

The public healthcare  
system and healthcare  
network **2008**  
Strategic lines



Presentation document (CatSalut 2008 Annual Report)  
for the Board of Management and the Catalan Health  
Council of 20 July 2009.

For more information, consult the 2008 CatSalut activity  
report in PDF and the reports on each healthcare region at  
[www.gencat.cat/catsalut](http://www.gencat.cat/catsalut)

© Department of Health  
Published by: CatSalut  
July 2009

Produced by: Hores extraordinàries  
Graphic design: Carlos Ortega i Jaume Palau  
Translation: Mots - Debbie Smirthwaite  
Photographs: CatSalut Photographic Archives, Blood and Tissue Bank, Catalan Healthcare  
Institute (Vall d'Hebron Hospital, Central Catalonia Territorial Management and City of  
Barcelona Primary Healthcare Board), CAPSE and Taulí Corporation.  
Printed by: Treballs Gràfics, SA  
Legal deposit: B 38.256-2009

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# Management and participation bodies

## Board of Directors

The highest body for the government and management of CatSalut (Arts. 13, 14 and 15 of the LOSC), which is composed of:

- The Health minister, who is its president, and as such is its institutional representation.
- The general secretary of the Department of Health, who is its first vice-president
- The director of CatSalut, who is its second vice-president.
- Seventeen co-opted members distributed as follows:
  - One member representing the Department of Economy and Finances.
  - Four members representing the healthcare regions and the same number representing the Department of Health.
  - Two representing the county councils of Catalonia.
  - Two representing the town and city councils of Catalonia.
  - Two representing the most representative trade unions in Catalonia.
  - Two representing the most representative employers' organisations in Catalonia.

## Catalan Health Council

Body for community participation in the public healthcare system of Catalonia (Arts. 18, 19 and 20 of the LOSC), which is composed of:

- The president is the head of the Department of Health (the Health Minister), who can delegate to the director of the Catalan Health Service and does not count as a co-opted member representing the Catalan Government.
- Co-opted members of the Catalan Healthcare Council:
  - Nine representing the Catalan Government.
  - Four representing the county councils of Catalonia.
  - Four representing the city and town councils of Catalonia.
  - Four representing the most representative trade organisations in Catalonia.
  - Three representing the most representative trade unions in the health sphere in Catalonia.
  - Four representing the most representative employers' associations in Catalonia.
  - Three representing the most representative business corporations in the healthcare sphere in Catalonia.
  - Three representing the most representative consumer and user organisations in Catalonia.
  - Three representing professional healthcare corporations in Catalonia.
  - Two representing Catalan universities.
  - One representing scientific bodies.
  - One representing Barcelona's Provincial Council.



# Introduction

This publication presents a summary of the overall activity of our health system and the public healthcare network. The information is ordered according to ten strategic lines, which guide CatSalut's work as a guarantee of quality, efficient, sustainable healthcare services that respond to the needs of the population's health.

In recent years our health system has initiated a transformation necessary to tackle the challenges posed by a more numerous, diverse, global and demanding society. The year 2008 was very significant in the sense of forecasting future needs and planning resources, and we have done this with the public presentation of the Healthcare, Social Care and Public health map and the Horizon 2010 Health Plan. In addition to these instruments that aid decision-making, are master plans for mental healthcare and addictions, social care, the circulation system, immigration and oncology, as well as different strategic plans for structuring services.

2008 was also the prelude for the future Public Health Act, an innovative regulation in Spain, which will incorporate services from this sphere into the public health system and which grants CatSalut functions for contracting out these services. Healthcare organisations must take into account services related with health monitoring, prevention and promotion, and align these with the portfolio of care services.

Growth in activity at our centres (contacts with the entire system have increased by 24% over the last five years and now exceed eighty million) has not meant any reduction in quality nor has it led to any fall in people's confidence level. Commitments to improvement are evident in the sphere of waiting lists for surgical operations, which since 2003 have shortened significantly, and in the guaranteed maximum time for thirteen diagnostic tests, whose waiting time continues to be reduced, as well as in the incorporation of the monitoring and management of lists of outpatients referred for specialised attention. This advance in the register systems, which contribute towards better knowledge of the activity being carried out, has also been seen in the minimum basic data set for primary healthcare, which will be launched across Catalonia in 2009, and in the improvement of hospital discharges.

Economic and financial limitations have affected our sector too and for this reason, actions designed to contain costs make greater sense. Mention should be made of costs related to pharmaceutical

prescriptions, which maintain their relative weight in the overall budget, with a cost below the Spanish average. Measures have been incorporated such as the use of generics, joint responsibility being taken on by professionals and centres and the promotion of rational use of medication by users.

The Department of Health maintains its investment effort in facilities for improving accessibility, territorial balance and new care models, thus increasing problem-solving capacity and quality of care within the public health network. These are advances that not only benefit users but also improve conditions for healthcare professionals, favouring team work and dedication to training and research. An investment – and benefits – that are also present in information technologies and communications, such as the telemedicine project or the shared medical records project for the whole of Catalonia.

Another aspect that we are reinforcing is the participation, commitment and joint responsibility of all agents in our system, from healthcare professionals, with evidence-based clinical practice and knowledge of the cost-benefit relationship of their work; through healthcare organisations involved in capitated assignment systems and increased autonomy in the management of their centres; municipal bodies and social organisations integrated into the regional health administrations; and citizens themselves and their associations of patients, as users responsible for their own health and active agents of community health (for example, expert patients).

At this moment in time the health system has to show itself as active, due both to its social and territorial cohesion function, and to the fact that it means essential support for the wellbeing of each person or family. And, no less important, due to its economic dynamism, which directly contributes major added value and is associated to other sectors with great economic and knowledge potential (pharmaceutical industry, medical technology, IT, biotechnology and training companies, etc.). This is the recipe for improvement in the present and thorough preparation for the future.

**Marina Geli**  
Health Minister

**Josep Maria Sabaté**  
Director of CatSalut

# Structuring healthcare based on people's healthcare needs

## The people of Catalonia and healthcare cover

CatSalut recognises the right to receive healthcare of all those people registered as resident in any of the municipalities of Catalonia via the individual healthcare card, which identifies and accredits healthcare cover or insurance for each person, in an individual and universal way.

The central register of insured people (RCA) establishes the annual reference population for the entire system once information quality has been verified with other sources. By the end of 2008, the total population of Catalonia stood at 7,611,711 people. The rate of growth was 1.5%, below that of 2007 (2.4%), and with a great diversity in the nationality of immigrants (15.3%). The top three countries of origin for new arrivals are Morocco, Romania and Ecuador.

**The RCA data are the key instrument, together with the Healthcare, social care and public health map, for defining the planning of services and adapting healthcare to meet the population's needs.**

## The reference framework in health: the Health Plan

On 31 July 2008, the Catalonia Health Plan for the 2010 horizon was presented at the Palau de la Generalitat. The Health Plan is the framework of reference for public actions by the Catalan Government in the health sphere and specifies the objectives and action strategies of the Department of Health, which are in line with international guidelines on healthcare policy. The Plan incorporates a wide-reaching vision in which health determinants acquire the same importance as preventive and care actions offered by the services and its ambition is to contribute towards reducing the inequalities in health due to gender, social class and region.

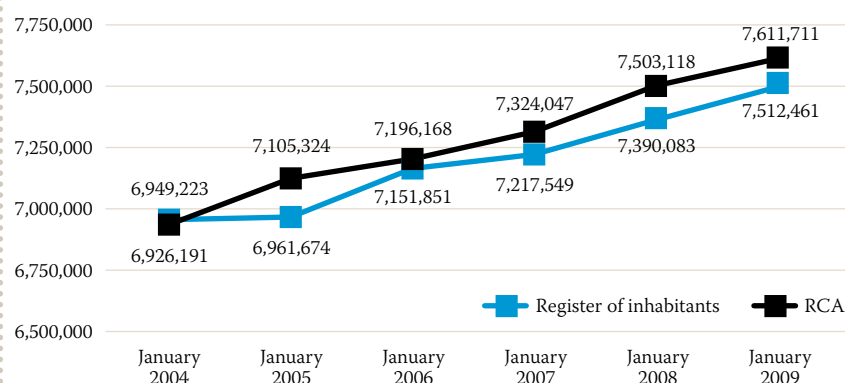
The first part of the Plan, "The Catalonia health report", describes in exhaustive detail the state of health of the population. It contains, among others, 60 basic indicators that provide information on the population's characteristics, behaviours and lifestyles, state of health and use of disaggregated healthcare services according to healthcare regions and regional health administrations (GTS). The report goes in depth into the study of inequalities



**The Catalonia Health Plan for the horizon of 2010 is the framework of reference for public health actions, at the service of this country's people.**

and also incorporates new spheres such as limitations in the activities of everyday life and dependency, disabilities, social support, quality of life, evaluation of primary healthcare and urinary incontinence. The second part, "The 5 strategic pillars that structure healthcare policies", presents the priority objectives and intervention strategies relating to inter-sectorial commitments, actions related to healthcare, social care and public health, the role of healthcare professionals, citizen participation in the healthcare system and responsibility towards own health.

## Evolution of the register of inhabitants and of the RCA, 2004-2009



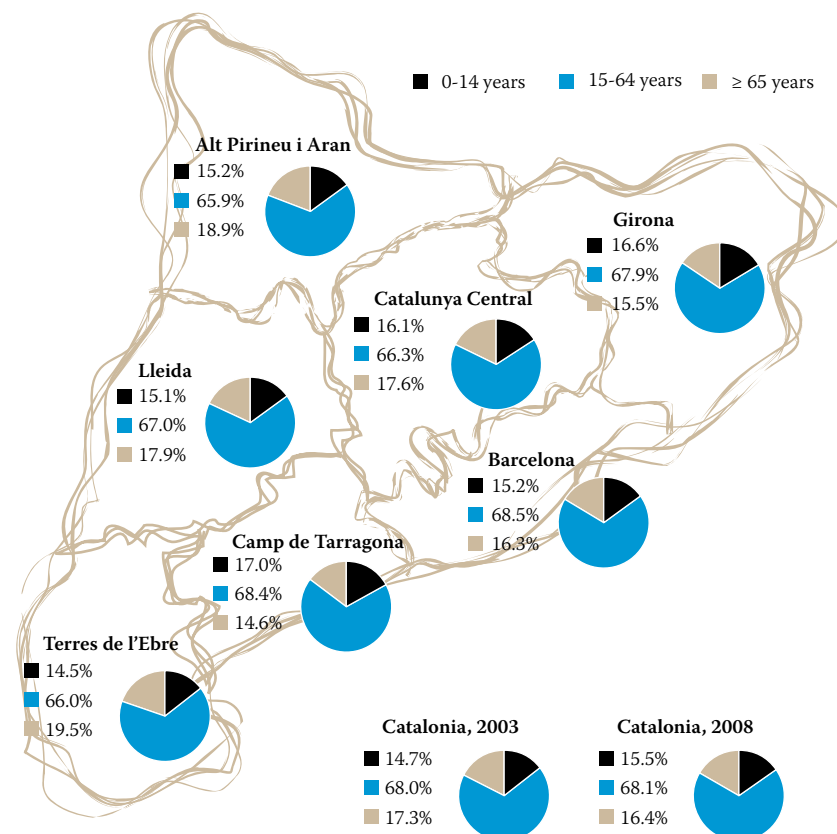
## Healthcare, social care and public health map

In February of 2008, Decree 37/2008 was published, which regulates the Healthcare, social care and public health map, which represents the incorporation of the planning of health services into Catalonia's healthcare planning system, complementing its Health Plan. The Decree establishes the Map's objective and aims, content, its production, approval and consultation procedure, as well as mechanisms for updating and monitoring, and it creates its Management Committee. It also establishes that CatSalut must adapt the provision of services, through management contracts and agreements, to make directives for development and for regional adaptation of services that result from the Map effective.

