ThiNKTANK
High Level Group

Analysis of Public Investment in Healthcare in Spain

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PANEL DE EXPERTOS

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The members of the panel of experts are not necessarily in agreement with all the questions analysed. This document has been prepared with the contributions of those experts and reflects their different visions and opinions, and some of these may not coincide with the unanimity of the members.

Positioning, considerations and final conclusions reached

Every day the National Health System (SNS, as per the Spanish acronym) faces the challenge of responding to the health needs of the Spanish population in a complex situation of continuous transformation. While needs increase every day, the resources with which to tackle them are not increased accordingly or even diminish from one year to the next.

Along with the challenges faced by the SNS in the immediate future; the transformation of the system to attend chronic patients, the effective arrival on the market of innovative products and technology, the recognition and involvement of the professional as a key piece of the system, participation, education and training of the patient as central to the SNS; we find the difficulty of managing the public health system with economic resources that in recent years have shown a deficit.

In recent years, Health budgets have suffered significant adjustment. In 2015 the relationship between public health expenditure and GDP in Spain was 5.7% compared to 5.9% in 2014 and 6.7% in 2009. In the period from 2010 to 2014 the budget of the Autonomous Communities destined to Health has fallen by some 11.2%.

In addition, according to Spanish Government forecasts, it is not expected that the public health expenditure will increase beyond 6.5% of GDP before 2020 (the figure reached in 2010).

In other neighbouring countries, the average spend on Health in the year 2012 (the last year for which official data are available) in respect of GDP was in the region of 7.5%.

At this juncture, and coinciding with the 25th anniversary of the publication of the Abril Martorell Report, Fundamed decided to bring together a group of high-level experts to analyse the measures that might be adopted by the SNS to preserve its future sustainability and its internationally recognized level of quality.

Fundamed organized the debate in two blocks of questions; one relating more to care; intended to try establish a series of measures to implement in the short to medium term to achieve better planning of available resources in the system and more efficient management thereof; and a second block that deals more with the economic and financial issues in an attempt to reach agreement on the optimum investment to guarantee the sustainability of the SNS.

The major conclusions reached by this group of experts are then compiled. In general terms, the debate can be summarized by the need to plan resources from a position of coordination and consensus between different Autonomous Communities (ACs), with the

involvement of professionals, and distributing budgets on the basis of real needs identified during the planning phase.

In short, these are the conclusions drawn from the debate and analysis carried out by the panel of experts:

- Need to **review and re-evaluate the SNS package of services**, both for the inclusion of new procedures, technologies or pharmaceuticals that have shown their efficiency and the divestment of those that are considered obsolete. This review should always be carried out with the coordination and consensus of all the Autonomous Communities.
- **Plan and forecast the future requirements of the system to carry out an adequate distribution of resources**. Use and share the abundance of information available in the system to foresee those upcoming budget requirements in such a way that innovation, the adaptation of health structures to changing morbidity patterns, etc. may be planned. Thus a stable regulatory framework may be established; one that favours research, innovation and more efficient management.
- **Involve and recognise health professionals**. All of the experts on the panel share the experience of having worked professionally in Health Management. Any change made in the SNS can only have its full affect with the participation of the professionals. This carries with it the need to publicly recognize their involvement, not only from an economic perspective but by applying a model of recognition in different ways.
- **Enabling, education and participation of the patient**. The need to rely on an educated patient, who is responsible with their illness and participates actively in managing their pathology and in the system in general, is one of the challenges to be tackled. The chronic nature of many pathologies, meaning that patients live with their illness for many years, makes the need to rely on an educated and informed patient ever more important.
- **Focus on prevention and early diagnosis**. It is the opinion of the experts that a coordinated, consensus-based effort on the part of the Autonomous Communities, focusing on prevention that has been proven to be effective (as in the case, for example, of vaccination) and early diagnosis, in which the Scientific Societies also a have a key role to play when it comes to determining criteria, at risk groups and tests to be carried out.
- **Increase the percentage of GDP invested in Health**. All the experts agree that Health needs further economic resources at its disposal, for which they call for an increase in the percentage of GDP invested in Health to 7.5%, bringing Spain into line with neighbouring countries.

- **Reduce the disparity between Autonomous Communities in terms of Health spend per capita**. The experts believe that the existing disparity (500 euros between that which invests the most and that which invests the least) in health spend per capita between some Autonomous Communities is excessive and does not help cohesion and equality in the SNS. Additionally, these differences are due in great part to the System of Financing of the Autonomous Communities and that these disparities must be addressed and corrected.
- **Need to reform Spanish tax system** to provide more budget resources for Health. In this case, proposed solutions included greater self-management of the Autonomous Communities; a greater say in the distribution of tax revenue; serving the real population base of each Community adjusted for age; the use of effective forms of interregional transfers; involvement in care coordination between Autonomous Communities or a specific financing structure for essential units and services.
- **To act based on coordination, consensus and dialogue between Autonomous Communities and the Spanish Government**, taking into account not only Health administration but also other departments and the Ministry of Finance.

Executive Summary

1. Identification of the healthcare needs of the National Health System.

Issues under analysis	Summary of conclusions reached
1. **Healthcare provision** by the National Health System	Service portfolio must be reviewed and updated on a permanent basis. An analysis to detect those services lacking clinical significance owing to their being obsolete must be carried out so as to divest in such services while new techniques or medicinal products which have proven effective are incorporated to the system. Such assessment and decision-making must be carried out in a consensual and coherent manner throughout the whole of the national territory in order to preserve equality and coordination within the SNS. Prevention is highlighted as keystone of the SNS in the future. Investing in prevention policies which have proven highly efficient, such as immunisation campaigns, must be an obligation for current health systems. In addition, early diagnosis may entail greater costs in the short term but a significant cost reduction in the medium term, not to mention the undeniable benefit that comes with early diagnosis for the prognosis of many diseases.

Cuestiones analizadas	Sinopsis de las conclusiones alcanzadas
2. SNS resources: how to adapt them to future needs.	The SNS has, in some cases, an obsolete **cost structure** and certain organisation or governance obstacles. In addition, there also are major challenges which need to be approached by the SNS, which require an **adaptation of its structural features**: a system that is no longer as focused on acute care and **instead targets chronic patients**, who involve **greater costs for Public Administrations**; the popularisation of lighter hospitals, with not as many beds; shorter average stays, more outpatient procedures not requiring hospital admission... More investment is required in **IT** favouring the use of **telemedicine**, as well as training healthcare professionals in chronic care, developing registries of patients with the highest morbidity, rearranging infrastructure so as to **provide care to elderly patients**, and providing training to caregivers. As for human resources, changes in the SNS can only be achieved with the **involvement of professionals**. **Effective pay for performance** is necessary, but such involvement must not only be rewarded in such a way, but a **more comprehensive reward system must be implemented**.
3. The role of **patients** in the future of SNS	Nowadays patients are **more active, better trained and more willing to participate in decision-making processes**. In addition, patients must be aware that they are highly responsible for their own health condition. Patients are **entitled to all of the information available about their disease and its therapies. Arrangements should be made for patients to be part of the strategic or assessment planning decisions made** regarding healthcare technologies.
4. Planning the future of SNS	SNS has sufficient **information to carry out a predictive analysis on the future needs of the SNS**. Building on information on demographics, morbidity and mortality, **the planning and distribution of resources can be carried out in a more realistic manner**. One of the challenges of the SNS for the oncoming years will be how to incorporate innovation to the system. For such innovation implementation to be possible, **coordination and efforts must be joined among all of the involved administrations**: Autonomous Communities, the Ministry of Health, Social Services and Equality and the Ministry of Finance. Innovation will not arrive by surprise, and this is why planning is possible as long as it is driven in a coordinated manner. A **stable framework is essential to foster investments in innovation**. As for the different management approaches of public health systems, it is agreed that administrators must endeavour to provide patients with all resources available within the system for a better and free-of-charge healthcare system. For the partnership between public and private health to be efficient and beneficial for patients, as well as to stand for the universality and equality inherent to SNS, **decision-making powers must be assigned to public administrators**. Highlight must also be given to **transparency and the assessment of results of certain models against others**.

