocated using criteria that take into account the region and focus on prioritizing needs. Structures and activities are commissioned, but the social utility or the results in terms of health improvements are not assessed adequately. The commissioning of hospital services, acute care facilities, and other inpatient units combine structural maintenance with payment for the agreed activities. The commissioning of primary care services basically considers the structure.

It is not unusual for service providers who act in the same region to work in a context that does not facilitate the complementarities of activities or the accumulation of enough experience to maintain and improve the quality of healthcare tasks.

The commissioning of inpatient and community services is currently carried out by areas of services, which does not f integrated healthcare.

3.1.6. Quality and safety in clinical healthcare

Professionals should work in organizations that enable them to provide quality healthcare that is safe for them and for the patients. The quality of healthcare processes is guaranteed on the basis of premises related to the availability of resources, the appropriate organization of work, and the prioritization of reflection on professional, group and individual practice. The aim is to detect problems and introduce the corresponding methods of improvement, even when the public has a good opinion of the healthcare that that is provided.

Safety involves the application of healthcare measures of proven effectiveness; and the professionals that use these measures must have extensive experience of them. In addition, it involves a culture of clinical safety, which is based on preventing avoidable adverse effects that may be due to many factors: the use of drugs, communication with the patient, treatments and technical procedures. In short, professionals who have the required level of training to perform their tasks with quality, safety and efficiency—without passing the limit of their independent decision-making ability—should carry out the actions related to prevention, diagnosis, treatment and planning of treatments in facilities that are also ideal.

It is essential to reflect on whether the current community services sustain these premises or whether an exercise of self-evaluation needs to be undertaken to meet certain guarantees. Such guarantees include: ensuring that professionals can access training activities; the continuous improvement of existing skills; and the expansion of knowledge to tackle new goals that arise as a result of the general and specific services offered by the centre, service or team.

We must insist more than we have to date on strengthening strategies to form alliances between various centres and teams. The aim of such alliances is to provide mutual support and to place more value on the

information that professionals have, in order to discover the real situation of activities in various centres, teams and professionals in the regional environment. Thus, decisions can be taken on the basis of selecting the most suitable resource.

The quality and safety of healthcare cannot increase in a context of inappropriate or excessive use of the resources of a system in which the patients are not aware enough of their responsibility for improving their own health. Current overmedication also makes it difficult to draw up strategies to improve the quality and safety of healthcare and does not lead to better health, either individually or collectively.

3.1.7. Use of services and healthcare activity

The Health Survey for Catalonia (ESCA) 2006 has also provided important data on the use of primary healthcare resources by the public and on public opinions of assigned doctors and nurses.

Out of the population, 88.6% stated that they had visited a healthcare professional at least once in the last year (87.5% of the adult population and 95.4% of the child population).
In the last twelve months, visits to a general practitioner were most frequent in the adult population (72.2%), whilst in the child population; the most frequent visits were those to paediatricians (84.9%).
A total of 17.8% of the adult population and 14.5% of the paediatric population stated that they had visited a nurse at least once in the last year.
Three out of ten people of 15 years and over stated that they had used an emergency service in the year prior to the interview. In children under 15, this figure rose to 4 out of 10.
A total of 57.5% of the population stated that they had taken some medication in the two days prior to the interview.

According to the 2006 Health Survey for Catalonia (ESCA), 91.3% of the population of 15 years and over identified their general practitioner or the centre that they usually went to when they were ill or needed advice about their health. Just over half of this population had had the same doctor for at least five years.

Out of the total population, 94.6% stated that when they had a new health problem they would visit their general practitioner or paediatrician before

they went anywhere else. A total of 78.7% stated that they were always seen by the same general practitioner or nurse and 73.4% said that their doctor was aware of their main health problems. A total of 80.2% stated that they would recommend this doctor to a friend or relative.

A total of 76.5% of the interviewees declared that, when they are ill and their health centre is open, they can see a healthcare professional at the centre on the same day. In addition, 58.5% stated that when they are ill and their centre is open, they can obtain information rapidly over the phone. If the centre is closed, 72.7% of the interviewees stated that there was a telephone number that they could call. In addition, 51.4% declared that when they have a question they can talk over the phone with the general practitioner or nurse that they know best.

The volume of visits and the number of requests for tests and consultations dealt with by the primary healthcare team in Catalonia in 2008 is shown in the following table:

Total visits	**51,082,637**
Visits to a general practitioner	27,395,923
Visits to a paediatrician	5,088,196
Visits to a dentist	1,176,352
Visits to a nurse	17,059,991
Visits to social services	362,175
Requests for clinical analyses	3,005,975
Requests for diagnostic imaging	1,177,802
Referrals	1,628,760

Source: the Catalan Health Service's primary healthcare database, 2008

Below, we describe the activity carried out by primary healthcare teams in terms of coverage, for example, in the case of home care, preventative and monitoring activities for the main chronic health problems.

Coverage of Home Healthcare

Population treated in the assigned home healthcare programme (ATDOM)	
>74 years	9.10%
<64 years	5.00%

ATDOM (individuals included in the programme of home healthcare)
Source: Catalan Health Service, 2008

Treatment and care for the most prevalent health problems

Results for the health problem	% observed
Hypertension with optimal control of blood pressure	47.8%
Diabetics with good control of HbA1c level	61.8 %
Smokers who have stopped smoking	49.7 %

Source: Catalan Health Service (2008)

With respect to the rational use of medication, there was an increase in the use of generic drugs and a decrease in the prescription of drugs with no added value.

3.2. Background to the innovation

The PIAPiSC does not start from zero. In recent years, the Ministry of Health, CatSalut and healthcare providers have begun a series of activities to analyse problems and made progress in drawing up new strategic areas and proposals of actions.
The Catalan Health Service commissioned the Institute of Health Studies (IES) to draw up a report on the assessment of various models of primary healthcare service provision in Catalonia. This report was presented at the end of 2006. As mentioned above, the analysis revealed the importance of increasing the autonomy of management of health centres and teams, whilst maintaining the cohesion of the system. This would lead to greater motivation and satisfaction of professionals and a perception of proximity to decisions that affect them, among other factors.

At the beginning of 2004, the Minister for Health's Advisory Council drew up a report on primary care. Subsequently, the report called the *Informe Vilardell* [Vilardell Report] also addressed the main problems.

Advisory Council recommendations to improve primary healthcare (2004)
Increase the autonomy of centres
Improve the healthcare continuum
Complete the primary healthcare reform
Increase problem-solving capacity
Boost the leadership and competences of primary care nurses
Extend the profile of competences of general practitioners
Improve coordination with the public health sector

Source: Advisory Council of the Minister for Health

The Board of Directors of the Catalan Health Service approved the main areas of the Innovation Plan in the first quarter of 2007.

In recent years, the Ministry of Health's Directorate-General of Planning and Assessment has developed a series of strategic plans to reorganize

services and master plans on areas directly related to primary care, such as paediatrics, sexual and reproductive health, mental health, cardiovascular diseases, locomotor system diseases and social care.

The Strategic Plan for the Organization of Paediatric Services in Primary Healthcare introduces new criteria for the organization of paediatric activities and the coordination of the functions of these specialists, who continue to be the first point of contact for the population under 15 years old. Paediatricians in primary healthcare are organized into regional teams. The responsibility of nursing staff in the primary healthcare teams will increase significantly in the *Protocol for Preventative and Health Promotion Activities in Paediatrics and in the Care Provided for Various Health Problems*. The aim is to implement this Plan gradually. By 2011, it should have been implemented throughout Catalonia.

In 2008, the Government of Catalonia approved the new Health, Social Health and Public Healthcare Map of Catalonia, which includes a lot of data on the views of the public, professionals and managers. These opinions have already been discussed above. The Map also contains a considerable amount of information on primary healthcare resources and activities, with a focus on future planning.

The 2006 Health Survey for Catalonia (ESCA) is an initiative of great importance that has provided important data on the public's view of primary health services and professionals in relation to their use of the system.

These studies have been complemented by initiatives promoted by associations of providers and professionals, scientific societies, the Medical Profession Council of Catalonia and the Nursing Profession Council of Catalonia, who have also helped to make it possible to draw up the proposals in the PIAPiSC.

Below we will discuss some of the main data from these and other studies, in order to meet the essential objective of ensuring better comprehension of the focal points of the Plan, from a strategic and operative perspective.

