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REPORT
HEALTHCARE SYSTEM: CURRENT SITUATION AND PERSPECTIVES FOR THE FUTURE
CONCLUSIONS AND PROPOSALS

CONSEJO ECONÓMICO Y SOCIAL **ESPAÑA**

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REPORT 01|2024 HEALTHCARE SYSTEM: CURRENT SITUATION AND PERSPECTIVES FOR THE FUTURE

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INTRODUCTION

The health system is a vector of social cohesion and economic growth which is going through a critical moment, in which important challenges that have existed for decades are coming together, to which must be added that of incorporating the lessons learned from the pandemic and facing new challenges, such as the impact of environmental risks on health and the system's own contribution to the ecological transition. The Spanish system has traditionally enjoyed a good reputation and in international comparisons shows very favourable results in terms of health and life expectancy with a lower-than-average level of expenditure. However, in recent years the high level of appreciation for the National Health System (NHS) among the population has been tarnished by a worsening perception of it. Public concern about its deterioration is growing[1], making it all the more important to regain public confidence in the NHS by strengthening its resources and improving its quality.

Since the emergence of the global COVID-19 epidemic, which hit our country particularly hard in its early stages, healthcare in Spain has been able to show some of its strengths, in a context of extraordinary pressure on the structures of the system. But it has also revealed important weaknesses that place it at a crossroads. Identifying the priorities for action at this time from the point of view of this institution is the reason of this report, which incorporates the Economic and Social Councils' (ESC) contribution to the debate on one of the components of the welfare state most appreciated by the population.

Even before the pandemic, the system was already facing important challenges such as, without being exhaustive, tackling the transition from a model based on acute care towards the management of chronicity; adapting to the aging population and the necessary reinforcement of primary care and public health structures; the shortage of human resources and their ageing; the incorporation of digitalisation, new technologies and advanced therapies and artificial intelligence; innovation in management or greater participation of patients and progress in some of their rights. This is the start-

NOTES

1 CIS, Survey No. 3427, Barometer November 2023. Question 8 (Multi-response). Health was the situation most frequently mentioned as Spain's second main problem (10.3 per 100).

ing point of this report, which is eminently oriented towards the opportunities that have arisen from the healthcare crisis, despite the bad experience.

The first chapter of the report, devoted to health and well-being, reviews the health profile of the Spanish population based on the main indicators that provide information on the state of health of the population, which, according to the definition of the World Health Organisation (WHO), is understood as a state of complete physical, mental and social well-being, and not merely the absence of disease or illness. This is followed by a discussion of the system's portfolio of services, its limitations and the need to specify and complete the current catalogue and to introduce evaluation in the procedure for incorporating new benefits.

The next chapter of the report addresses the situation and challenges of the system from the perspective of the system's coverage and universality, as well as its human and physical resources. In the first case, it notes the limitations of coverage and points out some persistent constraints to making the principle of universality effective and improving the equity of the health system. The following sections of this chapter look at the challenges the system faces in responding to the human resources crisis it is experiencing in terms of staffing and quality of employment. It also provides an overview of the provision of infrastructures and technical resources at the different levels of care, emphasising the challenge of maintaining an adequate level of health infrastructures and equipment in a context of permanent updating and technological innovation, which require a major effort of evaluation.

The third chapter looks at the activity provided at the main levels of care (primary care and specialised/hospital care), showing the significant increase in attendance and activity, paying special attention to the impact of the pandemic, its aftereffect and the current situation. The data point to a clear worsening of the problem of effective accessibility to the health system due to waiting lists, the saturation of primary care in certain areas and the need to reinforce this level, the delay in scheduled appointments and the consequent postponement of tests and treatments in specialised care, with consequences for the health of patients and the organisation of consultations. Another separate section was devoted to public health, whose need of reinforcement is evident both to support preventive strategies as a basis for improving health and the sustainability of the system itself, and to prepare for the possibility of new health crises. The lessons learned from the management of COVID, compiled in the recently published Evalua-Covid evaluation report, should be incorporated into the roadmap in the coming years.

The worrying situation of mental health in Spain and the inadequacy of the existing public mechanisms for its proper care is analysed in a specific section of this chapter, which ends by addressing the necessary improvements in pharmaceutical provision, the challenges of equal access to medication and the policy of rational medication use. Special emphasis is also placed on coordination between levels of care (primary, spe-

cialised, hospital, mental and social and health care), which has proved to be so necessary during the pandemic.

On the other hand, the COVID-19 health crisis has only increased the challenge of guaranteeing a level of spending and a financing system that will ensure the sufficiency and adequacy of resources for the provision of quality, efficient services adapted to the requirements of a changing and increasingly demanding society. For this reason, the fourth chapter has been devoted to this issue. It should not be forgotten that, together with the significant increase in investment linked to the health crisis, the factors driving up public health spending continue to be present, including the incorporation of new technologies and advanced therapies, the ageing and chronicity of illnesses, the demand to update the portfolio of services and improve their quality, the anticipation of future epidemiological events and the necessary reinforcement of the public health system and the improvement of accessibility in rural areas. The situation of the system is firstly analysed from a comparative perspective, noting the lower public effort that Spain continues to devote to this item in comparison with other European countries, on the one hand, and the higher private spending, and exploring the reasons for this and suggesting ideas for consolidating sustainable financing compatible with the current framework for the distribution of responsibilities.