2. Identification of the economic and financial needs of the National Health System.

Issues under analysis	Summary of conclusions reached
1. Which **percentage of the GDP should be used to fund Public Health**	Linking investment in health with the GDP involves the risk that, in times of crisis, the GDP may drop. The course of action for such an event should be determined beforehand. Ideally, investments should be made proportionally to the resources available and the actual needs of the system. EU countries, comparable to Spain in terms of economic and demographic features, invest an average of 7.5% of their GDP on their healthcare systems (OECD 2014 data regarding 2012). Bearing in mind that the proportion between GDP and investments in public health care in Spain is 5.9%, Spain should allocate an additional 1.6% of its GDP to fund the SNS so as to reach the European average.
2. How to solve the **Healthcare budget deficit** issue	The theory is quite simple: balancing revenue and expenditure. There is not much we can do with expenditure. A better, greater planning is required so as to properly distribute resources. However, actions can be undertaken with regard to revenue in order to contribute to revenue-expenditure balance. In this regard, a reinforcement of the tax system is proposed so as to obtain a GDP share resulting from tax revenue that is in line with EU averages. In addition, for budgets to better adapt to the SNS reality, cycle or multiannual budgets are suggested so as to contribute to a greater flexibility when approaching the needs of the Spanish public healthcare system.
3. The **differences between the expenditure per capita in Autonomous Communities**	The differences between healthcare expenditure per capita between Autonomous Communities are, in some cases, too remarkable and could jeopardise equality within the SNS. The solution would involve greater self-management capacities for Autonomous Regions or greater participation in tax revenue, according to the actual population base of each region and the age thereof, and to enhance coordination between autonomous regions; using inter-regional transfers and specific funding for services and units of reference.
4. **New funding approaches** for public healthcare	Experts believe that tax revenue is the only funding alternative, so they insist in the need to remodel the Spanish tax system so that tax collection levels with respect to GDP and the tax collection system reach the average of the surrounding countries. As for the possibility of the healthcare system returning to a targeted funding, there are different opinions: some believe that revenue and expenditure should be considered as a whole and administrators should be offered the possibility of providing budgets according to the needs at each moment; some others believe that a specific targeted funding is necessary for the SNS, and some others find that circumstantial budget items or those beyond a local/regional level (immunisation campaigns, rare diseases, large innovations...) should be assigned targeted budget shares.

Principal measures to be adopted in the short/medium term by panel of experts of the Think Tank

- **Identify those services and provisions that do not add clinical value and stop financing them.**
- Implement **clinical management processes** ensuring real development between the management and clinical spheres.
- Implementation and **real use of new Information and Communication Technologies (ICTs)**. It is essential to exploit these for the management and planning of health information systems and connection between them.
- Develop **self-management** in the form of clinical management units, or self-management in medical centres; in such a way that the professionals themselves become managers and are involved in sustainability in their areas.
- In the area of **health planning**, to be proactive in implementing measures for the treatment of chronic illnesses, fundamentally in the management of cases, the real implementation of telemedicine and the monitoring of patients with risk factors.
- **Measure results and costs** of what has been done in Health.
- Institutionalize and expand **assessment of the efficiency of health technologies** and **introduce economic assessment on a practical and regulated basis**.
- **Introduce patient responsibility** and personalized budgets.
- Implement measures for the coordination of **health and social services** with short term returns.
- In the area of **Human Resources**:
    - Implement a **real, efficient and transparent system** of performance related pay. The performance objectives must be clear, stimulating and realistic, and serve to involve the professional in the organization and cover a variable part salary of approximately 30%.
    - Include **non-monetary incentives** for productivity and work done well.
    - Attractive **professional career**.
    - Improve the salaries of professionals, while always maintaining peer review.
    - **Professionalize health management and improve governance at all levels** of the health system, developing the principles of professionalization, transparency and accountability.

- In the area of **pharmaceutical policy**:
  - Definitively reach a **stable and lasting agreement** between the industry and the Administration.
  - **Availability of centralized orders to encourage innovation**.
- With regard to **public health**:
  - Develop programmes for **health education, screening and early diagnosis**.
  - Further adapt the use of **vaccines** and introduce an adult vaccination programme, especially for those aged 55 up.
- In **economic-financial** terms:
  - Establish **budgets based on forecast costs of activity**, with consideration for the population to be treated, adjusted for the complexity of prevalent pathologies, age, etc. in addition to referral units to be maintained, variations for the eventual free choice of patients or referrals to or from other Centres or treatment systems.
  - Increase the percentage of GDP destined to financing the SNS.
  - **Reinforce the tax model** to increase available revenues.
  - Centralize decisions and break with budgetary silos. Interconnect budgets from the different health spheres.

Introduction

Every day the National Health System faces the difficulty of how to address the new challenges involved in the management of Health in Spain.

The need to adapt to an ageing population and increasing chronicity; the difficulty of flexible adaptation to pharmaceutical and technological innovation; the complexity of managing the system's human resources, the obligation to innovate in management to achieve greater efficiency of resources, the opportunity to rely on a more educated, trained patient and the problem of scarce resources to cover the demands of the system, are some of the challenges to be faced by the administration and managers.

To address these future challenges, the first necessary step is planning. Forecasting the system's most immediate needs and the distribution of the available resources accordingly will account for a great part of the success of this adaptation process of the health systems to future challenges.

This planning must benefit form the opinion and involvement of professionals, both managerial and clinical staff as that they are the ones who have the greatest information regarding the health needs of the population.

If we are capable of good planning, the task of preparing budgets and assigning resources will be much simpler and will be better suited to the reality faced every day by health managers.

In respect of the financial resources available, it must be remembered that in recent years, in which the economic situation has forced the adoption of a number of important adjustments in public budgets, health budgets have particularly suffered in this regard. This situation has been aggravated by the recession and the adjustments that administrations have been forced to apply to public expenditure budgets, and in which Health has suffered important cuts to investment.

In 2015 the relationship between public health expenditure and GDP in Spain was 5.7% compared to 5.9% in 2014 and 6.7% in 2009.

In absolute terms, in the period 2010 - 2014, the years in which the greatest adjustments were made due to the recession, the budget for set aside for Health by the Autonomous Communities has fallen by 11.2%.

The update to the Stability Programme of the Kingdom of Spain 2015-2018, approved by the Spanish Government at the end of April 2015 does not forecast that expenditure on health will exceed 6.5% of GDP before 2020 (figure reached in 2010). From 2020, a gradual increase is expected, reaching 7.8% of GDP in the year 2060. By this date, 2060,

according to the demographic forecasts of Eurostat, more than 31% of the Spanish population will be aged over 65 and more than 14% octogenarians (at present over 80s represent in the region of 5%).

However, the National Health System must be capable of combining this budgetary scenario with the obligation to respond to the health needs of the population with the best possible quality. Some growing needs that are particularly important in light of the demographic evolution, which in spite of the global decrease in population, sees older age segments continuing to rise; chronic nature pathologies, the emergence of innovations disruptive to prevention, diagnosis and treatment of pathologies, changes in morbidity patterns and, definitively, the need to adapt the structures of the SNS based on the past to cover the challenges of the future.

Objective

The objective of this work is to prepare an analysis document that compiles all the measures and reflections for a correct preparation and adaptation of the SNS to the needs and requirements of the future population; in such a way that quality health treatment can be guaranteed as one of the backbones of the welfare state.

For that, we hosted an intellectual debate at the highest level; with a group of experts with experience from the different spheres that affect the SNS, to prepare an independent report that tackles the question from different perspectives and adds value to the debate around the public health system.

Survey put to the members of the working group

Identification of the healthcare needs of the National Health System

1. Do you believe the Abril Report, on its 25th anniversary, remains relevant?

Preliminary Considerations

The Abril Report was published in 1991, the year in which health transfers from the State to the Autonomous Communities were contemplated and soon after the publication of the Medicines Act. The Report compiles 64 recommendations geared towards improving the management of the human and technical resources of the SNS, ensuring quality treatment and containing or reducing health expenditure.

