# TPG International Health Academy
# Executive Trade/Study Mission
# Madrid, Spain September 13 - 18, 2014

## Executive Summary

Thirty healthcare executives made their way to Madrid, Spain in September 2014. The goal of the trade/study mission was to understand how the Spanish healthcare system works and to identify potential ideas and practices that could be brought back to the United States. The group found their Spanish hosts to be friendly and forth right, and very willing to share information on their healthcare system with the mission delegates.

**The Organizational Structure of the Spanish Healthcare System**
The Spanish healthcare system provides universal coverage and provision of services for its entire population, and the system is financed almost entirely by income tax. The concept for universal coverage can be traced to the 1940s, just after WWII when the dictator in power mandated that any employed worker and their family would have access to health insurance. It has since morphed into the current model. At the time that universal insurance was conceptualized for Spain, most of Spain's population was young, and a healthcare system was generally used for acute needs. Recently, the Spanish healthcare system has faced a number of stressors including an aging demographic, increased chronic disease care needs, increased pressures from high cost technology and drug therapies and an economic crisis with 25% unemployment and 40% reduction in wages, leaving this young system in need of reform.

While Spain is one country, it is made up of 17 autonomous regions, each of which is governed independently but answer to a central government. The main role of the central government in regards to healthcare is to collect taxes, calculate and apportion tax money back to the regions and set the basic portfolio of covered services. In addition, the central government sets drug pricing and pays for all prescriptions. Each of the 17 regional governments receives an allocation of tax money from the central government, and is responsible for prioritizing its spending on roads, schools, other civic duties and to cover healthcare services for the citizens of that region. The calculation for regional funding is based on many factors including the GDP of the region, rural or urban status, the size and age of the population. It is important to note that each region is supposed to spend the same on healthcare per capita and they are funded accordingly. It should be noted that the region may spend their allocated portion in any manner they choose as there is no law that governs how the resources allocated to each region are spent. Regions may also make their own rules about who is eligible for services, e.g., only citizens, or anyone who presents to a healthcare facility.

Recently, some of the regional governments have begun to push back against the current system. There are two reasons for this growing discontent. First is that historically the Ministry of Health (the central governing body) helped to coordinate healthcare across the country. This is no longer the case. Today the dominate role of the Ministry of Health is to approve drug and new technologies for the country and then to negotiate the nationally recognized price.
Spain's regions consider their lack of decision-making authority over healthcare coverage decisions as well as the need to actually provide the care required by the central government places them at an unfair disadvantage. These regional governments are requesting redistribution of taxes and greater input into regional funding formulas. This regional reaction is being voiced not only in the area of healthcare but in a number of areas where there is central control. How this issue evolves is, at this time, unclear.

The group found it interesting that favoritism and politics play a role in Spanish healthcare just as they do in the United States. One of the speakers shared an example of how he is "highly encouraged" to purchase services, such as operating room (OR) time from private hospitals while the operating rooms in public hospitals remain unused. He opined that the government was subsidizing private healthcare organizations, while allowing public resources to be wasted. It was also noted by the group that in the U.S., healthcare and health reform are used as political pawns. Although this does not happen in Spain, politics still plays a role in shaping Spanish healthcare; the system is in need of reform but no politicians are willing to reduce the level of provided services as this would be an unpopular act.

**Coverage and Access**

All 46 million people in Spain have health insurance which allows them access to both primary and specialty (hospital) care. Citizens have a very high level of coverage free of charge, with minor exceptions. In normal circumstances, care is provided regionally in the area where a citizen lives, and citizens are assigned to a central place to seek healthcare services. Regions offer a certain number of primary care centers and hospitals based on distance of the citizenship to a center and the size of the population.

The Spanish healthcare system is based on a primary care model in which the General Practitioner (GP) can meet many basic care needs of a patient. When a patient requires more specialized care the GP will refer them to hospitals or specialists. In addition to a patient being referred to a hospital by their primary care physician they can also obtain hospital care through the emergency department or through a specialist In addition, they may visit their hospital to receive a high cost drug therapy (i.e., specialty drug) as only hospitals dispense and administer specialty drugs, which are administered free of charge to the patient.

