Primary Health Care in Spain and Catalonia: a nursing model perspective*

ATENÇÃO PRIMÁRIA NA ESPANHA E CATALUNHA: UMA PERSPECTIVA DA ENFERMAGEM

ATENCIÓN PRIMARIA EN ESPAÑA Y CATALUÑA: UNA PERSPECTIVA DESDE LA ENFERMERÍA

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ABSTRACT

Many years have passed since the Health Care Reform in Spain, nevertheless there are still questions about the achievements in this health care level, as well as the aspects and expectations that are still pending for the medical discipline as well as for nursing. The present article analyzes whether the innovation plans recently put into action in different communities, particularly that taking place in Catalonia. Furthermore, it also addressed the current academic development in nursing in Spain, the development of the different nursing areas and aspects related to nursing prescription, screening and care to acute pathologies in Primary Health Care.

DESCRIPTORS

Nursing care
Primary Health Care
Education, nursing

RESUMO

Muitos anos após a Reforma da Atenção Primária na Espanha, analisa-se os resultados alcançados nesse nível assistencial, assim como os aspectos e as expectativas ainda pendentes, tanto para a disciplina médica como para a Enfermagem. Analisa-se também os planos de inovação recentemente implementados em diferentes comunidades autônomas espanholas, com destaque especialmente no que está se desenvolvendo na Catalunha. Além disso, aborda-se o atual desenvolvimento acadêmico da Enfermagem espanhola, o desenvolvimento das diferentes especialidades de Enfermagem e aspectos relativos à prescrição de Enfermagem, a triagem e a assistência de Enfermagem às patologias agudas na Atenção Primária.

DESCRITORES

Cuidados de enfermagem
Atenção Primária à Saúde
Educação em enfermagem

RESUMEN

Muchos años después de la Reforma de la Atención Primaria en España, se analizan los logros alcanzados en este nivel asistencial, así como los aspectos y expectativas aún pendientes, tanto para la disciplina médica como para la enfermería. También se analizan los planes de innovación recientemente puestos en marcha en diferentes comunidades autónomas españolas, especialmente el que se está desarrollando en Cataluña. Se aborda además en este texto, el actual desarrollo académico de la enfermería española, el desarrollo de las diferentes especialidades de enfermería y aspectos relativos a la prescripción de enfermería, el triaje y la atención de enfermería a la patología aguda, en Atención Primaria.

DESCRIPTORES

Atención de enfermería
Atención Primaria de Salud
Educación en enfermería

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Nursing studies in Spain became studies of university range in 1977[1]. Previous non-university studies opened space to the new qualification of Nursing University Graduate.

It was the moment when the World Health Organization (WHO) celebrated the First International Conference on Primary Health Care in Alma-Ata, Kazakhstan, in 1978. This conference defined and recognized internationally the concept of *primary health care* as a strategy to achieve the objective *health for all by the year 2000.* At this meeting, primary health care was declared and identified as

> essential health care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system, bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process[2].

Nursing, as for these terms, had to implement the design of the new study plans, and it was one of the first disciplines in Spain to include the recommendations of Alma-Ata into the learning contents of nursing university programs.

On the other hand, also in 1978, Spain voted for the new constitution, a vertebrating instrument of the recent democracy, which gave place, a few years later, in 1981, to the transfer of competences to the new Autonomous Communities (CCAA). All over Europe, different countries began health care reforms to adapt to the recommendations of Alma-Ata. In Spain, it was the beginning of the Primary Health Care Reform (Reforma de la Atención Primaria de Salud - RAPS) in 1984[3].

Another political fact of great significance in Spain was the enactment of the public health law (1986), aimed at organizing the National Health System and the different systems of the CCAA, which progressively assume health competences, according to modern tendencies[4].

Over the years, the RAPS had a heterogeneous development in the different CCAA, mostly due to the different political, economic and professional support provided. The change caused by the RAPS conflicted with concepts, attitudes and interests of different professional groups and conditioned the implementation of the change[5].

In Spain, the primary health care reform meant a series of changes for the system, identified in Chart 1, which assumed unquestionable advances. For nurses, this reform was seen as a great opportunity that allowed the development of new professional perspectives (Chart 2) and the execution of the new guidelines of the study plans for nursing graduates.