The Abril Report opted, in its recommendations, for greater decentralization of the system, the possibility of applying the instruments of business management and strengthening the functions of the Inter-territorial Council.

Its proposals, clearly geared toward liberalization, included that the system have the capacity to buy services, and that public hospitals and medical centres might be transformed into state companies that would function subject to private law in addition to its most controversial proposal: the co-participation of the user through charges for specific services and pharmaceutical benefits.

Response of the Panel

The Abril Report provoked an interesting debate that at the time casued a strom in the health sector.

For the first time, and in a consistent manner, the issue of the impossibility of maintaining the viability of the System if it were not reformed was raised.

Some aspects of the Abril Report, in the problems it raised, remain valid, have become chronic or even aggravated. But in 25 years, new needs for the system have emerged, new social and economic conditions that the Abril Report could not have foreseen.

In respect of the recommendations contained therein, the greater number of them have not been completed, in large part due to a lack of support within the health sector itself.

In respect of the citizen's co-responsibility in the financing of the system, no advance has been made, although today there is information available indicating that co-payment is of little use as a financing mechanism. Co-payment for treatment services has proven to be a disincentive for use of unnecessary services but also of necessary ones.

It appears that a new Abril Report is necessary to respond to the current problems of the SNS.

2. Do you consider it necessary to review the SNS's package of services from both the treatment and pharmaceutical perspective?

Preliminary Considerations

In accordance with that set out in Article 2 of Royal Decree 1030/2006, of 15 September, the Basic Package of Services of the SNS is the set of techniques, technologies and procedures encompassing each of the methods, activities and resources based on scientific knowledge and experimentation, through which present heath benefits are implemented.

In the Spanish Constitution, along with the General Health Act and the Cohesion and Quality Act in particular, guarantees health protection, guaranteed health protection, equality and treatment adequate health treatment, to which all citizens are entitled, regardless of their place of residence. For this reason it is important that the SNS be flexible in incorporating further scientific innovations more innovative in clinical practice and that allow for a wider catalogue of health services.

The update of the Basic Package of the SNS must be carried out by order of the Ministry of Health, Social Services and Equality, subsequent to the prior agreement of the Inter-territorial Council of the SNS. Similarly, this must be sufficiently flexible to ensure that public intervention does not constitute a barrier that makes it difficult for users to benefit from scientific and technological advance, guaranteeing that no new technique, technology or relevant clinical procedure is generally made available in the system without a prior assessment of its security, efficiency, cost and utility.

The provisions of the basic package of services shall be financed by autonomous communities in accordance with the transfer agreements and the financing system in place at autonomous community level. Equally, in the ambit of their competencies, they may approve their respective packages of services which must include the Basic Package of Services of the SNS, which guarantees the same to all users.

Response of the Panel

The Package of Services must be continuously reviewed and updated. It is necessary to include new procedures, technologies and medicines that have demonstrated in the appropriate assessment processes, that they add efficacy, effectiveness and efficiency to the resolution of health problems.

At the same time, through this review, the SNS must divest itself of those provisions not considered effective or that may become obsolete or those that fail to offer added clinical value. It is calculated that in the region of 25-30% of clinical procedures add no clinical value .

The current climate, marked by deficits in system financing, obliges us to carry out this review of the basic package of services to assess how it must be financed. Moreover, the package of services must be uniform and equitable throughout all the Autonomous Communities, something which is not the case at present.

The incorporation of new provisions must be carried out with an explicit methodology and by consensus, awarding a fundamental value to the assessment, which must be rigorous, carried out by independent accredited bodies and must take into account the economic element in addition to the technological and therapeutic.

In any case, it must be made clear that talking about review does not always mean a desire to reduce.

3. The SNS health structures bring with them a number of cost structures, established some years ago. Are these structures adequate for the SNS today?

Response of the Panel

The SNS's costs structure is conditioned by the organizational shape of the system, still very focussed on the treatment of acute processes and, save for exceptional cases, poorly equipped for dealing with chronic patients.

The SNS does have great virtues, but also some problems such as the slowness and rigidity of its structures, an archaic costs structure and organisational and governance difficulties.

Today, it must undergo a process of adaptation of these health structures to the demands of the prevalent pathologies, in addition to the need to be more efficient.

The traditional administrative systems have great difficulty in carrying out this adaptation, and they are better addressed by other management systems. Multi provision systems such as the Catalan one allow a great number of providers of healthcare in the public system to have more business-like structures, which provides for greater management autonomy and greater ease when it comes to adapting to different needs.

Today it behoves us to make hospitals "lighter," with fewer beds (due to the reduction of medium-terms stays, the growth in outpatient surgery and the implementation of rapid resolution etc.), greater home health services and better exploitation of ICTs in diagnosis, in the monitoring therapeutic compliance and in continued care.

However, it appears that health policies continue to often focus on infrastructure and, even more so, on the addition of new beds for acute care. In the present situation of contracting investment and the evolution of the patient profile more towards a patient with chronic pathologies, coordination formulae in the area of public healthcare must be studied, as a formula for obtaining more beds for medium and long-term stay. In all Autonomous Communities, beds can be found in the public sector that are not in use and that could be used by the health systems with a minimum provision of resources from the health perspective.

For the sustainability of the health system it would be recommended not to open all hospital structures due for inauguration and that were built in times of the economic bonanza.

In the reorganization or adaptation of the health structures towards more chronic type patients, similarly this must be combined with a greater presence for prevention and health education in the system. This would all mean a different cost structure.

4. Do you believe that patient participation must be fostered in the SNS? How can participation be maximized?

Preliminary Considerations

It is considered that therapeutic non-compliance affects almost half of patients with chronic pathologies and up to 20% of those that suffer from acute illnesses. Studies show that educated and conditioned patients reduce the number of medical visits, show a reduction of complications and the number of hospitalizations and of acute emergency situations, improve therapeutic compliance and, in addition, the number of cases of depression and episodes associated with the disease. There is no doubt, therefore, about the necessity of health promotion in the general population and the empowering of patients to act as experts in the control of their illness. The expert patient should maintain a dialogue with the professionals and defined therapeutic objectives on a shared basis, which can help them know more about their illness and be more responsible in their self-care. Patients

have become professionalized through patient organization, becoming valid stakeholders within the SNS, concious of their rights and responsibilities, as they feel affected by the sustainability of the system, which implies the efficient use of resources.

Response of the Panel

All health managers have said, at some stage, that the patient is the centre of the system. In practice, however, it does not always turn out this way. This report should serve to correct this imbalance and make the patient the centre of the system in a real, responsible and honest way.

Using ICTs and with the support of health professionals, we can achieve more active, better educated and more responsible patient that makes adequate use of the system.

It is necessary to remind the patient that there is significant personal responsibility in the state of one's health and that one can contribute to preserving it by living a healthy lifestyle. The patient must be co-responsible for their health. In this sense, initiatives such as patient schools and the application of experiences in other countries with regard to personalized health budgets. Similarly, it is interesting to look in greater detail at experiences that stimulate adequate use of the health system such as non-attendance of appointments, non-compliance with treatment and even the repeated adoption of unhealthy lifestyles.

In the final instance, where health has been lost, the health system must abandon this paternalistic approach and offer the patient all the information in relation to their illness and the therapeutic measures within their reach and their results, so that the patient can actively collaborate along with their doctor.

Form the management perspective, maintaining a close and fluid relationship with patients' associations gives us more knowledge of their point of view, to inform them and involve them in the strategic decision making process, as they have a right to participate in health planning and the assessment of services as citizens.

Finally, the patient, as a citizen and taxpayer, has the right to know how their taxes are managed, making it important that public managers are held accountable in the forums provided for this purpose with the appropriate frequency.