The harsh experience of the pandemic has also showed the need to further strengthen the guarantees of patients' rights and person-centred care, in a new scenario in which questions related to safety and information on medical acts take on a new dimension and new requirements are posed in terms of participation in the system. For this reason, the fifth chapter of the report addresses the quality of care from the perspective provided by the indicators of effectiveness, accessibility, safety and satisfaction offered by the NHS information system. This approach is completed with an analysis of rights during the care process, patient autonomy and participation in decisions affecting their health, on the one hand, and from the perspective of the development of social participation mechanisms, on the other.

The European *Next Generation* funds represent an opportunity for the transformation of the healthcare system, promoting biomedical research, digitalisation, technological renewal of the system and innovation in healthcare processes. The sixth chapter of the report is devoted to the opportunities and challenges of biomedical research in Spain (a field in full expansion, where our country is well positioned) and the challenges of the digitalisation of the healthcare system.

As demonstrated during the management of the health crisis, health governance is both highly complex and essential to ensure the principles that inform the NHS, its efficiency and sustainability, and chapter seven of the report reflects on the needs and prospects for improving coordination and cooperation mechanisms.

On the other hand, there are a number of cross-cutting issues that are addressed throughout the report. Although the report focuses mainly on the analysis of the chal-

lenges the NHS faces, it does not lose sight of the perspective of the health system as a whole. Thus, data and trends in the private sector are incorporated into the analysis, and an attempt is made to visualise the extent of public-private collaboration (e.g., through concerted activity) where possible, since the official sources available do not always allow for this.

Similarly, attention is paid to equity from different perspectives, especially from the approach of territorial inequalities, especially those affecting rural areas, and from the necessary incorporation of the gender perspective into all decisions in a system where women predominate as providers and recipients of health services and where it is necessary to deepen knowledge and address gender inequalities in health.

A final chapter draws the main conclusions that emerge throughout the report, which in most cases give rise to a series of proposals, with no intention of being exhaustive and with no other intention than to open up a debate in which expert diagnoses already abound, contributing the ESC vision to the roadmap for public decision-makers in this field.

CONCLUSIONS AND PROPOSALS

The health system is a vector of social cohesion and economic growth which is going through a critical moment, in a context in which important challenges that have existed for decades come together, to which must be added the need to incorporate the lessons learned from the pandemic and face new challenges, such as the impact of environmental risks on health and the health system's own contribution to the ecological transition.

The Spanish health system has traditionally enjoyed a good reputation and in international comparisons shows very favourable results in terms of health and life expectancy with a lower-than-average level of expenditure. It is necessary to highlight the universal nature of the NHS, the extension of the portfolio of services, the high degree of accessibility to them, the qualification and professionalism of its human resources, the quality of the care offered and the continuous adoption of measures to improve the system, including digital transformation and the incorporation of the most advanced therapies and technologies, but also the advances in providing an increasingly closer experience focused on the needs of the patient. However, in recent years the high level of appreciation for the healthcare system among the population has been tarnished by a worsening perception of it. It is very important to regain public confidence in the National Health System by strengthening its resources and improving its quality.

The following is a summary of some of the main central ideas that emerge throughout the report, which in most cases give rise to a series of proposals, with no intention of being exhaustive and with no other intention than to open a debate in which expert diagnoses abound, in the hope that the ESC vision will contribute to the roadmap of actions that must be undertaken for the consolidation and improvement of the NHS.

Increasing the positive impact of the health system on health and wellbeing

Health is the result of the interaction of very diverse social, cultural and environmental variables that act as its determinants, having a decisive importance in the quality of life, in the duration of life and in the burden of disease (understood as the impact of health problems in economic and mortality terms). In this sense, the role of the health system is limited, but it is possible and desirable to increase its positive effect by strengthening its care capacity and extending its preventive action.

Life expectancy, as a reflection of the health of the population, is currently among the highest in Spain, despite the decline experienced during the COVID-19 crisis. However, progress in survival has not been homogeneous, with significant differences being observed by educational and socioeconomic level, gender and territory, which are often confluent factors.

On the other hand, the increase in life expectancy has been accompanied by an increase in healthy life expectancy, an aspect of notable importance in a society in which the over-65s make up an increasingly large segment of the population, which, together with the fall in the number of births, is contributing to the ageing of the population. Notwithstanding this improvement in the healthy life expectancy indicator, the percentage of people over 65 suffering from chronic diseases is still significant –and higher in Spain than in the rest of the European Union, probably due to the greater presence of very old people–, which has an impact both on their quality of life and on the burden of disease due to chronicity. The greater survival of women increases the probability of suffering from chronic diseases, revealing the need to approach prevention and health care with a gender focus that adapts resources to the reality in terms of the prevalence of pathologies in women and men.

In the European Union –and also in Spain–, the main cause of death is due to diseases of the circulatory system, with some differences between autonomous communities and with higher mortality among women than among men throughout the territory. While the risk of circulatory diseases increases with age, it should not be forgotten that the vast majority of heart attacks and premature strokes are preventable with healthy lifestyle habits.

