Spanish National Health Service: diagnosis and proposals to move forward

(Summary and proposals)

Coordination

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Although this document seeks to synthesize the response given by the members, the final content is the responsibility of the *Asociación de Economía de la Salud* [Association of Health Economics] Board of Directors.

Citations

When using any of these proposals or wishing to index the document, the recommended citation is: "Asociación de Economía de la Salud. Sistema Nacional de Salud: diagnóstico y propuestas de avance. Barcelona, November, 2013".

Motivation and Process

In 2008, the Asociación de Economía de la Salud (AES) [Association of Health Economics] put together a diagnostic report on the Spanish National Health Service (SNHS) from contributions made by several of its members, with the aim of contributing to the debate that would precede an eventual Health Agreement.

A lot has happened since then. There have been numerous regulatory changes that could change the structure, functioning and content of the SNHS as we know it. The economic crisis that has accompanied us since the release of the above summary document is constantly used as the justification for reducing regional budget allocations destined for healthcare and there are constant calls for the need to increase the efficiency of the public health system.

In this context, so different from 2008, the Board of AES considered it necessary to draft a new document that, on an objective basis and following scientific parameters, would once again take the pulse of the SNHS, examine the changes introduced by recently-enacted legislation and propose reform measures based on health economics analysis.

The report consists of four broad-based chapters: (i) Financing and Public Coverage; (ii) Healthcare Organisation; (iii) Health Policies; and (iv) Good Health Governance. Each chapter is subdivided into a number of different sections. This document provides a summary of the main messages of each of the chapters and the list of 166 proposals.

A large number of people associated with AES were invited to reflect on the chapter themes identified and to propose evidence-based measures, supported by reliable references, for change or improvement. The purpose of the invitation was to gather a body of information which would allow the drafting of a sound document, with scientific quality criteria, which would represent the different perspectives and reflect the rich and diverse views co-existing in a multidisciplinary association such as AES. The various contributions of the people who responded to the invitation were compiled as chapters by the AES Board. Responsibility for the final content of the document therefore falls to the Board and an acknowledgment is in order to the collaborators for their work and contributions.

The Board selected these people on the basis of their scientific and intellectual expertise and on their involvement with the Association. There were no other considerations and nor was, a priori, any other type of representation sought. We have had the generous and invaluable help of 50 people associated with AES, but as coordinators of the project, we are aware that there are many others who might also have contributed and provided us with valuable scientific/professional opinions and assistance. The Board has therefore never considered this text as a finished work, but merely as a first version of a working paper aimed at stimulating reasoned debate, in which the close to 700 members of AES, other associated, professional, scientific and political experts, and ordinary people, are invited to take part. Nor is it considered to be a definitive document, but rather an additional contribution to a process of continuous debate cultivated through other activities promoted by AES and the participation of its representatives and members in different forums. This is a debate which is constantly shifting and regenerating in response to advances in knowledge and the economic and social

situation, in which profoundly important structural elements are brought to light, and these issues are dealt with in this work.

For this reason, the report will be permanently accessible and on display at the AES website and all members and those with no links to the Association are invited to read it and make their own contributions and recommendations through the AES suggestion box, which can be found at http://www.aes.es/sugerencias.php.

Barcelona, 3rd October 2013

Introduction

Health is one of the pillars supporting the well-being of individuals and societies. From an individual perspective, although good health is not enough in itself to achieve or maintain a high state of well-being, as various studies on happiness and life satisfaction have shown in recent years, it is, in general terms, a necessary condition. The large volume of resources invested by our own and neighbouring countries in preventive measures and medical treatments that seek to avoid or mitigate, as far as is possible, the pain and suffering caused by diseases and health problems is unquestionably a reflection of the high priority we attach as a society to protecting our health.

Healthcare is the public service most used and valued by Spanish citizens, and the one which they consider to justify their taxes the most. That said, citizens also consider it to be the service of which the worst use is made, and where there is most room for improvement. This is consistent with the identified inflexibility and problems in adapting the system to an environment which has gone through considerable changes, and in which the refusal to undertake reforms seriously compromises its ability to respond to demographic, technological and social changes and, in short, its solvency in the coming years.

The Spanish National Health Service (SNHS) is proving to be one of the key social stabilizers for preventing the economic crisis from descending into a large-scale social crisis in Spain. The fact that, until recently, citizens have had almost universal access to a public health service is both an achievement and a right, but it is also an element of development, progress, growth, social cohesion and health protection that is demonstrating its true value in the most difficult moments of this long crisis.

The social contract that exists between citizens and their representatives and between health professionals and their patients is solid and any attempts to question it should be laid open to intense social debate. This does not mean that the system cannot and should not be subject to change. In a context of reduced public revenue and with little or no room to increase the debt, an imperative need that will be difficult to escape is to achieve better performance with fewer resources. *Doing the same with less* will inevitably lead to an erosion in the quality of the system and in our health conditions. New rules and practices are therefore needed that address both the current problems and the future challenges that await the SNHS and seek support in its many strengths.

The solvency of the SNHS and the possibility of developing intersectoral health policies to cushion the effects of the economic crisis on people's health will necessarily combine efficient resource management and the simultaneous improvement of equity in the implemented policies. To achieve this, we must build on the strengths of our system, while also eliminating pockets of inefficiency, learning from others' experiences, applying them to our environment intelligently and realistically, appealing to the leadership and commitment of health professionals, fostering citizen participation, making informed decisions and promoting a culture in which our policies are evaluated.

The objectives of this document are to diagnose the SNHS, put together a set of proposals and measures to support its solvency and then place these factors under discussion. The report is divided into four chapters whose main ideas are summarised below.

Chapter I. Financing and Public Coverage

The first decade of the new century saw strong growth in public health expenditure in Spain. The growth was sustainable due to the extraordinary vitality that resulted from tax revenues. However, the sharp fall in these revenues as a result of the crisis has triggered the urgent problem (cyclical) of lack of liquidity, while also bringing to the fore a possible problem (structural) of lack of financial sustainability, and even raising the question of the SNHS's solvency if major reforms are not undertaken.

In principle, the financing system approved in 2009 for most of the Autonomous Communities under the common system meant important changes in relation to the degree of financial autonomy attributed to those Regions and the equity criteria built into the funding mechanisms. However, the economic crisis has led to tax revenues eroding to such an extent that the Autonomous Communities are now receiving less through this system than they were in the years before the reform (and the crisis), and there has been no reduction in the level of dispersion of per capita funding among the different Autonomous Communities.

It is important to differentiate between whether we are facing a lack of liquidity problem or a public health system sustainability issue. The answer will be in the way the economy and tax revenues evolve in the medium and long term, always bearing in mind that the question of financial sustainability must be viewed in the context of debate on use of public resources with multiple potential destinations (health and non-health). For the present, what can be said is that, according to OECD statistics, health expenditure in Spain is approximately what it should be in terms of our per capita income and the type of health system we have. Going beyond this question and bearing in mind that the dynamics and distribution of spending before and during the crisis have been very different; the main objective of reforms should be improving the efficiency of the system and not so much the reduction of health spending. In terms of the changes necessary to move forward on this path, there is a large room for manoeuvre without having to change the essential elements that make the Spanish Public Health Service renowned.