5. The health professional. How can the professional become involved, as a pillar of support, in these changes faced by the SNS? What role must professionals play within the SNS?

Preliminary Considerations

The involvement of professionals in the sustainability of the National Health System is indisputable for its survival. The economic crisis has seen several debates in this respect. On the one hand, Scientific Societies and clinics have become conscious of their role in this respect and have positioned themselves as guarantors of the quality of medical treatment in the face of the possible adjustments that have been made in health administrations. Added to this, the Clinical Management Units, tools that have been implemented in some SMS centres to a varying extent, have garnered strength and have depended more on will of the professionals than of managers.

Nevertheless, this approach is expected to become more widespread with the introduction of the Royal Decree legislation, expected to be approved shortly, which will offer a broad framework, even if some autonomous communities already have their own version developed. Close to this concept is the debate surrounding economic incentives and the changes to the remuneration model, more centred on performance related pay. Parallel to this, a sense of precariousness has gripped the health professions, with the danger that this would bring with it for a health system that is fundamentally based, in large part, on the good work of its professionals.

Response of the Panel

Any change that is to be carried out in the SNS will only be possible if it can rely on the participation and involvement of health professionals.

The Autonomous Communities have made important efforts to improve staff recognition, however in these times of crisis, and for reasons of survival, health professionals, along with the pharmaceutical sector, have borne the brunt of the cuts to expenditure. This situation means that motivation can, on occasions, flag and it is for this reason along with the demand for greater involvement in management, that it is necessary to make it possible to develop clinical management in medical centres, support training and research capacity, promote the diffusion of these results in the sector and in society and articulate strategies to internally recognise improvements, recognising the professional for what they do and not for what they are.

The real involvement of the professional calls for a change that goes beyond what it might appear to be. This recognition must not be exclusively economic, as there are other ways, such as research bonuses that have an important reputation al effect beyond that of a mere

"bonus." Management, for its part must assume the implementation of a model of recognition that involves a greater responsibility in the control and monitoring of the model and must consider that, in addition to the recognised group, there will be another group that remains excluded with the cost that might involve for the organisation.

Similarly, it is of great interest to establish mechanisms that might allow for comparison between professionals and centres, on the basis of common standards.

The information, transparency and measurement of results will be key when it comes to achieving this involvement. However, it must be borne in mind that it is professionals that must accept and lead the transformation of the sector with managers, and not only as leaders in their clinical capacity but also organizational and management leaders.

6. It is possible to turn early diagnosis into a sustainability tool?

Response of the Panel

The long-term perspective, the social perspective and overcoming budgetary compartmentalisation must be incorporated into all projects taken on by the National Health System. The incorporation of new therapies for Hepatitis C has demonstrated the need to institutionalize the assessment of new health technologies and to recover the idea of comprehensive long-term planning.

Early diagnosis involves greater short term expenditure but a more substantial saving in the medium term. Savings will be made on cancer treatments and transplants. At the same time, as an intervention, early diagnosis must be accompanied by primary preventive intervention for cancer, Hepatitis and HIV.

It results quite difficult to strengthen health policies of this kind when the vision of managers is short term and there is a struggle for budgets with other areas, despite the fact, as signalled, that a greater budgetary effort in the short term on these strategies translates into medium to long-term savings that compensate for the initial effort. The reversal of investment is so important in areas such as hospital, pharmaceutical spend etc.; areas that it is very much worth investing in.

Early diagnosis determines a lot when it comes to influencing a good forecast for serious illnesses such as cancer and chronic pathologies such as heart diseases or those with with great repercussion in the area of mental health.

In the area of early diagnosis, the work of the Scientific Societies is very important when it comes to determining the protocols, both in terms of access for the population in general and in the screening of the at risk population.

7. It is possible to use prevention as a sustainability tool? Is greater investment in prevention policies such as vaccinations adequate?

Preliminary Considerations

Vaccination is a measure that has had an extraordinary impact on the health of citizens over the years. It is worth highlighting that today it prevents more than 26 infectious diseases and has seen a reduction of 49% in the global infant mortality rate between the years 1990 and 2013 according to the World Health Organization (WHO).

With a population over 65 of approximately 8 million, forecasting an increase directly related with life expectancy, it is evident that the Spanish health service systems must continue to evolve to adapt to this reversal of the demographic pyramid of the population, and the challenges that entails such as innovations in attention, care and treatment of different pathologies and greater social awareness.

Response of the Panel

Prevention is always key. Prevention policies must be established with the citizen in mind although it also provides other additional benefits such as reductions in health expenditure.

There are very clear cases in which prevention must be addressed, along with fostering healthy lifestyle habits, such as in pathologies caused by cardiovascular risk, smoking and diabetes. There are even countries where restrictive measures have been applied in terms of access to the health system for citizens that are not responsible with their own health.

It is therefore obvious that there are many processes that cause non-communicable diseases that have preventable aspects.

If we look at vaccination, and in spite of the fact that in some cases there are no uniform criteria among the professionals themselves, the reality is stubborn in this sense, and each vaccine presents a positive cost-effectiveness ratio.

Vaccination is one of the most successful and most efficient public health measures. In this sense, the great challenge of the health systems is to achieve the implementation of a vaccination calendar for adults similar to that which has been implemented for children. In this sense, adult vaccination and above all in the case of those aged over 55 is one of the most efficient strategies for the prevention of illnesses such as the flu and herpes zoster for example.

Investment in prevention must be reinforced in the case of vaccination and, moreover, those that attack it from within and without must be strongly countered.

In any case, prevention must be assessed to establish if expenditure on prevention is the best option possible among all those available. In a number of cases it has been found, in different countries, that certain prevention programmes are not efficient. Too much money is spent on them compared to the results obtained in terms of health.

8. Public-private collaboration: the role of private healthcare in the sustainability of the SNS.

Preliminary Considerations

When we speak of public-private collaboration it is worth pointing out that it is to mean just that. In Spain, when we refer to collaboration between public healthcare and private, we are talking about the management or provision of some services by private healthcare, but financed by the public administration.

In this sense, private healthcare has for years been complementing public health both in terms of services associated with healthcare that are not strictly clinical (security, cleaning, health transport), and in healthcare provision through agreements and contracting of specific services (x-ray, clinical analysis, surgery waiting list...) and partial or complete medical centres.

Since the passing of Law 15/1997, which opened up possibilities for the introduction of new forms of health management, there began to appear in Spain administrative concessions, normally known as the "Alzira model," as the Alzira Hospital was the first to be put to tender under this model and was later extended to other centres, mostly in the Valencian Community and the Community of Madrid. In this case, although the owner of the centre remains public, its management is awarded by concession to a private entity, which receives a capitated budget for each patient whose treatment is assigned. These concession centres are centres that form part of the network of centres of the regional health system.

Response of the Panel

Private healthcare has, for decades, been seeking this complementary relationship with the public sector in the form of referrals from public centres in the cases of lengthy surgery delays, diagnostic tests where the technology lacking in public centres or in cases of long waiting lists and for specific rehabilitation, dialysis, home oxygen therapy, etc.

In all cases, the will of all parties is that the arrangement benefits all, patients being the ones that must be the major winners of these arrangements.

It seems that the most flexible management tools in the case of private management may offer some competitive advantage in the production of more efficient services. In any case, this evolution is usually accompanied by the development of free choice of centre and doctor, which completes the full circuit of satisfaction of patients and citizens, the ones who ultimately pay for the services as taxpayers.

Private healthcare has for a time been assisting the sustainability of the system in two ways. Firstly, because it faces a demand that, due to the concept of majority double insurance in this country, should not be tended to by the public system, with ensuing saving that this involves for the SNS. Secondly, as a provider of the SNS itself, it is permitted to provide certain flexibility and efficiency in the areas of the public system where it is a provider or or if it offers provision directly.

Managers must try to make all the resources of the system available to the patient. Today, all of the Autonomous Communities have some experience of this collaboration between private and public healthcare; some with more traditional models and other more specific such as in Catalonia and the Valencian Community, each with its own unique features.