For its part, cancer is the other major group of diseases responsible for mortality in Spain, occupying second place after the circulatory system. In 2019, three out of every 10 deaths in men and two out of every 10 in women were caused by cancer. However, the increase in the quality of care in the diagnosis and treatment of this disease over the last decade has made it possible for five-year survival rates in Spain to be above the European Union averages for most types of cancer.

The influence of lifestyles together with the socio-economic and cultural conditions of the population on the incidence of these diseases, which are largely due to factors, mainly tobacco and alcohol consumption and obesity, highlights the significant scope for improvement in preventive policies.

In addition to these lifestyle factors, environmental conditions are another major group of determinants of health, which is why an increase in the quality of the environment has a positive impact on the health status of the population. However, global warming is a direct cause of morbidity and mortality, and its irreversibility in the medium term urges the implementation of adaptation measures to minimise its effects on health.

A commitment to public health, prevention and preparedness for new shocks

The main challenges the system faces are the high prevalence of chronic diseases in the context of ageing, and tackling the groups of diseases that cause most deaths, that is, those affecting the circulatory system and cancer. The onset of these pathologies is often due to unhealthy lifestyles, which are therefore avoidable and respond favourably to prevention. However, the health system alone is not capable of meeting this challenge. In this sense, the effectiveness of public health policies requires a commitment to act on the main health determinants, with interdepartmental public health plans, with high levels of collaboration and coordination and making the paradigm advocated by the WHO of "Health in all policies" a reality.

In the specific area of cancer diseases, screening programmes have proven to be highly effective, significantly reducing cancer mortality. However, there is considerable room for improvement in these programmes in terms of adherence of the target population and the inclusion of new screening, in line with the new approach to screening in the European Cancer Plan.

The recent global health crisis, generated by the spread of the zoonotic SARS-CoV-2 virus, has fuelled interest in a multisectoral approach to health, which should not be neglected in the development of national public health policies. Human health needs to be understood as the result of the interaction of multiple factors inseparable from its environment. Thus, this report has reflected the importance of the *One Health* strategy in assessing and responding to health problems from the perspective of the interdependence and linkages between human health, animal health and the environment.

Proposals:

- Activate the "health in all policies" approach with the involvement of all administration in the orientation of policies favourable to health with an intersectoral perspective.
- Improve adherence to existing cancer screening programmes, especially colorectal cancer, reducing inequalities between autonomous communities.
  Advance in the incorporation of new screening programmes for the most prevalent types of cancer, such as prostate, lung and gastric cancer, in line with the new recommendations of the European Plan to Combat Cancer and the Recommendation of the Council of the European Union of 2022. It is also necessary, in this regard, to follow the recommendations to extend the age range of the target population in breast cancer screening.
- Extend the application of the "One Health" approach in the development of public health policies.

- Develop a national zoonosis surveillance plan that integrates population health and animal risk assessment.
- Explore possibilities that the human-animal link brings to the health system, for its benefits to people's physical and mental health.
- Provide the NSH with the necessary resources to deal with large-scale health crises, strengthening the coordination at all levels. To this end, it is urgent, among other measures, to create the State Public Health Agency, with adequate resources.
- Strengthen and give continuity to actions such as the PRAN 2023 Campaign with the aim of raising public awareness of the appropriate use of antibiotics.
- Address the health effects of global warming, minimising the contribution of the health system to climate change developing adaptation strategies.
- Strengthen the role of community pharmacy in promoting public health, as proposed in the Opinion of the Congressional Commission for Social and Economic Reconstruction.

Advancing towards effective universality of the NHS

The principle of universal access constitutes, together with that of public financing and free services at the time of use, one of the main aspects of the right and one of the most characteristic pillars of the Spanish public health system. The practically universal nature of the NHS contributes to guaranteeing a high level of individual and collective health protection. However, some exclusions remain, some of which were intended to be addressed in the previous legislature, an initiative which the ESC viewed favourably in its Opinion 7/2022 but which remained unfinished after the general elections were called.

Likewise, the process of integrating the different public health protection subsystems into the NHS, as envisaged in the LGS (General Health Law, by its initials in Spanish), has not been completed, with the result that universal insurance is not provided solely through the NHS, but the peculiarities of the Administrative Mutual Scheme are maintained. The full integration of prison healthcare into the NHS is also still pending.

In any case, making the principle of universal health care coverage effective requires strengthening the NHS, completing the necessary reforms to optimise its resources, governance and cooperation throughout the health system, as well as the quality of patient-centred care.

Proposals:

- Definitely uncouple access to the NHS to the condition of Social Security insurance, consistent with its nature as a universal benefit financed from general taxation.

- Advance the universality of the health system, extending the right to health care to people whose entitlement had not been explicitly recognised.
- Approve the pending regulatory development of Royal Decree-Law 7/2018, homogenising and simplifying the administrative requirements for access to the right, eliminating barriers that hinder access to healthcare.