Since 2004, the Ministry of Health has undertaken a series of activities that are summarized in the following tables:

Actions undertaken in the last term of office (I)

Healthcare improvements	Improve 24-hour healthcare services: 12 emergency primary healthcare centres (CUAP) were created and the growth of hospital A&E was limited.
	12.3% increase in home visits by nurses
	70% of the population have an assigned nurse
	Participation of 129 nurses in the Health and School Programme
	25% increase in the drug prescription quality index; and a 4.74% reduction in spending compared to the State average
	17,000 patients taking anticoagulant treatments monitored at health centres
	Eye screening for diabetic patients with 80% coverage of the region
	Cervical cancer screening for women from 25 to 65 years old (60% coverage of women)

Source: Ministry of Health, 2004

Actions carried out in the last term of office (II)

Professionals	PHC Action Plan (2004-2006)
Service innovation	Sexual and Reproductive Health Services (ASSIR) Programme
	Child and youth care
ICT	90% of primary healthcare teams (EAP) with digital primary healthcare clinical records
Improvements in structure and facilities	328 actions completed (624,194,429 euros) and 316 underway (1,663,649,568 euros)
	1.900 health centres equipped for diagnosis and treatment (euros)

Source: Ministry of Health

The Ministry of Health has strongly encouraged the hiring of professionals by primary healthcare providers. The graph shows the increase in professionals in the 2004-2006 period (Primary Health Care Action Plan). The increase in the number of professionals in 2008 is as follows: 170 general practitioners, 20 paediatricians and 251 nurses.

Human resources. Primary Health Care Action Plan

300
250
200
150
100
50
0
MF = general practitioner
PAD = paediatrician
INF = nurse

1,039 new professionals in three years

Source: Catalan Health Service

3.3. The main challenges

An analysis of the available scientific data and the documents generated by various Ministry of Health organisations and institutions, including the Medical Profession Council of Catalonia and the Nursing Profession Council of Catalonia, have enabled us to identify the main challenges that need to be met in primary healthcare today and in the entire Catalan health system, to make progress in the areas of excellence and sustainability.

The **public** still needs to perceive significant improvements in the information that is provided on the health system and in the organization of health centres and services, particularly in primary healthcare. In the

new approach of regional decentralization (regional health authorities (GTS), it is important to refocus the mechanisms and resources for information provision and public participation in the healthcare processes that are undertaken in the community area.

Available data (ESCA) indicate that the public considers that the system is too complicated and they find it difficult to use the resources of the various providers in the region rapidly and with ease.

In addition, there is evidence of continuing problems with access to primary healthcare centres and professionals (particularly over the telephone or when patients wish to be seen by their usual professionals in non-scheduled consultations). The development and extension of the use of ICT in the community sector has still not been achieved satisfactorily.

There has been an improvement in the ability of members of the public to choose their own health centre and general practitioner, nurse etc. However, in the future, progress must be made in the planning and commissioning of services, as well as in the selection of services and consultants, with the agreement of the general practitioner.

Citizen's and healthcare professionals demonstrate a clear need to correct the delay in access to complementary testing and medical consultants and specialists, at least for cases categorised as preferential in terms or the graveness or urgency of the problem needing treatment.

Healthcare **professionals**, both those working in primary healthcare and others, express an array of problems which have a negative influence on their level of motivation and sense of pride when it comes to their association with a centre, service or team. Evidence of these problems can be found in numerous papers published in scientific journals and in documents produced by scientific societies and professional organizations. In addition, there is a clear need to boost the role of primary healthcare nursing staff as a first point of contact for the public. According to the Heath Survey for Catalonia (ESCA), members of the public have little contact with their allocated nursing staff.

There are clear, increasing difficulties in primary care in the following areas: in the establishment of a satisfactory work-life balance for professionals; the lack of flexibility in the organization of tasks; incentive policies that frequently do not discriminate between the quality and quantity of work carried out; the occasional lack of clear leadership and professional autonomy; an excessive work load and the imbalance in healthcare tasks due, in many cases, to a lack of definition of functions and professional skills; and the problems that professionals can encounter in accessing training or research activities. All of these aspects create a situation that needs to be tackled decisively. It is essential to boost the role of some of the professionals who have not been prioritized enough to date, such as the auxiliary nurses and the medical receptionists. New training instruments need to be devised for these members of staff.

The **organization** of healthcare resources in the region into GTS has not yet managed to eradicate the problems of continuity in heath care processes that are perceived by both professionals and patients. In a study by the Josep Laporte Foundation on patients' perceptions and expectations of primary healthcare in Catalonia, which was finalized in July 2008, it was found that: "the lack of technical means and difficulties in establishing referrals to specialists is leading to a situation of growing

demotivation of professionals in this sector, among other factors". The management of primary healthcare provision still faces problems in terms of the autonomy of management of centres, teams and professionals. This topic (with some exceptions) still has not been tackled decisively in a general way. These issues have been the subject of various documents and actions carried out by professional organizations, scientific societies and councils of healthcare professions. Healthcare professionals do not want to be directly involved in management, but they do want to have a greater, more or less direct, influence on the decisions that affect their daily work.

The professionals consider that too many bureaucratic tasks accompany healthcare activities in primary healthcare. For many years, in various declarations and reports, organizations and professional associations have asked for this problem to be addressed in a decisive way.

A regional approach to the organization of paediatric care and sexual and reproductive health is one of the main recommendations in the plans for the reorganization of these healthcare areas, which must be embraced within the framework of the proposals in the Innovation Plan.

The **resources** in primary healthcare and the rest of the services in each GTS region still function with little focus on the network. This problem has a negative impact on the development of healthcare processes. There is still a lot of progress to be made before this strategy is fully operational, mainly in the activities of the various institutions in the GTS area.

One of the main challenges that has to be faced by healthcare systems in developed countries, and hence also in Catalonia, is that of providing care for people with complex diseases in a frail state. Such care should be addressed with proactive strategies implemented in the framework of primary healthcare and community care. This area of problems, which has still not been resolved, is related to the need to foster strong links between community healthcare and social services, to bring about the gradual integration of care for dependent persons and to adopt an intersectoral approach to an increasing number of activities in the field of health. This can be achieved through the integration and coordination of the resources of community healthcare, public health and social care.

We must reanalyse the structure and function of health centres, as core elements in community healthcare. Health centres should be able to take on the healthcare and public health functions that are assigned to them, in accordance with the needs and priorities in the GTS region in which they are situated. This requires a context of greater flexibility and versatility.

The **instruments** that are used to implement these proposals must refer, inevitably, to the fields that are beyond the limits of community and primary healthcare. Such fields should be situated in higher or central levels of the Catalan health system.

In the framework of the Coordinating Commission for Healthcare-Providing Entities, mechanisms should be established for drawing up agreements between the various community resources in the region. This will ensure maximum effectiveness and efficiency and lead to improvements in accessibility and problem-solving capacity.

In recent years in the health system, significant progress has been made in the field of information and communication technology. Instruments

such as the shared clinical record, e-prescriptions, virtual consultations and telemedicine are essential to the development of the proposals in this PIAPiSC.

The mechanisms and indicators that are used to assess the processes and results of healthcare should also be reanalyzed, with a focus on decentralization into regions and on the integration of healthcare functions in different areas of care.

4. Focal points for innovation

In this section of the document, we will address focal points that delimit innovation from a triple perspective. Firstly, innovation in the area of people, the public and professionals in their organisations, who are the main agents in healthcare processes. Secondly, innovation in the area of the health system, including the planning, assessment, provision and management of services, and in the conceptualization of portfolios of services according to the region and the structures of the system. Thirdly, innovation in the instruments that are required to implement the proposals in this Plan, such as new features of the processes of financing, commissioning and hiring, as well as interaction among the providers of different levels and areas of healthcare in a region. In addition, information and communication technologies, which increase speed and cooperation, must act as elements that aid and support innovation.

The Plan's proposals for innovation do not start from zero. For many years, healthcare initiatives and projects have been developed around Catalonia that translate some of the stated concepts and strategies into daily practice. This Plan is a central component of these innovative dynamics and the strategies that it proposes represent a step towards increasing the coherence of the general health model that is promoted by the Ministry of Health.

For the PIAPiSC to have an impact, the entire health system must be involved, as integrated care and continuity of provision are key concepts in the development of the model promoted by the Ministry of Health and implemented by the Catalan Health Service. The aim is to strengthen a global view of the entire set of health care services that provide care to individuals, their families and the communities in each GTS region. The concept of working in a network fosters the regional coordination of all services, providers and their professionals, in order to focus actions on health care results and to increase the effectiveness and efficiency of activities. A network is needed to attain this healthcare continuum.
Operational examples of the strategies in the Plan include: the development of the concept of proactive[1] care in relation to the level of health risk, maximization of the competences of general practitioners in primary healthcare, the deployment of the competences of nurses and nursing auxiliaries and greater interdisciplinarity in the organization and integration of social and health services in the region.

4.1. People: the Plan, the public and the professionals within the organizations

4.1.1. The public

If we know and understand the **expectations of people** about their health and diseases, we can forecast and adapt demand to real needs and secondarily, allocate and organize healthcare services.
Strategies should be designed to **educate people** and their families by means of interventions throughout their lives, so that they can attain the **maximum level of control** over the determinants of their health. This

[1]Timely health care, rather than reactive or after the event.

education should be provided by various social sectors, not just the health service.

In addition, the public need to know what resources are available in the area where there work and live. It is also important to ensure that these resources are **used appropriately** so that daily life is demedicalized, in accordance with the axiom that establishes that more healthcare interventions does not mean better health.