**The Healthcare, social care and public health map defines the planning of healthcare services up to the year 2015, with the aim of giving a balanced and efficient response to problems related to health and services quality.**

On 20 May, the Catalan Government approved the Healthcare, social care and public health map, under the title *Services for Health: looking to the future*, and on 31 July it was presented at the Palau de la Generalitat. During the last quarter of 2008, the project began to generate a monitoring system for the Healthcare, social care and public health map of Catalonia, which would allow its continual monitoring and facilitate its use and continuing support for making planning decisions, by providing access to relevant information in an ordered and contextualised way.

## Population of Catalonia, by age group and healthcare region, 2008



## Public health, a service of the public health system

The forthcoming approval of the Public Health Act which will create the Public Health Agency of Catalonia will establish a substantial modification in the sense that the overall set of public health activities and services will become a service provided by the public health system. This will mean that the set of service portfolios at the different healthcare facilities will be aligned, which represents a commitment and an assurance for the population.

CatSalut will broaden the sphere of its functions to those of public health as planner and buyer of these

services. Moreover, the General Board of Public Health and the General Board of Planning and Evaluation will strengthen public health policies and strategic planning through the Health Plan for Catalonia and the future Interdepartmental public health plan, envisaged in the Act.

**The new Public Health Act is the first regulation of these characteristics in the whole of Spain to incorporate the main international tendencies in the monitoring of public health, promotion of individual and collective health, illness prevention and health protection.**



## Master plans

Master plans, adapted to the real situation in Catalonia and its economic and healthcare context, define the activities and organisation of services necessary to develop the policies proposed with an integrated vision of the situation and tackling everything from health promotion and illness prevention to rehabilitation, including diagnosis and treatment measures. The plans define a model of care and organisation of services based on the real situation and allows continuing progress to be made in system efficacy and quality.

### Master plan for circulatory system disorders

This Plan aims to improve care for vascular disorders through the restructuring of resources and actions for promoting health and preventing illness. This Plan's most important action areas focus on vascular prevention, tackling congenital heart conditions in children and adults, monitoring and control of heart failure, the organisation of cardiac rehabilitation services and acute coronary syndrome. This syndrome is very frequently a main cause of death and has a great impact on people suffering from it.

**Code Infarction.** Code Infarction involves the activation of a series of care facilities that enable emergency care in the acute phase of the illness when a patient is suspected of suffering from acute coronary syndrome and is a candidate for immediate reperfusion. Code Infarction is being applied already in some regions, with a univocal designation of reference centres for each of them, as is the case for the Lleida and Barcelona healthcare regions. The rest will be incorporated into Code Infarction in 2009, the year in which its information system will also be launched to notify cases and analyse them. Current data show an increase in both coronary recanalisation and in angioplasties carried out.

**Code Ictus.** Meanwhile, Code Ictus aims to reduce frequency of strokes and their impact as a cause of invalidity. Application of the Code addresses the improvement of emergency care and reduces both mortality rates and the quantity of brain tissue damaged, meaning that the patient is much less severely affected. Within a maximum of 6 hours from the start of the stroke, patients are referred to one of 13 reference hospitals. This model has been in operation in 100% of Catalan regions since May 2006 and data

from 2008 show that of approximately 11,900 admissions due to strokes, some 2,278 activations took place, of which 75.4% were correct. Treatments with thrombolytic drugs increased from 19.6% of the cases activated in 2007 to 22.4% in 2008.

### Oncology master plan

**Rapid diagnosis of cancer.** Fast access to diagnosis and treatment is one of the essential features of quality oncological care, as it helps reduce patient anxiety levels and improves the care process. After three years in functioning of the rapid diagnosis circuit for breast, colorectal and lung cancers, in the year 2008 circuit monitoring indicators were analysed and it the circuit was extended to include bladder and prostate cancers. If we compare the results of monitoring indicators for the rapid diagnosis circuit for breast and lung cancer for the year 2008 with those obtained for 2007, we can see that the number of patients included in the rapid diagnosis circuit has increased (in lung cancer the increase was 35.8%, especially due to the increase in the number of centres for which information is available), as has the percentage of patients meeting inclusion criteria, and that the average time between entry into the circuit and start of treatment has improved. In colon cancer, this stands at around 27 days, in breast cancer it remains at around 31 days and for lung cancer, around 32 days.

In relation to the rapid diagnosis circuit for bladder and prostate cancer, data relating to centres included in the rapid cancer diagnosis programme have been analysed with information from the second half of 2008. As for the results of monitoring indicators for the bladder and prostate rapid diagnosis circuit, 784 bladder patients and 737 prostate



patients have been included. Some 34% of those diagnosed with bladder cancer and 39% of those with prostate cancer come from the rapid diagnosis circuit and the average time between circuit entry and start of treatment was 28 days for bladder cancer and 17 for prostate cancer (information from 53.3% of centres).

**Early breast cancer detection.**

Breast cancer is the most frequent tumour in women and its incidence continues to increase. Currently survival rates – also increasing – are 80.9% for five years after diagnosis, slightly higher than the European average, which for the same period stood at 79%. The causes of this improvement are fundamentally progress in diagnosis at increasingly early stages of the illness, early detection through mammography and improvements in treatments. The breast cancer early detection programme is aimed at women aged between 50 and 69 years, and encourages them to go for a screening mammogram every 2 years. Participation and coverage has increased over the years and, although we do not have data for 2008, in the previous year, 823 cancers were detected.

**Social care master plan**

This Plan aims to improve care for people included in the four healthcare lines that it tackles: geriatric care, Alzheimer’s disease and other dementias, other neurological conditions that may present with disability and end-of-life care.

In 2008 priority was given to:

- Definition of the organisational model for social care in Catalonia as a response to the implementation of the Act promoting autonomy and dependency care.
- The drafting of the Dementias Plan of Catalonia (DemCat), which includes all care levels and the entire Catalan region.

- Production of the resources agenda for families of children with acquired brain damage and evaluation of the adults’ agenda.

- Joint work with the Healthcare map for the design of the document for the organisation of care for neurological disorders that may present with disability.

- Improvement in tackling bioethics aspects in the social care sphere.

- Definition of the model, description and consensus on criteria of care complexity and end-of-life care levels.

- Implementation of the *National Health System Strategy for Palliative Care*.

- The running of training activities for healthcare professionals related with the four strategic lines of the Master plan and different care levels.

- Dissemination of the results of the external evaluation of the social care network and the drafting of good practice guidelines for the improvement of social care quality.

**Mental health and addictions master plan**

Improving mental health is one of the Department of Health’s prior-

ity policies and for this reason this Plan was created, under the guidance of an advisory council and working groups of experts. During 2008, targets were set to respond to a shared vision and a comprehensive, unified, effective and efficient model; to guarantee the inclusion and social participation of those affected as full citizens, promoting the integrated functional organisation of the networks, services and actions run by different agents in the territory; determining intervention programmes for each target population (pre-school, school age, teenage population, adult population and elderly people); progressive consolidation of priority projects such as those listed in the table below; and also the promotion of programmes addressing vulnerable populations. The first phase begun was the development of a global map of resources and their territorial distribution.

**2008 was a key year in progression towards a comprehensive care model for mental health.**

**Level of implementation of mental health projects, 2008**

New portfolio of services in primary healthcare	43% of the Basic Health Areas (ABS)
Promotion and prevention within Health and School	100%
Emergency psychiatric house calls	Barcelona city, L’Hospitalet and Cornellà, and Camp de Tarragona
Incipient psychotic disorder	14% of the CSMAs
Increase in psychotherapeutic offering	7% of the CSMAs
Care for teenagers with substance consumption problem	20% of the CAS 21.7% of the CSMIJ
Individualised Services Plan	80% of the territory
Serious mental disorders	67% of the CSMIJs
Community rehabilitation	56% of the CDs
Reorganisation Plan for eating disorders	Girona, Lleida, Alt Pirineu i Aran and Catalunya Central
Reorganisation Plan for compulsive gaming care	85% of the territory

### Immigration in the health sphere master plan

The Master plan for immigration in the health sphere has prioritised reception, mediation and training plans. It has identified the functions and profiles of community health-care translators, mediators and agents, as well as the need for 50 further mediators with specific training homologated by the Health Studies Institute. In the year 2010 there will be 53 health mediators with official certification. Furthermore, this project has allowed 25 mediators to be employed in 2008 and 25 more for 2009. In total, the project will provide coverage for 77 non-hospital centres and 24 hospitals.

**Mediation is an important resource in the use of healthcare resources at times of high influx of immigrants to Catalonia.**

In 2008 there a total of 4,335 interventions were recorded, ranging from information for users and linguistic and cultural interpreting, to the production of materials and documents. The specialities in which the mediation service has been most requested were gynecology, obstetrics, paediatrics, internal medicine and family medicine. As for origin, the majority of people helped were of Maghrebi, Asian and Sub-Saharan origin. Even so, mediation should be understood as a bridge between community and health services and as a temporary resource, necessary only insofar as flows of newly arrived populations continue.

### Services organisation strategic plans

The Department of Health and CatSalut work in coordination to improve services offered, fairness, quality and efficiency, and for that

reason various strategic plans have been initiated and developed that will allow progress to be made towards set targets.

The **Strategic plan for organising paediatric care in primary healthcare** was developed with the aim of organising paediatric care in order to continue providing high-quality care, a more decisive model, better coordinated between different care levels, as well as paying attention to the natural environment of children and teenagers, fundamentally at schools and in the community. Presented in 2007, in 2008 it has been transmitted to institutions, providers, primary healthcare centres, hospitals, professionals and scientific societies. The Monitoring Committee was also constituted.

The **Strategic plan for the organisation of care for nephrology patients** sets down the bases for improving quality in the provision of dialysis services and establishes the planning criteria for the development of new care points. In 2008 the Plan's development was completed, and its proposals included in the Healthcare, social care and public health map, and public information was given on decree projects on requirements for the authorisation of centres and dialysis units and on quality standards.

The **Strategic plan for the organisation of specialised care** must design a new organisation model for specialised care that adapts to health and service needs of the current Catalan population. In 2008 the last phase was developed to determine those specialities that allow a maximum level of outpatient care and accessibility.

In the **Strategic plan for the organisation of maternity care and sexual and reproductive health**, it is important to highlight the start of implementation of the new regional model at the 42 sexual and repro-



ductive healthcare units and the 43 maternity hospitals in a progressive way, as well as the new protocol for prenatal diagnosis of congenital fetal abnormalities in the first three months of pregnancy.

It is also important to highlight one of the priority lines of action for maternity and newborn care, which is enabling women to choose assistance with natural birthing and, for this reason, CatSalut is financing the infrastructures and material necessary for this process to be attended to in warm, safe conditions, in addition to financing midwives at the hospitals of Olot, Puigcerdà, Manresa, Santa Caterina de Salt, Parc Taulí de Sabadell, Vic, Mataró, Sant Pau and Clínic-Maternitat so that they can respond to the demand generated.

The **Strategic plan for organisation of care for patients with polytrauma and severe trauma** is to permit improvement of care for these patients through regional reorganisation of services and flows, regulated comprehensive and high-quality training and a patients information register.