In general, there is an agreement in which the private management adds value to public management, by introducing business-like management concepts.

However, there are two determining factors when in it comes to incorporating private initiative into public management: transparency is necessary in management and a correct evaluation or results and comparative studies form a cost-effectiveness perspective.

In this area there are experts that consider the present balance between public and private healthcare as healthy as sufficient, but that it is not necessary to promote private health any further, for reasons of equality in the system.

In Autonomous Communities such as Catalonia, there are other innovative models of provision such as the association-based entities (EBAs), where a group of professionals constitute a company to offer for primary care to a population area.

All experts agree that the directive that marks the policy to be followed in health must be public, that is to say, drawn up by the regional health services of the Autonomous Community in each case.

9. Changes in morbidity patterns: is the SNS prepared to respond to the challenge of an ageing population and chronicity?

Preliminary Considerations

Spain is on the way to having the typical population pyramid of an ageing country with a high percentage of the population over 65. At present, the percentage of the population aged over 65 represents 18.2%. If current demographic trends continue, this percentage will reach 24.9% in 2029, and 38.7% in the year 2064, according to forecasts carried out by the National Statistics Institute.

Response of the Panel

Ageing and chronic illnesses are, among other factors, the result of the success of the health system. Decades ago, the majority of patients with stroke and heart attack died and did not become chronic patients. Today, haemodynamic therapies and new medicines allow these patients to live many more years and, consequently, accumulate various pathologies.

This being said, it is evident that both the growth in chronic illnesses and ageing present new challenges, not just for the SNS, but for all of society, with life expectancy never having been as high as it is at present. Although we will need many new responses, we are not starting from scratch and, moreover, we have a deep knowledge of the systems and its possibilities and this is one of our main advantages.

Most Autonomous Communities have put in place specific programmes for treating chronic illnesses. For example, in the Basque Country, the 2009 to 2013 legislature was known as legislature of chronicity; in Catalonia, the current legislature put in place the Programme for the Prevention and Treatment of Chronic Illnesses; and many other similar initiatives such as the successful experiences of innovatively managing chronic illnesses at Hospital La Fe in the Valencian Community.

In brief, to address the challenge of chronic illnesses we must work towards the following:

- Invest in ICTs, to extend telemedicine and teleassistance
- Training of staff, both doctors and, especially, nurses, for the management of this type of patient.
- Develop up-to-date databases of patients that in involve greater morbidity and greater frequency.
- Carry out a restructuring of health infrastructures, gearing them towards an older patient and with increased length of hospital stay.

- Training carers, who are the ones that will prevent complications and relapses and the consequent congestion in public services.

It is also important to talk about uniform measures throughout the country. Although we observe with astonishment the forecasts for the ageing of the Spanish population over the coming years, we have not promoted joint and coordinated actions among all the Autonomous Communities to face this very real challenge.

The system is better prepared for the ageing population than it is for chronicity. A deep transformation of the SNS is required so that it focuses on the chronic patient, reducing the weighting of the acute patient and taking the ageing factor into account. Despite the greater use of health resources by older persons, numerous studies carried out in Spain show that their contribution to the growth of future expenditure will be moderate and partially compensate by the demographic effect, as the Spanish population is currently shrinking. On the other hand, a great deal of the spend associated with ageing is not related to ageing as such so much as to death and care during the final years of life. For this reason, ageing only becomes a problem for those in the oldest age bracket, without this necessarily involving more expenditure.

In any case, it is worth highlighting that the response to chronicity and ageing cannot be exclusively the preserve of the health system as other, broader and multidisciplinary solutions are required, and bearing in mind at all times the social and welfare services of each Autonomous Community so as to initiate joint actions.

This response must adapt to new family structures and to new resolution potential of mHealth.

10. Disruptive Innovation. What actions should be taken upon the rise of major innovations? What lessons have been learnt in recent times to this end? Do you believe it is necessary to invest in strategies that offer long-term results such as in the case of Hepatitis C?

Preliminary Considerations

Over the coming years innovative drugs will be introduced thanks to new technologies and advances in clinical research, development and innovation enabling a change in the natural evolution of certain pathologies and even eradicating some of them.

What happened with Hepatitis C with the arrival of new pharmaceuticals has revealed the challenges and lack of anticipation and planning within the SNS when it comes to introducing these molecules in the SNS.

To this end, preliminary studies with epidemiological data for Spain to determine the scope and characteristics of the pathology as well as sound involvement of government interests to improve the framework of the pathology to be treated through prevention, diagnosis and treatment.

Moreover, the implementation of a national plan will foster and guarantee equity in all Autonomous Communities, thereby ensuring it will always be effective.

Response of the Panel

When speaking of technological or pharmaceutical innovations, the truth is that the only way to act is to adopt them when they actually offer improvements in patients' health and their efficacy and efficiency have been proven.

Over the coming years, healthcare managers must work with an innovative mentality so as to increase the value of what is done in relation to the costs incurred.

The influence of professionals and clinical criteria must be allowed to carry more weight in order to include innovation in the system.

The inclusion of innovation must be organized and institutionalized in order to have permanent mechanisms available that are capable of forecasting and establishing road maps for the inclusion of these new technologies. They must be prestigious structures with the utmost scientific rigour in which patients, healthcare professionals and all citizens trust. Solving these problems with sudden, knee-jerk statements is truly inadequate in a country such as this one in the 21st century.

The key would, therefore, lie in coordination, forecasting, planning and having a stable framework of action. Innovation is not a surprise. Regulatory agencies have information on the new molecules that are about the reach the market. What is needed is for the Spanish Medicines Agency to be able to coordinate this information through the Spanish Ministry of Health and the Autonomous Communities. Moreover, it is important to get the Finance Administrations involved as they are the ones who have the last word concerning public budgets.

Regardless, healthcare organisations still need to mature in order to effectively enroot innovative new technologies as they are set in a rescue and acute care model. Technological innovation is very much necessary for effective management of chronic patients. This is where expenditure ceiling agreements may be useful instruments if designed adequately and do not prevent the entry of new innovations in the market

In any case, the National Health System's resources must be increased evenly among the various Autonomous Communities in order to effectively incorporate innovation.

There are measures that may expand the resources available; however, they must be combined with solving the infra-funding problem present in the National Health System. To this end and at the same time, it is possible to negotiate decreases in the prices of medications which are no longer subject to patents, commit to the use of generic and biosimilar medications, and for economies of scale where nation-wide centralized procurement is very important in addition to risk policies combined with expenditure ceiling control.

Even still, it will be difficult to guarantee Spaniards equal access to innovation if the decreasing trend continues in healthcare budgets.

In recent years, we have actually learnt a few lessons in this area which should be taken into consideration. At time there has been a desire to appear innovative, for snobbish reasons, hoping to be seen in a better light thanks to costly and sophisticated investments (such as surgical robots, for example) which has unnecessarily made healthcare processes more expensive without any real justification for the suitability and/or utility.

The greatest opportunities for innovation have come with pharmaceuticals that have made a different therapeutic approach possible for many pathologies with a higher degree of improvement and, on a number of occasions, even definitive cures for patients.

Incorporating a new healthcare technology is a dynamic process that must be subject to long-term planning and not just be limited to the period of authorisation.

Furthermore, innovative behaviour have been penalised in public healthcare in recent years as it involves greater expenditure in the market introduction periods and working with limited budgets which are very strictly managed.

11. Do you believe the SNS needs a redistribution of resources, with disinvestment in some areas in order to invest in others?

Response of the Panel

It is necessary to address the challenge of disinvestment but under the premise of doing so in all Autonomous Communities at the same time and with the greatest possible consensus. One of the ways to foster the sustainability of the system is actually to adjust the portfolio of services and disinvest in technologies, procedures and medications that offer patients no value.

To provide an example, if the economic limitations we will have to get used to living with are added to everything involved in personalized medicine based on genetic studies, the only answer will be to redistribute resources to that which has proven to be more effective and abandon anything left obsolete.