Improving equity in access to healthcare services in the NHS

Equity, understood as the guarantee of access to healthcare services under conditions of effective equality, has been another of the principles of the National Health System since its creation. Despite the efforts made to ensure equal access, the data show the persistence of inequities in different areas of NHS action, which can manifest themselves most acutely in a reverse care effect. This means that in certain circumstances the people who need care the most receive the least. Throughout the report, a number of different types and scopes of care have been identified and the risk of a deepening of this problem has been highlighted:

- The insufficient resources allocated to mental health in the NHS has meant that only 2 out of every 10 psychiatric consultations take place in the public system, while 8 out of every 10 are carried out in the private sector. This distribution of total activity, which involves expenditure for the majority of patients, may result in a situation of reverse care, with less attention being received by those who need it the most.
- According to the Ministry of Health data, participation in cancer screening programmes is lower in lower-income and less educated segments, which are precisely those more at risk of ill health. This lower adherence to established public health programmes limits the chances of early detection and increases rates of aggravation and worsens prognoses.
- Digitalisation of consultations. One of the most important changes in primary care activity in recent years has been the advance of telemedicine which, while offering interesting possibilities for improvement in terms of efficiency, may be generating negative effects by worsening the levels of detection of risks and diseases, as well as in the control and monitoring of chronic pathologies. Elderly people and those with fewer skills in digital tools are precisely those who need more medical care, but they are also those who are less likely to access care by digital means, the progress of which has been confirmed, partially replacing face-to-face care.
- Addressing health emergencies, such as the COVID-19 pandemic. From March 2020 to June 2023, COVID was responsible for one in ten deaths in Spain, but the territorial differences are very striking (ranging from 15.5 to 4.4 per 100), with

the groups that most need care receiving less attention in some communities, resulting in an increase in the number of deaths.

Proposals:

- Increase efforts to detect, analyse and assess inequalities in health and in access to health system benefits, paying attention to the emergence of emerging pockets of inequalities that may also manifest themselves in a reverse care effect.
- Analyse the impact on equity of co-payments and exclusions of benefits, medicines and health products from funding.
- Improve equity in NHS by acting proportionally, with progressively more intense responses according to socio-economic conditions, applying selective measures to improve the circumstances of the most vulnerable people.

Specifying, updating and improving the NHS portfolio of services

The NHS portfolio of services has been enriched and has incorporated numerous benefits over the years, in response to the necessary evolution of a system in which the needs linked to chronicity, public health, social and healthcare coordination or specific care for risk groups are gaining importance. However, in the catalogue of services, most of the benefits are still listed in a very generic way, allowing for a wide margin of variability in their specific development.

It is necessary to modernise and improve the coverage of the NHS portfolio of services, especially in some areas of care where the lack of specificity or the existing gaps are giving rise to significant social and territorial inequalities in health. Component 18 of the PRTR (Recovery, Transformation and Resilience Plan, by its initials in Spanish) also includes several commitments to increase the common portfolio of public health services, in line with other strategic documents such as the Primary and Community Care Action Plan 2022 and 2023.

In an environment in which therapeutic innovations are constantly appearing, it is also particularly important for the system to have procedures for continuously updating the catalogue of benefits, guaranteeing the incorporation of scientific and technical advances after assessing their impact, clarifying the functions and action plan of the existing assessment bodies and providing them with adequate resources for the proper performance of their tasks.

On the other hand, it is necessary to avoid health exclusion for economic reasons. In this regard, it should be remembered that the contribution of users to outpatient pharmaceutical care is the main exception to free public healthcare in Spain. Since the approval of RDL 16/2012, a co-payment scheme has been in place based on different levels of contribution depending on income level, status (active or pensioner) and degree of illness. The equity component of the system has been reinforced by the successive increase in the number of people exempted due to their socio-economic vul-

nerability. However, several years after the adoption of this new co-payment scheme, it is necessary to evaluate it from the point of view of its effects on the protection of people's health and on the quality of pharmaceutical provision.

Proposals:

- Specify the description of the benefits that make up the NHS portfolio of services, especially the scope and contours of benefits such as socio-health care, public health benefits and mental health care.
- Improve the coverage and scope throughout the NHS of oral and visual care, podiatry, pharmaceutical care, orthopaedic care, support for special diets, early care and care for the terminally ill.
- Analyse the feasibility of new reforms to further the objective of equity in the regulation of co-payments, such as ending the differentiation between active and pensioners; subdividing the current range of between 18,000 and 100,000 euros into more brackets to make the system more progressive; extending the maximum contribution limits to more groups or considering multi-pathology as a weighting factor for co-payments.
- Take the veterinary sector into account in the system's portfolio of services, in line with the *One Health* approach advocated by the WHO and the European Union.
- Simplify the categorisation of the portfolio of services established by Royal Decree 16/2012 recovering the single portfolio and eliminating the distinction between basic, supplementary and accessory portfolios.

Making primary care the true backbone of the system

The consensus on the importance of primary health care stems from the evidence of better health outcomes, greater equity in the distribution of resources and, ultimately, greater efficiency of health systems with strong, quality primary care systems capable of resolving most pathological conditions without the need to resort to the next step, the much more costly specialised/hospital care.

In a context of marked demographic ageing, primary care will have to take on the necessary reinforcement of its preventive role in the coming years, in order to increase the length of life in good health and free of disability. The sustainability of the health system in a demographic horizon with a growing proportion of the population over 65 years of age (around one third in 2050, according to projections) will be conditioned, among other factors, by the health status of this large segment. Moreover, one of the main challenges primary care faces is the specificity of rural environments, which are more ageing, where depopulation and population dispersion converge as conditioning factors in the provision of care.