The main innovations included by the new study plans were the introduction of the *Community Nursing* class discipline, which gathered the new tendencies implemented by the RAPS, as well as basic disciplines such as biostatistics, epidemiology, demography and human ecology, fundamental instruments for the scientific development of the profession. This course, which is mandatory for all nursing graduates, was complemented with the execution of practices in the community and in new primary health care centers. Similarly, the *Geriatric Nursing* class discipline was also included to the program to respond to a population that was, and still is, getting old progressively.

Twenty years after the Declaration of Alma-Ata, some professional groups[6] performed critical analyses regarding the development of the presented projects. The conclusions they provide are almost the same as those highlighted, years later, by other researchers[7]. According to these analyses, the current opinion of the medical collective regarding the operation of the primary health care could be summarized in:

For nurses, this reform was seen as a great opportunity that allowed the development of new professional perspectives...

- lack of clinical direction of the staff.
- poor community orientation, since individual health care brings clinical visits to a standstill.
- excessive care to patients with chronic pathologies.
- insufficient financing with unbalanced quantities directed at hospital care.
- heterogeneity in the budget of the different CCAA, as well as in the portfolio of services.
- poor coordination with the specialized care, which sometimes results in the duplicity of examinations, with evident consequences for the system and the user.
- lack of coordination and communication to the social services, which produces, in many cases, a transformation of, almost exclusively, social problems into health problems.
- poor definition of the nursing work, almost exclusively limited to the care to the population with chronic health problems and the lack of interest in assuming other roles within the team.

Some of these aspects are objective, such as the irregular distribution of public health expenditure, both in Spain and in Catalonia[8-9], and the heterogeneity in the

Chart 1 - Consequences of the Royal Decree for the primary health care reform in Spain.

New orientation of the primary health care.
Conceptual changes in the system organization, which considers the primary health care as the center of the system.
Definition of the new primary health care functions, which aim at health and include the promotion, prevention, care and educational function.
Conceptual and philosophical changes in the organization of the primary health care.
Inclusion of teaching and continuing education into the working hours

Source: modified from: Caja C, Roca M, Úbeda I. *La enfermera comunitaria*. From: Roca M, Caja C, Úbeda I. *Elementos conceptuales para la práctica de la enfermera comunitaria*. Barcelona: MONSA Publishing Institute; 2005. p. 87-114[5]

Chart 2 - The primary health care reform: professional perspectives for nurses.

New functions and activities
Different fields of practice
Different criteria for the provision of human resources
New access scales
Better salaries
Consideration and encouragement for continuing education.

Source: modified from: Caja C, Roca M, Úbeda I. *La enfermera Comunitaria*. From: Roca M, Caja C, Úbeda I. *Elementos conceptuales para la práctica de la enfermera comunitaria*. Barcelona: MONSA Publishing Institute; 2005. p. 87-114(5).

distribution of health expenditure by CCAA and the different countries of the OECD[10-11] (Figures 1 and 4).

Some of the other aspects include facts of subjective interpretation of the authors and interviewees, which must be contrasted with the manifestations of the nursing staff.

In this context, gathering the results of several studies[12-14], the nurses state that the current portfolio of services:

- provides a limited part of the possible nursing activities;
- has a prevalence of biological aspects over psycho-social aspects;
- promotes dependent and passive attitudes in the users;
- neither promotes nor orients the community participation;
- presents uncertain areas of specific responsibility of the different professionals in the primary health care staff;
- presents inflexibility in the offer of services and in their adaptation to the needs of the population of reference, and
- presents a lack of scientific evidence regarding the technical guidelines and many other aspects of the nursing practice.

The same authors highlight that the portfolio should:

- be based on the needs of the population and their expectations;
- be defined by nursing professionals in coordination with other professionals from health centers, hospitals and social services;
- incorporate the nursing view to the services integrated in the area, promoting the autonomous development through their own body of knowledge;
- consider the opinions, suggestions and recommendations of the population, carrying out the principle of civic participation;
- guarantee the accessibility, equity and feasibility, as well as the effectiveness and efficiency of the health system, and
- have an appropriate computing system for the registration and evaluation of the quality of the services provided, and the added amount that the nursing services provide to the health system.