The first step is to identify the services and benefits that add no clinical value and stop funding them.

In the model we are moving towards, we will likely need to reinforce the roles of prevention, promotion and health education to the detriment of Specialised Care budgets.

On the other hand, care for prevalent pathologies requires sufficient resources and prioritising care based on criteria of seriousness and opportunity. On the other hand, research and care for rare or uncommon diseases must not be ignored; they must be funded with intervention resources.

The strategies for handling chronic disease require the proper allocation of resources.

Likewise, reinforced investment is necessary in information and communication technologies which foster electronic medical records in all areas of healthcare with inter-communicability among all throughout the National Health System to enable patient monitoring at home and in their daily lives.

In any case, the sustainability of the National Health System goes beyond the distribution of resources as it is more a problem of budget allocation. However, healthcare budgets have either decreased or remained static for the last 6 years.

The truth is that resources need to be taken wherever they are most needed at any given time, but the fundamental issue to be handled in order to ensure the financial sustainability of the system with the quality levels that have always been present within the National Health System is to increase the budget allocation.

12. With respect to the distribution of resources, some accounts are very much measurable and are monitored such as the pharmaceutical spend where the exact evolution is known from month to month. However, there are other accounts such as in the area of collaboration agreements, health-care products, disposables etc. where there is no tracking. Would it be useful and would value be added if other expense accounts were monitored?

Response of the Panel

When it comes to making decisions, information is important, meaning account monitoring, which also allows for the assessment of the health results achieved in each area, is very important.

Regardless, it is important to consider the relevance of the magnitudes to be measured. The total pharmaceutical spend is quite high worldwide; its commercialisation is highly regulated and tracking and monitoring are not complex. This is not the case for other healthcare technologies and this would be appropriate.

Nonetheless, it would be worth considering for quantitatively high and unitarily significant accounts such as prostheses and implant devices in cardiology, traumatology, neurosurgery, etc.

Even still, a lot of information is currently available and there are many expenditure accounts for which information is available although the information is disperse and should be connected, inter-operable and, thus, more easily interpretable.

13. Is it possible to apply predictive analysis to forecast the future evolution of the population's real healthcare needs in order to redistribute the resources beyond where they may be more necessary?

Response of the Panel

We have enough information to do these types of forecasts. New technologies are not completely unforeseeable. Their development requires time and the directions they will take can be studied. We also have a certain degree of knowledge as to the future evolution of the population, morbidity and mortality. We will not eliminate the uncertainty but we can limit it. This is where scientific research is fundamental and progress in research must be transferred to the minds of healthcare administrations.

There is a precedent along these lines in England: the Wanless Report ("Securing our Future Health. Taking a Long Term View") despite the fact that the recommendations it contained were not observed. This exercise should be done in Spain but at the request of the Government, so it will not be left behind as just another report or study. This would lead to resource planning and allocation in accordance with the population's real needs.

Although we cannot predict the future, we can work towards shaping it to resemble what we want it to be. In the healthcare field, we see day after day how we leave behind what we once thought to be subject to unattainable limitations in order to establish new barriers to be broken down sooner or later. Surgery will continue its progressive evolution to minimally invasive techniques which will become more and more common for a larger number of processes. Diagnostic techniques will be more and more accurate and will provide ever more reliable and fitting results. Medications will be able to solve more and more problems each day. In addition, the eruption of biotechnology and genetics in treatment will involve anticipating interactions between patients and medications which will improve treatments and reduce undesirable effects. However, new difficulties will arise within the National Health System such as security, which will be develop extraordinarily (medicines, care, information, confidentiality, ICTs, etc.) or the cost of personalized medicine will pose another significant handicap which will have to be overcome, not to mention the excessive medicalization of everyday difficulties which will require new efforts and attention.

14. What tangible short-term improvements would you adopt in terms of management, resource allocation, clinical management, etc.? What to do and what not to do?

For better understanding, all of those mentioned by the members of the Working Group have been categorised:

1. Package of Services

- Identify the services and benefits that add no clinical value and stop funding them.
- Foster public health with health education, screening and early diagnosis programmes.
- Foster the use of vaccines and establish an adult vaccination programme, especially for those aged over 55.

2. Human Resources Policy

- Implement a real, effective and transparent performance related pay system based on real objectives. Implement clinical management processes while ensuring real

"contractual" development between administration and clinical care where there is a directing of funds to those who achieve efficiency. Objectives established for professionals must be objective, clear, stimulating and attainable. The purpose must be to involve professionals in the organisation and the overall objectives. They should be connected to a variable portion of a professional's salary of approximately 30%.

- Introduce improvements such as: an attractive professional career; a systematic culture to be shared by all professionals of participation and leadership in projects serving patients and professional and scientific excellence; proper pay for proper work; abandoning the system of positions for life; the introduction of results measurement and supervision systems; monetary and non-monetary incentives for productivity and good work, always based on peer assessment.

3. Pharmaceutical Policy

- Definitively reach a stable and long-lasting agreement between the Industry and the Administration to prevent unexpected new adjustment measures that affect companies' strategies, irrespective of the isolated circumstances of the economy so as to guarantee stability and access to the best medicines.
- The availability of centralised accounts would be necessary to foster innovation.

4. Organisation and Management of the SNS

- The implementation and real use of new ICTs. This is a challenge that is changing the way professionals work, making it possible to share available information, generate notifications of various situations, communicate with patients, and facilitate citizen participation in the management of their health in addition to how patients communicate with the healthcare centres where they are being treated. It must be exploited in order to manage and plan healthcare information systems and connect them.
- Self-management should be implemented in a real way at clinical management units or self-management at healthcare centres so the professionals themselves become administrators and are involved in the sustainability in their areas of action and, logically, with the corresponding recognition. A general framework is needed for the practical development of clinical administration at Healthcare Centres.
- Be proactive in the implementation of measures to treat chronic illnesses fundamentally in managing cases, the real implementation of telemedicine and monitoring for patients with risk factors.
- Measure the results and costs of what we do in healthcare.

- Institutionalize and expand the assessment of efficiency of healthcare technologies and introduce economic evaluation in a practical and regulated way.
- Professionalize healthcare administration and improve the governance of the healthcare system on all levels by developing the principles of professionalization, transparency and account reporting.
- Centralize decisions and break with budget silos. Inter-connect the budgets of the various healthcare areas.
- Make patients co-responsible and introduce personalized budgets.
- Implement coordination measures for healthcare and social services with short-term returns.
- Establish budgets based on forecast costs of activity, with consideration for the population to be treated, adjusted for the complexity of prevalent pathologies, age, etc. in addition to referral units to be maintained, variations for the eventual free choice of patients or referrals to or from other Centres or treatment systems.

Identification of the Economic-Financial Needs of the National Health System

1. In view of the data gathered in the attached progress report, do you believe it is possible to reach an agreement as to a healthcare investment floor in terms of a percentage of GDP which may not be lowered under any circumstance?

Preliminary Considerations

One of the consequences of the economic crisis in Spain has been the decrease in public expenditure in general and healthcare investment in particular. Public healthcare expenditure in respect of GDP has been continuously reduced in recent years, dropping from 6.7% of GDP in 2009 to 5.9% in 2014 and even 5.7% for this year, 2015. In respect of GDP, the total public healthcare expenditure planned for 2015 accounts for 5.7%.

According to the Stability Programme for the Kingdom of Spain, the Government does not expect public healthcare expenditure to exceed 6.5% of GDP before 2020 (figure reached in 2010). Beyond 2020, a gradual increase is expected, reaching 7.8% of GDP in the year 2060.

The weight of public healthcare expenditure with respect to the total public expenditure was at 14% in Spain in 2012 whereas it was 19% in Germany and 16% in France.

Evolution of the Overall Public Healthcare Budget between the years 2009-2014.

Financial Year	Total Healthcare Budget (millions of €)	Drop with respect to previous tax year (%)
2009	64,317.71	-
2010	63,457.41	0.08%
2011	57,826.13	12.65%
2012	57,660.43	10.43%
2013	55,272.80	14.88%
2014	53,512.49	1.58%

Source: Annual Public Budgets of the Autonomous Communities.