In 2008 the **Programme for the development of diagnostic imaging** began, which will improve accessibility for citizens to diagnosis using medical digital imaging techniques, favouring their use under criteria of quality, safety and efficiency, promoting coordination and cooperation between centres and improving information systems.



## Innovation plan for primary healthcare and community health

Since 2007 and throughout the year 2008, work has been carried out on the strategic and operating design of the Innovation plan for primary healthcare and community health, oriented towards improving organisation based on sharing, cooperation and working as a network, sharing knowledge between professionals, introducing a new way of providing services and progressively eliminating the frontiers between the different care levels, especially between primary care and hospital admission and between insurance cover and public health cover. The most innovative actions address:

- Gearing the healthcare system towards the population's needs and promoting participation and joint responsibility in care of own health.
- Devising a model of networked care that favours new work dynamics between healthcare professionals and allows functional integration of services, focusing on people.
- Promoting continual professional and individual development under the principles of subsidiarity that allows a balancing of skills of professionals as a group.
- Strengthening the role of professionals in decision-making.
- Introducing changes into the management of services, making use of new technologies and other measures to improve management autonomy for centres and quality of care for citizens.
- Introducing community interventions that have already proven themselves to be cost-effective into the offering of primary healthcare and community health services.
- Redimensioning centres from the perspective of the integrated health centre.

- Contributing towards defining criteria for financing, purchasing, contracting and evaluation that contemplate the functional integration of services and professionals in the territory.

## Implementation of priority projects

The objectives of the MISAPP Project (Methodology for implementing, monitoring and evaluating priority projects) are to apply a common methodology for the development of projects, identify critical factors and give strategic and operating support in the region to those priority projects that are part of the Department of Health's master and strategic plans, within the framework of the 2008 and 2009 strategies for health of the Ministry of Health and Social Policies. The MISAPP project is being run in the Baix Camp, Vallès Occidental Est and Barcelona GTSs. It is forecast that this methodology will be extended to six new regions in 2009.

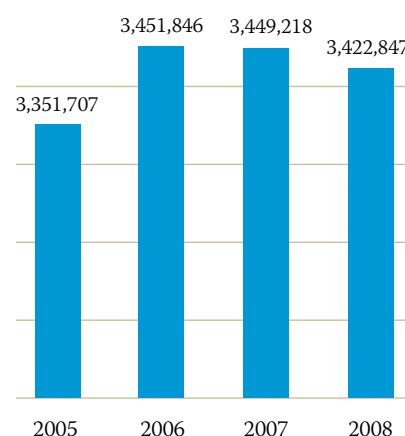
Priority has been given to 10 projects to develop simultaneously at each GTS, which correspond to the strategic spheres of the Minister of Health and Social Policy:

- Colorectal cancer screening
- Code Ictus
- Code Infarction
- Portfolio of mental health services in primary healthcare
- Extension of coverage of end-of-life care
- Support of an expert geriatric care team within hospital emergency services
- Application of the new portfolio of maternity services and sexual and reproductive healthcare
- Natural assistance in normal birthing
- Screening for ocular retinopathy in the diabetic population
- Programme of physical activity, sport and health

## Accident and emergencies model

In 2008 a series of priority interventions for improving and transforming the accident and emergency care model have been introduced, with an implementation that must be gradual and adapted to requirements and opportunities in each regional sphere and at each care level. The necessary steps have been taken to begin implementation of the Triage aid programme (PAT) from the Andorran model in hospital emergency services, in primary healthcare emergency centres (CUAPs) and at some continuing care centres. The implementation of a single triage system for the entire network will allow a reduction in waiting times and improvements in comfort and help adjust supply to demand. Measures have also been designed to decongest the emergency services, increasing beds for hospitalising subacute and post-acute patients during times of increased demand for care, when the Comprehensive Emergency Services Plan of Catalonia (PIUC) is activated. Another of the essential elements for improvement is the incorporation of information into the statistic registers of the Department of Health and specifically into

### Emergencies treated, 2005-2008



the minimum basic data set (CMBD) which includes data of care activity at hospitals in Catalonia, based on discharge reports. During the year 2008, design has begun of the minimal basic data set for emergencies.

### New tertiary services model in regional terms

*Tertiary services* refers to a set of highly specialised services or services with a very advanced technological and professional expertise requirement which, due to their complexity and special characteristics, benefit from concentration among a small number of providers. The general objective for reorganising tertiary services follows regional balance criteria and equality in access, care quality and efficiency. In 2008, work has been carried out on five issues:

- Extension of the Code Infarction to the whole of Catalonia. Work has been carried out together with the Catalan Cardiology Society and the SEM to define criteria of regional sectorialisation in Catalonia according to the hemodynamics laboratories open 24 hours per day, 7 days per week.

**The new tertiary services model allows the provision of highly specialised services to be balanced with quality, equality and efficiency criteria.**

- Improvement of the time between the appearance of ictus and early, expert assessment of patients. Implementation has begun of the TeleIctus programme, with connection between reference centres and district hospitals in the region, which allows visualisation of x-ray images in real time with remote exploration by a professional expert in cerebral vascular pathology.

- Reorganisation of oncological surgery. Planning criteria have been established for procedures that can be encompassed under the concept of *tertiary services* which include paediatric oncology.

- Intra-arterial treatments for cerebral ischaemia.
- Surgery for Parkinson's and epilepsy. Criteria have been devised for defining reference centres.

### Comprehensive dependency care

A process of consensus has been carried out between healthcare regions and the Interdepartmental programme of care for people with dependencies (Prodep) to define a model of integrated care for people in situations of dependency due to an illness. The main healthcare element established in the model is case-management based working, focusing on integration of the health services of the healthcare network, to share them with the social network and for professionals to jointly formulate an Individualised integrated care plan (PIAI).

Moreover, an analysis has been made of the situation of the social care and mental health long-term stays and progress has been made on developing bases for adapting these services to future scenarios, guided by the Dependency Act.

The 93,534 requests for assessment made in 2008 were accompanied by their corresponding state of health reports, produced mostly by healthcare network professionals. It is important to highlight that 46% of people admitted to social care and mental health centres in the last quarter of 2008 have been assessed or are being assessed and that, of these, 88.5% are affected by degrees of levels of dependency that generate a right to support services.



### Prevention plans: PIUC and POCS

Within the Comprehensive emergencies plan of Catalonia (PIUC), whose objective is to limit the impact of epidemics of flu and other winter illnesses, resources have been increased with respect to the previous year: hospitalisation capacity by 16,241 admissions of acute patients, 1,323 of sub-acute patients and 1,832 social care patients. Staff have also been reinforced with 188 doctors, 338 nursing professionals and 137 administration staff.

The Action plan to prevent the effects of heatwaves on health (POCS) in summer has given good results in care and control of populational health. In all the healthcare regions the census of frail people was updated, reaching almost 100% of the primary healthcare centres. Around 80.5% of people were attended to in their own homes, others directly from the CAPs (40%) and when required, they have been attended to from the CAP and also in their own homes.

**During 2008, there has been an increase of 13% up on the previous year of the additional purchasing for acute cases within the Comprehensive winter emergencies plan.**

### Extension of the services portfolio

**Oral and dental health.** The agreement between the Department of Health and the Ministry of Healthcare and Social Policies has established the shared financing of the extension of oral and dental services for the child population aged between seven and eight years. The envisaged services portfolio includes an annual examination (including radiographic exploration, if necessary), healthcare instructions regarding diet and dental and oral health,

## Public healthcare network facilities. Activity, 2003, 2007 and 2008

Facility	Indicator	2003	2007	2008
Primary healthcare centres and local surgeries	Appointments	41,868,008	49,242,553	51,082,637
	Inter-consultation requests	1,919,459	1,037,386	1,628,760
	Clinical analyses requests	1,856,886	2,514,371	3,005,975
	Diagnostic imaging requests	836,465	1,037,386	1,177,802
Hospitals in the public health network (XHUP)	Standard hospital admissions	667,755	598,088	598,740
	Psychiatric hospital admissions	10,202	8,435	8,485
	Major outpatient surgery (CMA)	105,609	147,743	159,247
	Minor outpatient surgery	202,837	253,769	259,514
	Emergency services	3,304,534	3,449,218	3,422,847
Transplants	Number performed	748	788	832
External consultations	First hospital appointments	— <sup>1</sup>	2,930,471	3,076,894
	Successive appointments	9,227,647 <sup>1</sup>	6,288,392	6,293,327
	Appointments at primary care centres (CAP II)	2,736,389	2,181,331	1,721,347
Social care centres	Patients cared for in long-term units	13,993	12,067	12,031
	Patients cared for in convalescent units	14,940	17,414	16,882
	Patients discharged from palliative care	4,998	4,609	5,609
	Care episodes of patients cared for in day hospitals	6,656	6,181	6,250
PADES Homecare and support-team	Patients cared for	15,597	13,480	13,110
ETODA Direct observation therapy teams	Patients cared for	—	269	203
Psychiatric hospitals	Discharges from psychiatric hospitalisation	10,887	12,868	13,954
Mental health centres for adults (CSMA)	Appointments with adult patients	688,550	968,411	887,974
Mental health centres for children and teenagers (CSMI)	Appointments with child and teenage patients	207,250	301,629	308,514
Psychiatric day hospitals	Adult patients discharged	2,289 <sup>2</sup>	2,467	2,617
	Child and teenage patients discharged	— <sup>2</sup>	1,668	844
Mental health daycare centres	Patient discharges	1,008	1,150	1,244
Drug dependence treatment	Individual appointments at care and monitoring centres (CAS)	535,297	534,636	462,846
	Discharges due to hospital detoxification	1,284	1,084	1,066
	Discharges due to outpatient detoxification	10,578	6,799	6,580
Healthcare transport	Emergency transport services	456,820	739,343	748,997
	Scheduled transport services	1,816,025	2,213,305	2,400,064
24-hour Sanitat Respon helpline	Calls received	309,789	4,541,886	4,516,671
Rehabilitation	Outpatient care	92,280	171,571	227,020
	Home care	6,828	28,889	34,667
	Speech therapy	9,553	13,174	15,028
Oxygen therapy	Patients attended	28,601	45,005	49,506
Renal substitution treatment	Patients in dialysis	3,736	3,958	4,030 <sup>3</sup>
<b>Total</b>		<b>65,041,429</b>	<b>78,285,407</b>	<b>80,534,876</b>

1. Successive appointments of 2003 include the first appointments. 2. Discharges of adults include children and teenagers. 3. Estimate.

application of topical fluoride, sealing of fissures in permanent molars, filling of permanent teeth, endodontics, exodontics, tartar removal and treatment of permanent incisors and canines in cases of illness. Excluded are orthodontics, cosmetic and/or repair treatments of temporary teeth and dental implants.

**Chiropody care** for diabetic people with vascular pathologies and chronic neuropathies. During 2008,

work was carried out that will allow inclusion in the next financial year, of preventive chiropody care as a complementary benefit to the common services offered by the national health system. Over 170,000 diabetic people will be able to benefit from this new service.

**Surgical treatment of gender identity disorders.** In the last quarter of 2008, surgical treatment began for sex reassignment (genital recon-

struction, mastectomy and hysterectomy) at the Gender Identity Disorders Unit of the Hospital Clínic, a reference centre for the whole of Catalonia established by the Department of Health. Three interventions have been carried out there.