One key aspect amended by Royal Decree-Law (RDL) 16/2012, of 20th April, is the regulatory framework of the criteria for access to public health coverage. In contrast to NHS models where healthcare coverage reaches all citizens for the mere fact of being one (though Spain, until the enactment in 2011 of the General Public Health Law did not completely "subscribe" to this and there were small groups who were left outside the coverage), the RDL 16/2012 establishes the conditions of "insured" and "beneficiary of an insured", similar to a social security system, despite the fact that healthcare is financed by general taxes and not social contributions. Since this is an important structural measure, the RDL would not seem to be the most appropriate formula for implementation. Instead, the reform should have been made open to civil and parliamentary debate in order to allow detailed and measured examination of

both advantages and risks of establishing the right to healthcare based on the notion of "insured" and "beneficiary" as opposed to regulation as a right of citizenship.

In the area of benefits coverage, there is a definite lack of application of efficiency and equity criteria to guide the update of services provided by the SNHS. The defining and application of clear and explicit criteria is necessary in the framework of disinvestment policies and efficient use of resources. As detailed as the definitive list of healthcare services included in the basic package may be, the indications and groups of people who might most benefit from them needs to be specified. It is not enough to simply have good legislation. The rational use of services requires appropriate clinical management and the expertise and commitment of health professionals. In the case of public funding and price regulation in pharmaceutical provision, several RDL include consideration of the incremental clinical benefit, the cost-effectiveness and budget impact as general criteria for public funding. However, at the time of writing, there are serious questions about how the Government is going to implement the approved regulation and this is a source of uncertainty which is not at all helpful to the health service as a whole. Also, after successive reforms of the Spanish reference pricing system, this has in fact proven to be a lower price system and any possibility of effective competition in retail prices has been cancelled out. The fact that the competition is now confined to negotiation between the companies selling the medicines and pharmacies and any benefits from competition are not being passed on to either the public funder or patients should give pause for thought on how the current system might be improved.

Last, other important changes recently introduced have to do with the contribution of the user to the final cost of the service. In the case of Spain, this contribution so far only applies to prescription medications, but we must not forget that there are plans to introduce co-payments for services listed in the supplementary catalogue and that in other non-health but related areas (social services) or areas of health where certain services are not covered (oral health), co-payments are decidedly high. In the aforementioned reform, the new scheme of co-payments for drugs means that they are no longer free-of-charge for certain age groups and the disadvantaged are exempt from payment. However, the distinction remains between pensioners and non-pensioners. There is a means-tested payment and reimbursement scheme, clearly open to improvement, created for pensioners with certain levels of income, while the working population is not entitled to any reimbursement which, for some families, can represent a significant burden. Other countries solve these problems by limiting the maximum annual amount accumulated by any type of healthcare co-payment to a percentage of income (1% or 2%). Furthermore, an intelligently-designed user-contribution scheme should consider the cost-effectiveness of drugs, but this issue has not so far been addressed in the Spanish scheme.

Chapter II. Healthcare Organisation

The need for structural reforms of the healthcare system and, by extension, its organisation and management, does not only date back to the start of the crisis. The crisis was simply the catalyst.

There are large pockets of inefficiency in the system, unquestionably the result of mismanagement, a degree of corporatist behaviour and over-rating of professional interests, which are put before those of the patients. However, wishing to reduce these without consulting medical opinion and disregarding the importance of professionalism in the health sector would seem to be a totally irrational, if not malicious, idea. Many of the decision makers who now question the solvency of the public health system are the same people who previously refused to undertake reforms claiming that the system was flawless.

The specific problems in each area of care have been identified: hospital-centrism; the need to reform primary care; vertical integration; management autonomy; the role of the public-private partnership; redefining of the package of services provided, etc. However, the unavoidable need to coordinate levels has still not been accepted. There needs to be a shift in the focus of healthcare, from an organisation that thinks only of recovery to one that recognises that the burden of care is in the management of chronic diseases, patients with various diseases, the fragile and the terminally ill, all of which, above all, affect the area of primary care. To do this, we need to leave behind healthcare management based on a compartment mentality and focus resources on the justified cost of the holistic care a patient requires, regardless of where they receive it. In other words, the resources need to be redirected to pay for what everyone actually wants, which is health outcomes.

That, however, requires not only moving decisively in healthcare coordination, but considering the health problems and needs of people whose autonomy is compromised together as a whole. In short, it means moving forward with a single, coordinated vision of the health care and long-term care systems. This will not happen on its own. Bridges will have to be built between the two systems since each sector has a different culture, there are marked regional differences in organisation, very different levels of competence, quite distinct financing systems, separate and sometimes even parallel structures and care processes, and different information systems. What is necessary therefore is to identify success stories and failures in our own and other countries and, given the complexity of the endeavour, carry out quasi-experimental pilot projects before implementing major reforms affecting large areas of the population.

A key aspect of any health policy is its concern for equity in the health system, which, according to Spanish legislation, includes ensuring equal access to public health services. There is a consensus in literature on the subject that access to and use of primary care services are consistent with the principle of horizontal equity. The same cannot, however, be said of specialist care and non-emergency hospital admissions, where a certain degree of inequity can be observed that favours individuals with higher purchasing power.

Another area of activity that concerns this chapter is the analysis of recent experiences of public-private partnership. It is sad that after more than two decades of experiments with different forms of direct and indirect management, there has been no rigorous, objective and independent evaluation in Spain of the efficiency of the different forms of management. However, even looking at the international studies on the subject, we cannot conclude that private management is superior to public (or vice versa). In any event, more important than the management formula adopted, the key to good management lies in who regulates,

finances and monitors it and in the rules that apply to it (see Chapter IV Good Health Governance) and not in the mere ownership of the centres.

The quality of the human capital, their identification with the goals and objectives of the system and their level of motivation are factors which are essential for the system to work. One of the effects of the economic crisis has been the departure of health professionals seeking job opportunities in other countries. The important underlying question is whether the health service can afford such a mass exodus of human capital. Coupled with that, the reorganisation of tasks proposed as a measure of improvement and efficiency has to be supported by a solid structure of nursing and medical technicians taking on the tasks that do not correspond to the doctors. Along with this redefinition of functions, general practitioners (primary care, geriatricians and internal medicine specialists) have to take on a greater role and increase their decision-making capacity in order to improve production capacity. Moreover, without strengthening of the virtually non-existent merit-based culture in the civil service and greater professionalism in key management positions, it will be difficult, if not impossible, to address serious reform in this area.