Response of the Panel

The opinions gathered are summarised below. The majority believe sufficient investment for healthcare should be agreed upon and arranged, yet not through regulation. Each country decides how to use most of the budget.

In general, the idea is that healthcare investment requires at the very least similar growth as GDP. However, there are clear difficulties in all cases to reach an agreement of this nature that is binding for all Autonomous Communities.

The risk of connecting healthcare expenditure to GDP is that it may contract and, thus, affect investment in healthcare.

The suggestion is to incorporate the right to public healthcare as a fundamental right in the Spanish Constitution, thus obliging the State to allocate sufficient resources to the system in order to guarantee this right.

On the other hand, there are experts who are against these agreements as they hinder, a priori, the Government's capacity to act. These people suggest investing based on the needs and available resources under transparent agreements and accounting for the use of resources.

For some, a mandatory expenditure floor introduces ill-advised inflexibility and so, they advocate budgets in accordance with cost/benefit analyses as applied to healthcare without recurring to false arbitrary solutions and spending efficiently; in other words, what offers the best results in healthcare for each Euro spent as opposed to any comparable alternative.

2. What figure do you propose for public health expenditure in respect of GDP?

Preliminary Considerations

Along with the data gathered in the course of considerations related to this question, it is worth highlighting some figures that compare the Spanish public health expenditure figures with those of neighbouring countries.

As may be seen in the table below, according to data from OECD Health Statistics 2014 and with the most recent data available updated to 2012, the public healthcare expenditure percentages with respect to GDP in references countries for Spain such as Germany and France are at around 9%. The countries in the table were listed based on their GDP (from highest to lowest) for the year 2012.

% Expenditure in Public Healthcare with respect to GDP in 2012.

Country	Percentage
Germany	**8.4**
U. Kingdom	**N.D.**
France	**8.6**
Italy	**6.9**
Spain	**6.5**
Netherlands	**10**
Sweden	**7.3**
Poland	**4.4**
Belgium	**8.2**

Source: OECD Health Statistics 2014.

As can be seen, the average (without counting Spain or the United Kingdom as no public expenditure data is available) is 7.7%.

Response of the Panel

In general, the experts seem to favour situating the healthcare expenditure with respect to GDP in line with the OECD countries of similar characteristics to Spain such as Germany, France, Italy and the United Kingdom. According to figures published by the WHO in 2014 with data from 2012, this percentage would be around 7.5%.

Some of the experts indicate that these macroeconomic figures must be correlated with income per capita in each country.

In any case, some of the members of the panel believe this should largely depend on the care model Spain develops, because if a series of necessary changes are not adopted within the system to improve the efficiency of chronic and pluripathological patient management, a much higher allocation will be necessary.

3. Annual Public Budgets. How should limitations be approached? What can be done with the healthcare budget deficit?

Preliminary Considerations

Public healthcare in Spain has accrued deficits year after year, thereby generating significant financial stress among all stakeholders in the National Health System. The final budgets of the various Regional Ministers of Health are always above the initial expenditure budgets.

National Health System debt with suppliers increased by 173% from 2009 to 2011.

In 2012 and 2014, the Government of Spain passed two Extraordinary Payment Plans to pay off the debt due with healthcare suppliers. Six months after the second Payment Plan in September 2014, Fenin reported that the debt contracted by the Public Administrations was already 25% higher than in the month of February when the 2nd Payment Plan was passed.

According to the most recent data provided by Fenin, the sum of bills payable by the Autonomous Communities pending collection by sector companies as of the end of March 2015 totalled 1.640 billion Euros with average payment periods of 229 days despite the measures adopted to eradicate payment defaults.

Sector employers' organizations have many times demanded adjustments to budgets to reflect actual expenditure.

With respect to the initial healthcare budgets prepared by the Autonomous Communities for the year 2015 and considering the historical evolution in pharmaceutical expenditure,

eleven of the seventeen regions do not have enough budget to cover the fiscal year. Some of them are not able to cover even the first 9 months of the year with the budgeted amounts.

Response of the Panel

The budget deficit in public healthcare is a serious problem that must be taken on decisively and courageously.

Everything possible has been done within the National Health System to minimise this situation: efficiency gaps have been eliminated, management has been improved and, with the crisis, we have learnt to do more with less although at the cost of the professionals' salaries, but everything has its limit.

The underlying recipe is simple: income and expenditure must be balanced.

Expenses are well-defined and there is little room for improvement. More efficient management may be feasible but it would be difficult for this to produce a significant margin of savings.

In terms of income, this cannot depend exclusively on the evolution of GDP because it would be difficult to make adjustments to the National Health System if the economy does not grow as expected.

Measures such as economies of scale, centralized procurement, shared risk or some citizen co-responsibility in the system could improve not only the direct revenue but also reduce expenditure.

The Funding Agreement in effect is based on transferring a percentage of tax revenue from the national government to the Autonomous Communities. If this revenue drops, less money will be transferred to the Autonomous Communities. Although the Autonomous Communities prioritise healthcare expenditure, the revenue may not be enough. The Autonomous Communities may then become indebted with financial institutions or seek other formulas in order to pay for their healthcare expenses but the national government took the decision to limit this competence as a measure to prevent an increase in the general deficit.

The funding model does not provide for maintaining healthcare funding by the State in a situation of a drop in revenue to ensure equal or greater transfers than the preceding year. However, the obligation of providing the service is maintained even in a situation of crisis although less funding is received. Some of the regions that have been receiving the transfers for longer periods have been subject to infra-funding for decades.

Added to all of this, Spain has a taxation problem when compared to the reference countries. With similar tax figures and rates, its collection is 8 points below the lowest GDP. The taxation model must be reinforced in order to attain revenue in relation to GDP in line with the EU average.

4. In view of the need to adapt healthcare budgets to expenditure reality, how could public budget inflexibility be handled? How do you believe more dynamic budgets could be adopted to allow managers a greater capacity for action and adaption?

Response of the Panel

In general, all of the experts agree that there is a need to be able to manage healthcare budgets in a more flexible manner and most of them agree upon the difficulty of finding adequate measures to do so.

In any case, one of the possibilities most of the members of the panel pointed out was multi-annual budgeting.

Comprehensive budgeting and, above all, cyclical budgeting instead of annual budgeting. If a portion of the agreed budget is available cyclically instead of annually, the system could become more flexible.

Anything that could improve business flexibility, decentralization, and autonomous management and streamline business operations along with results-based account control and reporting would help better profit from the resources allocated for healthcare and the provision of other public services.

5. In 2015, there was a difference of more than 500 Euros per capita between the Autonomous Community which spent the most per capita on healthcare (the Basque Country) and the one that spent the least (Andalusia). More than half of the Autonomous Communities have a per capital healthcare bill of less than the average (€1,248). How does this fact affect equality and what is the solution?

Preliminary Considerations

Considering the initial Autonomous Region Healthcare Budgets, the average expense per capita is 1,248 Euros. However and as indicated in the question, this distribution per capita shows significant differences between the regions. The Basque Country and Navarre top the ranking as regions not subject to the common funding system. The list ends with three regions with great population weight in Spain: Catalonia, Valencian Community and Andalusia.

Healthcare Expenditure per Capita in the Autonomous Communities as per the initial budget for 2015

Autonomous Community	Euros/Inhab.
Basque Country	**1,565.2**
Navarre	**1,466.8**
Asturias	**1,409.4**
Aragon	**1,403.9**
Cantabria	**1,342.2**
Castile-Leon	**1,309.2**
Rioja	**1,278.2**
Canary Islands	**1,245.1**
Extremadura	**1,227.1**
Balearic Islands	**1,159.9**
Galicia	**1,153.9**
Castile-La Mancha	**1,148.3**
Madrid	**1,145.0**
Murcia	**1,130.4**
Catalonia	**1,118.6**
Valencia	**1,106.8**
Andalusia	**1,004.3**
Spanish average	**1,247.9**

Response of the Panel

In general, the members of the panel of experts agree that these differences are too significant and that, therefore, they may condition the equality of the Healthcare System.