**Since 2003, contacts with the public healthcare network have increased by 24%.**

# Guaranteeing efficient management of services: fairness, efficacy and efficiency

## Waiting lists: surgery, diagnostic tests and outpatient consultations

In October 2008 the project was concluded for the functional design of the new application that will allow the monitoring and management of the waiting lists defined up to now (surgery waiting list and diagnostic tests waiting list) as well as incorporation of the outpatient consultation waiting list, among other functions.

### Surgery waiting list

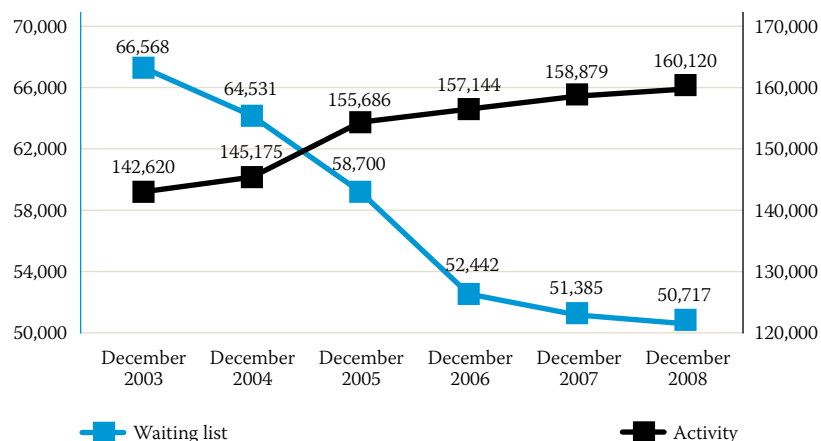
With regard to the fourteen procedures with guaranteed maximum waiting times, during 2008 there was evidence of a reduction of 3.6% in the number of patients on the waiting list for each 10,000 inhabitants, and of stabilisation of the activity carried out with respect to 2007 (increase of 0.8%). Resolution time has been reduced by 2.1%, and in December stood at 3.8 months.

Moreover, monitoring of the thirteen new groups included in the guarantee period has continued. The 27 procedures represent monitoring of 65% of those included in the nominal register of surgical waiting lists.

### Diagnostic tests waiting list

For the last four years there has been a nominal register for the diagnostic tests waiting list, where hospital centres for acute patients inform on the tests carried out. Monitoring of thirteen tests is carried out.

Evolution of the surgery waiting list and activity, 2003-2008



### Diagnostic tests waiting list, 2007 and 2008

	2007		2008	
	People	Days	People	Days
Echocardiography	10,622	62	11,110	59
Abdominal ultrasound	11,093	53	8,894	51
Abdominal and urological ultrasound*	2,420	52	2,756	42
Gynaecological ultrasound	7,587	38	6,800	36
Urological ultrasound	8,989	66	9,919	65
Colonoscopy	8,727	45	9,804	49
Esophagogastric endoscopy	4,964	31	4,871	33
Computed Axial Tomography (CAT scan)	25,610	30	25,105	28
Mammogram	15,716	75	9,552	80
Polysomnogram	4,642	98	3,992	79
Magnetic resonance	20,882	47	24,613	44
Ergometry	1,929	40	1,755	34
Electromyogram (EMG)	7,039	69	7,005	57
Gammagraphy	3,928	27	4,078	28
<b>Total</b>	<b>134,148</b>	<b>48</b>	<b>130,254</b>	<b>45</b>

\* These will be notified separately.

**On the Catsalut website, waiting lists can be consulted by centre and by healthcare region.**

### Register of the basic minimum data set for primary healthcare (CMBD-AP)

The aim in creating this register is to have access to information on the morbidity of the population served by the primary healthcare teams (EAP) to allow improvement of the quality of planning, management and evaluation processes of the primary healthcare services. The CMBD-AP is incorporated, therefore, into the Department of Health's registers, which are obliged to include healthcare activity data for public and private healthcare centres in Catalonia.

The register unit is the **contact or appointment**, which is defined as any type of care interview between patient and healthcare professional that generates information registered in the medical record. The CMBD-AP involves the Healthcare administration, supplier organisations and healthcare professionals and their associations. Since the year 2006, four pilot tests have been carried out and it is planned that from

the year 2009 it will be able to be progressively implemented.

The information provided by the CMBD-AP allows the following patient data to be known:

- Personal identifying data (sex, date of birth and place of residence).
- Data relating to the process (appointment date, financing, etc.).
- Clinical care data (diagnostics and procedures).

The graph shows an example of the information that can be obtained corresponding to analyses of activity during the months of February and March 2008 at twelve EAPs which took part in the latest pilot test.

### Transparency through the Agreements and contracts register

The creation in 2007 of the Agreements and contracts register for providing healthcare services in the sphere of public healthcare affects those attached to CatSalut, the Catalan Health Institute, the attached public companies, the healthcare consortia with majority shareholdings, the organisations that

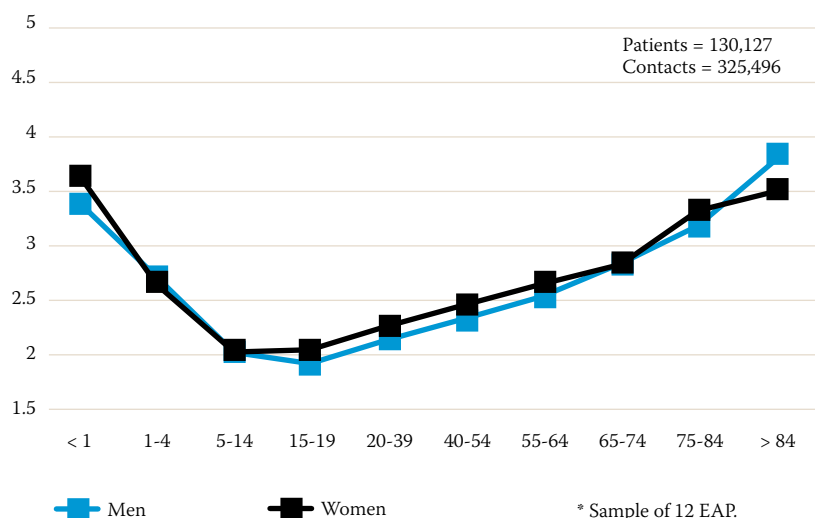
own centres that are part of the Public Use Hospital Network and those that own healthcare or social care services centres with which agreements or contracts are established, whose total worth continues to be over 50% of their total income. With the instruction of CatSalut 04/2008, dated 20 October, the procedure was established for the communication of data by supplier organisations to the Register of agreements and contracts for healthcare services provided by healthcare service providers. Periodical publication of this information on the CatSalut website has begun with the agreements and contracts established in 2007.

**The organisations contracted by CatSalut and the financial value of the contracts are now published on the website.**

### Implementation of the register of the minimum basic data set (CMBD)

1990	Hospital for acute patients
1995	Monographic psychiatric hospitals
1996	Major outpatient surgery and day hospitals
1998	Mental health outpatient centres
1999	Social health resources
2009	Primary care

### Average contacts in the EAP by patient, age group and gender, 2008\*



### Shared medical records project of Catalonia

This is one of the key strategic projects of the Department of Health that will make an impact in improving healthcare for citizens and allow healthcare professionals the shared use of information available on patients at any healthcare centre in Catalonia. Citizens will have access to this information via their personal health folder.

**The shared medical records project of Catalonia has received the National Prize for Information Technology and Health 2008 for the Best Project involving Innovation and Research in Health Information Technologies from the Spanish Society for Healthcare Information Technology (SEIS).**

In 2008 a further six organisations were incorporated, leading to a total of 15 hospitals, 292 primary healthcare centres and 40 specialist care primary healthcare centres. In a first pilot phase, health data (diagnostics, pharmaceutical prescriptions and some clinical documents)

are already available for 6,268,906 people and 3,575,143 clinical documents are indexed. In the year 2009, its contents will be increased with digital medical imaging, laboratory data and the development of tools for communication between healthcare professionals. Also, all hospital centres for acute patients and primary healthcare centres within the comprehensive public use healthcare system of Catalonia (SISCAT) will be invited to join the project.

### Rationalisation of costs of pharmaceutical services

The introduction of rationalisation measures in pharmaceutical services must contribute to the financial sustainability of the healthcare model, while guaranteeing a quality service that is efficient, accessible, safe and rational. Action strategies are based on encouraging co-responsibility of all agents, the redefining of services and benefits, improvements in quality and efficiency, strengthened evaluation and control, and the improvement of information systems.

Thus, priority has continued to be given to the policy of prescribing generic medicines (with a growth of

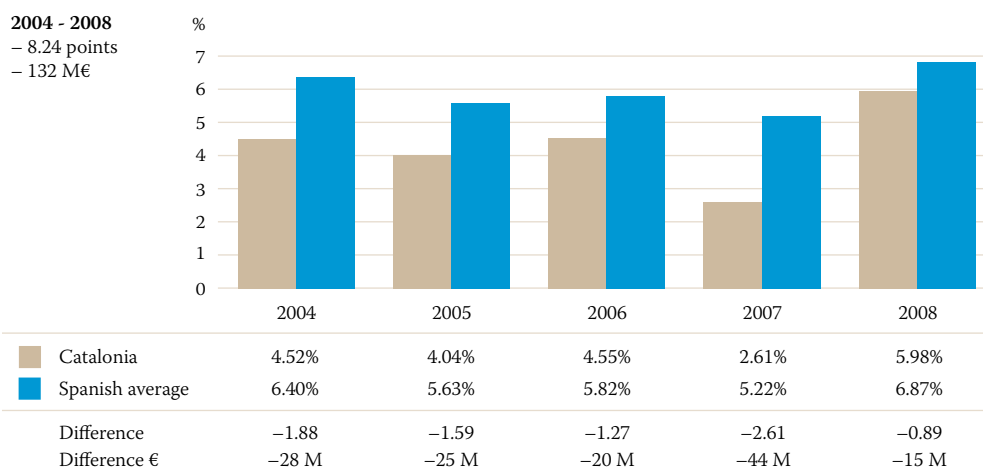
9.1%), which now reach 27.3% of use. Programmes for prescriptions for chronic conditions have been optimised, allowing for the renewal of prescriptions by health centres guaranteeing coverage of common quality criteria. Also the decree project for the new model of pharmaceutical services at social residential centres has continued to make progress, aiming to implement a payment model that separates the cost of medication from payment for professional pharmaceutical services.

**The rational use of medication, an improvement for everyone.**

In 2008 Catalonia was the second autonomous community in terms of lowest growth in pharmaceutical expenditure on medical prescriptions (5.98%, some 0.89 points below the average for Spain, which stood at 6.87%). It should be highlighted that between 2004 and 2008, Catalonia would have spent 132 million euros more if it had behaved like the Spanish average.

In the case of outpatient dispensed hospital medication (which has grown some 13.95%), expenditure objectives have been assigned

### Growth differential in pharmaceutical spending Catalonia-Spain, 2004-2008





to hospitals to improve prescription efficiency.

### Electronic prescription

April 2008 saw completion of the pilot phase of the electronic prescription system at five ABS in the healthcare regions of Terres de l'Ebre and Girona. In May its gradual introduction in the rest of the territory began in a coordinated way with all the agents, and added to the aforementioned regions were Lleida, Alt Pirineu i Aran and Camp de Tarragona. Furthermore, in 2008 the order to develop the electronic prescription decree was published.