In the health system resources and the community itself, it is important to prioritize an **integrated view** of healthcare and community processes that embraces the health care departments themselves, the users or patients, disease support groups, groups that work with families and community pharmacies.

The public should occupy a central position in the health system. Beyond declarations of intentions, this means that **actions** should be given maximum priority and **implemented** in the following main areas:

- information and communication,
- the capacity to choose and decide,
- participation, and
- access to services and to professionals.

4.1.1.1. Information and communication

The public must perceive and know that they are treated in health centres that provide approved services, in which the professionals offer high quality health care in a safe and comfortable environment. They must be assigned their own doctors and nurses in the health care team. These professionals are the public's first point of contact. They provide information; personalized, integrated care; and continuity of care. In addition, they help to manage the patient's contact with the various resources in the health system and in the use of all the services in the region (including hospital services).

One objective that must be attained is the provision of health portals as spaces for interaction for use by the public and their families.

The public must receive sufficient, comprehensible, continuous information on:

- Their health.

- Health system resources in the general area and in the region, which should be provided by the GTS and CatSalut via the various mediums and methods available.

- Basic data on the CVs of the professionals who are their first point of contact in the health teams as well as information on other specialists.

- The organization of healthcare provision in the region, which should be provided by the various providers.

- The accessibility of various types of resources, which should be provided by the GTS, CatSalut and health care providers and include the waiting times and the waiting lists for each speciality and, subsequently, for each professional.

- Data on satisfaction with services, which should be provided by CatSalut and based on indicators in surveys (and other instruments) of previous users of the services.

- Access to data in personal clinical records.

The public have increasing access to health data via social communication and the Internet. Professionals must be able to respond appropriately to patients who do not always have the correct information.

Information	Different media	Accessibility	GTS
		Satisfaction	CatSalut
	Continuous	Resources Organization	Providers

The GTSs and CatSalut in the region must carry out all of the information activities for which they are responsible and adapt the contents, media and methods to the needs and characteristics of each community area (see the figure).

The **information activities** that are the responsibility of the providers must be established, particularly in the **contracts** drawn up by CatSalut.

In the framework of the Innovation Plan, the minimum specific items of information that the public must receive, regardless of the authority that is approached, are listed below.

-All areas of healthcare in the region

-Organization of services:
- The provider.
- The physical location.
- The opening hours.
- The professionals.

- How to use the resources in case of a need for:
- Ordinary care.
- Urgent care.
- Home care.
- Social care.
- Administrative services.

4.1.1.2. Capacity to choose and decide

Members of the public with the capacity to choose and decide must have all the required information and facilities in order to select the most appropriate services and professionals to handle their health needs, as described in the previous point. The public have the right to a second opinion on their health problems and to the choice of basic health area (BAS), primary healthcare centre (CAP) and the professionals within these institutions.

These premises must be put into practice by ensuring that people can choose their health centre and their regular doctors and nurses. The Plan proposes that the public, in conjunction with their regular healthcare professionals, should participate in the processes of choosing the services and professionals who will intervene in specific areas of care, when there are reasons to justify this. Mechanisms should be established that enable progress to be made in this process, within the framework of the current organizations and regulations, particularly with respect to second opinions.

It is important to take the necessary actions to ensure that the public have the key role that they deserve, with respect to information, treatments and other diagnostic interventions that they may undergo.

4.1.1.3. Participation

The participation of the public should be considered from an institutional and formal perspective, as well as from a more individual approach that is related to normal interactions with healthcare services and, consequently, with primary healthcare.

Patients' shared responsibility in clinical decisions has demonstrated the importance of attaining the **commitment** of patients to understanding the causes of their health problems and to adhering to treatment. This commitment to participation will lead to better clinical results, increased satisfaction and even financial benefits.

Decree 38/14 March 2006 on the creation of regional health authorities (GTS), recognised the Health Council as a body for participation.

The GTS Health Council is a public participation body that provides advice, consultancy, supervision and monitoring of GTS activity. It is made up of the most representative regional associations of trade unions, businesses, neighbourhoods, users, professionals and relatives of patients. The Health Council must be chaired by the person who acts as the president of the Consortium's Executive Committee.

In the area of primary healthcare, the active participation and exchange of knowledge between expert patients and other patients is essential. The aim of this activity is to transfer knowledge, change habits and improve quality of life. It is a priority for the centres and healthcare teams to put this strategy into practise for chronic diseases and for the most prevalent illnesses.

4.1.1.4. Access to services and to professionals

The public must be able to access the services that they need at the appropriate place and time. This objective involves the **removal of barriers** caused by bureaucracy, opening times, location and other factors that make a rational, non-consumer use of the system's resources possible.

It is an essential to obtain an appropriate level of access to services and professionals in the region. This objective must be attained in societies that have a high degree of ICT development. From an operational perspective, this means that in each region, **the required human and financial resources** need to be dedicated to designing and implementing communication and information systems and their interconnectivity.

It is vital to guarantee that members of the public receive same-day care provided by their regular health team or professionals, if this is required by the type of problem that is presented.

There is usually a certain delay for patients who have a priority appointment (i.e. the request for healthcare requires a diagnostic or therapeutic response in a shorter period than normal) for a basic specialized service or to access a basic complementary test that is prescribed by the patient's regular professional in the health team. This delay in access time should be gradually reduced until a wait of no more than 15 days is attained. This objective should be defined in collaboration with the specialist who the patient is referred to or should be discussed and modified during the commissioning of services and the interaction with the entire network.

A decisive effort should be made to make primary healthcare activities **less bureaucratic** by removing many of the current procedures and making them virtual.

In the areas of accessibility and the responsibility of providers, it is important to create new ways of organizing the **schedules of the professionals** who are the first point of contact and regional professionals. Thus, scheduled appointments can be identified and differentiated to enable non-scheduled appointments to be incorporated into the working day. Bureaucratic aspects should be removed and specific spaces created for non face-to-face care.

On the basis of an improvement in available resources, it is essential to ensure **better telephone and internet access** to the professionals who are the first point of contact in the healthcare team and to the rest of the professionals and services in the public healthcare network in the GTS region (emergency care, administrative procedures, information on services, communication of the results of examinations and complementary tests, etc.).

It is vital to introduce **consultancies among professionals** who are the first point of contact in the health team and other specialized services in the region. The aim is to meet specific healthcare needs without face-to-face visits. This can be achieved via a range of services that are based on ICT such as, for example, Internet consultations or the communication of results by SMS or email.

4.1.2. Professionals and organizations

The organizations that are commissioned to provide primary healthcare are responsible for improving the objective conditions in the working environment. They must also boost professionals' autonomy and participation in decisions that have a direct or indirect impact on their activities. The main mission of the health system, which is to provide the public with health care of the highest quality and safety, can only be fully attained when the healthcare professionals in the heart of the organizations are motivated and satisfied.

In addition to mid- and long-term changes, the proposals in the Innovation Plan should include immediate actions to solve some of the current problems that are faced by the primary healthcare organizations and professionals, who are responsible for meeting health needs and for the services offered to the public and the users of healthcare centres.

4.1.2.1. Leadership and competences

Strengthen leadership and professional autonomy

These concepts are related to boosting professionalism, in other words, to the **continuous professional development (CPD) of professionals in primary healthcare and community health, in the framework of the required labour agreements.** The relationship between leadership and CPD does not imply that professional development should be put before the development of leadership. Professional development is currently in the preliminary stages of implementation in institutions and professional organizations.

The healthcare providers are responsible for designing strategies and actions to strengthen the concept of **work-life balance**. Working hours must be made more flexible, according to the needs and availability of the providers of teams and services and of the professionals themselves. This

flexibilization of labour should lead, in the areas for which the organizations are responsible, to a wider range of working days and timetables. Thus, professionals will be able to work in the morning and the afternoon, according to different schemes for dividing and extending the working day. The above considerations of labour flexibilization must be analysed in the framework of planned areas of negotiation with the trade unions and employers' organizations.

The accessibility of services and professionals must be protected with centre opening hours that guarantee this access and with an increase in out-of-hours and home care.

The appropriate use of ICT will facilitate this change and, at the same time, will enable more rapid, effective and continuous contact to be made in the GTS region, both among professionals and between professionals and the public. Thus, new concepts of availability shall be introduced.

The providers must ensure that a suitable **work climate** is maintained. The following factors have a significant impact on this aspect: motivation, satisfaction, an increase in autonomy in order to organize schedules; guarantees of time during the working day when the professionals do not have consultations, together with the design of individual incentive schemes that take into account both the quality and quantity of activity undertaken by the professionals and their degree of involvement in the health care project, teaching and research in the centre or services. All of these are instruments that contribute to constructing the professional career.

In addition, the providers should consider **incentive policies** that have a more professional and personalized approach. Incentives should be related to results, mainly in terms of efficiency, quality, safety and user satisfaction rather than with the workplace.