Although not sufficient in itself, one condition necessary in terms of addressing reforms that underpin the solvency of the SNHS is to strengthen the social contract health professionals have with their patients and their system. Global changes (economic, political, social and technological), in conjunction with others specific to health, are transforming the conditions under which health services are delivered. Health professionals and society must fully understand the fundamental principles governing the professionalism (primacy of patient welfare, patient autonomy and social justice), and the entailed responsibilities (including not exposing the patient to unnecessary services and considering the opportunity cost of clinical decisions).

Last, informed decisions cannot be carried out at the macro, meso and micro levels or design policies that allow progress to be made in improving efficiency and equity without having adequate information systems (which provide reliable information from intersectoral sources). Making progress towards better integration of information within and between health services and public health, the integration of regional health services into one robust SNHS, improving the reliability and integrity of the information they contain and ensuring the transparency and public accessibility of the information are four challenges which, if not taken on, will result in a very substantial opportunity cost.

Chapter III. Health Policies

Health does not only depend on healthcare interventions. It is heavily influenced by the person's environment, how they live, work, eat, sleep and relate to others, how they get around and how they spend their free time. These living conditions are the result of individual decisions and are determined by social, cultural, economic or environmental factors. Therefore, among the important decisions that influence health are those related to health services and policies and those stemming from the public and private, and political and civil

arenas. We must promote policies that transcend the strictly healthcare-related and expand the initiative "Health in all Policies", pushing forward with action on health determinants present in sectors other than health (e.g. education, housing, taxation, labour market, environment, mobility policies and immigration).

In times of crisis, socially desirable objectives are excluded from the political agenda; the urgent tends to overshadow the important. Programmes that require investment now but whose results will only be seen in the long term may be postponed indefinitely. This becomes important when designing cross-cutting health promotion strategies (beyond the bounds of the health sector) and in terms of numerous preventive interventions. The list of health measures or policies from sectors other than health is too long to discuss in any detail here and so we have opted to analyse only a few for which there is empirical evidence to show their impact on the population's health.

First of all, there are conditions and patterns of behaviour that represent health risks; obesity, smoking, consumption of alcohol and illegal substances, without exhausting the list, are some of the most important. When designing and implementing policies aimed at changing these patterns of behaviour, we need to steer clear of simple explanations based solely on individual decisions and understand them all in their complexity, identifying the causes and interactions between the various determinants, understanding the role of peer pressure and acknowledging the existence of a social gradient in these patterns of behaviour which leads them to occur with greater frequency in disadvantaged groups. Interventions should be designed to incorporate the specifics needed for each group and must then be evaluated and adapted. There is a surprising lack of both economic evaluations on implemented programmes and strategies and tools and data collection mechanisms to provide reliable and comparable records.

In the context of the current economic crisis, it is essential to assess the relationship between childhood poverty, education and health. People born into low-income families have lower income, fewer employment opportunities and poorer health in childhood and adulthood. The economic crisis has increased poverty in Spain and there is concern it may cause irreparable damage to the health of children. We need to look at the experiences of other countries in the fight against child poverty without forgetting that prenatal care, the home, school and day care are the natural places to promote child health. Moreover, education is one of the socioeconomic variables which has the greatest bearing on health inequalities in children and adults through its impact on other variables such as labour market opportunities or adopting healthier lifestyles. Any educational reform should be accompanied by the evaluation of its impact on educational outcomes and welfare dimensions (job opportunities, health status).

Health inequalities are associated with socioeconomic factors such as education, income or employment status, which persist over time. To reduce the inequality, more needs to be learned about the scale of its various causal mechanisms. A greater emphasis on regional health plans in this area and the design of a common framework for action and coordination at national level, as well as promoting cross-sectoral approaches along the lines proposed by the WHO Commission on Health Determinants, are key to reducing inequalities in health in Spain.

Environmental policies are another example of the type of policy that plays a key role in population health, both through the benefits of those aimed at reducing pollution or environmental exposure and through the implementation of urban planning policies that prioritize the provision of public spaces. At the same time, there is great scope for improving population health through continuous improvement of road safety policies, given that figures for injuries and deaths are still far worse than many other European countries. For these two cases, proposals must include the development of information systems which encourage cooperation between the various authorities and make it possible to, on the one hand, predict potential short, medium and long-term consequences of climate change in multidisciplinary contexts and on the other, obtain data on road traffic accidents to allow measurement of the associated costs. Then, the systems must be capable of evaluating the implemented policies.

The evaluation of interventions, programmes, strategies and policies is a cross-cutting theme present in all chapters of this book. Spain lags behind other countries in the formalisation of systems to evaluate measures that are introduced on an official level. Clearly, introducing a framework for public policy evaluation in Spain would require deployment of financial resources. Nevertheless, the fundamental key lies in the political will to drive the necessary changes in the design and implementation of policies. That same political will is also essential to ensure an impartial, scientifically sound and publicly available policy evaluation.

Chapter IV. Good governance for health

The structural changes that the SNHS needs have to be made in an appropriate organisational context solidly founded on values. The concept of "good governance" goes beyond compliance with the law, good results and the absence of corruption or mismanagement and nepotism. It also demands that decision-making takes place according to a set of agreed rules of democratic participation, transparency, responsibility, accountability and obedience to codes of conduct; rules which, in turn, are based on ethical values and civic virtues.

The citizens are the true owners of the health service; not solely the patients, ministries, finance or health departments, or the government in any guise, and not the suppliers, managers, doctors, or other health service personnel, care-related or not. Decision-makers and healthcare professionals, in their macro, meso and micro levels, are agents in whom the public has placed its confidence through a social contract.

The healthcare system is particularly complex due to its changing environment, the large amount of specific information distributed, the high degree of scepticism underlying individual and collective decisions, the high level of training of the healthcare professionals, their particular organisational structure and their considerable variety of interests. From this comes the need to adequately justify decisions and the policies implemented in their wake.

The very process of deliberation, participation and communication of policies is a key factor of good governance and affects the quality of regulation, its legal safeguards and even the democratic culture and social cohesion. Within this framework, the agents of the system must first adopt, and then maintain, procedures to ensure that decision-making at all levels of public

health is well informed, transparent and open to civic, political and expert consultation and participation. Transparency and accountability are closely linked concepts. Although not a universal panacea to heal all the ills of the system, they are essential for progress in any aspect considered desirable.

In order to steer health services towards higher levels of quality, safety, effectiveness and efficiency, adhering to the values and principles of good governance, we need to redesign the way all public healthcare is organised and operates, with this including regional health services and its organisations and the network of public health services, while at the same time giving special attention to the chronically ill and efficient intersectoral coordination.

The healthcare organisation management demands mean that a substantial degree of autonomy is necessary, with the need for conditions to be set according to the levels of autonomy required: the defining of independent government bodies with decision-making capacity in the centres; the development of tools and good management practices; and the professionalisation of public managers.

