



# Executive Summary

## Case Studies report on Primary Care reforms



April 2023

**RFS REFORM/SC2021/058**

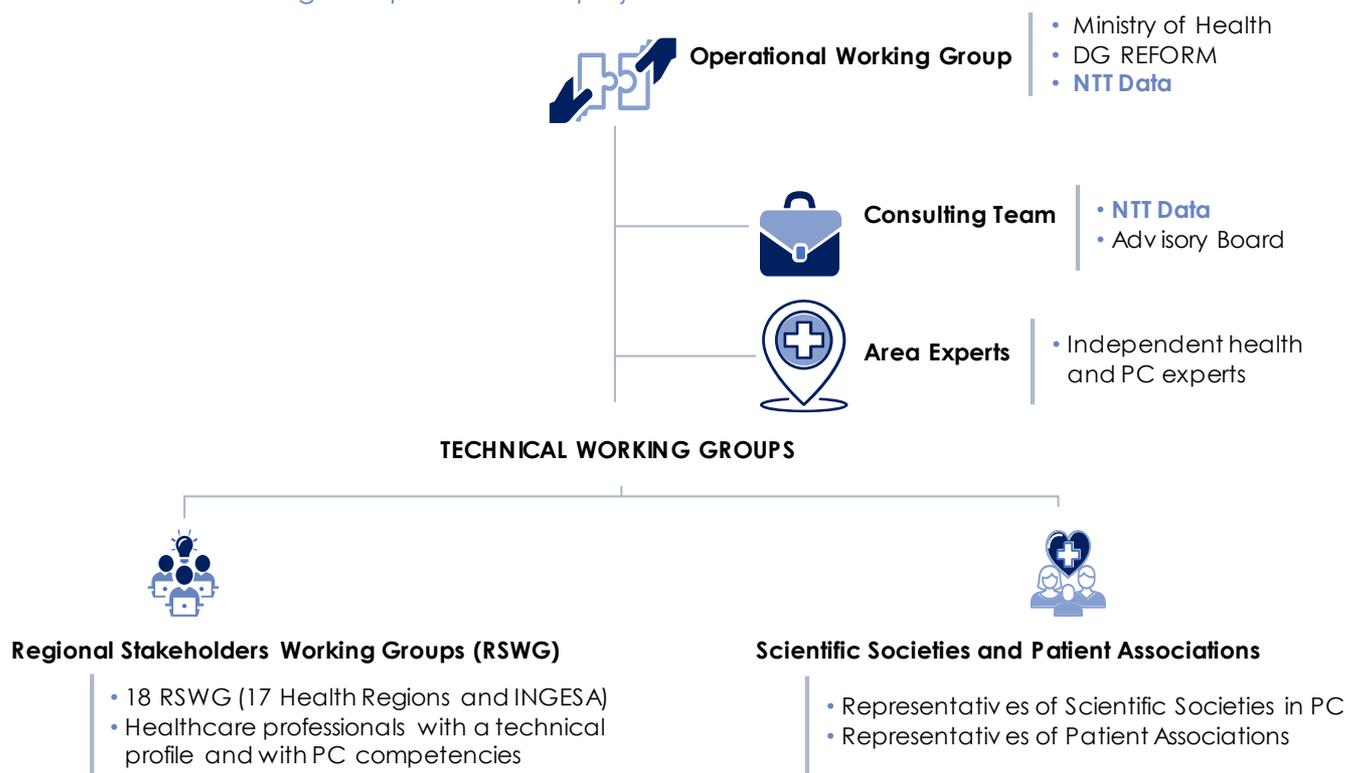
**AARC - Consortium**

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

## Working Groups

Different working groups participated in the elaboration of this report, including drafting and reviewing the document. The members and role of each working group involved in the report are explained below. All Health Regions are represented, at technical level, by the Regional Stakeholders Working Groups (RSWG).

Illustration 1: Working Groups involved in project Phase 3



- **Operational Working Group (OWG):** responsible for the operational and strategic monitoring of the project, as well as for reviewing and validating the project deliverables.
- **Advisory Board (AB):** responsible for advising the NTT Data team.
- **Area Experts:** responsible for providing information on reforms carried out in other countries (mainly in Europe).
- **Regional Stakeholders Working Groups (RSWG):** participation in online Workshops I of international Case Studies to provide their opinion and knowledge on aspects of the reforms that may be transferable to the reality of Primary Care in Spain. Some members of the Regional Stakeholders Working Groups appointed representatives to attend the sessions.
- **Scientific Societies and Patient Associations:** participation in online Workshops II of international case studies to provide your opinion and knowledge on aspects of the reforms that may be transferable to the reality of primary care in Spain.