Clinical leadership and leadership of management should be translated operationally into an ability to **maximise the development of competences** and to define the **principle of subsidiarity**, to ensure that no professional undertakes tasks or assumes responsibilities that can be taken on by another.

In the exercise of their recognised authority and responsibilities (without authoritarianism or paternalism), the individual who leads the primary healthcare team or service must ensure that all of the professionals assume **the objectives defined by the entire** organization. At the same time, they must respect individual professional autonomy. The exercise of leadership also involves the capacity to define accurately the paths that need to be followed to attain the results (how) and to assign responsibilities to each professional (who). Those who lead should not focus mainly on administrative bureaucracy, but on **innovation in interpersonal relationships** in the various interest groups. They must foster a **new framework of values, resources and motivations for all of the professionals who share the aim of offering integrated care to the public.** Leaders of the professionals and the heads of the organizations must have an **influence on decision-making processes** in the **regional administration structures** of the GTS. This can be achieved via active participation in the Coordinating Commission for Healthcare-Providing Entities, in order to share priorities.

Professional autonomy within primary healthcare must be understood not only from the perspective of handling resources, but also in the following areas: organization of individual and team activities; clinical

decisions taken in the process of attending to problems and healthcare needs. In other words, a balance must be attained between autonomy and responsibility.

In this context of personal and group autonomy, the professionals work in organizations that are part of a network, in order to improve the healthcare continuum. Participative **work in a network** contributes to the provision of integrated healthcare in the different areas of the service in the GTS region, with particular emphasis on healthcare, public health and community health services. This work dynamic should be fostered by the creation of institutional and non-institutional areas in which initiatives, organizational experiences, and healthcare, teaching and research activities can be shared.

The availability and intensive use of ICT and the establishment of common work spaces will be essential operational elements that can support these new focuses.

Develop and maintain competences

The organization of services as a network requires a new **balance of competences** in all of the professionals who work in the various organizations. On the basis of respect for the specific characteristics of each discipline or profession, it is important to create **new work dynamics**¸ either individually or in a team, in the primary healthcare and community health area.

The professionals must work proactively to provide care for individuals, families and the entire population, according to needs and risks.

To attain integrated healthcare, professionals must share the following types of decisions: preventative, diagnostic, therapeutic and rehabilitative. In short, on the basis of specific and common competences, professionals must be able to establish relationships of trust and have shared values and objectives.

The maximum development of competences in each professional group and the principle of subsidiarity must be put into practice via the full and effective incorporation of all of the different professions that make up the portfolio of primary healthcare services into the public healthcare network of the GTS region or that of several GTSs. Some of the professions are still not represented and others (experts in professional training, transport, chiropody, physiotherapy, diet and nutrition, occupational therapy, etc.) can be gradually incorporated in the future, depending on the development of the portfolio of services and the level of problem-solving capacity that needs to be attained.

We need to move towards the replacement of the current competency model (based on functions and tasks) with a new model that enables the full development of skills, knowledge, abilities and attitudes in each professional area. The approach should involve boosting the shared and personal competences in each professional group. With respect to the nursing profession in particular, it is essential to stimulate the fields that enable nurses to assess and define the health situation and to plan and prescribe in all situations that effect health maintenance, living conditions and the resolution of health problems. In addition, it is essential to develop, to a greater extent than that seen to date, the role of community pharmacists as health agents that are among the first to be approached.

Access to lifelong learning programmes and activities must be guaranteed in the context of the continuous development of all primary healthcare and community health professionals. In addition, it is essential to move towards the establishment of systems of periodic recertification of competences. Contracts with providers should guarantee conditions that facilitate availability for the acquisition of continuous education credits and the other types of credits required to attain this objective. This should be conceptualized as a right and a duty in the framework of individual continuous professional development (CPD).

Foster teaching and research

The universities must significantly increase teaching resources in the regions to bring about the changes in focus, contents and methods that are required in undergraduate education and to develop training programmes and academic structures for primary healthcare and community health.

Resources for postgraduate education must be increased and devoted to improving the quality of teaching programmes. Simultaneously, contact should be increased with the centres and regional resources of the various professions and specialities.

In primary healthcare, data that is commonly researched includes accessibility to the population in general, a continuous relationship over time (particularly as a guarantee of the healthcare continuum) and activities in the early stages of disease, among others. Primary healthcare occupies a privileged position in health research.

Research should be considered another of the provider's activities. Professionals should have the resources they need to ensure that their healthcare and research activities are compatible.

Professionals should also have the time and resources they need to undertake teaching and research activities. In addition, the educational accreditation of centres, services and professionals should be boosted and operational centres of applied, clinical, public health and community health research should be created. Research into primary healthcare and community health is still in an initial stage of development. The access of primary healthcare professionals to these types of activities should be strongly encouraged and research projects should be financed that enable progress to be made in the culture of research. In this field, there must be competition and the involvement of institutions and professionals to consolidate the development of primary healthcare and community health entities that promote and manage specific research into this field. It is also important to foster the recognition of the scientific community.

4.1.2.2. Organization

Assigned professionals and consultants

Primary healthcare doctors and nurses are the professionals who are responsible for all of the healthcare that the patients on their lists receive, including the direct provision of community care and the management and monitoring of the contact that their patients have with other resources in the healthcare system. They constitute the main "point of contact" between society and the health services and the importance of their

decisions may lead to better use of the competences of all professionals in the public healthcare network. In addition, their value and expertise contributes to healthcare in the region.

The primary healthcare centre and team constitute the structural and organizational aspects, respectively, of the basic health services that are available to the population in the GTS region. The core of integrated health centres is made up of the primary healthcare doctors and nurses, paediatricians, nursing auxiliaries, medical receptionists and healthcare administration staff. Paediatric care is organized into teams on a regional basis, so that all children between 0 and 14 years old have an assigned paediatrician and the opportunity to be seen by a competent professional in highly accessible facilities. Midwives are the main point of contact within the basic health areas (ABS) for the care provided in the normal course of a pregnancy, birth and the postpartum period, as well as prevention and promotion activities related to sexual and reproduction health. They operate in conjunction with obstetricians and gynaecologists, who are the consultants that work in this area in the provision of regional services. Various other professionals work either permanently or occasionally in the primary healthcare centres. The type and number of these professionals depends on the social and health needs, the portfolio of services, the geographical and sociodemographic characteristics and the available physical ad technological resources in the region. Finally, the provider is responsible for the most appropriate configuration to ensure that quality healthcare is available.

In accordance with the needs of each region, the competences of all staff in the centres and teams must be developed. Particular attention must be paid to auxiliary nurses, who should make a major contribution to the provision of many of the centre's tasks. This also applies to the administrative personnel in health centres, who are essential in the areas of reception of users and in the management of appointments and schedules.

The organizational design of the basic services must foster integrated and joint care in a context of interprofessional and interdisciplinary cooperation. This will aid the definition and attribution of responsibilities for results to the activities of each professional. The specific definition of organizational aspects, including the physical location of professionals and their daily interactions, must be established in the organization of each primary healthcare provider.

The general planning of the services that support primary healthcare centres and their professionals must be undertaken from a regional perspective (although the departments of the institutions and the provider must be respected). Clearly, not all of the regions will cover all the healthcare services. Therefore, collaboration agreements must be established with other regions to ensure provision.

If all of the specialities are to be equally recognized, **the traditional distinction between the levels of primary and specialised care should be gradually eliminated**. Instead, we should refer to the set of specialities that are available in the regional framework of the GTS. The specialists, who act regionally through organizations of providers in networks, will work mainly as **the consultants** who constitute the referral services.

Autonomy of management of professionals

Autonomy of management—in its broadest sense and from the perspective of developing the full potential of the related concepts of independence and responsibility—is central to many of the strategies for change in health systems, whether they address the hospital environment or other healthcare areas.

Diversity, participation and transparency should be the three basic principles of the organization that supports the service management structures in the GTS region. The application of these principles is perfectly compatible with a cohesive system and, in the case of healthcare professionals, must also be able to boost leadership abilities.

The professionals, both individually and as a group (team), must feel that they play a leading role in healthcare, teaching and research projects. They should be proud of the fact that they are part of an entity, an organizational project and a specific job.

We must analyse the possibilities for developing autonomy of management that are provided by the legal frameworks, including the LOSC (Law on Healthcare Organisation in Catalonia), statutes of public companies such as the ICS and those of the approved entities that constitute the public healthcare network that provides the services.

Currently, various self-management initiatives (association-based entities, EBA) are being undertaken in Catalonia. In addition, the Catalan Institute of Health has designed an independent management project that has been implemented in a pilot phase in various primary healthcare teams (EAP). In the next three years, the aim is to progressively extend this initiative to the rest of the EAPs that are managed by the ICS.

As part of their independent management, other providers have designed various projects that increase the independence of the healthcare teams. These experiences show that we should continue to analyze different legal formulations that enable the progressive establishment of various models of independent management. Such models should be established for all those who guarantee equitable access to public services, the quality and safety of the care that is provided and responsibility for the results of the management that is carried out.