Also, collective and civic participation as a basic principle of democratic pluralism strengthens the social acceptability of government action and promotes the efficiency of public services. Therefore, the pursuance and promotion of channels that provide information to citizens and encourage freedom of choice are basic elements to be incorporated in the rules of good governance. It is also necessary to involve health professionals in the sustainability of the system, the development of health policies, management and decision-making. Appealing to professionalism is essential, but not sufficient. There need to be effective structures for participation and professional guidance, and professional organisations need to be revitalised so they respond to the needs and challenges of 21st century medicine, prevent healthcare professionals from becoming detached from their environment and increase their sense of identification with it. This should be present from the very first stages of their training and take root while they are practicing their profession so they can take on leadership and management roles in the system.

To conclude, we must ask ourselves whether we can afford the luxury of allocating our resources on public policies that do not work. How can we properly invest our resources without first identifying the strengths and weaknesses of the target strategies and policies? The evaluation of public policies is an important piece of unfinished business in Spain. One cultural issue that needs to permeate the healthcare system is that when designing a policy or strategy, its evaluation before, during and after is not only essential, but must be planned in parallel, have its budget guaranteed and be an integral part of the actual strategy or policy.

List of Proposals

I. Financing and Public Coverage

Regional Funding

- P1. Provide Autonomous Communities with more financial autonomy in qualitative terms (regulatory capacity), especially in relation to direct taxation, as EU legislation limits indirect taxation.
- P2. Link receiving state funds from the Regional Liquidity Fund to the maintaining of minimum regional quality standards (not necessarily identical) in the provision of health care.
- P3. Give healthcare providers access priority to the above-mentioned funds in order to avoid shortages due to delays or defaults in payments to these providers.
- P4. Reform the current financing system for the Autonomous Communities under the common system with the primary objective of mitigating, at the source, inequities caused by unjustified differences in terms of funding per unit of need. In this sense, "holding fast" to the base year as a status quo which has to be protected should be avoided.
- P5. Create a specific fund, within the regional financing system, aimed at ensuring effective coordination (not uniformity) of regional health systems by the *Ministerio de Sanidad, Servicios Sociales e Igualdad* (MSSSI) [Ministry of Health, Social Services and Equality].
- P6. Adoption of any fiscal policy should be accompanied by the pertinent simulation analysis to reveal the advantages and disadvantages of the proposed measures (see Chapter III. Health Policies)

Health Expenditure

- P7. Implement reforms to increase the efficiency of the public health system that result, ultimately, in a rationalisation of an increase in health expenditures.
- P8. Any undertaken reforms must take into account the transitory elements of the public health system sustainability problems which are due to the current economic crisis.
- P9. The reforms should be primarily aimed at improving the efficiency of the system rather than reducing growth in health spending at all costs, while it is not necessary (or desirable) to modify the essential elements that make the Spanish public health system what it is.
- P10. Clarify the opportunity cost of the healthcare budget, in order that a sensible, transparent decision can be made on the volume of public resources that should be allocated to finance the Spanish health service. This task requires the creation of a genuine culture of evaluation at all levels to inform this decision.
- P11. Move forward with the system of co-responsibility of the different players. With the industry, by encouraging joint-venture contracts when there is too much uncertainty about the efficacy, safety and budget impact of innovations, until the effectiveness, safety and cost-effectiveness of new drugs or technologies can be proven. That of health professionals, through proper utilization management,

prescribing, referral, process and outcome transparency. and the adoption of a care model for the chronically ill. That of the patients, redistributing the current pharmaceutical co-payment and moving towards avoidable, differential co-payments (the more cost-effective, the lower the co-payment), with an income-related limit and excluding the poorest.

Population Coverage

- P12. Open a civil and parliamentary debate to stimulate detailed and measured examination of both advantages and risks of establishing the right to healthcare based on the notion of *"*insured*"* and *"*beneficiary*"*, as established by RDL 16/2012, as opposed to regulation as a right of citizenship, in line with the provisions of Article 1.2 of the General Health Law and Article 43 of the Constitution.
- P13. Exclude healthcare benefits from the Social Security financial system, in accordance with majority doctrine position, and at the same time, introduce effective mechanisms for coordination between the health services in the different Autonomous Communities with the aim of ensuring equal access to health care.
- P14. Abolish the requirement of *"*actual and authorised residence in Spain*"* introduced by RDL 16/2012 as a precondition for foreign people to access health care, and replace it by "actual residence and proof of insufficient income", as regulated in other European countries.
- P15. Improve the systems for recognition and control of the right to health care of citizens of states that are within the scope of EU regulations coordinating social security systems or bilateral agreements on social security that include healthcare provision.
- P16. More efficiently manage the registering, billing and collection of payments for the healthcare provided to citizens of the countries mentioned in the previous point. All billing should be digital and there should be one single registry for the European Union.
- P17. Regulate migration flows through immigration policy and not through health policy.

Public Coverage of Health Services

- P18. Review and adapt in an objective and transparent manner the bases for decisions on incorporating new health technologies of the major international assessment agencies in this field such as the British NICE. This is a cost-effective strategy in a context of crisis like the current one, which should guide the recommendations of the Spanish Network of Agencies for Health Technology Assessment and SNHS Healthcare Provision in the task of planning the basic general package of SNHS services.
- P19. Use economic evaluation and budget impact analysis as key decision-making tools for public finance and pricing of medicines and medical devices.
- P20. Targeted financing based on these tools should include in the pharmaceutical provision only those products whose added therapeutic value exceeds the opportunity cost of incorporating or maintaining the innovation. Consistent with this method of deciding on public coverage, SNHS financing prices must meet the criterion of "value

based pricing"; i.e. the prices of drugs and devices included under public coverage should ensure a favourable cost-effectiveness balance.