While patients often have access to same day care in a primary care center, for specialty care waiting lists are a fact of life in the Spanish healthcare system. Because waiting times are visibly posted and drive citizen complaints, allowances have been made in an attempt to decrease wait time. In fact, some regions have enacted laws that define how many days a person should wait for various procedures, acute illnesses or medical priorities. In past years, people did not know exactly where they were on the waiting list, but more recently there has been an attempt to be

more transparent about waiting lists and patients now know how many people are ahead of them. In addition to increased information about waiting times, there are some regions within Spain that are utilizing available private sector health resources to make healthcare resources available in a more timely fashion.

Over the last few years there has been an increase in interest and availability of private healthcare insurance. One driver of this interest is the on-going frustration over waiting times for services. Another reason people may choose to buy private healthcare insurance is for the conveniences, such as a private hospital room, or comfort care, as private insurance does not cover any greater actual medical services then are offered in the public sector. Another driver for private insurance is that a number of large corporations offer their employees the option of private healthcare insurance. In addition to employees of some large companies, Spanish civil servants are also provided private insurance as part of their work benefits. Even with these potential reasons for increased desire and availability of private healthcare insurance, only 6 million people in Spain have private insurance.

**The Differences Between Private and Public Healthcare in Spain**

The largest portion of the healthcare system is publically funded and publically delivered, and it is important to understand that portion of healthcare. The care is delivered by physicians that are civil servants. These are dedicated people that receive significantly less in salary than we do in the United States. The Chairman of Radiology of one of the hospital systems that we visited makes less than $100,000 dollars annually. In speaking with her she shared with us a number of important facts. These physicians have a large portion of their medical training expenses paid for by the system, they work about 6 hours a day, and, at the end of their careers, they receive a pension. The group asked a number of the physicians why some physicians go to the U.S. to train (The Chairman of Radiology at Hospital Rey Juan Carlos trained at Johns Hopkins) but return to Spain to practice. They uniformly stated that they understood that they could get paid more but that quality of life was more important to them than salary. In addition to the lower salary that physicians receive, there is also no pay differential for medical or surgical specialist versus primary care physicians within the public healthcare system in Spain. The physicians shared with the group that there were some challenges within the public healthcare system regarding care coordination and decentralization that makes their jobs more difficult. They went on to say that regardless of the challenges and somewhat lower pay, there was a great deal of pride in the care that they gave and the quality of outcomes that they delivered

In contrast to the public system within Spain which tends to be quite rigid, the private system finds greater flexibility for both the provider and the patient. Providers have more flexibility in both the fees that they are paid and where they work. Patients have to wait less time for their care and have the option of private rooms and more integrated care. The group asked a number of the speakers whether they have had the choice to consider private insurance and what they choose. Interestingly it was evenly divided as some chose to receive their care from the public insurance model and others from the private model. Those that chose private insurance did so through a system that looks very similar to the new health insurance exchange model in the U.S.

**Saving the Health Care System**

Healthcare is one of the engines that unifies the 17 separate regions in Spain. The Spanish healthcare system provides comprehensive and chronic care for all 46 million citizens and inhabitants and bases coverage for all on solidarity and access equity principals. The Spanish motto "Each and every one, according to their needs" may be summarized in two ways. A citizen should expect to receive the same level of care in every region, and if one region does not provide a service, no region will. However, there are very few items that are excluded from coverage. The financial crisis highlighted some of the vulnerabilities of a healthcare system both provided and paid for by the government. However, the citizens of Spain may be somewhat shielded from knowledge about the financial threats to their current healthcare as they enjoy a high level of services, and they have not experienced discomfort associated with cuts in services nor increased cost of services. There is no doubt that the portfolio of services must be modified to retain a policy of universal coverage funded by taxpayers. However, this will be difficult, because the citizens are used to a generous basket of services free of charge.

**Healthcare Costs**

To address some of the financial pressures that the healthcare system is facing, there have been several measures discussed by the government. Unfortunately no presenter discussed detailed plans to keep the system solvent or identified the size of the deficit. Currently, one of the largest items in the budget is salaries, as most healthcare workers are civil servants. Since the beginning of the financial crisis, there has been a 15-20% reduction in salaries. It is unlikely that this item of the budget will be targeted further for future cuts because salaries are already capped and artificially low and also represent the lives of 600,000 voters. The central government has begun to take some steps to reduce expenditures in areas such as drug costs by negotiating for lower cost on branded drugs, calculating reference-based pricing on generics and reducing profit margins for high volume dispensing at pharmacies, which are private enterprises in Spain.