The providers in a GTS should be structured as facilitators of service provision in a network in the GTS area or in all of the GTSs, rather than according to a regional perspective. The fact that the ICS has been converted into a public company should bring about the establishment of agreements for management and service provision with other public providers in the GTS.

Information systems must be interconnected and compatible, if we are to implement strategies for independent management alongside those for collaboration between providers within the GTS. The healthcare authority will define the basic criteria that the various providers must meet in this area.

Adapt the organization to health needs

In the framework of the independent management of providers, we should analyze carefully the healthcare tasks undertaken by professionals. We should avoid uniform proposals that do not take into account the specific characteristics of each region, centre and team. The establishment a priori of a fixed proportion of users assigned to each professional and

the universal application of this figure could lead to errors and inequalities.

It is vital to examine the past development of trends in healthcare demand, the current situation and the prospects for the future. In addition, we should assess the impact of these trends on the professionals who work in the centres and teams. This analysis must also take into account the new context of professional competences and tasks. Two factors must always be taken into account: on the one hand, guarantees of accessibility, quality and safety of healthcare activities and an increase in the satisfaction of the public and professionals; and on the other hand, production of the best possible results in response to demand.

Reduce the level of bureaucracy in the healthcare activity

Action must be taken on all the bureaucratic and administrative processes that are not directly related to healthcare activities, that generate a significant workload and that unnecessarily reduce the time available for patient care.

To implement these actions and hence reduce the bureaucracy in healthcare, it is essential to follow strategies and procedures that are not detrimental to the public and that are consistent with the responsibilities of each type of professional and organization. Before such actions are undertaken, all of the agents involved must be informed, including those within and outside of the health system. In addition, legal consultations and consensus meetings should be held with professional organizations and the administration. Furthermore, the specific way in which the proposed measures are applied must be adapted to each healthcare area.

The introduction of shared clinical records and e-prescriptions, as well as the promotion of ITC for communication among professionals and with the public, shall have a significant impact on the solution of many problems that are due to the excessive number of bureaucratic tasks in health care activities. These factors should be taken into account when specific activities are selected.

The following should be considered as areas in which bureaucracy can be decreased:

- Prescriptions generated by others, prescription authorization and narcotics.

- Certificates, reports and medical certificates (including sick notes).

- Requests for complementary tests and referrals.

Unnecessary procedures should be eliminated, simplified or redistributed. The professionals who are the first point of contact for the public and patients (primary healthcare doctors and nurses) must take on the bureaucratic tasks that are inherent to their jobs. They must also provide essential information as part of their role as guarantors of the continuity of healthcare and managers of the contact that their patients have with other resources in the system.

4.2. Resources

4.2.1. The Plan and the public healthcare network in a GTS region or in all GTS

The Primary Healthcare and Community Health Plan is within the framework of processes of organizational change that began in recent years in the entire Catalan health system and its providers. Hence, the areas of activity that are described in this section incorporate various conceptual aspects that are related to the aforementioned processes.

4.2.1.1. The model of services in the region: the public healthcare network in the GTS region and the portfolio of services

The regional health authorities (GTS) are key instruments in the process of decentralizing decisions within the Ministry of Health. The priorities and guidelines established for the healthcare of the population in a GTS region should be translated into actions that develop more effectively in a context of operational integration of all of the services provided in the region.

The governing body of the GTS defines its healthcare priorities in a strategic, multi-annual plan, on the basis of proposals drawn up by the directors of the sector, the executive management of the GTS, the Committees of Providers and the Health Council.

To attain a suitable level of working in network in the different areas of services that are included in the regional portfolio, organizational methods that foster this approach must be created and encouraged. To achieve this, primary healthcare and community health need to be situated at the heart of the network.

The specific services of each GTS may vary according to the types of resources found in the region. However, in any case, the requirements established in the portfolio of common services must be covered. These services may also be available to the population of other adjacent or non-adjacent GTS.

CatSalut must establish the corresponding portfolios of services, with the consensus of the GTS and in accordance with the new model of working in a network that must be introduced. This should be the result of current experiences and new initiatives aimed at maximising the efficiency of the healthcare resources that are available in each region.

The priority of this network model must be to improve the accessibility of services and to resolve health problems in accordance with the principles of subsidiarity and the guarantee of the healthcare continuum.

4.2.1.2. Basic services

Portfolio of basic services. The healthcare team is the main point of contact in general practice and community health. The general practitioners, nurses and paediatricians in the teams have a population assigned to them and are responsible for meeting the health needs of this population, including direct care and monitoring and coordinating the care received from other health care levels, through shared clinical records.

Family healthcare and community health (including paediatrics), basic services (professionals who have an assigned population)

Other services (including consultant paediatricians)

- Other outpatient healthcare services*
- Medical and nursing specialities*
- Sexual and reproductive health (ASSIR)*
- Emergencies and continuous care*
- Physiotherapy and rehabilitation*
- Speech therapy*
- Care for patients with complex diseases in a frail state (proactive care for people with severe multiple pathologies or dependency problems, including the support teams' home care programme (PADES) and palliative care without hospital admission)*
- Transport*
- Dentistry*
- Public health *
- Optics and optometry*
- Community pharmacy*
- Chiropody*
- Labour health*
- Diet and nutrition*
- Social services*

*Services that may be coordinated within the regional network

All of the areas of healthcare have a regional perspective. To facilitate working in a network, it is considered appropriate, as stated in the section on professionals and their organizations, to progressively reduce the gap between the traditional levels of primary care and specialized care in the GTS region.
Community pharmacies are the healthcare resources that have the greatest coverage and accessibility. Pharmacies and pharmacists are resources that can offer an increasing number of services and that act as agents of health that can contribute decisively to the development of programmes of activities in the health sector.

With a view to guaranteeing the quality and safety of healthcare, we should take advantage of the new opportunities provided by the development of ICTs. This technology facilitates collaboration between the different types of professionals in organizations of the healthcare network within a GTS region.

The increase in the prevalence of diseases of the locomotor system and neurological diseases associated with ageing and labour activity, as well as the need to promote physical activity and healthy eating habits, make it essential to prioritize the role of physiotherapists and other professions (speech therapists, dieticians, intuitionalists, etc.) who work in the region.

The concept of the public healthcare network in the GTS region or in all of the GTSs includes all of the services available from healthcare providers in the region. This concept incorporates the centres and services of general practice and community health as well as those that make up the portfolio of services in the other areas that are specific to the region.

4.2.1.3. Areas for progress in the portfolio of primary healthcare and community health

Care for people with complex diseases or in a frail state

A new area of **proactive care** with coordination between the various services in the region shall be created for patients with complex diseases or those in a frail state. The aim is to improve the quality of life of such patients and increase their personal autonomy, so that they have the opportunity to remain in their usual home environment. The attainment of this objective often requires major resources in terms of personal and home care and the effective integration of the work of various services, healthcare professionals and social and community areas.

It is essential to identify the people with multiple pathologies who are more likely to require these services. In this way, areas of proactive healthcare and specific healthcare pathways can be created for each group of needs and problems, with varying levels of involvement of professional activities and technological resources. The identification of these individuals shall enable personal risk to be predicted on the basis of data from various sources: population censuses, health centres and teams; hospitals, social health centres, social services, the Public Health Agency of Catalonia (ASPCAT), community pharmacies and mental health services, among other services in the public healthcare network in the GTS region.

On the basis of organizational efficiency, it is essential to approach this kind of care from a regional perspective. The specific method shall depend on the local characteristics. However, one proposal is to create home healthcare teams made up of professionals from the basic services and consultants who provide specialized support services. Patients who require intense or complex healthcare could be the recipients of proactive monitoring and control provided by the home healthcare teams and the telephone healthcare centres. In addition, the patients must be able to get in touch with the centre 24 hours a day, so that the centre' can address the problem and resolve it directly or ensure that the appropriate professionals carry out a home visit.

Healthcare for dependents

By definition, activities in the area of healthcare for dependents have an intersectorial aspect. Combined healthcare and social actions are central to this area, but must be accompanied by the activation of other community services and resources that are linked to various institutions.

Healthcare for dependent people with diseases is one of the main present and future challenges in primary healthcare, both in terms of preventative aspects and the promotion of autonomy, and with respect to coordinated

healthcare interventions that are carried out by the primary healthcare and dependent care facilities.

To attain this objective, the administrations with authority in this area should define an appropriate action plan.

Continuous care, urgent care and emergency care

The concept of emergency includes a set of services of a diverse nature such as continuous care, urgent care and emergency care. This division of health needs reflects the management approach of professionals and institutions. However, the public often do not perceive any difference between these services, particularly between the first two.