- P21. Make it a rule to apply already existing guidelines and recommendations (Abellán et al., 2009; López et al., 2009) for the presentation of economic evaluation and budget impact studies. This should be supplemented by a consideration of other technical aspects, such as the therapeutic value, and policy aspects, such as the importance of equity, the severity of the illness or absence of relevant treatment alternatives, in the style of the 'social value judgments' applied by NICE to overcome the difficulties inherent to the efficacy, safety and quality criteria.
- P22. Promote research to empirically estimate what should be the threshold for efficiency or maximum price per unit of effectiveness (Quality Adjusted Life Year) for the SNHS. This 'basic' threshold should be weighted by factors that are deemed relevant for setting the price of new health technologies, similar to how they aim to do it in the UK.
- P23. Develop a long-term strategy of reinvestment, so that the criteria for updating the core and supplementary packages of SNHS services cover not only the introduction of new health technologies, but also divestment in those found not to be cost-effective.
- P24. Start the process of reinvestment with the following technologies: a) the unsafe (with high risk-benefit ratios); b) those not used to treat serious illnesses; c) the highly invasive whose impact on the patient is high (risk of undesirable effects); d) those whose reinvestment will cause the least suspicion and resentment among patients and providers; and e) those with clear effective alternatives, and (f) those with high budgetary impact and those with low impact on the human resources devoted to them if financing is withdrawn. It is important that these measures be accompanied by reinforcement of the use of interventions with good cost-effectiveness ratios that are being underutilised.
- P25. Implement reinvestment: (i) limiting the indications on the basis of efficacy and safety criteria, relative effectiveness and incremental cost-effectiveness; (ii) specify which providers can supply which services (under criteria such as regionalisation of services, supply volume, training, experience and clinical expertise); (iii) limit the frequency and duration of certain treatments in light of the above criteria; (iv) implement programmes of the 'guided-use' and conditional-reimbursement type, so that the financing of certain services is temporary, conditional on sufficient scientific evidence being gathered on its effectiveness within a reasonable period; and (v) develop appropriate methods to investigate the case for reinvestment. Methods proposed include studies on medical practice variability, cost-effectiveness studies (used to identify and prioritise candidate technologies for reinvestment) and budget and marginal impact analyses.
- P26. Establish a transparent, efficient and non-discriminatory regulatory framework for drug and medical device prices that offers maximum guarantees of independence and legal safeguards for providers. In this regard, it should be ensured that effective marketing of the presentations serves as reference and not mere authorisation.
- P27. Encourage competitive pricing policies in the generics market, exploring measures to improve and consolidate the design of the existing systems for fixing maximum reimbursement, measures for tracking competitive prices in order to reimburse

pharmacies only with actual acquisition costs and measures to promote competitive pricing in public procurement based on market instruments such as competitive auctions.

- P28. Reform the reference price system so that: (a) new patent drugs are included in the reference price system by default, unless they show they provide sufficient value to merit a price different from the set of prices that would correspond; (b) reference prices are not calculated linearly as the lowest price of the presentations grouped in each set, but they are weighted according to the number of generic drugs present; and (c) users can take a drug which is more expensive than the reference price, paying the difference (avoidable co-payment).

User Contributions

- P29. Move gradually from the current linear, obligatory pharmaceutical co-payment to an avoidable co-payment system based on cost-effectiveness, or at least effectiveness, criteria. This should be extended to the other types of provision in the supplementary services package. A way of introducing these avoidable co-payments based on effectiveness or cost-effectiveness is through a hybrid system, like in Germany for example.
- P30. Do not differentiate between active workers and pensioners. Co-payment differential criteria should be income and health status (chronic diseases).
- P31. The maximum limits for users' monthly expenditure, which at the moment only apply to pensioners, should be extended to active workers. Consideration should be given to quarterly or annual caps for all types of co-payments and limiting the maximum annual amount accumulated for any type of healthcare co-payment to a percentage of income (1% or 2%), as in other European countries.
- P32. The above maximum limits can only operate efficiently if once achieved, the user stops contributing. The ideal way to run these limits is by using electronic prescriptions general to all regional health systems.
- P33. Otherwise, the length of time the user has to wait to be reimbursed after having to pay over their maximum limit should be kept to an absolute minimum. The maximum period of six months provided for in Royal Decree-Law 16/2012 is clearly disproportionate. Agreement should be reached within the SNHS Inter-Regional Council to reduce this time period.
- P34. Urgently evaluate the impact the co-payment reform has had in terms of patient groups and drugs, in order to determine how much of the reduction in spending on prescription drugs is due to the price effect (reducing excessive consumption attributable to them being free) and how much to the income effect (reduced necessary consumption as a result of more expensive access), with the aim of addressing potential problems in relation to non-adherence to treatment and worsening health conditions.

II. Healthcare Organisation

Primary and Hospital Care

- P35. Improve performance of healthcare service delivery, given that the potential for improvement should be seen in terms of the whole system rather than at each level of care; the focus is therefore on the relationship among the parties.
- P36. Improve management of the chronically ill. This does not mean either creating new resources or structures, or adding up individual experiences. It is a shift that affects the entire system, with information and proactive management according to the needs of patients.
- P37. Evaluate health outcomes, compare them and use them in the decision-making (see Chapter IV of the document) and observe the principles of transparency and accountability.
- P38. Use health information systems purposefully, with levels depending on the decision-making setting. To perform an analysis of needs, planning and evaluation of public policies, it has to be possible to compare in space and time; standardisation, interoperability and aggregation are therefore needed (better on a national level than regional; better European than national).
- P39. Apply global knowledge to specific conditions and environments (advisory role for agencies, with manageable schedule not dominated by the "well paid" drawing up of clinical practice guidelines).
- P40. With regard to the services package (as a catalogue of services and public coverage healthcare), the what, for whom and under what conditions needs to be regulated. This three-dimensional approach, using cost-effectiveness, necessity and financial capacity criteria, may help overcome the demagoguery of “everything for everyone and for free”.
- P41. Integrate the vision of citizens, professionals and managers to align the service's goals and values. The healthcare provision should follow the patient so that home care is maximised. This means relaxing intransigent structures and going for closer proximity to the patient.
- P42. Liaison strategies between primary and specialist care need to be enhanced with internal medicine support and development of new case management and disease management services.
- P43. Coordinate health and social services together, and these with public health structures.
- P44. Open the hospital in two ways: sub-regional hospital networks, where large hospitals take on a motherly role in relation to small local centres and make it viable for them to stay open; and regional networks of highly specialised units where patients and physicians circulate to take advantage of the concentration of cases and skills. In these regional networks, shared services (general, central and clinical) can be set up which provide efficiency without sacrificing quality or local availability of expertise.
- P45. Payment according to results should also apply to the funding of the centres: paying more for having healthy patients, not for having more episodes of deterioration in chronic patients with poor adherence to pharmacological treatment; paying more for high resolution clinical encounters.
- P46. Paying for performance requires integration of compartmentalised budgets between levels of care (primary, specialist, health and social care, pharmacy) by fixed, pre-agreed funding for all of a person's care according to their characteristics (risk, comorbidity) to help provide a broader picture of the overall cost.

- **Health and Long-term Care**

- P47. Unify the financing of health care services and long-term care services as the backbone of the integration between systems, following a risk-adjusted capitation model.
- P48. Move ahead with the convergence of the two systems in areas such as co-payments, healthcare professional working conditions, common information systems and creating single super-structures such as a National Health and Social Services Inter-Regional Council.
- P49. Propose a common package of health and social services. Develop a common HR policy which puts professionals from both environments in direct contact and design training programmes for managers that draw from the experiences of both systems.
- P50. Introduce economic evaluation in care of dependent persons as a management tool for policy planning. This involves incorporating social costs (social care, job losses, informal/family care) into economic analyses.
- P51. Move forward with quasi-experimental pilot programmes to assess the strengths and weaknesses of strong coordination programmes or of integration between health care and long-term care services in controlled scenarios before implementing major reforms.
- P52. Create multidisciplinary health and long-term care teams and design single points of entry to both systems for citizens.
- P53. Put all health and social information together on the SNHS Personal Health Card.
- P54. Improve existing information on equity/inequity in the provision of long-term and health services to people with limited autonomy and funding in this area (public and private).