### Economic Evaluation and Budgetary Impact Commission (CAEIP)

With the aim of improving efficiency in the selection of medications, it was decided to incorporate economic evaluation and budgetary impact into the pharmaceutical policy of CatSalut, and to strengthen, in general, pharmacoconomics in the sphere of pharmaceutical services.

The priorities in this area are systemic reviews of studies on economic evaluations of the main therapeutic groups, studies on budgetary impact (especially of high-complexity pharmacological treatments), the dissemination and monitoring of the recommendations issued to healthcare professionals, the development

of studies and proposals that allow decision-making in the area of the financing and training of healthcare professionals in this sphere.

For the performance of the above functions the Economic Evaluation and Budgetary Impact Commission (CAEIP) has been constituted, within CatSalut and which boasts the participation of recognised experts in medication evaluation issues. This advisory commission aims to ensure the efficiency of the public resources invested in prescriptions and reinforces the concept of opportunity cost of decisions in the use of medication. Its reports and verdicts are public and those relating to statins and proton pump inhibitors, together with working and internal functioning procedures, are available for consultation on the website.

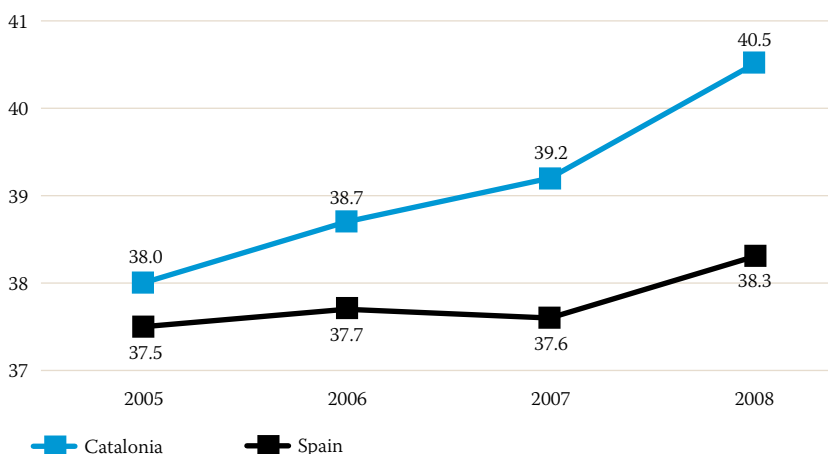
During 2008 systematic reviews were also carried out on the economic evaluations of atypical anti-psychotics for the treatment of schizophrenia and on medication for post-menopausal osteoporosis.

### More facilities for giving blood

Catalonia has reached the milestone set for 2008-2010: achieving 40.5 donors per thousand inhabitants per year (the Spanish average stands at 38.3). This year 41,579 new people have joined the blood donors collective. In 2008, a total of 298,443 blood donations were made, which represents an increase of 5.6%. With the aim of making giving blood easier, collection resources have increased, allowing greater presence across the country. With 16 permanent centres and 17 mobile units, two thirds of municipalities have been visited, totalling over 98% of the population.

**Catalonia is approaching the blood self-sufficiency level recommended by the WHO, which stands between 43 and 45 donations per 1,000 inhabitants.**

Evolution of the blood-giving index (per 1,000 inhabitants), 2005-2008



## Donation and transplantation of organs, tissues and cells

The increase in organ transplants was 6% up on the previous year, with a total of 832, with highlights being pancreatic transplants, which increased by 48%, followed by a 41% increase for heart transplants and 19% for lung transplants. This activity gives Catalonia one of the world's highest transplant rates per million population. In the year 2008, the first intestinal transplant was performed in Catalonia.

Some waiting lists have reduced considerably: by 46% for heart transplant and by 33% for pancreatic transplant, even though the list for kidney transplants, with a larger volume of patients, has increased by 9%. At the end of 2008 there were 1,284 people on the transplant waiting list. Moreover, the number of donors of valid cadavers fell by 3.8%. Around 5% of patients on the waiting list for kidney and liver transplants are patients from the rest of Spain, as are up to 70% of those awaiting a pancreas transplant. Some 9% of donations and 5.4% of transplants correspond to people from other countries.

As regards activities such as donating, obtaining, tissue banks and transplants, these continued

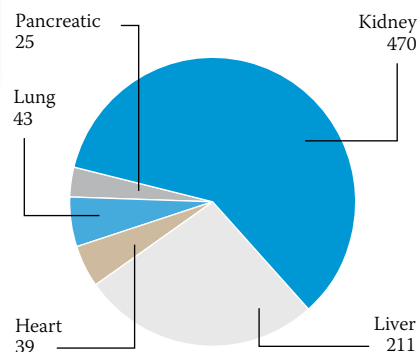
**Catalonia stands among the countries with the highest transplant rates in the world.**

to increase, this year by 6.2%. The number of transplants of human tissues (osteotendinous, vascular, ocular, skin, amniotic membrane and ophthalmological preparations) stood at 4,319 units implanted. Catalonia also has a system of biomonitoring that guarantees the quality and safety of tissues and cells, and during 2008 has processed 20 notifications (55% due to microbiological causes and 44% due to logistical issues involving transport and tissue reception).

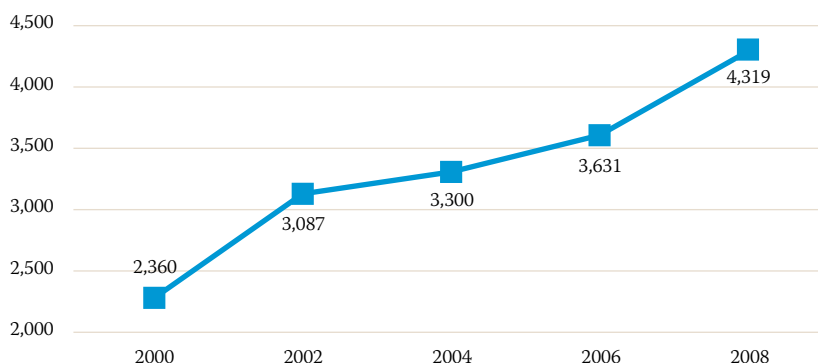
A total of 377 transplants were carried out using hematopoietic progenitor cells. The number of autogenic transplants was 190 (50.4%) and total family and non-family allogeneic transplants numbered 187 (49.6%). Some 10.6% (40) of the total number of transplants were carried out with progenitor cells from umbilical cord blood.

**The Vall d'Hebron University Hospital in Barcelona carried out the first intestinal transplant in 2008.**

Transplants, 2008



Evolution of the activity of tissue transplants (grafts used), 2000-2008



# Continuous improvement of the quality of services for citizens, in the quest for excellence

## Listening to people: incorporating their voice to improve the quality of services

One of the main elements required to be able to offer continuous improvement of healthcare services is knowledge of the quality perceived by people insured. For this reason, since 2002 CatSalut has promoted the design and implementation of methodological tools and techniques to measure it. The Catsalut Plan for Insuree satisfaction surveys (PLAENSA 2008), which carries these out with a proactive approach, is framed within current tendencies, which consider the measure of perceived satisfaction as an indicator for assessing the quality of services. They also allow access to information that bring citizens' perceptions and expectations closer to the bodies responsible for planning and managing services, based on a process of continuous improvement. During 2008, studies have been carried out on emergency hospital care, specialist outpatient care, the perceptions of children aged under 15 years regarding healthcare, and a study on non-urgent healthcare transport was begun.

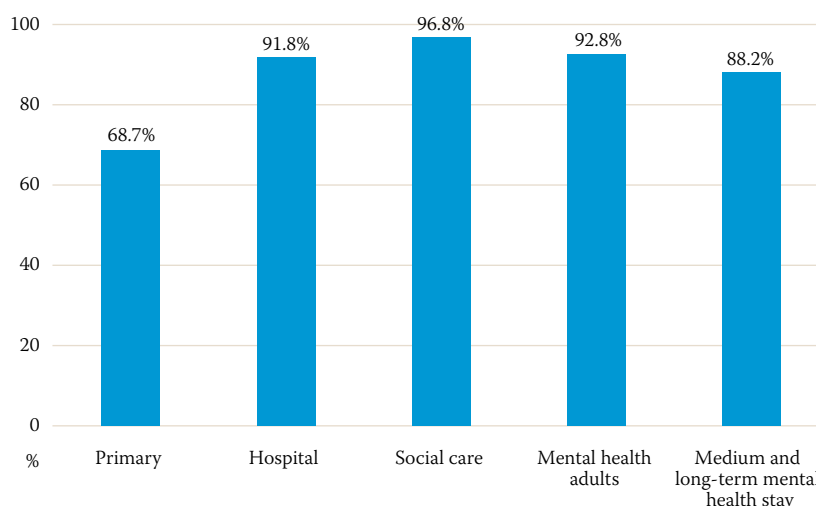
**The CatSalut website incorporates the analysis of each of the satisfaction studies, as well as the planning of those envisaged up to 2012.**

## The quality perceived by citizens in services purchasing contracts

CatSalut includes in its contracts for purchasing healthcare and social care services specific clauses so that each of the supplier organisations can make progress in those aspects detected in the results of studies as areas for improvement. The projects are selected by the different suppliers in accordance with the areas for improvement detected in the periodic studies that the CatSalut carries

out with people who have been attended to on the perceived quality of service. During the 2007-2008 period, the improvement projects carried out were related mainly with clinical and/or organisational information, and the improvement of communication, with a total of 881 projects.

### Achievement of improvement projects, 2008



### Results of surveys, 2008

Study	Method	Cases	Global satisfaction (0-10)	Loyalty
Hospital emergencies	Telephone survey	5,381	7.31	80.2%
External consultations	Telephone survey	7,986	7.55	83.2%
Non-urgent healthcare transport	Telephone survey	2,227	In data analysis phase	
Opinion children aged 7-14 years	Focus group	60	Qualitative report	

### Complaints analysis as a tool for improving services

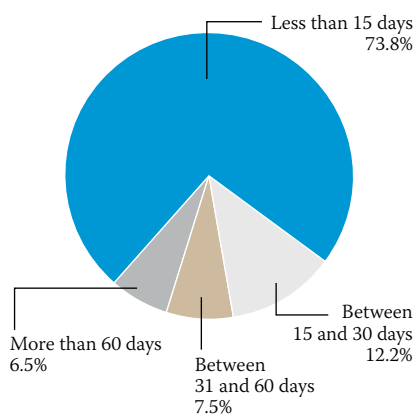
In 2008 some 50,839 complaints were received, representing 6.78 per 1,000 inhabitants, with a resolution rate of 95.1%. If we relate these with all the contacts between citizens and the public healthcare system, over 80 million, they represent just 0.063%, and only 0.00034% ever reach the courts (270 lawsuits brought in 2008). The average resolution time was 12.72 days.

As for main reasons for complaining, those of previous years were maintained:

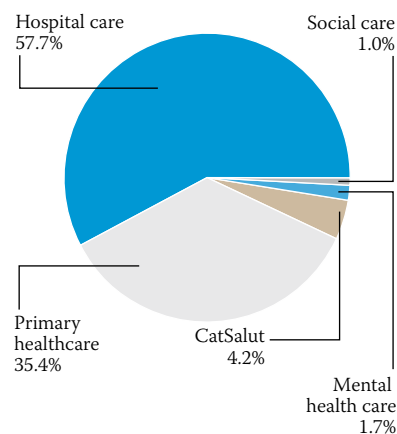
- In primary care: disagreement with change or assignment of GP, dissatisfaction with care and unsuitable treatment or attitude of staff.
- In specialised care: excessive waiting list for surgical intervention, excessive waiting list for consultation/prior appointment and dissatisfaction with care provided.