In order to make it so that all Autonomous Communities have access to more resources, all of them point out the possibility of granting more fiscal responsibility to the Autonomous Communities so they may manage more of their own revenue. In any case and given the differences in income among the various Spanish regions, transfers from the richest regions to the poorest would also be necessary.

One essential point highlighted is coordination and collaboration among the Autonomous Communities given that this coordination would mean super specialized hospital units and transplants would be necessary in all regions.

Equity involves similar funding among all regions and this should not depend on old-fashioned criteria.

In any case, it is important to manage the budgets well and choose the care model society needs and not create healthcare focused on the implementation of new infrastructures designed prior to the crisis.

6. New National Health System Funding Formulas. Would it be appropriate for the healthcare system to have a specific funding system outside the "ordinary" autonomous community-based funding system? Should the healthcare system receive intervention funds?

Preliminary Considerations

Healthcare funding was intervention-based until 1996.

After that time, the Autonomous Communities started receiving transfers of funds from the State which, along with their own revenue, have been distributed into annual budgets based on the needs of any given time.

Successive reforms of the regional funding model in 1996, 2001, and finally, in 2009, increased the participation of the Autonomous Communities in what was known as effective fiscal co-responsibility, which enabled greater participation by the Autonomous Communities in their tax management as well as the revenue the State obtains from national taxes (personal income tax, inheritance and donations, VAT, wealth tax, stamp duty, etc.).

Given the specific needs of the regional healthcare systems, certain administrators have advocated that funding for healthcare as well as compensations by the State such as, for example, those derived from treatment for national citizens abroad or foreigners should not go into a "single cash box" under the Tax Administration departments but rather be directly returned to funding public healthcare.

Response of the Panel

There are a number of opinions here. Notwithstanding, most of the opinions gathered are in favour of intervention funds.

Some of the experts who formed the panel believe healthcare should involve intervention funds and there should be an equal expense per inhabitant in all of the Autonomous Communities. We must remember that, in the beginning, healthcare was supported by intervention funds and that the new funding models of 1996 and 2001 changed the system whereby a non-intervention funding model for healthcare was defined. For this reason, several experts believe taking a step backwards is highly unlikely.

Some maintain that there should be intervention funds for accounts that go beyond the local or regional level or that affect extraordinary accounts or items that have appeared during the fiscal year such as the cost of new innovation, a budget for caring for rare diseases, vaccine programmes, etc.

On the contrary, some members of the working group believe that earnings and expenditure must be considered comprehensively and that the National Health System should be financed via taxes in accordance with the needs that arise at any given time considering the room to manoeuvre available to managers.

7. New Funding Sources. Is it possible to find a new funding source for the healthcare system so it may benefit from more resources? If so, cite them.

Preliminary Considerations

As already mentioned, public healthcare funding comes from tax collection by the State and the Autonomous Communities. The funding model that entered into force in the year 2002 (which was modified in 2009), expanded the "tax basket" subject to transfer to the Autonomous Communities. After that time, around 50% of the non-financial earnings in the autonomous regional budgets has come from taxes assigned by the State.

The logical result is that the lower the collection, the lower the revenue. However, the needs of the public healthcare systems do not drop in times of crisis but rather increase.

When the financial capacity is reduced but the needs which must be faced are at least maintained, debate inevitably arises as to the need to search for new funding sources which make it possible to keep a National Health System universal and of quality as is found in Spain.

Response of the Panel

All members of the Think Tank see only one means of funding public healthcare and that is taxation. To this end, several coincide in the need to reform the Spanish taxation system and point out the possibility that certain rates such as those on tobacco, alcohol or hydrocarbons could be reserved to fund healthcare in an interventionist manner. However, this is a possibility they deem unlikely given the experiences seen in some of the Autonomous Communities which have attempted to do so (Catalonia) and due to the fact that Public Tax Administration experts do not favour intervention taxes. Nor must it be forgotten that increasing fiscal pressure in times of economic crisis is very difficult.

None of the experts who have participated in the High-Level Group believe co-payment for healthcare to be a valid source of funding.

8. How can an Autonomous Community-based funding system be defined to preserve equality? How can the most disadvantaged Autonomous Communities be compensated?

Response of the Panel

The policy of redistribution and compensation has been used for 35 years and it has ended up producing the current situation as a result, which is very disparate funding among the Autonomous Communities. The road indicated by the experts is for the Autonomous Communities to be able to use more self-management and receive more of their tax revenue, that treatment be provided based on each region's actual population, with adjustments for age and provisions made for inter-regional transfers and specific funding for benchmark units and services.

Addendum I – Survey sent to the panel of experts

1. Identification of the needs within the National Health System

1.1 Do you believe the Abril Report, on its 25th anniversary, remains relevant?

1.2 Do you consider it necessary to review the SNS's package of services from both the treatment and pharmaceutical perspective?

1.3 The SNS health structures bring with them a number of cost structures, established some years ago. Are these structures adequate for the SNS today?

1.4 Do you believe that patient participation must be fostered in the SNS? How can participation be maximized?

1.5 How can the professional become involved, as a pillar of support, in these changes faced by the SNS? What role must professionals play within the SNS?

1.6 Is it possible to turn early diagnosis into a sustainability tool? Do you believe it is necessary to invest in strategies that offer long-term results such as the case of hepatitis C?

1.7 Is it possible to turn prevention into a sustainability tool? Is greater investment in prevention policies such as vaccinations adequate?

1.8 Public-private collaboration. The role of private healthcare in the sustainability of the SNS.

1.9 Changes in morbidity patterns: is the SNS prepared to respond to the challenge of an ageing population and chronicity?

1.10 Disruptive innovation. What actions should be taken upon the rise of major innovations? What lessons have been learnt in recent times to this end?

1.11 Do you believe the National Health System needs a redistribution of resources, disinvestment in some areas in order to invest in others?

1.12 With respect to the distribution of resources, some accounts are very much measurable and are monitored such as the pharmaceutical expense where the exact evolution is known from month to month. However, there are other accounts such as in the area of collaboration agreements, healthcare products, disposables... where there is no tracking. Would it be useful and would value be added if other expense accounts were monitored?

1.13 Is it possible to apply a "horizon scanning" analysis; in other words, forecast the future evolution of the population's real healthcare needs in order to redistribute the resources beyond where they may be more necessary?

1.14 What tangible short-term improvements would you adopt as concerns management, resource allocation, clinical management...? What to do and what not to do?

2. Identification of the National Health System's economic/financial needs

2.1 In view of the data gathered in the attached progress report, do you believe it is possible to reach an agreement as to a healthcare investment floor in terms of a percentage of GDP which may not be lowered under any circumstance?

2.2 What figure do you propose for public health expenditure in respect of GDP?

2.3 Annual public budgets. How should limitations be approached? What can be done with the healthcare budget deficit?

2.4 In view of the need to adapt healthcare budgets to expenditure reality, how could public budget inflexibility be handled? How do you believe more dynamic budgets could be adopted to allow managers a greater capacity for action and adaption?

2.5 In 2015, there was a difference of more than 500 Euros per capita between the autonomous region which spent the most per capita on healthcare (the Basque Country) and the one that spent the least (Andalusia). More than half of the Autonomous Communities have a per capital healthcare bill of less than the average (€1,248). How does this fact affect equality and what is the solution?

2.6 New National Health System Funding Formulas. Would it be appropriate for the healthcare system to have a specific funding system outside the "ordinary" autonomous regional funding system? Should the healthcare system receive intervention funds?

2.7 New Funding Sources. Is it possible to find a new funding source for the healthcare system so it may benefit from more resources? If you so, cite them.

2.8 How can an Autonomous Region Funding System be defined which preserves equity? How can the most disadvantaged Autonomous Communities be compensated?

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