After the pandemic, primary care is going through a particularly critical situation, with a clear deterioration in waiting times in all health services, as only a quarter of the population gets an appointment in the first 24-48 hours, a figure that before the pandemic was close to 50 per 100. It is therefore necessary to strengthen this level by improving timely response, inter-level coordination and responsiveness.

Proposals:

- Promote, monitor and disseminate the results of the full implementation of the Primary and Community Care Action Plan 2022-2023 and continuous evaluation of its objectives, especially with regard to increasing the number of professionals, guaranteeing their availability and improving working conditions so that accessibility, longitudinality, stability, attracting talent and consequently reducing temporary employment to below 8 %.
- Increase the resolution capacity of the primary care level.
- Move towards a model of systematic care for patients with chronic diseases, evolving towards a system centred on the needs of the patient, and simplifying care circuits.
- Prioritise preventive measures through the promotion of healthy lifestyles, in order to increase the healthy lifespan, reducing the need to resort to specialised care structures.
- Deepen actions aimed at guaranteeing quality care in both urban and rural environments, especially in areas of difficult coverage, optimizing the management of both material and human resources.
- Move towards territorial convergence to ensure that the population has access to primary care within 48 hours of requesting an appointment.
- Encourage greater collaboration between primary care and the pharmacy network by promoting initiatives, such as the existing personalised medication dosage system (SPD, by its initials in Spanish), that improve the quality of pharmaceutical provision, adherence to treatment and care focused on patients' needs.

Specialised care: tackling waiting lists as a multifactorial problem

Waiting lists are a multifactorial problem whose operational solution would require taking into account the evolution of morbidity and frequentation of services, available human resources, funding, the degree of coordination between the primary and specialised care levels, the provision of resources (including technological resources), private healthcare resources, changes in the registration and information system, management processes and even health education, among others. For this reason, the analysis of their evolution over time in the NHS is notably complex in a context of great variability in the

autonomous community management models, which are manifested in very different situations in the autonomous communities.

Waiting lists for consultations with specialists or for interventions at this level have usually been tackled with "Shock Plans" that seek to decongest the waiting lists through intensive use of the system's resources or by outsourcing them. Beyond the results of this type of circumstantial measures, which should be evaluated using cost-efficiency and health outcome criteria, structural instruments are needed to prevent the formation of pockets of patients waiting for care and to manage times in an effective, transparent and assessable manner.

Proposals:

- Develop the appropriate analyses to gain precise knowledge of the causes of the increase in waiting lists, avoiding resorting to opportunistic and circumstantial measures.
- Reach an agreement on common criteria for managing waiting times in the NHS, configuring a structural mechanism for anticipating and responding to the formation of waiting lists, with criteria of transparency and evaluation of results, which acts on the factors of demand, supply and management.
- Question and evaluate the excess of self-generated activity that is not always necessary, which may be giving rise to excessive controls, revisions or tests, articulating measures to avoid the use of defensive medicine.
- Promote the use by the NHS of all healthcare centres and resources, including those assigned to the Mutual Societies collaborating with the Social Security, as provided for in article 82.4 of the revised text of the General Social Security Act, which establishes that they may carry out diagnostic tests and therapeutic and rehabilitative treatments, with the aim of avoiding the unnecessary prolongation of temporary incapacity processes for common contingencies, with the prior authorisation of the public health service doctor and the informed consent of the patient.

Strengthening the comprehensive model of mental health care

Mental health is undoubtedly one of the weakest aspects of the Spanish health system, which calls for major reforms. This conclusion is reached not only because of the growing concern of the Spanish population in this area, especially since the COVID-19 pandemic, but also because of the clear cross-cutting nature of this issue throughout this report. Thus, for example, it is worth remembering that the quality of the NHS is undermined by problems of adequacy and effectiveness of the system in terms of urgent psychiatric readmissions, which have increased by 20 % and currently 1.5 out of every 10 patients who are discharged are readmitted urgently in less than 30 days. As an unavoidable challenge

for the system, the need to reinforce mental health care emerges, from primary stages to more serious cases such as urgent readmissions of psychiatric patients.

In Spain, the cost of mental health problems is estimated to be equivalent to 4.2 per cent of GDP. However, despite the importance of epidemiological data, and its implications for welfare and the economy, mental health accounts for a small share of the system's resources in terms of specialised staff.

In this context, the worrying increase in mental health problems in the child and adolescent population is inseparable from the transformation of lifestyles, leisure patterns and new modes of socialisation in which digital technologies have taken on an enormous role. Behavioural addictions, disorders such as addiction to problematic or pathological gambling, addiction to information and communication technologies and the indiscriminate use of screen tools and cyberbullying are increasingly common forms of problematic behaviour associated with ICTs among young people.

On the other hand, also in terms of quality, the safety of the system is compromised by the inappropriate use of different drugs, among which benzodiazepines and hypnosedatives stand out. The problems detected in the use of these drugs have generated some controversy regarding their efficacy and safety, not only because of their high rates of use, especially unsafe in people over 65 years of age, but also because of gender patterns in consumption patterns.

Proposals:

- Increase the resources dedicated to mental health and extend a comprehensive therapeutic approach to it, guaranteeing multidisciplinary care, continuity of care and the perspective of equity.
- The NHS must increase its resources to tackle mental health problems, both in terms of specialised human resources (including child and adolescent psychiatry and psychology) and devices.
- Improve the preventive dimension in the approach to mental health in the entire population, including the child and adolescent population, paying special attention to communication technologies and social networks as risk factors, as well as to potentially addictive behaviours.