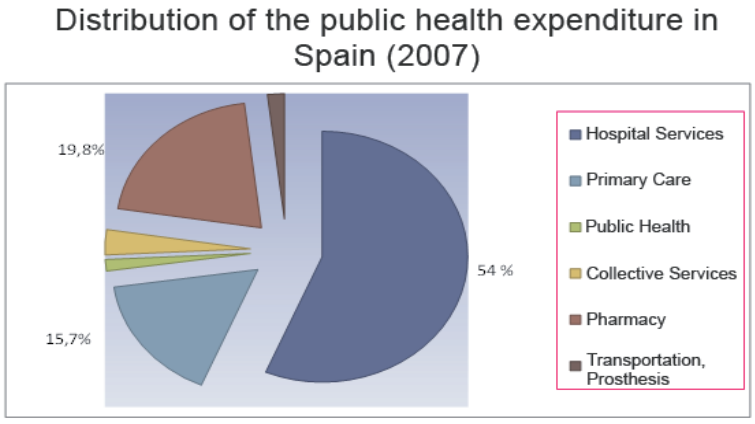


Figure 1 - Distribution of the public health expenditure in Spain, 2007

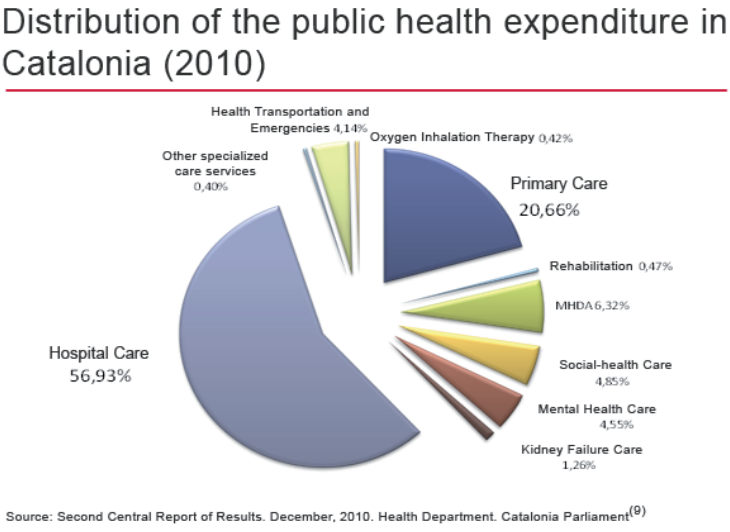


Figure 2 - Distribution of the public health expenditure in Catalonia, 2010

Nowadays, in Spain, nursing activities in the primary health care are developed as:

- clinical appointments in health centers, which may be either scheduled or made through direct and immediate demand of the user;
- home care: directed to people who cannot move to the health center, either due to a physical condition (immobility, lack of an elevator etc.) or due to a terminal life situation or any other health problem of long evolution, which complicates the movement, and
- family and community care, although this type of activity is not generalized and does not have the same characteristics in the different centers and CCAA.

At all these health care areas, nurses develop techniques of diagnosis, therapeutics, health promotion, disease prevention, care, teaching and researching, either being delegated or autonomously.

The Spanish health system, similarly to that of other countries, has great interest in learning the perception that the recipient population of the services has regarding the assistance they receive. Thus, a national survey is performed every year, and in Catalonia[9], the Health Barometer Survey and other reports[15-16]. Results are also published every year (Figures 5 and 6).

In general, it is observed that both nationally and in Catalonia, there is a slight increase in the appreciation of the system. However, for the specification and questioning regarding which the most appreciated aspects are, the

answer, in Catalonia, refers in first place to the cleaning of the centers, followed by the manners of doctors and nurses and by the clarity of the information received[9].

Spain and in its 17 autonomous communities have the Spanish National Health System (Sistema Nacional de Salud - SNS), which is configured as a coordinated group of health services of the Administration of the State and Health Services of the CCAA, integrating all the health provisions and functions that, according to the law, are the responsibility of the authorities, transferring other competences to the CCAA. Therefore, the central government has authority[16-18] over the basic legislation, which affects all the Spanish population and the coordination among the different CCAA, the great aspects regarding health financing, the pharmaceutical policy, the international politics, as well as everything related to the education of specialist professionals.

On the other hand, the CCAA are competent in the subsidiary financing and legislation, the deployment of public health in their territory, the organization of their health system, and aspects regarding the accreditation, planning, purchase and provision of services.

The Spanish National Health System[17-18] is characterized by its universal integration to public financing through taxes, and provides integral care to the population. It is organized in levels, decentralized in the CCAA, and has a specific portfolio of services, including the copayment of non-hospital pharmaceutical prescriptions and a system of evaluation.