### Complaints response time, 2008

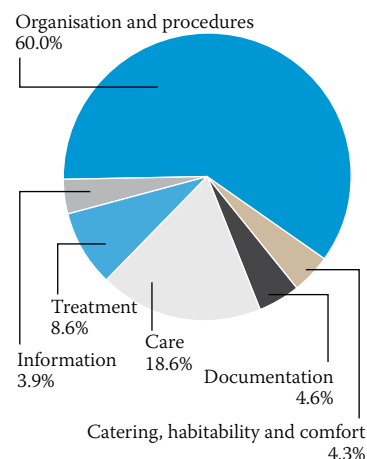


### Complaints by care line, 2008



Total: 50,839 complaints

### Complaints by reason, 2008



### VINCat programme

Nosocomial infections constitute an important public health concern, both because of the morbidity and mortality that they cause, and the financial cost that they represent. In the hospitals of Catalonia there is a long tradition of initiatives in the control of nosocomial infections but, in general, they lack a common link. The vast majority of XHUP hospitals have an infections commission and monitoring and control programmes, as recommended by the Health Plan. In the year 1999, ICS hospitals launched a common programme known as VINICS. The positive experience with VINICS led to the introduction two years ago of a monitoring programme common to all centres in Catalonia, the VIN-Cat programme. The aim of reducing nosocomial infections through the establishment of this standardised monitoring system, which allows the introduction and application of preventive strategies, has been achieved with notable success in terms of participation. During the year 2008, over sixty hospital centres have taken part and data have been analysed from over 10,000 elective surgical procedures, with specific data available on problems related with the use of vascular catheters, use of antibiotics and the main problems of bacterial resistance.

**The implementation of a homogeneous monitoring programme common to all the hospitals represents a very important advance for Catalonia in its fight against nosocomial infections and confers a degree of maturity upon the health system.**

# Ensuring the economic and financial sustainability of the health system sector

## Population-based purchasing system

The capitated payment model is a system for contracting a service provider or group of integrated providers, based on the transfer of a per capita amount adjusted to the characteristics defined in each region.

In 2008 the model was consolidated. Thus, work was done which involved defining a model that consolidated the experience of the population-based services purchasing pilot test, extending it to the whole of Catalonia, and responding to the different challenges that arose:

- Favouring the creation of integrated health systems based on the population's healthcare needs:
  - Placing people at the heart of the system.
  - Facilitating cooperation and non-competition between the different providers and care levels.
  - Improving system efficiency and favouring more coordinated resource management, continuity of care and collaboration between providers.
  - Seeking replacement facilities for service lines.
  - Eliminating duplication.
  - Gearing the organisation towards the end product: people's health.
- Eliminating competition between regions (GTS): in the payment system, eliminating invoicing between regions due to people travelling.
- Stimulating improvements in healthcare services quality, placing care at the most suitable level.
- Incorporating health prevention, promotion and protection.
- Calling for joint liability at the different care levels by transferring part of the risk to providers.
- Introducing a target-linked variable/penalisation.

Progress was made in the evaluation of the purchase and payment systems of different service lines and results were compared with those obtained based on the new population-based purchasing model.

**Currently, 46% of the population is covered by the population-based purchasing model.**

## Budget 2008

In 2008, the approved consolidated budget for Catsalut and the Catalan Health institute (ICS) totalled 8,945,090,653.86 euros, which represented an increase of 5.56% compared to the budget approved for the year 2007.

As of 31 December 2008, three concepts must be differentiated: the initial budget, which was the result of consolidating the budgets of CatSalut and of the ICS, approved by the Parliament of Catalonia; the final budget, which includes the effect of the variations in loans that occurred during the financial year both in the CatSalut and the ICS budgets alike, and the expenses entered into the books.

The consolidated expenses entered into the books for 2008 totalled the sum of 8,979,196,460.89 euros, which represents an increase

of 6.11% compared to the expenses entered into the books for the previous financial year.

Bearing in mind the economic nature of the expenses, they can be structured into three major groups: current operations, which account for 97.05% of the total, capital operations, which represent 2.94%, and financial operations, which represent 0.01%. A slight increase can be observed in the specific weight of the capital operations in relation to current operations, while financial operations maintain their negligible specific weight.

The current consolidated operations for CatSalut/ICS totalled 8,714,496,955.70 euros, which represents an increase of 5.67% over spending in the previous year.

In general, it can be seen how the specific weight of the items purchasing for healthcare services and staff costs increased. This is where the payment agreements adopted within the framework of healthcare industry negotiations had the greatest influence.

**The Government allocates one out of every four euros to healthcare so that citizens receive the best service.**

## Economic budget, 2003, 2007 and 2008

	2003	2007	2008	2008/07
Staff costs	1,280.25	1,826.21	1,857.27	1.70%
Goods and services	421.70	552.61	592.94	7.30%
Purchases of healthcare services	2,067.06	3,717.81	4,011.89	7.91%
Outpatient dispensing of hospital medication	176.62	404.01	487.52	20.67%
Pharmacy	1,313.93	1,668.84	1,698.88	1.80%
Services and other	111.07*	66.70	75.20	12.75%
Investments	119.34	237.52	221.39	-6.79%
<b>Total</b>	<b>5,489.97</b>	<b>8,473.69</b>	<b>8,945.09</b>	<b>5.56%</b>

In millions of euros.

\* Includes interest payments.

Ensuring the economic and financial sustainability of the health system sector

**Initial budget by programmes, 2003, 2007 and 2008**

	2003	2007	2008	2008/07
Primary healthcare	2,500.02	3,103.69	3,176.21	2.34%
Specialised healthcare	2,808.88	4,985.77	5,353.91	7.38%
Management and general administration	181.07	123.65	133.25	7.77%
Other health services*	—	260.59	281.72	8.11%
<b>Total</b>	<b>5,489.97</b>	<b>8,473.69</b>	<b>8,945.09</b>	<b>5.56%</b>

In millions of euros.

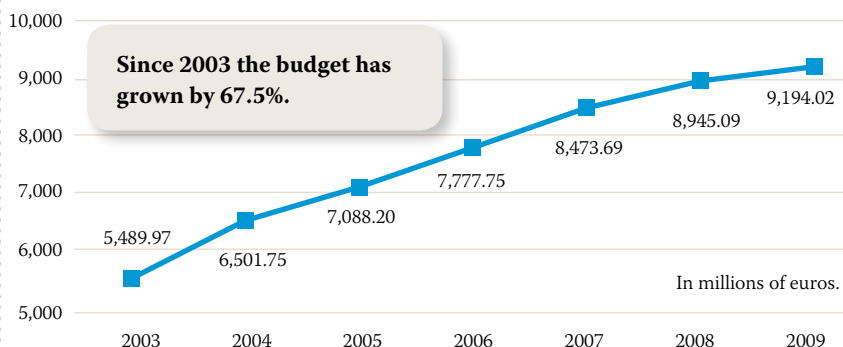
\* Includes biomedical and health sciences research. In 2003 this expenditure was not differentiated.

**Budget execution, 2008**

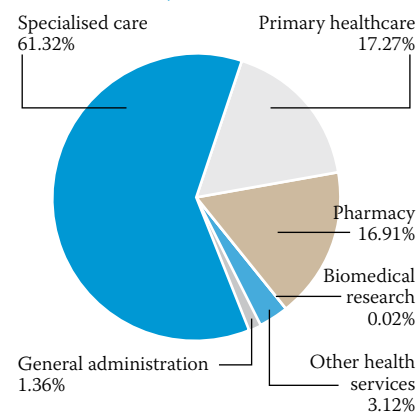
	Approved budget	Final budget	Itemised expenses	% of execution
I. Staff salaries	1,857.27	2,050.49	2,037.07	99.35%
Goods and services	765.57	762.80	754.48	98.91%
Purchases of services	4,326.78	4,331.36	4,330.51	99.98%
II. Purchases of goods and services	5,092.35	5,094.16	5,084.99	99.82%
Pharmacy	1,698.88	1,518.88	1,518.76	99.99%
Other services	42.05	42.30	41.74	98.67%
Public companies and consortia	14.28	14.38	14.35	99.79%
Other current transfers	17.62	18.24	17.59	96.48%
IV. Current transfers	1,772.83	1,593.79	1,592.44	99.91%
<b>Total current operations</b>	<b>8,722.46</b>	<b>8,738.44</b>	<b>8,714.50</b>	<b>99.73%</b>
<b>Total capital operations</b>	<b>221.39</b>	<b>284.01</b>	<b>263.82</b>	<b>92.89%</b>
<b>Total financial operations</b>	<b>1.24</b>	<b>1.24</b>	<b>0.88</b>	<b>71.05%</b>
<b>Total budget</b>	<b>8,945.09</b>	<b>9,023.70</b>	<b>8,979.20</b>	<b>99.51%</b>

In millions of euros.

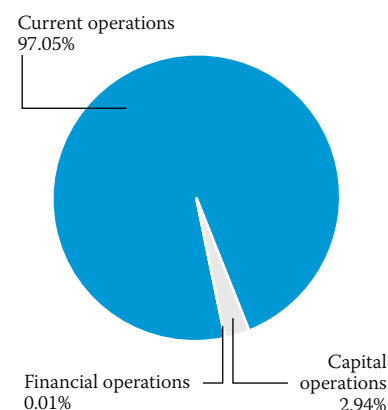
**Evolution of the CatSalut budget, 2003-2009**



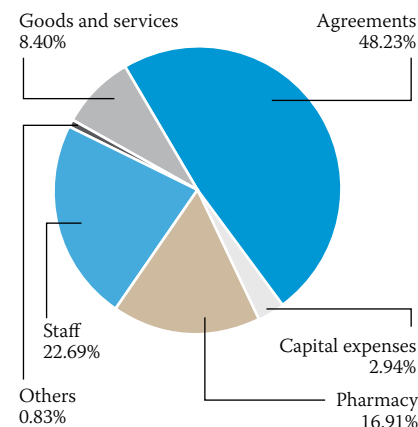
**Functional structure of consolidated expenses CatSalut/ICS, 2008**



**Structure of consolidated expenses CatSalut/ICS, 2008**



**Economic structure of consolidated expenses CatSalut/ICS, 2008**



# Guaranteeing the improvement and modernisation of the public network of healthcare facilities

## The Horizon 2012 Plan

The Horizon 2012 Plan will allow the in-depth modernisation of the network of healthcare facilities that Catalonia needs. It also responds to a Plan of investments in healthcare facilities for the period 2004-2012 which is the result of the public desire of the Department of Health to give a response to the population's health needs, included in the Health Plan for Catalonia and envisaged in the planning instruments (Healthcare map, master plans and strategic plans), in order to improve healthcare across the entire region in terms of accessibility and proximity, and also increase the capacity for resolving problems and the care provision quality of the network of healthcare facilities for public use.

In this sense, the Horizon 2012 Investments Plan is a planning instrument that, in accordance with the health needs detected and the priorities determined by healthcare regions, establishes the actions that have to be developed in order to:

- Facilitate access and ensure proximity of services, regardless of place of residence and socioeconomic level, so that people can resolve most of their health problems near to their residential environment.

- Respond to current and future needs in accordance with demographic changes, the increase in people dependent upon care and the priorities established in the Healthcare Plan.

- Consolidate the network of public healthcare facilities by improving and modernising existing infrastructures, increasing effectiveness and efficiency through the incorporation of new diagnostic and information-system technologies.