Enhancing the quality of pharmaceutical provision and rational use of medicines

Pharmaceutical provision and rational drug use policy play an essential role in the fulfilment of the right to health and the development of healthcare. The NHS guarantees a wide range of financed medicines, with a significant proportion of generic medicines, although below the European average, and biosimilars, with an unequal degree of territorial penetration.

The data on medicine consumption in Spain largely reflect the health profile of the population described above, with a constant increase in the weight of therapeutic subgroups indicated for the treatment of pain and chronic pathologies such as diabetes, hypertension and mental disorders. Spain stands out in the European comparison, particularly for its high consumption of antidepressants. In the profile of hospital pharmaceuticals, anti-tumour drugs, immunosuppressants and antivirals are predominant, accounting for 60.6 % of the expenditure in this area.

Strengthening autonomy and guaranteeing supply is a challenge in a context where shortages of some health products and medicines are a global problem. Some regulations at regional level and various initiatives under the PERTE (Strategic Projects for Economic Recovery and Transformation, by its initials in Spanish) for cutting-edge health aim to strengthen and develop the capacities of NHS centres, as well as the development and modernisation of innovation-oriented industrial capacity, while the initiative to create a strategic health reserve was put on hold following the dissolution of the Courts.

The development of medicines for advanced therapies and for some rare diseases for which there was no treatment until recently, as well as the discovery of alternative uses for existing medicines, open up new expectations for patients, while at the same time posing a major challenge, not only from the scientific and manufacturing point of view, but also in terms of their inclusion in the portfolio of services and their financing. There is a need to align research and innovation with unmet health needs.

In comparative perspective, in Spain too much time elapses between the authorisation of some medicines and their actual prescription, so that access to innovative medicines and therapies is not always accessible to all patients at the same time, depending on marketing practices, pricing policies, market competition or the speed of administrative authorisation procedures. Improving time to market is important.

On the other hand, the advance of antimicrobial resistance is reducing the ability to treat infectious diseases and even to perform routine surgery, and is a multifactorial problem with a global reach.

All this, together with the high weight of pharmaceutical spending as a whole, points to the need to continue to deepen policy actions for the rational use of medicines, improving the quality of pharmaceutical prescribing, reducing inappropriate consumption of medicines and encouraging proper adherence to treatment.

In any case, promoting the effective, appropriate and rational use of medicines is part of the public health policy of the NHS. The prominence of pharmaceutical prescription within the NHS is related to the problems of primary care; the limited time that professionals can devote to patients, as well as the weakness of the rational drug use network in primary care, the scarcity of resources for preventive public health programmes and the promotion of healthy lifestyles, the scarcity of resources dedicated to mental health care and the inability of the system to date to extend a comprehensive

therapeutic approach to mental health problems, where pharmacological treatment is part of a continuum of care provided by multidisciplinary teams.

For their part, it should be remembered that pharmacies are healthcare establishments which, because of their proximity and closeness to patients, play a fundamental role in public health policy and the rational use of medicines, which should be strengthened.

Proposals:

- Promote strategic autonomy in medicines and health products, strengthening the resilience of the supply chain.
- Advance planning for a strategic stockpile of essential medicines and health products and a state coordination system around.
- Accelerate the implementation of the actions of the PERTE for cutting-edge health aimed at strengthening the production capacities of medicines and advanced therapies of the NHS and their coordination at the state level, as well as the development and modernisation of innovation-oriented industrial capacity.
- Promote the tasks of the AEMPS (Spanish Agency for Medicines and Health products, by its initials in Spanish) in the field of supply guarantees in collaboration with the entire medicine value chain, as well as the implementation and monitoring of the Medicines Supply Guarantees Plan approved in 2019.
- Promote innovation and the development of medicines in areas where there are shortages, such as neurodegenerative diseases, rare diseases and childhood cancers, as well as improve the population's accessibility to them.
- Articulate specific procedures that provide the inclusion of medicines with predictability and transparency and make progress in a process of setting appropriate prices.
- Continue to promote measures to reduce the overuse of antibiotics in both human and veterinary healthcare and to encourage the development of innovative antimicrobials or alternative to antimicrobials.
- Simplify the complexity of the administrative processes that precede the placing of medicines on the market.
- Promote abbreviated authorisation and registration procedures for medicines of special therapeutic need.
- Reduce territorial differences in the time elapsed between the establishment of pricing and reimbursement conditions for new oncology drugs and their approval for prescription in hospitals.
- Promote the Plan to Rationalise the consumption of pharmaceutical products and promote sustainability.

- Complete the implementation of the Action Plan to promote the use of biosimilar and generic medicines, as well as innovative medicines, in the National Health System.
- Promote training to increase the skills and knowledge of professionals in the rational use of medicines and health technologies.
- Strengthen the role of community pharmacies and pharmacy teams in this area, taking advantage of advances such as the interoperability of electronic prescriptions, both in primary care and hospital care.
- Improve the quality of pharmaceutical care for residents in social and healthcare centres.
- Adopt a comprehensive approach to animal and human health care, also in the area of pharmaceutical provision.
- Continue to make progress in prescription quality actions, with special attention to avoiding unnecessary medication in children and the elderly.