The set of service providers (with their centres and professionals) in the public healthcare network of a GTS region must meet the demand for continuous and urgent care. It is essential to coordinate face-to-face, telephone and ICT mechanisms to respond to health needs. The specific organizational model shall depend, logically, on the needs and characteristics of the population covered by each GTS (rural or urban) and the available facilities (including CUAP[1], hospital services, etc.). Telephone and computer response centres need to be created that are proactive and able to direct the public to the suitable professional (the GP team or consultants) and the appropriate services.

The coordination of urgent primary healthcare with emergency hospital services is one of the main factors that ensures the quality of problem solving.

[1] Emergency primary healthcare centres

The required resources and the services that support primary healthcare must reflect this coordination.

Emergency care should be channelled through rapid response centres and the immediate activation of ambulances with or without medical teams.

Public health

This area of services must also be defined with standardized criteria for all of Catalonia. However, the criteria must be adapted to the health needs of the populations in each region (GTS), in accordance with the guidelines determined by the Public Health Agency of Catalonia (ASPCAT), its decentralized management structures, the town councils and CatSalut, in a context of promotion and prevention.

Community pharmacy

The pharmaceutical care that is provided by pharmacy staff fosters the continuity of community care:

• Pharmaceutical staff should have the opportunity to intervene in three areas of healthcare: health promotion activities; disease prevention and risk groups (handling minor symptoms and promoting self-care, pharmacotherapeutic monitoring of patients who are prescribed several drugs, with particular attention to chronic or frail patients).

• It is essential to promote a portfolio of approved services that enable pharmaceutical staff in pharmacies to participate in health promotion activities and population-based preventative actions, as proposed by the Health Administration, which will establish the required competences.

4.2.1.4. Decentralized organization of the Ministry of Health and CatSalut

The Catalan Health Service shall be organized into regional catchment areas called healthcare regions, taking into account the healthcare organization established in the LOSC. At a second regional level, the LOSC defines health sectors. Decree 122/2009, which partially amends the delimitation of the health regions and sectors, establishes that the health sectors shall be adapted to the geographic range of the GTS, in accordance with the regulations on GTS in Decree 38/2006, to strengthen this level of decentralization.

In accordance with the LOSC, the health region has the following bodies for management and participation: the Board of Directors and the Health Council.

The management of the sector or the executive management of the GTS is responsible for coordinating the network of providers in the region, in accordance with the defined plan and using the instruments for commissioning services, monitoring healthcare processes, and evaluating services. The management of the sector or the executive management may undertake this role for more than one GTS region. He/she is appointed by the Board of Directors of CatSalut and reports to the Health Region Management. To carry out his/her function, the director receives the required support from the Health Region services and the central services of CatSalut.

The person in charge of the management of the sector or the executive management, as head of the GTS, shall be supported by the Coordinating Commission for Healthcare-Providing Entities, in which the various providers in the region participate. The entities and the management of the sector or executive management, together with the professionals, are committed to clinical management in the region.

The GTS services must have the scope and instruments required to ensure the accessibility and continuity of the care provided to the public from an individual, family and community perspective.

The sector management or executive management of the GTS is responsible for establishing objectives and measuring the health results, accessibility, quality and sustainability of the providers contracted by CatSalut in the GTS area.[1] To undertake this function, there is a convention on the population-based coordination of the commissioning system, which must include, among other aspects, the allocation of resources to develop the portfolio of basic and specific services that CatSalut contracts in the GTS region, in addition to the objectives of accessibility and problem solving that are established by CatSalut.

4.2.1.5. Intersectoral action

Evidence indicates that the level and state of individual and population health are related to actions in different healthcare sectors. This idea should be incorporated strategically and operationally in the planning and organization of GTS services.

The bill for the public health law assigns to the Public Health Agency of Catalonia (ASPCAT) the coordination and support of public health activities carried out in the healthcare centres of the public healthcare network,

[1] To attain this objective, support shall be provided by the Results Centre and the Agency for Information, Assessment and Quality (AIAQ).

taking into account the context of financing and the relationship and collaboration with the Catalan Health Service, particularly in the fields of health promotion and disease prevention.

To act on health determinants (which include biological, environmental, labour and social factors), the health services must work with other sectors in the framework of a **new** approach to **public health**. Qualitative and participative instruments and working methods must be developed that are adapted to the characteristics of each region. The following need to be boosted: the active participation of the population and the coordination of activities with other social sectors and other community professionals (in the fields of education, social work, etc.). In addition, various experiences of community intervention need to be analyzed, such as the AUPA project, the "Health in the Neighbourhoods" programme and the Plan for the Promotion of Health through Healthy Diet and Physical Activity (PAAS). All of these programmes have been developed in Catalonia to serve as a starting point for fostering the intersectoral integration of programmes and actions that have a clear impact on health.

The effectiveness of community interventions aimed at social factors that influence lifestyles, for example, diet and physical activity, can be ensured by the active involvement of community agents from within and outside the health system (dieticians, intuitionalists, professionals from the National Institute of Physical Education (INEF), etc.). Thus, it is essential to know and work with these agents.

Given the proximity of primary healthcare to the community and the collective nature of public health services, cooperation could serve to provide a more community dimension to the entire health system, which would contribute to improving the health of the community and strengthening a relationship of mutual cooperation between the community and the health system.

Intersectoral collaboration in primary healthcare should also consider the interrelations between the health and social services, mainly, but not exclusively, in the way that the issue of dependency is addressed and thus also in the promotion of personal autonomy. The provision of community social services should be boosted in the following areas: residential facilities, home help, day centres and telecare, among others.

4.2.1.6. Healthcare centres and healthcare teams

Structure

Healthcare infrastructures must provide integrated healthcare and coordination between the services. In this respect, healthcare centres can be considered one of the core structures of the public healthcare network in the GTS region where the basic services are provided (general practice, community health and paediatrics) as well as other services, if required, and public health. Beyond the physical structure (the building), healthcare centres should be interpreted as functional organizations that provide a significant part of primary healthcare and social care for the region. The functional organization of primary and community healthcare in a region can be based on multifunctional health centres, which bring together many of the services in the regional network. Alternatively,

depending on the location and taking into account urban development and budget restrictions, the services can be organized in clusters of centres that together constitute the physical basis for the tasks and the relationship between professionals. Both options are appropriate if we reject the idea that only the building is the main resource and reinforce the concept that the relationship between entities, services and professionals is what constitutes the network. The centres are the physical support that can be provided along with other resources, such as ICT.

The dimensioning of health centres, other centres and community services must be defined by taking into account the fact that each health team can cover a population of no more than 20,000 inhabitants. On the basis of a strategy of modular organization, the design of each healthcare centre should reflect the characteristics and needs of each region as far as possible. With this approach, the standardized criteria for dimensioning spaces according to the population are only guidelines that can be adapted to each region. A functional plan is required to define the type of services and spaces that can be included, the main characteristics of the infrastructure and the guarantees of accessibility and safety. Taking into account an overview of the whole region, the GTS must define the needs that their centres must meet and, consequently, their location, functional design and the types of services that they offer.

One of the main parts of the structure of health centres are the areas for consultations. In an ideal situation, the doctors and nurses that are the first point of contact should have individual consulting rooms. In addition, the support professionals who have permanent consultancies in the basic health area (ABS) should also have their own offices.

Finally, areas in every primary healthcare centre should be gradually adapted according to the proposed portfolio of primary healthcare services.

The reception areas for users and patients should be designed in such a way as to maintain the confidentiality of specific activities.

Management and organization

The management and organization of healthcare centres should be carried out with sufficient autonomy and flexibility to attain maximum adaptation to the sociological characteristics and the health needs of the population, and to the expectations and initiatives of the professionals. It should be balanced enough to ensure a suitable level of access to the services and to attain the objectives established and agreed with CatSalut.

The healthcare centre and healthcare team must respond effectively and efficiently to individual and group health needs management and organization must be adapted to the context. It is essential to ensure that the professionals work in an integrated way as real teams in which everyone shares objectives and responsibilities in a positive work environment. The size of the teams may limit this functional integration.

Another weakness that affects the cohesion of teams is the division into morning and afternoon shifts that still exists today. Therefore, new organizational methods should be assessed that—with changes that are reasonable and possible in the workplace—enable this division to be decreased without reducing the opening hours of the healthcare centres. The aim is for the entire team to coincide at some point during the day.

The various professionals in the health centres should develop all of the competences that correspond to them. Mechanisms should be put in place so that each professional can prioritize the competences that are exclusive to him/her and that cannot be taken on by other members of the team. In the case of primary care doctors and nurses, the aim is not to exchange competences, but, depending on the case, to boost the autonomous and shared implementation of the competences that form part of some experiences, when this is permitted by the current legal framework. Hence, the role of primary healthcare nurses as one of the first points of contact for users should be developed, as should their function of managing patients with complex diseases and frail patients, and their shared leadership in the areas of home and community healthcare, and health promotion and prevention.

We have already discussed the need to develop the functions and tasks of nursing auxiliaries in healthcare centres and those of all administrative healthcare staff, in the context of a debate that involves all healthcare professionals and in which consensus is required. In each case, it is important to assess the training and other activities that may be needed so that these professionals can perfect their skills and take on a wide range of healthcare tasks that have been performed by other members of the teams to date.