In December 2008, the Horizon 2012 Investments Plan envisaged 947 investment actions worth a total value of 5,323.9 million euros. Of these, 128 actions (13.5% of the total) are at the design stage, 113 actions (11.9%) are under construction, and 490 have already been completed (51.8% of the total).

## Most important actions in 2008

In 2008, a total of 80 investment actions were completed: 24 new facilities and 56 actions to expand and improve existing facilities, which led to the launch of 21 new healthcare centres and 3 new mental health facilities. Moreover, construction was underway on 53 new healthcare centres and 5 new hospitals (Sant Joan Hospital in Reus, Sant Pau Hospital in Barcelona, the hospitals in Mollet and Sant Boi de Llobregat and the Hospital del Baix Llobregat in Sant Joan Despí).

It should be mentioned that 57 new healthcare centres and 4 new hospitals (the Hospital Dr. Trueta in Girona, Montcada i Reixac Hospital, and the Granollers and Tàrraga proximity hospital) were at the design stage. The designs of two hospitals are now complete (the Cross-Border Hospital in Puigcerdà and the Hospital de la Garrotxa in Olot) and building work will start in 2009.



Design project of the Cross-Border Hospital of the Cerdanya



Salt-2 Primary Healthcare Centre (CAP)

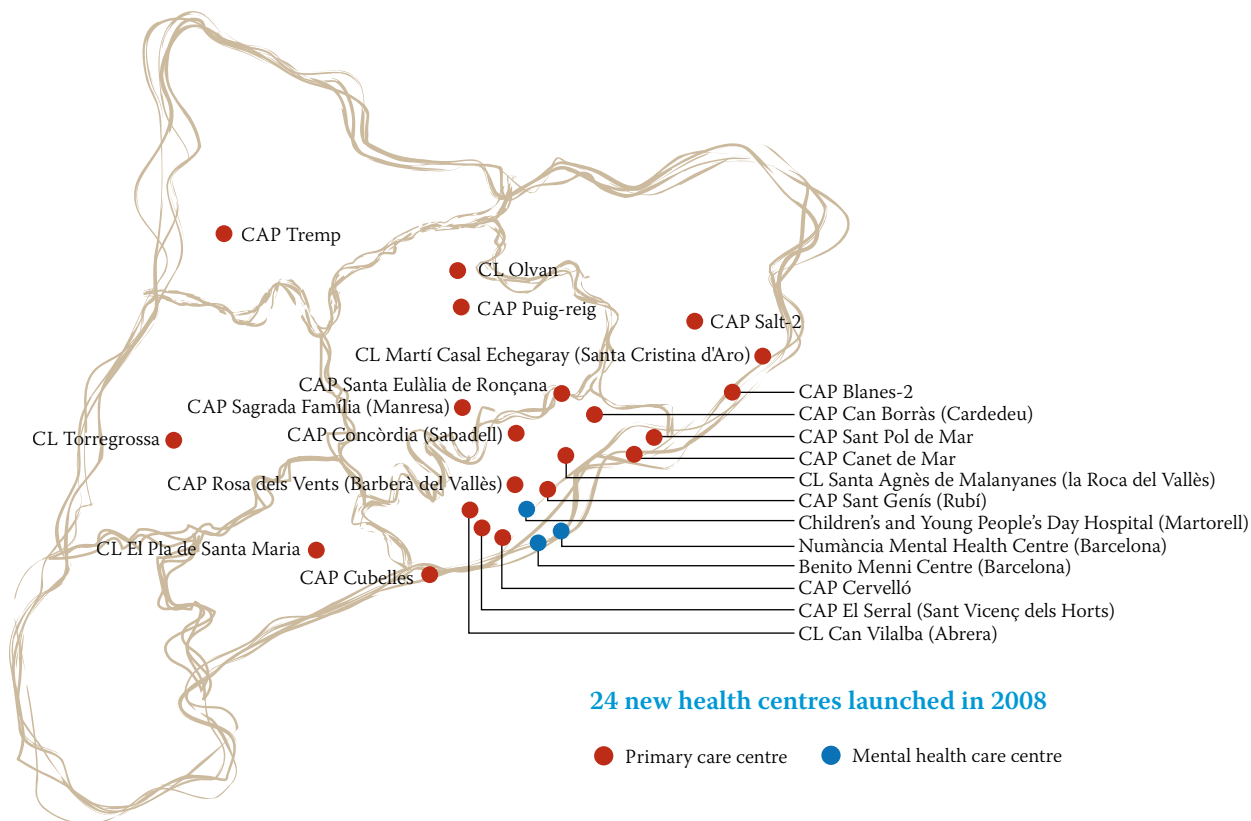


Sagrada Família (Manresa) Primary Healthcare Centre (CAP)

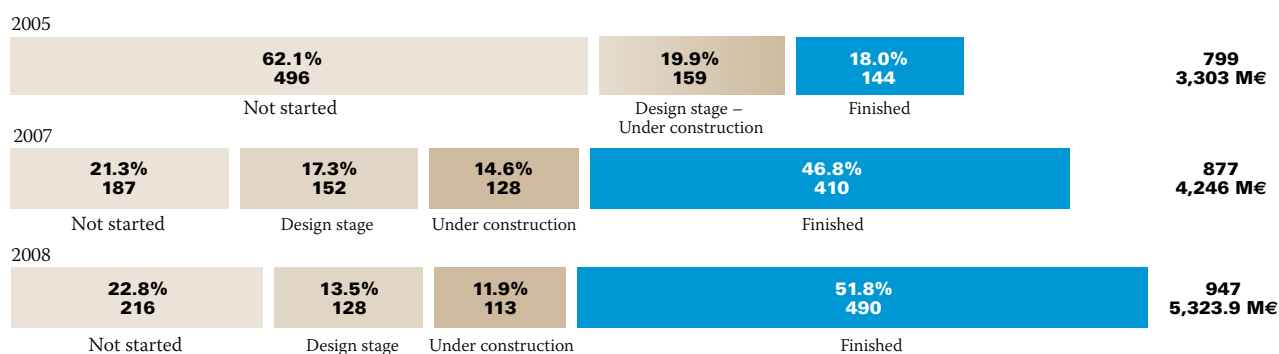


Hospital de la Santa Creu i Sant Pau (Barcelona)

### Investments in facilities. Horizon 2012



### Execution of investments in health facilities. Horizon 2012



	Not started	Design stage	Under construction	Finished	Total	M€
Primary healthcare	138	81	68	194	481	1,030.7
Hospital	67	41	37	257	402	3,858.4
Social care	8	2	4	15	29	278.6
Mental health	3	3	4	19	29	147.6
Other	0	1	0	5	6	8.6
<b>Total</b>	<b>216</b> 22.8%	<b>128</b> 13.5%	<b>113</b> 11.9%	<b>490</b> 51.8%	<b>947</b> 100.0%	<b>5,323.9</b>

# Ensuring service quality, regional proximity, accessibility, coordination and the healthcare continuum

## Results Centre

During the year 2008, the document *Information bases for the Results Centre of the Public Use Healthcare Network (XSUP)* was prepared, which establishes the conceptual framework, the principles of action and methodology of the functioning of the Results Centre.

The work involved in gaining consensus with the agents involved regarding the information that should initially be included in the Results Centre has configured a first set of indicators for gathering and analysing data. The definition of these indicators has also been included in the document *Information bases of the Results Centre of the Public Use Health Network (XSUP)*, which was approved in December 2008 by the Management Board of the XSUP Results Centre, which is the professional governing body whose members include representatives of the Public healthcare administration and of organisations and associations of service providers for the public provision healthcare system.

It is envisaged that the first data will be available in 2009, in order to progress towards the aim of measuring and evaluating the results of the agents of the Public Use Healthcare Network and placing within its reach the information necessary for the improvement of results and of service quality.

## Evaluation of purchases of healthcare and social care services

To guarantee quality public healthcare cover, CatSalut purchases and evaluates healthcare and social care services according to the population's health needs (established by the Health Plan) and acts as a guarantor of the healthcare services provided in order that healthcare, economic and human resources are at their service with criteria of fairness, quality and efficiency.

One of its basic strategic lines consists of the evaluation of the results of care processes of the healthcare and social care services that are purchased.

In the sphere of healthcare, CatSalut has the duty to ensure that the healthcare and social care services made available to the public contemplate achievement of these objectives. To fulfill this mission, it uses a tool for dealing with service providers, the service contract. This contract allows specification, during the process of purchasing services, of care objectives that follow the general lines established and adjusted to the specific realities of the population and the services in different regions.

Through this contractual relationship, service providers take on the commitment to provide people with quality healthcare. While exercising its functions as purchaser of services, CatSalut is responsible for assessing this healthcare through the evaluation of the results of the healthcare process and the performance of service providers with regard to their contacts. Also, the information and results of this evaluation allow the objectives of services purchasing to be reoriented, and also provide elements for evaluation through the setting or modification of more general healthcare policy objectives.



**The mission of the Results Centre is to measure, evaluate and disseminate results achieved in the healthcare sphere by the different agents forming part of the public healthcare system, to facilitate joint decision-making at the service of the quality of the healthcare provided for the people of Catalonia.**

# Promoting continuous improvement of organisational quality

## Information systems, IT architecture and communications network

CatSalut has continued to develop information systems in order to adapt to new and specific needs of the organisation and support the functions of analysis and evaluation, thus facilitating management and decision-making. Progress has also been made in the design of the new information system for managing healthcare waiting lists which includes external consultations and has to develop a model for the management and administration of patient flows. Also, new healthcare registers have been unveiled, such as those monitoring noscomial infections, second opinions, antimicrobial, treatments with cytostatic drugs, patients attended by the Acute Myocardial Infarct Code and inter-cultural mediation, among others. There have been improvements in the functionalities of the electronic prescription system, in workstation management of service providers and pharmacy offices. Progress has also been made in integration with Department of Health applications to validate activities invoiced to third parties.

Work is also being carried out on promoting electronic access to public services in the health sphere. Here the objective has been achieved of accessing interoperability services which mean that people do not have to bring the public Administration any data or documents that can be obtained by telematic means.

## Quality and internal communication plan

This Plan helps to review policies and instruments of CatSalut's internal communication and quality alike and to produce the corresponding improvement plans in order to push forward new actions that respond to the organisation's needs in these spheres. During the year 2008, information sessions were held regarding healthcare for immigrants, cancer tendencies in Catalonia and consequences for oncology services planning, healthcare planning and geographical accessibility to health services, the 2006 health survey (a new look at the population's state of health), telemedicine in real time, the new mental health and addictions portfolio in primary healthcare, development of the regional health administrations and the

model for citizen participation and innovation in the Administration.

Work teams have been identified, made up of professionals from different levels, and their superiors, and practical workshops were held on leading these teams in order to link their activity with CatSalut's general projects. As for *Flaix*, the internal CatSalut newsletter, work has been carried out on new contents to generate a more dynamic *Flaix*.



## Public companies and consortia

With regard to the management of public companies and consortia during 2008, of note was the creation of the sub-commission for the new accounting plan in the healthcare sector. This is to define the document containing the terms of execution of the budget of public organisations, mercantile companies, consortia and foundations that depend on the Department of Health and CatSalut. In relation with the Catalan Government's cash pooling system, during this year and as forecast, the totality of remaining public companies and consortia have joined the system.