An investment in the future: consolidating the NHS with sufficient and sustainable resources

The consolidation and budgetary strengthening of the National Health System should be seen above all as an investment in the future, both for its contribution to the well-being, longevity and quality of life of the population and for its redistributive impact and its contribution to the social and territorial cohesion of the country. But also for what it represents from a strictly economic point of view, and not only for what the health sector contributes in terms of added value and employment, already very significant in itself, but above all for its contribution to the potential growth of the economy. Spending on improving the health of the population means investing in human capital, with the positive effects that this has in terms of expanding the workforce, extending working life, increasing productivity and improving the performance of workers.

The availability of sufficient resources to meet the needs of the population and promote health prevention is a prerequisite for the provision of quality health care. This requires an adequate level of spending, comparable to that of countries with a similar health profile and economic and social development, as well as reinforcing the system's human and material resources, taking into account the needs of the population and existing health risks.

According to all indicators, health spending in Spain continues to be well below the UE-27 average, especially when compared with countries that also have a large population, such as France and Germany. Moreover, the weight of private health spending, both direct payments by households and health insurance, is differentially high in Spain and has a growing importance in households budgets, which is largely due to the very insufficient public coverage of some basic services and benefits, such as

certain therapeutical devices or oral and mental health services, but also to the desire or need to avoid long waiting times for some public services in specialised care, both inpatient and outpatient, which is correlated with a growing demand for private health insurance.

It is therefore very necessary for all public administrations to make additional efforts to increase the financing of the National Health System, in line with the recommendations of the Reconstruction Commission, so that they can provide a sufficient response to the health needs of the entire population.

Proposals:

- The autonomous communities should prioritise health spending on the basis of its particular economic and social usefulness.
- For the sake of the principle of fiscal co-responsibility fiscal and in the exercise of their tax autonomy, the autonomous communities should increase the allocation of resources to expand the portfolio of services and improve their health services.
- The announced partial assumption of the autonomous communities' debt by the State will mean a considerable increase in their fiscal margin, which the autonomous governments should take advantage of to strengthen their respective health systems.
- The extension of finalist state transfers to the autonomous communities, charged to the General State Budget and European funds, should be explored to strengthen the weakest or least developed health areas, such as primary care, dental services or mental health.

Boosting the planning and reinforcement of human resources in the NHS

The current crisis in human resources in the health system requires priority attention in order to safeguard the quality and accessibility of care, as well as the attractiveness of the health professions. The confluence of several factors alerts us to the importance of regulatory, planning and management decisions, which must be adapted to the needs of the population and social changes.

Important statistical limitations persist which affect the knowledge of the reality of the human resources of the health system as a whole, making any strategic planning exercise difficult. However, based on the fragmented picture provided by the different sources, a significant growth in the health sector over the last two decades is confirmed, reaching close to 1.3 million employed people by the end of 2022. All in all, Spain is around the average for EU countries in terms of doctors per inhabitant. And below average in terms of nursing staff, although the data may not be strictly comparable. The volume of other types of professionals is also clearly insufficient in some cases, such as psychologists, social workers or physiotherapists. Three out of four health pro-

fessionals work in hospital care, reflecting the preponderance of this level, a trend that has been increasing despite repeated commitments to strengthen primary care.

Despite the increase in the volume of staff in recent years, the levels of professionals per 1,000 inhabitants prior to the 2008 crisis have not been recovered. For its part, the significant reinforcement of staff recruited during the pandemic has not been fully maintained.

The next few years will be critical in Spain, both because of the shortage of staff in some specialities and because many health professionals will reach retirement age, although it is expected that from 2027 onwards there will be a certain rejuvenation with the gradual incorporation of more numerous promotions. Added to this is the increase in demand for care, both due to the emergence of needs stagnating during the pandemic and its after-effects, and to the advance of the ageing process of the population, among other factors.

Solving the mismatch between the supply and demand of medical personnel

The mismatch of specialist medical staff poses important challenges beyond quantitative planning, affecting the very criteria of entry to the medical and nursing degree; the lack of attractiveness of some specialities and places of employment or the very definition of the map of specialities and specialised training programmes. Some of these challenges can be extrapolated to other health professions such as nursing or physiotherapy.

The growing volume of applications for certificates of suitability to work abroad illustrates a propensity to seek work in other health systems which, apart from the individual advantages it may bring, is a waste of talent and resources for the system, given the cost, the difficulty and the duration of health studies.

Beyond the question of the quantitative need for resources and new recruitment, professional mismatches are underpinned by a complex reality that requires solutions from multiple angles, especially in the field of public management, improved incentives, motivation and working conditions that make less sought-after positions more attractive. Working conditions are often a deterrent, especially due to a high level of seasonality, frequent short-term contracts, difficulties in reconciling work and personal life, high mental workload, exposure to occupational hazards and increased incidence of violence in the workplace. Workforce instability hampers the already complex management of health care facilities and can negatively affect the quality of care.