- **Equity in Access and Utilisation of Health Services**
- P55. Promote longitudinal studies that reveal the health effects of inequalities in access to health services on the whole population, with special emphasis on disadvantaged groups.
- P56. Encourage greater inter-regional coordination to prevent problems in access to health services for the displaced population.
- P57. Adapt databases to the specific needs identified by the research into inequalities in access to and utilisation of health services.
- P58. Reduce exposure to risk and vulnerability to illness arising from gender.
- P59. Address the structural dimensions of gender inequality in access to and utilisation of health services.
- P60. Identify barriers to access (information, biases of healthcare professionals, monetary, linguistic) which lead to the existence of inequities in the use of health resources in order to design appropriate policies.
- P61. Evaluate the effect of any reform or health policy on inequality of access.

- **Public-private Management of Public Health Services**

- P62. Impartially and rigorously evaluate the advantages and disadvantages found where private management of publicly owned health centres has already been in place for a number of years, with indicators of effectiveness, safety and efficiency, considering structure, process and outcomes of their activities and making public the results of the different types of healthcare facility management.
- P63. Allow public access to the information used in the evaluation of management experiences, so that it may be replicated by any other researcher.
- P64. The above information should be used to encourage learning and develop flexible and permanent mechanisms for correction and improvement.
- P65. Enforce the principles of good governance in the processes of public-private partnership, with particular emphasis on the justification of policies, accountability to citizens, the efficiency of measures adopted, regulatory quality and control of corruption (see Chapter IV).

- **Human Resources**

- P66. Provide the public health network with definitively well-aligned and robust extrinsic incentives, as well as management tools which confer human resources with sufficient flexibility and adaptability to address the current situation and respond appropriately to the health needs of the population.
- P67. In situations where current or future financial constraints may lead to downsizing of the workforce, fixed across-the-board rules, and those involving dismissing or not renewing positions based only on the seniority criterion should be avoided. Firstly, it would be necessary to plan, restructure, implement, make explicit, measure correctly and consolidate on the basis of effectiveness, productivity and added value to the public health system and the citizen, and establish a model of regular assessment based on these criteria.
- P68. The public healthcare network should link incentives to healthcare professionals with the system's health objectives or, at least, with the effort to achieve them.
- P69. Move away from the fee-for-service model, because they represent an additional cost to the system that encourages productivity loss in normal working hours and tends to increase the number of patients undergoing unnecessary interventions.
- P70. Exploit professional skills using the criterion of the comparative advantage that each professional profile can provide.
- P71. Streamline the management of human resources to promote the healthcare professionals' involvement, appealing to their professionalism, and incorporate performance and loyalty to the system into the professional career. Additionally, delegate responsibility using performance-linked custom contracts.
- P72. Streamline the framework for implementation of the Law on Healthcare Professions to make the relationship between specialist areas more permeable, prevent difficult-to-reverse restrictive, compartmentalised growth, and promote specific areas of training that combine the advantages of the sub-speciality with those of cooperation between specialities.

- P73. Foster the reorganisation of hospital specialist services to unite them under areas of clinical management, and enter into clinical management agreements or contracts as the responsible mechanism for decentralisation and accountability.

- **Professionalism**

- P74. Gradually consolidate the weakened contract between society and the health professions, especially in regard to integrity and professional competence.
- P75. Reinforce the pillars of professionalism: primacy of patient well-being and autonomy and that part of the healthcare professionals' obligation to contribute to a fair distribution of the available resources and welfare, and to prevent discrimination.
- P76. Attack conflicts of interest and corruption at the root, and actively require timely public notification of the appropriate indicators of structure, process and health outcomes for the SNHS, including adverse events stemming from clinical actions.
- P77. Counteract the damaging effects to the SNHS of corporatist and mercantilist attitudes, as well as any actions from the sphere of health which reduce welfare.
- P78. Encourage the inclusion of the opportunity cost in clinical decisions and accept the complementarity (not contrast) of the market, the State and professionalism as parameters of the social organisation of work and vehicles for improving efficiency.

- **Health Information Systems**
  - P79. Redefine the strategic and operational objectives of the SNHS information systems to adapt them to the current conditions and needs.
  - P80. Interconnect the information systems specific to all sectors concerned with health-related activities (healthcare, social services, food, environment, education, economy, trade, legislative activities, taxation, urban planning).
  - P81. Definitively establish a unique identification for people and patients as core unit of the information systems.
  - P82. Complete, standardise and consolidate medical records and administrative, cost, medical care and public health databases as sources of information and primary records of the health information systems and ensure they include all the necessary functionalities.
  - P83. Order, unify and standardise the minimum set of fields, variables, indicators and services included in the SNHS services provision package, keeping it constantly updated and ensuring the availability as support of the national Conjunto Mínimo Básico de Datos (CMBD) [Minimum Basic Data Set].
  - P84. Ensure the reliability, security, confidentiality and quality of health information systems.
  - P85. Enable regular debugging mechanisms and provide the system with the human resources needed to meet this objective, so as to preserve the rigor in the collection, mechanisation, recording, processing, analysis, debugging and migration of data, and maintenance of software, databases, records and equipment.

- P86. Reach a national consensus and commitment on the requirements and minimum mandatory features that any public and private health information system must fulfil by law.
- P87. Insist on guarantees for the transparency of health information systems, penalising non-compliance, and promote evaluation of performance of healthcare devices, health outcomes, services management, health policy in general and the incorporation of scientific evidence decision-making.

- **Measurement and Evaluation of Healthcare Provision**
- P88. Replace single assumptions and uncertainties, which are often the only point of departure in observational, predictive or explanatory studies, including those for health policy, with a number of alternative assumptions with varying degrees of uncertainty; and give sensitivity analysis results, which will be closer to reality and express recognition of our uncertainty.
- P89. Adjust the strength of the conclusions and recommendations to the quality of the evidence supporting them, as the frequent violation of this principle (making stronger conclusions or going beyond what is actually validated by the designs and results) leads to loss of social credibility in science and policy.
- P90. Avoid unwarranted extrapolations and assumptions of invariance and accept that the credibility of the analysis depends on both internal and external validity, without preponderance of the former.
- P91. In all types of evaluations, steer clear of the deliberate selection of primary and secondary variables that most favour showing superiority of the most convenient alternatives; avoid encouraging the use of proxy variables whose association with outcome variables has not been proved, and of combined variables, without revealing the effects of the individual components. Also avoid selective reporting of the results that best suit.
- P92. Adopt all effective measures known to prevent publication bias in its various manifestations (before, during and after publication) and, when suspected, estimate and report its magnitude and effect on results.
- P93. Enhance and strengthen the use of post-marketing surveillance (drugs, biomarkers, medical devices and surgery), follow-up studies and evaluations of health interventions and policies to provide accurately-informed solid information on effectiveness, safety and efficiency of technologies, interventions and clinical decision-making, public health and regulatory policies, intersectoral or otherwise.
- P94. Encourage marketing approvals, financing (selective or not) or provisional authorisation where sufficient and rigorous proof of efficacy and safety is not available, and make funding conditional on obtaining the necessary information according to a pre-agreed timeline. For this purpose, it may be useful to use venture contracts, provided they are adequately resourced and monitored, anticipating the inherent obstacles and known hazards.
- P95. Do not focus exclusively on the problem with the methodology or forget the primary data sources. Do not discuss cost-effectiveness analysis or evaluation of efficiency without information on costs and actual results of the healthcare activity.