Most of the funding for healthcare services comes from income taxes of the employed, where the wealthier pay more (up to 50% of their income) and the less wealthy pay less in income tax percentage, and some people pay nothing. Yet, it has become apparent that tourists from other counties, mainly Northern Europe, also use the Spanish healthcare system without paying for it. There is an effort underway to charge their respective governments for the care that tourists receive, but it has not been terribly successful. Tourist use of healthcare services is generally seen as a larger drain on the system than illegal immigrants to Spain.

Two areas that have received a significant amount of attention in the United States since the inception of the Accountable Care Act are preventative healthcare services and the area of transitions in care and readmission. This care deficit also exists in Spain. Even though most hospital-based and primary care-based services are covered at no charge as part of universal coverage, a recognized gap is transitional care when a patient is discharged from the hospital, or needs step-down services. The country seems to rely on family-based care whenever possible. Because there is a low level of communication when a patient leaves the hospital, hospital stays might be longer than needed. Another area where Spain does not dedicate many resources is in preventative care. Currently, the Spanish healthcare system does not encourage its populace to

practice robust preventative care. Perhaps that is because the long life expectancy is seen as a good indicator, negating the need for some preventative care.

**Resource Management**

One aspect about the Spanish healthcare system that many attendees found interesting was that there is very little oversight of use of resources in the system. A doctor is free to prescribe, operate and treat as they wish. There may be some retrospective review of a doctor's practice, but there are no prospective utilization management tools in the system for either healthcare services or drug choices. One speaker said, "The healthcare provider has an unlimited power of use of services, and the politician needs to cater to the needs and the demands of the people, which can be the perfect environment for overutilization of services."

A modifier to this utilization issue is the fact that the Spanish government through the Ministry of Health decides what technologies and resources will be available through the public insurance system. This decision is made through the use of research tools that assess the evidence supporting these new technologies including new drugs, devices, surgical procedures and organizational systems. The Ministry of Health may request an assessment for safety and efficacy before a new technology is added to the portfolio of covered services or to assess a new surgical procedure or device. In the Spanish system, there are ongoing assessments for safety, as well as efficacy, to determine if the product is producing health outcomes as promised.

**Electronic Medical Record**

One non-treatment technology that is utilized almost universally through the Spanish healthcare system is the electronic medical record (EMR). The EMR is used throughout every hospital in Spain, as well as in every primary care center and, in addition, the central government collects certain data from every hospitalization. Thus, there is widespread use of this system. However, there is very little commonality between many of the systems that are used, with poor interconnectivity between hospitals and primary care centers. The main communication tool between hospitals and primary care is the patient's discharge letter, written by the specialist and sent to the patient's primary care provider.

In many of the health IT systems, medical information is stored in .pdf files for viewing, and not in data fields that can be manipulated for studies or other analysis. However, many hospital IT systems offer excellent access to read the data and since results (lab, etc.) are automatically uploaded, the data is very current. In addition, the interfaces that are used by hospital staff are interactive and responsive to voice or touch screen.

There are efforts underway to show the central government the value of using the data that is being collected. For example, researchers have developed a prediction model for high cost patients, which can be applied to different regions or hospitals. In addition, the central government has begun to open discussions about using their central database of health IT for industry sponsored research as a tool to create a source of funding.

**The Spanish Doctor**
The group had the opportunity to speak with a number of physicians during their visit to Spain and what they heard on a consistent basis was that physicians for the most part are motivated by the “mission” of being a practicing physician. The salary structure is one that creates a system of greater equality within the profession and with the population at large. The education pathway for physicians is quite different from that of the physician in the United States. Once a person completes high school they take an exam that gains them access to the University. Their University career lasts six years in which they get their basic medical education. Students have a choice of both public and private university education although most choose the public universities. Once a person completes the University they are required to pass an exam that then allows them to continue on and begin their Residency. Depending on your exam scores you may enter into a specialty training program. This training lasts 4-5 years and is required in order to work within the public health system. If the individual does all of their education through the public system, they begin their medical careers with little debt.

An additional area of debt and cost relief for the Spanish physician is in the area of medical malpractice insurance. Although malpractice does exist in Spain, it occurs less often and the reward amounts are significantly less. Malpractice insurance for the most part is paid by the Medical Society and not the physicians themselves. The exception to that is for some medical and surgical specialties which require more insurance and the physician may be responsible to purchase.