In Catalonia, the characteristics of the health system are configured by the regulation law of the Catalan Health System[19], whose principles are identified as:

- Health is a public service, publicly financed.
- Providing universal health care.
- An integrated health system: emphasizing health promotion and disease prevention.
- The health system must aim at the equity and overcoming of territorial and social inequalities in the provision of health services.
- Health care provision must take place according to the criteria of rationalization, efficacy, simplification and efficiency.

According to these principles, the Catalan Health System is articulated with the following characteristics:

- Separation of the functions of financing and purchase of provision services.
- Diversification of suppliers.
- Mixed market of planned and regulated competences.
- Variety of management formulas.
- Decentralization of services.
- Dismembering of the organization: in regions and health sectors.
- Community participation: through direction boards, health councils and the participation of governmental organs of the health institutions.

Catalonia, similarly to Spain and other European countries, has population characteristics that create some future challenges:

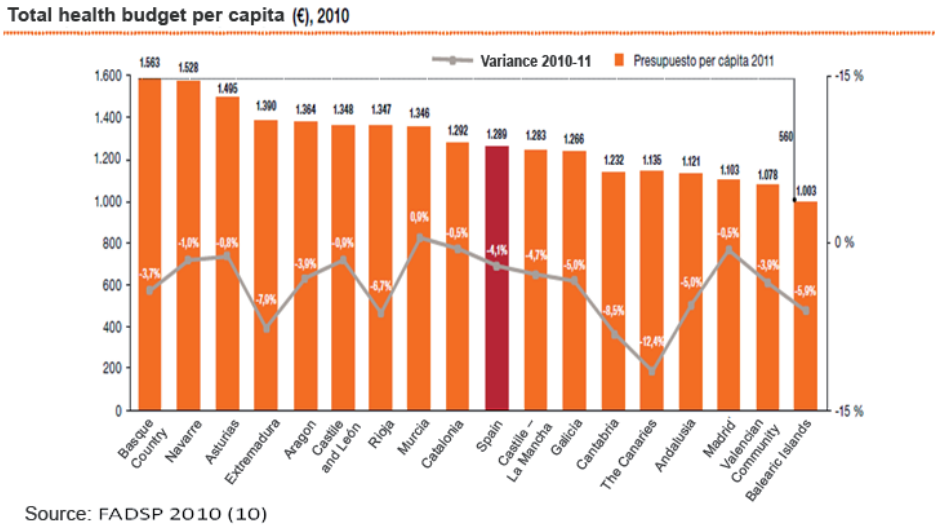


Figura 3 - Distribution of the public health expenditure in Catalonia, 2010

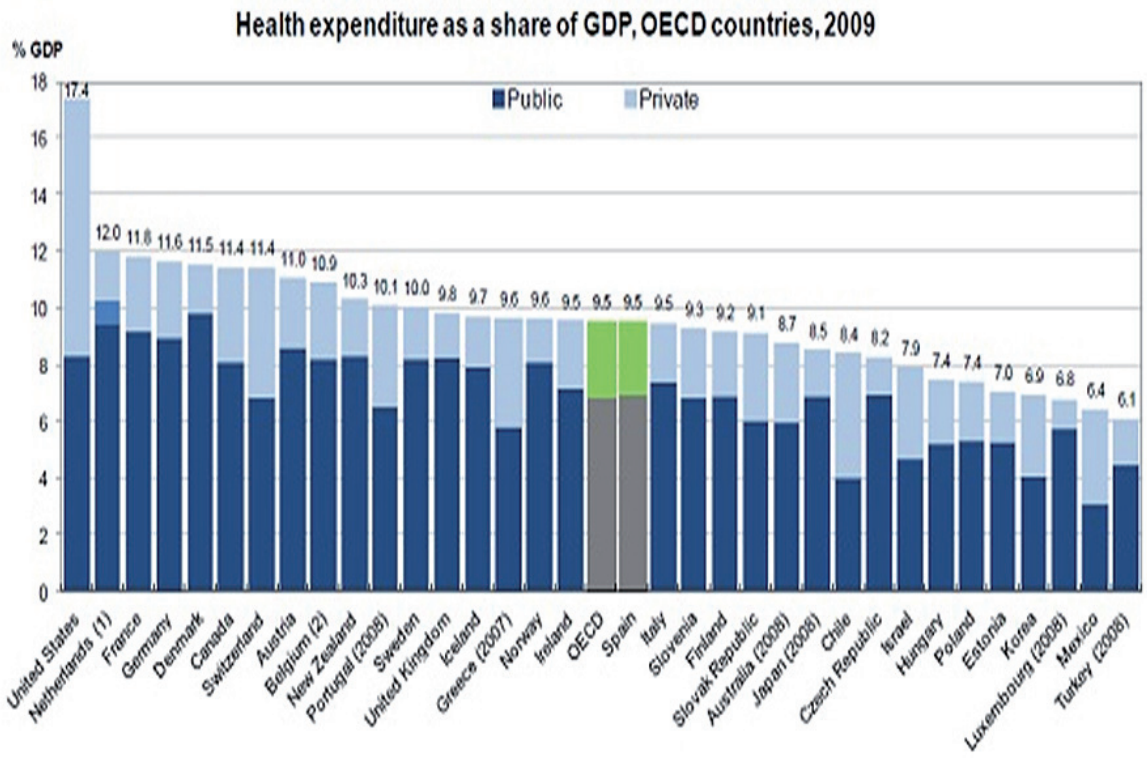
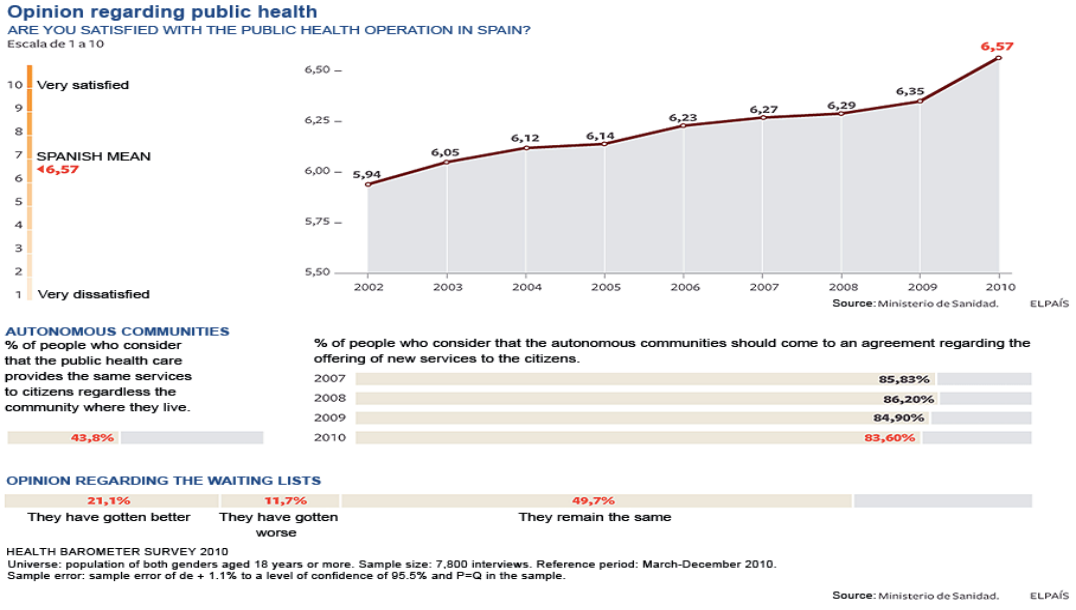
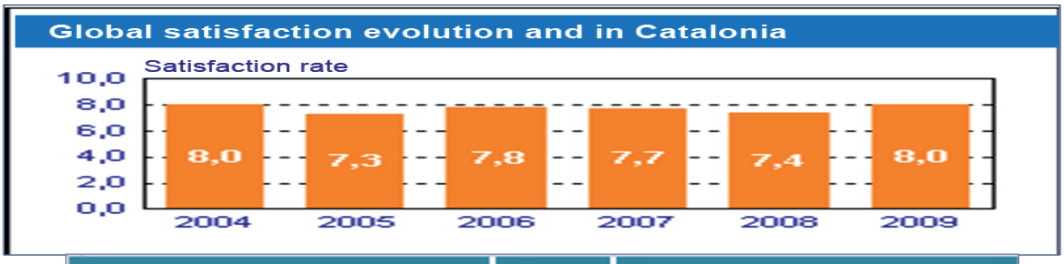


Figura 4 - Health expenditure as share of GDP, OECD countries, 2009



Source: OECD Health Data 2011. Available at www.oecd.org/health/healthdata[11]

Figure 5 - Opinion regarding Public Health



Care field	Cases	Total	Men	Women
Primary care	29.720	7,6%	7,6%	7,7%
Hospital care	4.683	8,3%	8,3%	8,3%
Mental health outpatient clinic	5.586	7,7%	7,7%	7,8%
Non-urgent health transportation	2.237	8,4%	8,4%	8,6%

Source: Second Central Report of Results. Barcelona: Health Department, Catalonia Parliament; 2010[9]

Figure 6 - Evolution of global satisfaction in Catalonia.