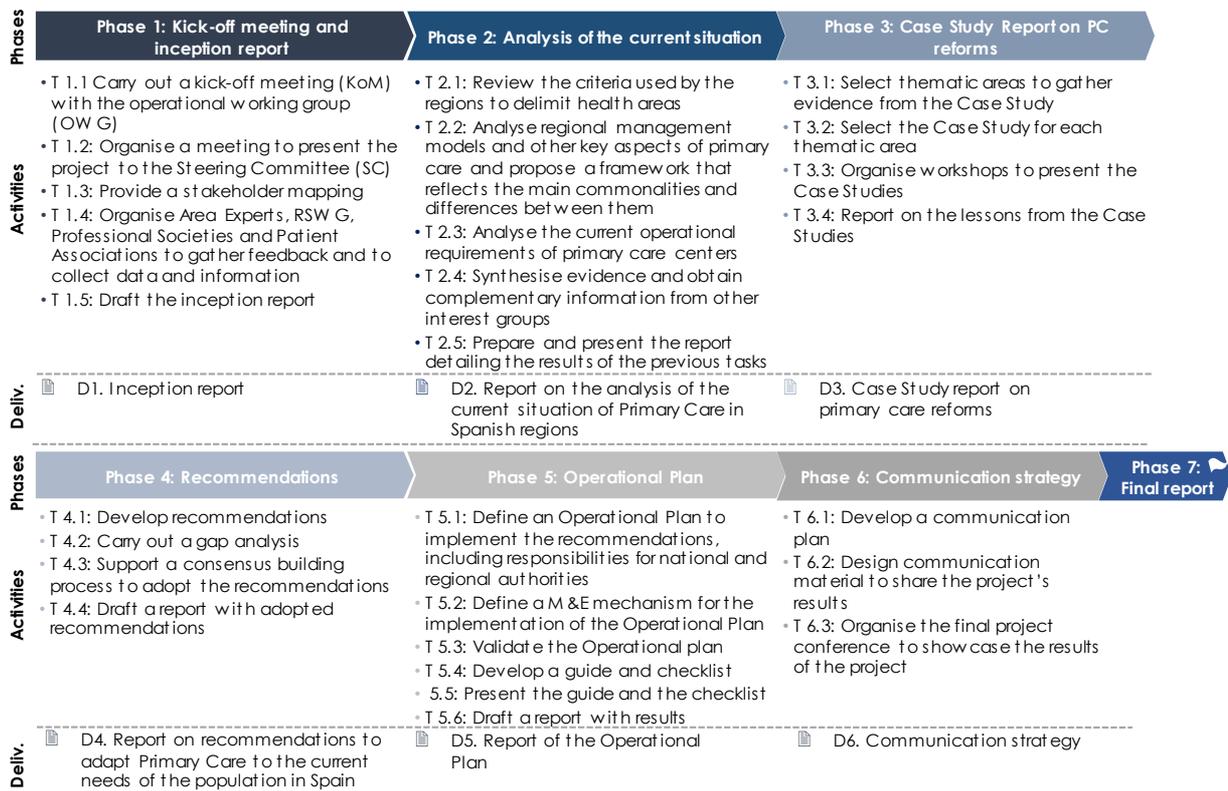
## Introduction and objectives

This document is part of Phase 3 of the project "**Adaptation of Primary Care (PC) to the current needs of the Spanish population**", financed by the European Union through the Technical Support Instrument and implemented by NTT Data, in collaboration with the European Commission's Directorate General for Structural Reform Support (DG Reform).

The main objective of the project is to develop a set of Recommendations on criteria, governance models and requirements to promote equity in access to high-quality Primary Care services. The expected result is to provide tools that allow the National Health System to adapt PC services to the specific needs of different contexts, such as urban areas, areas with hard-to-fill positions, care for chronically ill patients, etc.

The project consists of 7 phases and this document is the Executive Summary of the Report with the results of the deliverable (D3) of Phase 3 "Case Studies report on Primary Care reforms".

### Illustration 2: Project phases, activities and deliverables



## Phase 2 Objectives

The objectives of Phase 3 are:

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

## The project focuses on 5 areas of analysis:



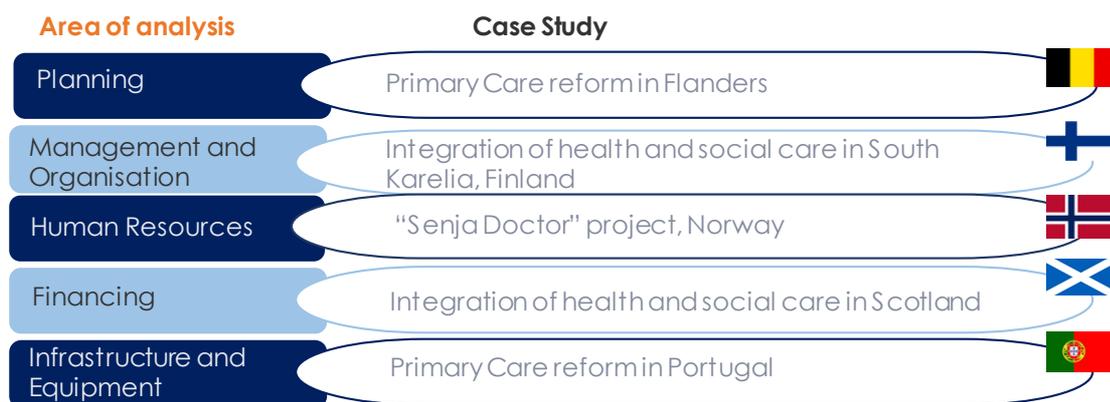
- 1. Planning:** Criteria for defining healthcare areas and basic health zones for healthcare provision; National and regional policies and regulations; Differences between urban and rural areas.
- 2. Management and Organisation:** Management models; Differences between rural and urban areas; Coordination models between levels of healthcare; Coordination models between health and social care providers.
- 3. Human Resources:** Human resources policies; Cooperation models between professionals; Composition of Primary Care teams; Staffing ratios.
- 4. Financing:** Share of the regional health budget devoted to Primary Care; Financing needs.
- 5. Infrastructure and Equipment:** Availability of medical equipment; ICT technologies; Quality of infrastructures (consultation rooms, etc.); Maintenance, renovation or building plans for Primary Care centers.

## Methodology

### Selection of case studies

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

Figure 3. Selected Case Studies for the online workshops



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

## 2 Online workshops on the case studies



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

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

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

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

### *International Experts – Case studies discussed on the online workshops*

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

# Results

## 1. Planning

### Primary Care reform in Flanders



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

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

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

## 2. Management and Organisation

### Integration of health and social care in South Karelia, Finland



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

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

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

### 3. Human Resources

“Senja Doctor” project, Norway



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

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

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

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

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

### 4. Financing

Integration of health and  
social care in Scotland



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

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

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

## 5. Infrastructure and Equipment

Primary Care reform in Portugal



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

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

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





# Annexes

## Annex I: Case Study Sheets

### Sources of information

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

#### Population characteristics and health information

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

#### Health System organisation and Primary Health Care characteristics

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

# 1. Primary Care reform in Flanders, Belgium

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



## General features

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

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

## Case study description

### Background and justification

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

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

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

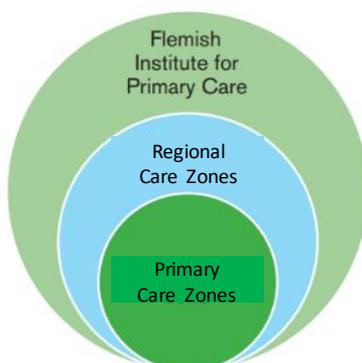
### Description of implemented measures

Main objectives:

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

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

### ***The new support structure in the Flemish health system***



**From top to bottom:**

**1. Primary Care Zones (PCZs)**

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

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

By mid-2020, their functions were:

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

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

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

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

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

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



## 2. Regional Care Zones (RCZs)

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

RCP functions:

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

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

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

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

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

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

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

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

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

### **Results and impact**

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

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

### **Justification for selecting the case study**

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

### **Bibliography**

[WHO \(2019\). \*Creating 21st century Primary Care in Flanders and beyond\*.](#)

[Solveig Wallyn, Danielle Massant \(2017\). \*Reorganise Primary Care in Flanders Region: change management and process 2010-2017\*](#)

[T. Cartier, L. Ryssaert, and Y. Bourqueil \(2015\). \*Building Primary Care in a changing Europe: Case studies\*](#)

[WHO \(2020\). \*Case study: Flanders' Primary Care Reform towards people-centred, integrated care\*](#)

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

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

### Population characteristics and health information

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

### Healthcare System characteristics and Primary Care organisation

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

## Case study description

### Background and justification

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

### Description of implemented measures

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

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

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

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

### Results and impact

The main implementations were:

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



## Justification for selecting the case study

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

## Bibliography

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[Tepponen M. \(2020\)](#). Eksote - Integration of the Social and Health Care. South Karelia Social and Health Care District, Finland.

### 3. 'Senja Doctor' Project, Norway

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



#### Population characteristics and health information

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

#### Healthcare System characteristics and Primary Care organisation

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

## Case study description

### Background and justification

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

### Description of measures implementation

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

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

### Results and impact

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

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

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



## Justification for selecting the case study

Interesting experience for the continuation of Primary Care.

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## 4. Health and social care integration – Scotland

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



### General features

#### Population characteristics and health information

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

#### Healthcare System characteristics and Primary Care organisation

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

## Case study description

### Background and justification

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

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

### Description of implemented measures

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

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

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

### Results and impact

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

## Justification for selecting the case study

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

## Bibliography

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## 5. Primary Care reform in Portugal

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

### Population characteristics and health information

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

### Healthcare System characteristics and Primary Care organisation

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

## Case study description

### Background and justification

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

### Description of implemented measures

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

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

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

### Results and impact

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



## Justification for selecting the case study

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

## Bibliography

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