Physicians initially receive 3-6 month work contracts. This model continues until a permanent position becomes available and the physician successfully completes a permanent position exam. Physicians in Spain work approximately 6 hours each work day. They can take on more hours for additional pay within the private sector. Some choose this additional work but many do not. The annual base income for a physician is the equivalent of about 100,000 dollars. There are a few things such as teaching and administration that can raise one’s salary but not by any significant amount.

The combination of the “mission” driven focus of physicians in Spain along with the national view of equality created a situation known as the “white tide” movement. During the 2013 budget talks, there was conversation regarding prioritization of healthcare resources in order to reduce coverage and utilization. The medical community showed their unhappiness in this proposed activity and went on strike and placed great pressure on the Spanish government. This activity caused the government to cancel this part of the budget process.

**Pharmacy Services**
The practice of pharmacy in Spain has similar aspects to that in the U.S. Some of the similarities are: 1) many prescriptions are transmitted by electronic prescribing, 2) pharmacists are encouraged to dispense the least costly drug, and 3) pharmacists are working toward being recognized for providing medication therapy management services so that they are not seen as a simple drug dispensary. Patients may have copayments, which are income-based and also calculated as a percentage of the total claim (20% to 50%), however poor citizens and those who are older than 65 have no copayments. The central government calculates the copayment with

the information that they have about the patient’s income status when the claim is adjudicated. The pharmacy is expected to collect the copayment, but the central government reimburses the pharmacy for the remainder cost of the claim.

**Operational and Payment Innovation**

The group visited Hospital Rey Juan Carlos (idcsalud), the largest hospital operator in Spain. The company has the only private research institute in Spain and utilizes both public and private hospitals and has partnered with primary care utilizing case rates and capitation of non-clinical services. idcsalud has entered into a 30 year contract with the Spanish government in order to create a public/private partnership. In this partnership the government will pay a capitated amount for the care of the patients in a pre-designated catchment area to idcsalud. This specific partnership covers approximately 180,000 lives. The patients have the freedom to go outside of the idcsalud system if they choose but, if that occurs, the hospital must pay back the government. This “freedom to flee” places a great responsibility on idcsalud, as they have to create a good atmosphere and achieve high patient satisfaction. The physicians who work within this system appear to be younger and more willing to look at both the clinical and financial aspects of healthcare. These providers also tend to be more productive. Unlike the providers within the public model, they can be fired from their positions but rarely are. To date, the model is proving to be more efficient as their expenses are approximately 15% less.

Some members of the group correlated this project with Accountable Care Organizations that are involved in CMS demonstration projects in the United States. The desired goal of this model (also called the Alzira Model) is to use a capitated payment method where some of the operational issues associated with the healthcare system can be overcome. Most of these problems sounded very similar to those we struggle with here in the U.S. including silos within the system, integration of in-patient and outpatient services and communication, allocation of staff and proprietary electronic medical records.

New models of care within the U.S. have created interest in wellness, chronic care management and transitions in care programs by the provider groups. Much of this work has previously been done by the health insurance companies. These management areas have not yet been the focus of idcsalud and other Alzira Models systems in Spain.

**Summary**

In comparing healthcare in the U.S. and Spain, the major differences include the broad insurance coverage for all inhabitants of Spain and the payment model being primarily based on taxation and very little consumer out-of-pocket. Although these are significant differences, there are a number of similarities that exist. As in most of the countries that TPG-IHA has visited over the last several years, Spain is facing the challenge of an aging population, increasing chronic disease, new and expensive therapies and a limited pool of money in which to pay for care. Both countries are testing public-private partnerships and new models of care hoping to address some of these challenges

Overall, the Spanish like their healthcare system. They receive high quality care from services provided by healthcare providers that are engaged in the system, which is mostly financed

through a tax structure. Although care is limited by governmental coverage, physician oversight of care and utilization does not exist and in the long run may create greater pressure on the system. To date, there has not been a thoughtful plan on how the system will address these challenges. Depending on the how the financial head winds effect the Spanish healthcare system, there could be negative sentiment by both the overall Spanish population and the physician community not dissimilar to what we have seen in the U.S. and the support that Spanish people have of their system may begin to deteriorate.

In conclusion, the Spanish healthcare system has strengths that the TPG-IHA delegation appreciated. In addition it was found that there are a number of places where the challenges are similar enough that both countries should share ideas around common challenges.

*TPG-IHA (www.tpg-iha.com) develops and conducts educational programs in countries outside the United States for senior healthcare executives.*