- demographic changes: the Catalan population has a lower life expectancy than the Spanish population (81.6 and 82 years, respectively), with a slightly inferior gross mortality rate than Spain (8.1/100,000 and 8.3/100,000 respectively), and the same happens to the infant mortality (3.1/1,000 children are born alive in Catalonia, against 3.3 in Spain). Another piece of information to be considered is the birth rate, with 11.5 / 1,000 inhabitants in Catalonia against 10.7 in Spain[8-9].

- cultural changes: the migratory phenomenon has had a great impact in Catalonia and in Spain over the last 10 years[20]. This immigration, which in part has contributed to increase birth rates and to rejuvenate the population pyramid, has also produced cultural and sociological changes.

- epidemiological changes: technological advances have allowed a betterment in the health of the Spanish population, contributing to an increase in the survival of people with one or more chronic pathologies.

These changes, among others, have caused the population aging, the existence of overaged population groups, with high proportions of dependent people and especially, the increase of health costs, which, being produced at a moment of world economic crisis, questions the system sustainability.

In face of this situation, the several health systems in State and autonomous community levels, are searching for possible solutions that allow to improve the situation without reducing the care quality. Since, on the other hand, it was evidenced that 75% of all health resources are used by less than 5% of the population, who are identified as complex fragile patients. Different CCAA have encouraged plans and programs aimed at the care to this specific population group[21]. The Catalan health system has set up a program of prevention and care to chronic diseases[22].

In 2008, 30 years after the Declaration of Alma-Ata, different countries submit their respective primary health care developments to a new analysis and agree on the need for an update, in order to improve the achieved success and to obtain what has still not been achieved, while trying to respond to the new scenarios created.

In Catalonia, in 2008, the development of the Plan of Primary and Community Health Care Innovation was initiated[23], contemplating the following key elements:

- Promotion of a sustainable, efficient and health-oriented system.

- System oriented towards the population, the professionals and decentralized in the territory.

- Integrating and coordinating the health care to the public health care and new emerging elements related to the care to dependence.

- Open, dynamic and flexible system in order to respond to the evolution of the society and to the scientific and technologic progress.

- Operating orientation towards the action.

In order to achieve these elements, some strategic axes are proposed:

- Incorporation of the community health to the habitual practice.

- Efficient and effective management of the demand, adjusted to the needs and resources.

- Adapting the home care to the new needs and to a more integrated organization of the hospital and primary health care services.

- Analysis of the financing system of the primary and community health care within the health system.
- Benchmarking of the different management models existing in Catalonia.
- Strengthening as much as possible the development of the professionals' competences.
- Integration, in the setting of the territorial governments, of the primary and community health care to the hospital, mental and social health care.
- Promoting the motivation and encouragement of the professionals.

This Plan of Primary and Community Health Care Innovation counts on the support of scientific societies and professional organizations and is currently in process of implementation.

In line with these events in Spain, the nursing professionals, result of the inclusion of this country in the European Space of Higher Education (EEES)[24] and the nursing program – which was catalogued as a university discipline of the first cycle, in other words, which could not provide, within the nursing discipline, the qualification of second cycle, bachelor's degree or doctorate – nowadays, have been approved for other university disciplines and may currently acquire the highest academic degrees. However, despite of these achievements, the competences that should differ the professional practice of a nurse with a basic degree to that of a nurse with higher qualifications have still not been defined.

Something similar happens to the specialty of community and family nursing[25], initiated in 2011, in regime of residency and complete dedication, during two years, but whose competences have still not been specified, in relation to the general nursing.

These are some of the challenges faced by the Spanish nursing area, from the point of view of the education, but there are other controversial aspects: the set up of the nursing prescription[26], and the nursing care to acute pathologies in the primary health care[27-28]. The consideration of these aspects divide even nursing professionals, some of which identify them as an advance in the acknowledgment of the capability and preparation of the current professionals, whereas others perceive them as a deviation of the nursing practice, with nurses becoming paramedics.

The author believes these controversies must be understood as an indication of the vitality of a profession in continuous evolution to adapt to the fast and necessary changes in society.

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