In the organizations, the schedules of professionals must comply with some basic common criteria. However, there proposals of each professional must also be taken into account, if they are compatible with the activities of the entire team to meet the commitment of the organization. Professionals should be able to distribute the time allocated to healthcare throughout the working day, without reducing the accessibility of patients. Hence, more importance should be given to healthcare that is provided over the phone, Internet or email rather than face-to-face, and time should be set aside to carry out these tasks.

Professionals in healthcare centres and teams must have workloads that enable them to devote enough time to healthcare in each type of consultation for each patient and to meet requirements for referrals. A local and continuous analysis of the workload of each primary healthcare centre (CAP) and professional should be carried out in order to manage, if necessary, any changes that enable the required balance to be attained.

Users' healthcare pathways are of key importance to attain an optimum level of quality. To manage requests for consultation, including diagnostic tests and special treatments, it is essential to create a locally adapted design and define which professionals are responsible for each part of the healthcare process, which must be the led by the primary healthcare doctors and nurses who are the first point of contact.

4.3. Instruments

4.3.1. Guidelines for accreditation

A significant step towards greater quality has been taken in the implementation of Ministry of Health initiatives in the area of accreditation models for the services in the public healthcare network and, specifically, the most recent experience in accreditation in the hospital network.

The Plan proposes that the Ministry of Health, through the Directorate-General for Healthcare Resources, should implement the new model of

accreditation in the primary healthcare network, starting with an initial stage of accrediting the network of healthcare centres. In this respect, it is important to take into account the European Foundation for Quality Management (EFQM) Excellence model.

Primary healthcare services must respect the guidelines that are developed for this purpose.

4.3.2. Financing, commissioning and hiring

In 2010, the new population-based model of regional allocation of resources shall be extended throughout Catalonia. Financial resources shall be distributed to regions in accordance with some adjustment criteria that are currently being defined (population structure, dispersion, immigration, income, double healthcare coverage, etc.).

Regional adjusted population-based financing is a key instrument for the integration of services. It must include incentives aimed at fostering coordinated management and continuity of healthcare, on the basis of alliances formed among various providers, in a context of accessibility, problem-solving and the commissioning and hiring of services.

4.3.3. Objectives of accessibility and problem-solving capacity. General criteria

The objectives of accessibility and resolution shall be described in a future agreement on access and resolution. This agreement shall be established between CatSalut, as the institution that commissions the services, and the providers in the GTS region. The agreement shall be on the coordination of a population-based system for commissioning services and

for the contracts established with the various entities in the region. The aim is to define the best criteria and the best dynamic for allocating resources to development, with the greatest possible degree of equity, efficiency and quality in the portfolios of basic and specific CatSalut services in the GTS region.

The general objective is to focus on the management of results, using the indicators of accessibility, level and ability of problem-solving to establish criteria for commissioning and hiring services for each of CatSalut's primary healthcare providers.

The general objective should be based on premises of transparency, equity and efficiency. Its contents should reflect four key aspects of service provision:

• Accessibility: understood not only from the perspective of time (waiting time and waiting lists), but also the absence of inappropriate barriers to the use of services (geographic, physical, socioeconomic, etc.).

• Capacity to efficiently resolve problems and meet needs, with particular focus on the most suitable place and professional for each case, and on the return of patients to the primary healthcare professionals who are their first point of contact.

• Quality: assessed in terms of health results, satisfaction and safety.

• Efficiency.

The objectives for primary healthcare, which do not affect the objectives that refer to all areas of service in the region, should include the following criteria:

• **Structure**: in relation to the characteristics of the resources that provide the services (accreditation).

• **Technology**: in relation to the availability of the technological support required in the provision of services, with a guarantee of interconnectivity and compatibility and particular reference to shared clinical records.

• **Organization** of the provision of healthcare and public health services (pathways, information systems, internal and external coordination, healthcare guides and paths), with the main aim of boosting the proximity and integration of networks and services.

• **Clinical management**: the need and ability of organizations to assume clinical management in the region via appropriate professionals. Basic credentials of the organizations and the professionals to adopt this responsibility.

• **Quality**: determined on the basis of parameters related to previous use of the services (complaints, satisfaction, results) and the consideration of programmes to continuously improve quality.

• **Compensation** per unit of services and per process, including pharmaceutical spending.

The objectives of accessibility and problem-solving capacity should be defined on the basis of the objectives and priorities set by the GTS in their multi-annual plans. The following general aspects must be forecast: the level of health of the population that is covered; the dynamics of use of the services (first or second visits, urgent visits, etc.); the waiting time and the waiting lists; the suitability of referrals and requests for complementary examinations made by the primary healthcare professionals; the return of patients to these professionals; the joint treatment of patients with the consultants; the intrinsic quality, safety and efficiency of treatments, with particular reference to medication; the length of inpatient stays, etc.

In addition, other specific aspects related to each problem or group of prioritized problems (heart failure, COPD, mental health problems, rhematological problems, etc.) should be anticipated in the field of individual and community health promotion and prevention, diagnosis, treatment or monitoring of processes, their evolution and complications.

The agreement must include the tools required for the development of policies of the rational use of medication with the objectives of quality, safety and efficiency and with the participation of various professionals, healthcare staff, experts in pharmaceutical policy and community pharmacy staff.

We have already mentioned the need to introduce regional public health strategies aimed at the development, from a community perspective, of health promotion and prevention actions and other factors that boost the autonomy and participation in the health sector of the public and public associations. This should be achieved in an integrated way through the healthcare services and their organizations.

The general objectives of accessibility and problem-solving capacity shall be the object of designs and profound developments in addition to those that apply specifically to primary healthcare. These aspects focus all agents in the system (the Administration, the providers and the professionals) on the results. In addition, the bases for the rights and duties linked to hiring services shall be established.

4.3.4. New technologies (ICT) to increase speed and cooperation

The ICT are essential instruments that ensure the feasibility of the strategy of integrating services. This statement carries even more weight in a context of diversification of service provision.
It is essential to clearly define the compatibility and interconnectivity of information systems. Without this, processes such as planning, organization, management and assessment of healthcare services and activities would not be undertaken satisfactorily in Catalonia as a whole and in each GTS region specifically.

The Innovation Plan can only be implemented in the aforementioned context. Hence, the areas of work being undertaken by the Agency for Information, Assessment and Quality (AIAQ) in the field of shared clinical records are a priority. With respect to electronic clinical records in primary care, we should assess the possibility that the Ministry of Health promotes a common model that can be used by professionals in all the provider organizations. The progressive introduction of the e-prescription is another aspect that should contribute to improvements in healthcare processes, as it will reduce the bureaucratic workload in consultations and provide the public with more rational and safe access to medication and other healthcare products.

The unification or at least the guarantee of compatibility, of the software for the information used in clinical management and in consultations between the various professionals in the network is vital to improve the healthcare processes and to ensure that professionals and the public can access data.

4.3.5. Assessment system and rendering of accounts

Assessment is centred on performance in terms of effectiveness, quality, safety and satisfaction. However, new focuses need to be incorporated into the concept in relation to primary healthcare, community health, and all of the resources in the public healthcare network in the GTS area (in addition to the current assessments of sectors, we should carry out evaluations of all services in the GTS).

A transparent system of evaluation and monitoring should be set up that enables CatSalut to assess the response of the regional health authority to the population's health needs, as well as the activity, quality and efficiency of the system and satisfaction of the users and professionals. The mechanisms for assessing the commissioning of services, as well as the indicators established by the future Agency for Information, Assessment and Quality (AIAQ) and the Results Centre shall contribute to attaining this objective.

Hence, it is essential to ensure the connectivity and compatibility of the information systems in the centres, services and other organizations in the GTS region.

The range of instruments and methods of providing information should be studied in depth. The joint use of quantitative and qualitative methods is considered to be of great importance.

In addition, we must establish the set of instruments and indicators that enable the implementation of the Plan to be accurately monitored, from a regional perspective (GTS) and for the various proposals for change that are made. In this context of major changes to the entire health system, it

is essential to closely assess all of the effects that these changes may have in different areas, such as financial aspects and health and quality results.

4.3.6. Other instruments to support the Plan

Legislative:

• Law 15/1990 of 9 July on Healthcare Organization in Catalonia (LOSC).

• Law 8/2007 of 30 July of the Catalan Institute of Health.

• Law 44/2003 of 21 November on the Organization of Healthcare Professions.

• Bill of the Law Public Health.

Administrative and organizational:

• The regional health authorities (GTS).

• CatSalut and its organization.

• The basic health areas (ABS) and primary healthcare centres, the providers and the professionals

• The public healthcare network.

• The Health, Social Health and Public Healthcare Map, the Healthcare Plan, the master plans and the strategic plans for the reorganization of services.

Instrumental:

• Information and communication technology (ICT): clinical reports in primary care, shared clinical reports and e-prescriptions.