Promote interoperability and use of protocols to bring together sufficient information and have a solid basis for evaluation (Cots et al., 2012b).

- P96. Conduct more pragmatic trials with intention-to-treat analysis (estimate of effect closer to that expected in clinic practice), in conjunction with per-protocol analysis (estimating the expected maximum efficacy) and publish all results.
- P97. Provide funding and incentives for comparative effectiveness studies in all areas, and do so by taking suitable care to maximise the, nonetheless reduced, capacity of the results to change health care, clinical practice or unhealthy behaviours and lifestyles.
- P98. Ensure the consistency of existing incentives with actions undertaken to translate scientific evidence into health policy, regulatory decisions, management of health services and clinical practice.
- P99. Avoid presenting unjustified extrapolations and ambiguous results of research. Minimise the effects of cognitive biases and do not judge/pre-judge new technologies as superior to those in place.
- P100. Use tools to support decision-making more often and efficiently, pay more attention to the characteristics and needs of the end users of the information generated by the comparative effectiveness studies and coordinate all the participating actors in advance to overcome the aforementioned barriers.
- P101. Make progress in the creation of longitudinal databases (panel data), much more useful for generating information than repeated cross-sectional surveys.
- P102. Take advantage of the wide range of already-existing and underused administrative databases, respecting the principles of confidentiality and anonymity of individuals.

III. Health Policies

- **General**
- P103. Scientific societies should put greater emphasis on promoting the need for progress on health policy programming in non-health areas (education, workplace, environment, taxation).
- P104. From the health sector itself, encourage the idea that health care is not the exclusive competence of healthcare professionals, as changes in the environment or behaviours can have significant effects on people's health.
- P105. Given the cross-sectoral nature of most health policies, specific performance measures should be implemented through the consensus of the main actors involved, encouraging their participation throughout the process, and adapting them to the precise moment when the probability of success is highest (AES, 2008).

- **Lifestyles, Behaviour and Health**
- P106. Respecting individual decisions when not arising from the same negative externalities, public officials have a duty to inform the public of the consequences of their actions and create environments conducive to the development of healthy lifestyles (AES, 2008).

- P107. Move forward on equalising the tax burden on different types of tobacco (increase the minimal tax on loose tobacco and that on cigars according to the amount of tobacco they contain to bring them in line with cigarettes) and introduce a mechanism to automatically update the tax on tobacco products to prevent inflation eroding their real value.
- P108. Tighten enforcement of the law on smoke-free spaces and reject attempts to introduce amendments at the request of regional governments.
- P109. The Spanish Government should support the European Council's proposal for a directive for standardised packaging of tobacco products (European Commission, 2012).
- P110. In the case of alcohol, the levels of excise duty in Spain make us one of the European countries with the lowest taxes across the range of alcohol products. There is therefore scope to increase both special *ad quantum* and *ad valorem* tax and excise duty on alcohol. The modification of these taxes should be linked to the alcohol content of the product in question. Given the complementary nature of alcohol and tobacco consumption, increased tax on alcohol might avoid simultaneous initiation of the two.
- P111. Policies on drugs have to adopt specific actions for the most vulnerable populations: the immigrant population; people with criminal/legal problems; families with special financial difficulties; the children of drug addicts; and people with mental health problems. Specifically, greater efforts are recommended in the allocation of resources to prevention actions targeted at these groups. Education policy has a vital role to play here that not only needs to be regulated, but must contain specific actions (properly reflected in the National Plan on Drugs).
- P112. It is essential that new plans of action against drug use, legal or illegal, include interventions aimed at increasing public awareness of the drug problem and the risks of drug use, with a review of the strategy on prevention being particularly important.
- P113. In anticipation of the adoption of any tax policy (tax on tobacco, alcohol, sugary drinks or high-fat products), it should be mandatory to carry out a tax simulation analysis in order to expose the benefits (reductions in consumption) and disadvantages (more imposing, often regressive) of the measures to be adopted and, where appropriate, approve corrective measures (e.g. increased tax burden on certain products together with subsidies in terms of income or in kind on other products in specific groups).
- P114. The design of any intervention to combat unhealthy behaviours should take into account the interaction between them. For example, anti-smoking programmes should include the offer of healthy diet programmes, so as to encourage both objectives simultaneously.
- P115. Promoting healthy practices in the community through the provision of free or low-cost spaces to facilitate exercise in deprived areas.
- P116. Promoting healthy habits in schools, for example, by introducing programmes proven to be cost-effective in other countries, such as the School Breakfast Programme or the National School Lunch Programme, which attempt to reinforce or develop a more balanced diet among children through the implementation of school

diets with minimum nutritional requirements (Millimet et al., 2008; Bhattacharya et al., 2006).

- P117. Correct the lack of economic evaluation when formulating preventive or palliative programmes on addictive substance use, inadequate food intake and insufficient exercise.
- P118. Tools and data collection mechanisms for better monitoring and evaluation of interventions must be developed which provide reliable and comparable records. Particularly relevant is the use of standardised questionnaires validated by national and international organisations and the design and implementation of surveys and use of registries which track users of programmes and interventions over time.

- **Childhood Poverty, Education and Health**

- P119. Develop and evaluate nutritional supplementation programmes in public schools and set up a network of low-cost childcare facilities offering balanced nutrition to offset the precarious situation, in terms of dietary needs, being experienced by many young families. Complement these measures immediately by introducing changes to reduce taxes and provide subsidies for low-income families with children.
- P120. Introduce subsidy programmes and tax incentives in the use of day care facilities for disadvantaged groups.
- P121. Public authorities should emphasize quality as a priority objective of the education system, reducing failure rates and implementing, or reinforcing, specific strategies and appropriate measures directed at educational support for children and adolescents at risk of failure.
- P122. Within the scope of education, give greater emphasis to the promotion of health policies on physical education, diet and road safety as a fundamental part of the school curriculum for children and adolescents.
- P123. Accompany any educational reform with an assessment of its impact on both educational outcomes and other dimensions of well-being (job opportunities, health status) in the affected population.