In early January 2008, the first new Trustees Board was constituted since the Spanish Government transferred to the Catalan Government the Hospital Clínic i Provincial de Barcelona through Royal Decree 1276/2007, dated 24 September. In this same sense, progress is being made with the incorporation of the Catalan Health Institute and the Hospital de la Santa Creu i Sant Pau Healthcare Foundation into the circuits and dynamics of the rest of the public companies and consortia of CatSalut.

With regard to the Municipal Healthcare Institute (IMAS), there has been successful continuation of the work by the mixed commission entrusted with making effective the Catalan Government's majority stake within this consortium and the change of statutes from January 2010.

Over this year the now customary conferences were given for presidents and managers of public companies and consortia, in which the strategic objectives of the Public Companies and Consortia Management Board were presented, especially focusing on the improvement in governance of the organisations and the structuring of mechanisms for adjusting standards to the reality of the health sector.

### Public companies

Institut de Diagnòstic per la Imatge (IDI)
Energètica d'Instal·lacions Sanitàries, SA (EISSA)
Gestió de Serveis Sanitaris (GSS)
Institut d'Assistència Sanitària (IAS)
Gestió i Prestació de Serveis de Salut (GPSS)
Sistema d'Emergències Mèdiques, SA (SEMSA)
Agència d'Avaluació de Tecnologia i Recerca Mèdiques (AATM)
Institut Català d'Oncologia (ICO)
Banc de Sang i Teixits (BST)
Parc Sanitari Pere Virgili (PSPV)

### Consortia

Corporació Sanitària Parc Taulí de Sabadell
Consorti Sanitari de Terrassa
Consorti Sanitari de Barcelona
Consorti Hospitalari de Vic
Consorti Sanitari Integral
Consorti Sanitari de l'Alt Penedès
Consorti Sanitari de l'Anoia
Consorti Sanitari de Mollet del Vallès
Consorti del Laboratori Intercomarcal de l'Alt Penedès, l'Anoia i el Garraf
Consorti Sanitari del Maresme
UDIAT, Centre Diagnòstic, SA
Corporació de Salut del Maresme i la Selva
Consorti Sanitari de la Selva
Fundació Privada Hospital Transfronterer de la Cerdanya



# Incorporate regional representatives into the governability of the health system

## Regional healthcare administrations

The Catalan public health system decentralisation model is inspired by values of regional proximity and participation, which materialises in the creation of a coordination framework for local and autonomous governments through the constitution of shared government structures in the region called *regional healthcare administrations* (GTS), which define a relational governance model that incorporates the different agents responsible for providing health and social services, as well as local people and the organisations that represent them. The aim of each GTS is to reinforce the adaptation of healthcare policies and the offering of healthcare and social services to people's needs and the peculiarities of each region. To achieve this objective, the basic function of the GTS is the organisation, prioritisation and coordination of the region's resources with the aim of ensuring effective provision of the health system's portfolio of services.

**61.3% of municipalities (580) and 59% of the population (4,427,625) are already integrated into the 22 constituted regional healthcare administrations.**

During 2008 an important boost was given in the phase of deployment of the regional healthcare administrations and 10 new GTS were constituted, so that by the end of the year there were 22 of the 37 planned:

Barcelona Ciutat (healthcare consortium already constituted)

Val d'Aran (healthcare consortium already constituted)

### 2006

Osona (26 September 2006)

Garrotxa (26 September 2006)

Baix Vallès (16 October 2006)

Garraf (24 October 2006)

Alt Urgell (24 October 2006)

### 2007

Lleida (6 February 2007)

Baix Llobregat Litoral (13 March 2007)

Baix Camp (4 December 2007)

Montsià (4 December 2007)

Baix Empordà (4 December 2007)

### 2008

Bages-Solsonès (29 January 2008)

Berguedà (5 February 2008)

Baix Llobregat Nord (8 April 2008)

Baix Montseny (15 April 2008)

Alta Ribagorça (29 April 2008)

Ripollès (3 June 2008)

Pallars Jussà-Pallars Sobirà (26 August 2008)

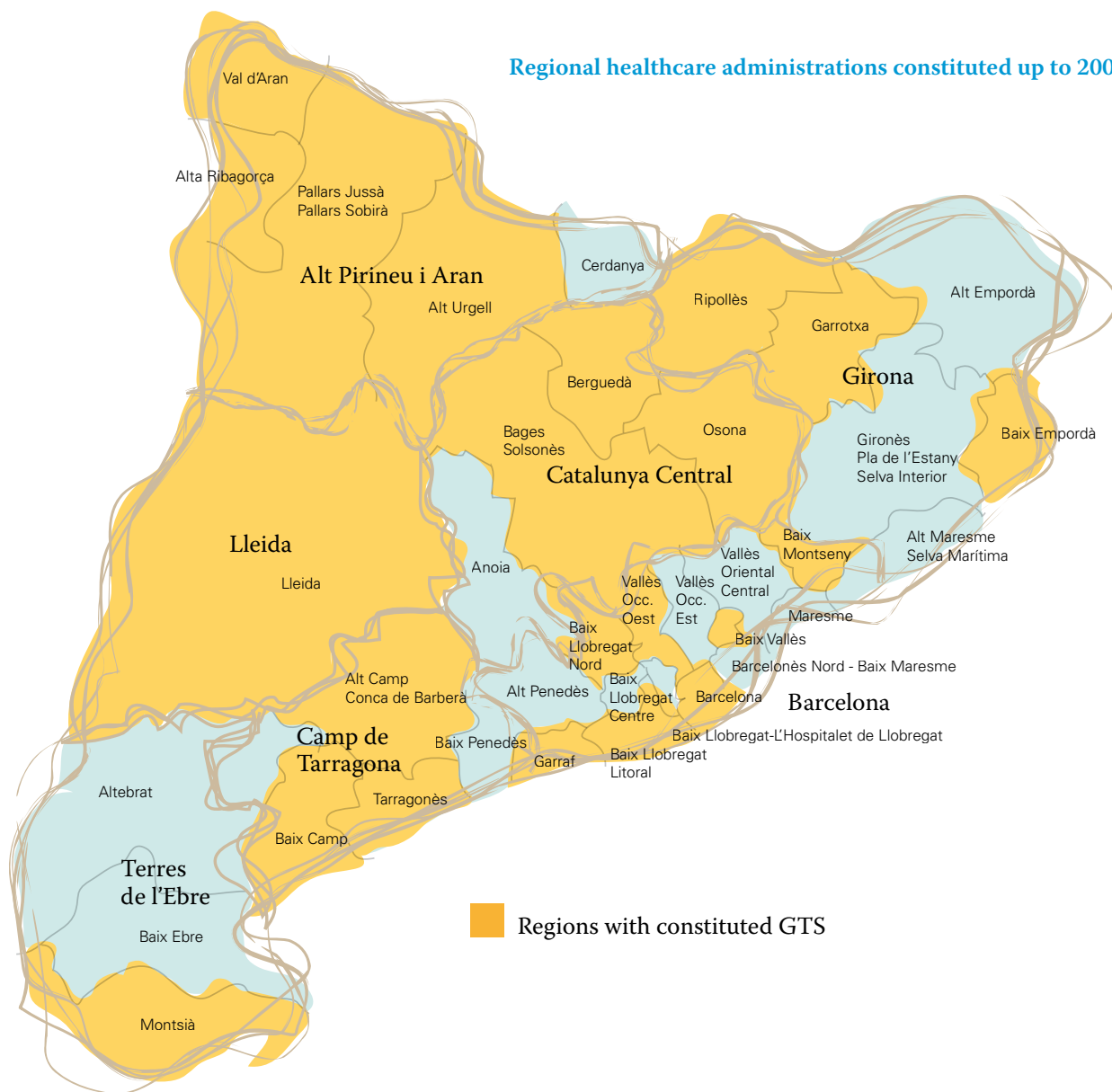
Vallès Occidental Oest (21 October 2008)

Alt Camp-Conca de Barberà (18 November 2008)

Tarragonès (23 December 2008)



Regional healthcare administrations constituted up to 2008



# Promoting the active participation of professional healthcare workers

## Catalan healthcare human resources policy

Throughout the 2008 financial year there has been consolidation of the economic aid effected via CatSalut to contribute towards the application of the improvements envisaged in the 7th collective bargaining agreement of the XHUP and arranged primary healthcare centres and to make effective the equalising of working conditions in the sector of reference. These new agreements mean equality in working conditions throughout the public liability network, with a target set in 2010 for the mental health network and the social care network.

As for the process of cost analysis of the 7th Collective Agreement, improvements in the public use hospital network and arranged primary healthcare centres, the process of analysis and verification of costs of the agreement improvements has been carried out, in order to comply with the requirement established in the Government Agreement authorised by the Department of Health to give support to the application of commitments acquired in the

negotiation of the working conditions of professionals in the arranged public use healthcare network and in the additional clauses of the services purchasing contracts for the corresponding care lines.

## Committees of professionals in the healthcare regions sphere

Within the framework of the promotion and structuring of the participation of healthcare professionals in the regional structure of CatSalut, professional committees have been set up in the healthcare regions of Lleida and Girona, with representation of medical and nursing staff who offer their healthcare services in the different healthcare provider organisations in the territory.

The aim of these committees is to make professionals participants in the identification of issues or needs related with the profession in the regional sphere, debating and formulating proposals, informing about plans and actions of the Healthcare Administration, and advising on planning and forecasting questions.

## Human resources information system for the public provision healthcare sector

Given the need for sufficient and updated information on the workforces of staff equivalent to the healthcare professionals of centres and services that configure the public provision healthcare network, an information system has been launched which is fuelled by the centres. This should allow a response to be given to such needs as operational planning, purchasing, financing and evaluation of services, while informing and attending to requests made from different units and bodies in the Healthcare Administration.

## Support for councils of medical and nursing professions and participation in them

Support and advice is maintained for the councils of the medical and nursing professions and active participation in them, with the ultimate aim of cooperating to better the working and professional conditions of medical and nursing staff. Along these lines, work has continued on such issues as professional demography, participation, continuing professional development, remuneration, time management, reconciling work and family life, image and leadership, among others.



# Encouraging active participation of patients and those closest to them

## The regional healthcare administration health councils, regional citizen participation

The regional healthcare administrations contribute towards taking decentralisation and participation in the health system further with the incorporation of the voice of the people. One of the tools conceived with the aim of improving community participation, humanising services and improving individual and collective health are the regional healthcare administrations' health councils.

The health councils are bodies for citizen participation for advice, consultation, supervision and monitoring of the activity of the regional healthcare administrations. The decree creating the regional healthcare administrations regulates the essential principles of their functions, composition, presidency and other aspects of a general nature. It also stipulates, for each regional administration, that an internal set of standards will regulate the health council and its relations with the advisory council.

Moreover, incorporating the voice of the people necessarily demands the existence of a model of deliberative participation based on prior planning and quality control criteria. With the collaboration of the Cata-

lan Government's General Board of Citizen Participation, 28 regional studies of organisations have been carried out (agent maps), which have served initially as a guide for choosing the most representative organisations of citizens in each region.

The objective is to achieve by 2010 the development of 52 health councils across the whole of Catalonia. The city of Barcelona, which already has a certain tradition in participation, currently has nine health councils. In 2008, the health councils constituted in this initial phase were those of Osona, Baix Llobregat Litoral and Noguera (Lleida). A total of 36 organisations have participated in them, representing a broad variety of professional health associations, trade unions and employers' organisations, user groups and neighbourhood and civic associations.

**In 2008, eight meetings of regional healthcare administration participation councils allowed direct listening of the voices of 215 associations and organisations from around Catalonia.**