• Population-based funding.

• Hiring services.

• The Results Centre and the Agency for Information, Assessment and Quality (AIAQ).

• The health portal.

Other instruments to be developed in the future:

• Guidelines for the accreditation of primary care.

• The Communication Plan for the PIAPiSC.

• The Implementation and Development Plan for the PIAPiSC.

• Indicators and the factors of accessibility and problem-solving capacity

(future agreement).

• Assessment of the Innovation Plan.

• Plan steering committees.

• The Innovation Plan as one of the Ministry of Health's programmes of interest.

5. The process of drawing up and implementing the plan

5.1. General schedule

The process of formulating the Primary Healthcare and Community Health Innovation Plan began during the first quarter of 2007. In that year, a series of working meetings were held with the institutions, professionals and the public, in order to draw up the strategic aspects of the plan. In the first months of 2008, the Plan's strategic document was written. It was then submitted for the consideration of the executive structures of the Ministry of Health and the Catalan Health Service. Subsequently, it was presented to the employers' organizations, the trade unions and all of the institutions and professional organizations that are involved. This period of presentations continued until July 2008.

In May 2008, the first reflections began on how to tackle the implementation of the proposals in the Innovation Plan. It was decided that a Central Advisory Working Group for the Plan should be formed of leaders in the various subject areas included in regional community services. This group began to meet once a week from the beginning of June (and then once a fortnight from October onwards). The group's task ended when the final document was drawn up in March 2009.

Between 15 September and 30 October 2008, the directors of the Plan held meetings with the management teams of the healthcare regions, for two reasons: to explain the main proposals of the Plan and to obtain direct information on expectations and opportunities for action in relation to the initial implementation of the Plan in some of the GTS regions.

Throughout this period of drawing up the Plan, the Plan's Management Committee continued to meet every fortnight. In December 2008, the Plan's first operational document was presented, which described both operational and strategic aspects. This document was then submitted for the consideration and contributions of all of the management structures and institutions in the sector. In the first nine months of 2009, a new round of presentations was organized to seek a consensus. This resulted in the new document that is presented here.

In addition, during the first nine months of 2009, the basic components of the Communication, Training and Change Management Plan were drawn up. This Plan had to provide the bases for the actions to progressively implement the Innovation Plan in the advanced regions. In addition, work began on the criteria for selecting the regions in which the Plan would initially be implemented.

In the final quarter of 2009, on the basis of the approval of the Board of Directors of the Catalan Health Service, CatSalut shall design the processes of implementation of the plan which will include, among other factors, the priorities for activities in the implementation regions, and the monitoring and evaluation system. The Board of Directors of CatSalut must be

periodically informed of the implementation. In addition, a Plan Steering Committee must be formed, with the participation of the Directors of the Plan (the Directorate-General for Planning and Assessment (DGPA), the Directorate-General for Public Health (DGSP), the CatSalut's Services and Quality Department) and the associations of providers.

5.2. Implementation in the region

As mentioned above, the Innovation Plan must be gradually implemented in the various regions (GTS), beginning in 2010. During 2009, these regions were selected in order to obtain positive results (successful experiences), as they are to act as an example for the rest of the regions.

The mechanism used to select the regions should be analyzed. Consensus was required among the health regions and the central management structures of the Ministry of Health, the Catalan Health Service and the Plan Steering Committee. The degree to which the regions meet the requirements for the implementation of the plan was taken into account.

To progress in the process of regional implementation, each Health Region Management shall choose at least one professional from his/her team who shall be specifically responsible for the function of promoting the Plan. These professionals, with the support team that is considered appropriate and the Plan Steering Committee, must maintain a free-flowing functional relationship with the provider institutions in the region and with the Directors of the Innovation Plan (the Directorate-General for Planning and Assessment (DGPA), the Directorate-General for Public Health (DGSP) and CatSalut's Department of Services and Quality).

5.3. Communication, Training and Change Management Plan. Bases

The Primary Healthcare and Community Health Innovation Plan is also known as **Project Oxygen**. This name stresses that the innovation will bring fresh air into the system and shall serve to foster new dynamics of functioning and relationships between the professionals that shall be less mechanistic, more vital and more "organic". In short, the aim is to promote a new health care context that is more flexible and comprehensive, for a public that are increasingly participative and assume joint responsibility for their health.

The changes that are proposed in the Primary Healthcare and Community Health Innovation Plan are profound and cultural. The planning, organization, financing, commissioning and management of primary healthcare services must be strengthened and, simultaneously, the way of interacting in a public healthcare network in the GTS regions must be reinforced.

Instruments for communication and training are required that can clarify as far as possible the innovation proposals and prevent unsuitable and erroneous interpretations. The Communication, Training and Change Management Plan shall become a highly important instrument to attain a calm, viable process of implementation in the various regions.

The Communication, Training and Change Management Plan must be coordinated with the various communication plans of the Ministry of Health and CatSalut and false expectations should not be created. The correct time sequence must be attained in relation to the changes in the

way services are provided (do and then advertise). In addition, we must identify and address the strengths, opportunities, potential weaknesses and threats that are related to the impact of the plan.

The Communication, Training and Change Management Plan must be drawn up jointly by the Directors of the Innovation Plan and the executive teams in the Ministry of Health and the Catalan Health Service that are responsible for these areas.

The Communication, Training and Change Management Plan must use existing technical and methodological media, particularly those based on the Internet. In addition, actions and instruments should be created and applied that are aimed specifically at the public and patients, healthcare professionals and management, the organizations, and the executive teams of the health system.

6. Methodology

The process of drawing up the PIAPiSC began during the first quarter of 2007, when the three directors and the president of the Advisory Council were appointed. The Plan comes under three institutions: the Directorate-General for Planning and Assessment and the Directorate-General for Public Health, which both come under the Ministry of Health, and the Healthcare Department of the Catalan Health Service. The dependency on these three institutions reflects the Plan's focus on integration of healthcare and public health services, as well as the need to put into practice the conceptual and organizational proposals for innovation.

To support and advise the Directors, the Advisory Council and the Permanent Committee for the Plan were established. These bodies are made up of leaders and representatives of the institutions that are involved. The daily work of Plan Management is the responsibility of the directors of the Management Committee, whose members include the directorates-generals of the Ministry of Health, the Catalan Health Service and the Catalan Institute of Health.

The creation of a dynamic of participation in the work to design and draw up the Plan has been one of the main concerns of those responsible. Throughout this process, we have received contributions from over 150 professionals and all the healthcare, scientific and labour organizations and institutions have had an opportunities to contribute to the working document of the Plan.

In 2007, six working groups were formed with a total of 94 participants, most of whom were healthcare and public health professionals. Through the virtual portal e-Catalonia and face-to-face meetings, these groups drew up the documents on specific subjects that served as the base for the creation of the first document of the Plan (*Elements estratègics per a la innovació* [Strategic aspects for innovation]) in March 2008. In 2007, four full meetings were help with the working groups and the coordinators, in order to foster discussion and the exchange of proposals.

The three directors of the Plan and other heads of the Ministry of Health and the Catalan Health Service visited countries such as Portugal and England and regions of Spain (e.g. Puertollano), where innovative projects are being carried out in primary healthcare and public health with an integrative approach. In addition, meetings were organized with English and US experts (Kaiser Permanente) in Barcelona, and we have exchanged visits with directors of the Galician Ministry of Health.

In 2008, once the Plan's first strategic document had been drawn up, health regions in Catalonia were visited and meetings were held with the management teams, to gain first hand knowledge of the expectations and characteristics of each region. In addition, in this period, the Central Advisory Group for the Plan was formed from professionals, leaders and experts in the different areas addressed in the Plan. This group has held various face-to-face meetings (every 7-14 days) in the Ministry of Health headquarters, to collaborate in the design of this document in conjunction with the Directors and the Committee of Directors.

The three directors who are responsible for the Plan have made many presentations on its strategic areas in various scientific, professional and educational environments. These presentations and debates have enabled us to disseminate the proposals and have also served to gather the contributions of debate participants.

From the beginning of the process of drawing up the Plan, many meetings have been held with professional organizations (associations and scientific societies), healthcare provider institutions, labour organizations (employers' organizations and trade unions). Many of the proposals made in these meetings have been incorporated into the Plan.

The document that includes all the strategic and operational elements of the Plan has therefore been submitted for the consideration of all the organizations, institutions and groups involved to include their contributions and thus attain the highest possible degree of consensus in relation to the Plan's proposals.

Once this process has been completed, as mentioned above, we shall move on to the stage of progressively implementing the Plan's proposals in the various regions (GTS) of Catalonia. This process shall be based on work to prioritize the objectives and the regions in the last quarter of 2009. The plan shall be implemented at the start of 2010, following the guidelines of the Ministry of Health and the Catalan Health Service, in the framework of the Plan Steering Committee.

7. Primary Healthcare and Community Health Innovation Plan: organizations and working groups

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Community Health WG
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