- **Socioeconomic Inequalities in Health**

- P124. Put information systems in place to identify and monitor inequalities, in addition to mechanisms that promote the visibility of the inequalities within and outside the health system.
- P125. Identify groups most vulnerable to the economic crisis and design and implement specific policies to protect those groups from situations in which their financial insecurity becomes a health risk.
- P126. The lack of uniformity observed in measures to reduce health inequalities in regional health plans emphasizes the need to develop a common framework for action at a national level, and to improve coordination mechanisms between the different central and regional levels of health administration.
- P127. Promote an intersectoral approach to reduce health inequalities in Spain, along the lines proposed by the WHO Commission on Social Determinants of Health (WHO, 2008).

- **Other Policies**

- P128. Introduce information systems to predict possible consequences of climate change in the short, medium and long term in multidisciplinary contexts.
- P129. Make progress in the coordination of efforts with a multidisciplinary approach towards the inclusion of health policies in a joint policy programme to allow adaptation to climate change and mitigation of its adverse effects.
- P130. Evaluate road-safety policies before, during and after implementation with the aim of providing an objective global assessment of their effects.
- P131. Improve the data collection system for road traffic accidents to allow detailed measurement of the costs associated with any traffic accident and the health status of the people who suffer them. These should be published and readily accessible to any interested citizen.
- P132. Promote cooperation between the different administrations on road safety.

- **Evaluation of Health Policies**

- P133. Promote the evaluation of public policies in Spain. This requires a certain release of financial resources, but the fundamental key lies in the political will to drive the necessary changes in terms of how to design and implement policies.
- P134. In view of the almost limitless menu of specific actions to choose from, and the limited resources available, each proposed policy should be evaluated in order to obtain useful information about their potential benefit or failure. This should help guide future policies (AES, 2008).
- P135. A good number of policies should start with a pilot phase in which participation is randomised among the population group expected to benefit. It should be mandatory for such a pilot phase to undergo full evaluation before the policy can be extended to the rest of the target population.
- P136. The expected outcomes of any intervention must be defined before implementing the policy. If necessary, the administrative databases should be modified to ensure that the impact of the policy is adequately measured.
- P137. The policy evaluation must be impartial and carried out according to criteria of scientific excellence. This process would be facilitated by the creation of an independent policy evaluation agency and distanced from biased political influences. Such an agency should be vested with real power to influence the design of public policies (so they can test different versions of the same policy) and in the choice of beneficiaries during the pilot phase.
- P138. Make the details of any evaluation available to the public to promote transparency and replication of results.
- P139. The Government should facilitate and even enhance access by researchers to the different administrative databases, as occurs in a number of neighbouring countries. This would make it possible to evaluate the effects of most current policies.

IV. Good Governance for Health

- **Good Governance Practices**

- P140. The procedure for prioritising healthcare policies should be much more participatory and transparent. The recent example of the British government's mandate to its National Health Service (Department of Health, 2012) sets a standard that could be replicated in Spain.
- P141. Improve communication of policies and strategies at the national and regional levels of the SNHS. The public must be informed about major strategies and policies in health and health matters when they are launched and when abandoned. They must be evaluated regularly, as required by law, and the results have to be put in the public domain.
- P142. As a general rule, all information generated with public money should be made public, unless it concerns individual privacy.
- P143. Provide free access to all citizens to public databases, subject to the limitations imposed by data protection laws.
- P144. Health plans must use indicators which are quantitative, measurable and can be made objective.
- P145. Evaluate the health plans according to previously agreed indicators and make the results public.
- P146. Any decision on the inclusion or removal of a provision within the SNHS must undergo a transparent process of evaluation of its safety, efficacy, effectiveness, efficiency and utility. Technical reports of these evaluations should be publicly accessible.
- P147. Publish data for quality of care by health centre (primary care, specialist centres or hospitals) and health zone or area and indicate whether the information given is gross or adjusted or standardised for population factors (age, gender) or clinical complexity of the population covered by the centre. In the latter case, indicate in detail the method of standardisation or adjustment and the standard population used.
- P148. Publish the economic-budget activity data by health centre (primary care, specialist centres or hospitals) and health zone or area, according to the assumptions outlined in the previous points.
- P149. Encourage comparison of healthcare outcomes between centres and between healthcare professionals.

- **Organisation, Management and Codes of Conduct**
- P150. Set up collegiate governing bodies (Councils of Government) to operate as advisory boards within healthcare organisations.
- P151. Promote codes of conduct based on good practice and professional ethics, including procedures to guarantee compliance and identification of responsibilities with corresponding sanctions and incentives.
- P152. Disseminate and allow free access to the records and reports of the meetings of the technical-healthcare medical boards, quality commissions and collegiate governing bodies (councils of government).
- P153. Create units or offices responsible for implementing anti-fraud and corruption policies and provide healthcare organisations with specific training and prevention plans in this area.

- P154. Contract senior positions in the SNHS through a meritocratic system where the advertising of these positions, the scrutinising of the candidates' professional curriculums and the final justified decision are open and public.
- P155. Require the disclosure of conflicts of interest of all healthcare positions filled by discretionary appointment, including a declaration of professional activities undertaken in the previous five years.
- P156. Create ethics committees to assess conflicts of interest for people who are going to occupy a senior healthcare position or have recently occupied such a position (within the period prescribed). The declaration of potential conflicts of interest made by these people should be transmitted to the committee. The committee should report directly to the SNHS Watchdog or a Health Services and Health Policy Assessment Agency and reports should be made public.

- **Citizen and Professional Participation**

- P157. Promote policies that enhance freedom of choice for the citizen of medical centre and healthcare professional.
- P158. Develop tools to provide information to the public and health service users. Stimulate health education and improvement in the skills of the citizens in acquiring information, understanding it, evaluating it and using it responsibly and in an informed way to improve their own health and personal autonomy.
- P159. Promote a culture of respect between citizens and healthcare professionals which enhances the idea of shared decision-making.
- P160. Develop appropriate channels and means for citizen participation in individual and collective decision-making in the healthcare setting and in the care and promotion of health.
- P161. Open all documents on policies and projects affecting medical activity to professional and public consultation and respond to them.
- P162. Set clear objectives, which are measurable and focused on efficiency measures (relationship between the cost and health outcome) for the evaluation of healthcare centres and professionals.
- P163. Develop an incentive scheme applied to career development based on merit and excellence, which fosters the development of professional autonomy and requires accountability in exchange.

- **Evaluation of Policies and Good Governance**

- P164. Before, during and after implementation of a policy or strategy, incorporate its evaluation into the design as an inherent element of the policy or strategy with its own budget.
- P165. Systematically communicate the results of the evaluation to the scientific community, managers and healthcare professionals and the public. Detailed technical reports must be accompanied by other reports written in a language which is not weighed down with technical terms and is understandable for citizens unfamiliar with the subject.
- P166. Create an Agency or Watchdog for the Evaluation of Health Services and Health Policies, the features of which include impartiality, scientific rigor, participation and

transparency. To ensure its independence, the agency's funding would come from the State Budget and it would report directly to Parliament, which would ensure that the agency remained in operation for a sufficiently long period to allow its social utility to be evaluated.