The need for changes to improve job quality, efficiency and patient care

The approval of the stabilisation process for healthcare staff through Royal Decree-Law 12/2022 had its origin in la Law 20/2021, of 28 de December, on urgent measures for reduce the temporality of public employment, which modifies the EBEP and

the Framework Statute for statutory health service staff, in line with the commitment of the PRTR (C-18), on the renewal and expansion of the capacities of the NHS. This opens the way for the consolidation of some 80,000 temporary workers in the NHS. However, other commitments are still pending, such as the approval of incentives to cover vacancies in certain underserved geographical areas, as well as other measures that contribute to professional development and retain talent in the Spanish system, with the introduction of improvements in the working environment and conditions, not only in terms of economic conditions, but also through the opening up of possibilities in teaching and R+D.

Underlying the heterogeneity and dispersion of remuneration in NHS is the absence of an integrated model based on coordination between the different competent administrations, as well as information systems that facilitate the evaluation of the different remuneration policies implemented in each autonomous community.

It is also necessary to consolidate an adequate planning of permanent training, to provide the means for people working in the health sector to take advantage of the training on offer and to make it compatible with the performance of their duties and their personal lives. The evaluation of the quality of the training provided, as well as the work of accreditation and validation of the usefulness of this training, has special relevance.

Proposals:

- Provide the State Register of Health Professionals with full operability, as a fundamental planning tool of health human resources.
- Prepare a map of the human resources of the Spanish health system, permanently updated.
- Improve the coordination of the policies of human resources in the NHS, including retributive policies.
- Strengthen the collaboration between health and educational authorities for the planning of undergraduate degree, postgraduate degree and continuous training.
- Avoid the decoupling between the number of graduates in Medicine and other studies required in the NHS (such as psychology and nursing) and the number of posts available for subsequent specialist training via the FSE (MIR, PIR or EIR)).
- Increase posts in the territories that require it.
- Reconsider the suitability of the entry criteria for medical and nursing degrees at universities and guarantee the sufficiency of posts.
- Increase the attractiveness of the specialties in which year after year there are void vacancies, improving work conditions.
- Design incentives to fill vacancies in destinations with low demand or excessive turnover, especially in rural areas.

- Analyse the causes of the emigration of healthcare personnel trained or with experience in Spain, tackle talent retention policies and encourage their return.
- Implement programmes to manage the age factor in order to encourage people to remain in active service and avoid retirement before retirement age.
- Favour geographic mobility of health professionals in the NHS.
- Professionalise the management of NHS centres and hospitals.
- Reduce the high bureaucratic burden of the health professions.
- Deepen in the collaboration and coordination of functions between medical, nursing and administrative personnel, and opening up the possibility of creating new figures, taking up what was agreed in the Professional Classification Agreements.
- Favour the access of women to management and strategic positions in the system.
- Consolidate an appropriate permanent training planning.
- Improve the assessment of the training given, with homogeneous criteria.

Guaranteeing the necessary health infrastructures and equipment

The management of the material resources of the system faces important challenges in a context characterised by the strong boost experienced by therapeutic and technological innovation, including the development of personalized treatments, more and more advanced and of a higher price, what faces health systems with the challenge of their financing and guaranteeing equity to access them. The centres and services of the health system face the need for adequate resources, based on evaluation and efficiency criteria. New challenges add to this, such as environmental sustainability and the reduction of carbon footprint in hospital activity, the adaptation to user and working population ageing, as well as the need of adaptability of infrastructures, equipment and organisational structures to changing and unexpected needs, as shown during the pandemic. A physical and technological conception is also necessary, which facilitates the cooperation between different hospital services and with other levels of care, particularly primary care.

The availability of adequate and up-to-date technology is essential to guarantee increasingly accurate diagnoses and more effective treatments from the earliest stages of the disease. Despite most recent investments, Spain is below the European average and that of its closest neighbouring countries in terms of high-tech equipment, and the public effort in this type of investment has been modest. Moreover, there are significant territorial differences both in the endowment of this equipment and in the weight of high-tech public and private ownership and the efficient use of equipment.

Advancing in the evaluative culture of the Health System

The efficiency of health centres and hospital services requires providing them with the necessary re-

sources, as well as the development of robust methods to generate valuable information to improve the quality of care, the information available to users and the rational and sustainable management of resources.

Since the approval of Law 15/1997, the proliferation of organisational forms of direct or indirect management of health centres and services through any entities permitted by law has become a reality, especially at the hospital and specialised care level. However, until now there has been a lack of a system for evaluating the health outcomes of the different management formulas, both direct and public-private, based on evidence and in accordance with common and homogeneous indicators, in order to facilitate decision-making and the appropriate use of public resources.

In addition to the temporary injection of resources provided by the INVEAT Plan within the framework of the PRTR, it is important to remember the need to structurally optimise the systems for the incorporation of health technologies into the NHS and the evaluation of their efficiency in Spain, since, as reflected in Chapter VII of the report, devoted to governance, the mechanisms currently in place are characterised by the absence of a system-wide design, with a certain organisational confusion and confusion in the assumption of responsibilities between the different levels.

In addition, hospitals are faced with the need to adapt their resources to provide comprehensive care for chronic and frail patients linked to multi-pathology and old age, who require a type of integrated care shared between primary, inpatient and public health care.

Proposals:

- Continue to drive the reduction of the obsolescence of the technological park, balance the density of equipment per 100,000 inhabitants by overcoming territorial differences and encourage its efficient use.
- Boost the utilisation rate and efficient use of equipment.
- Advance in the evaluative culture of the health system, at the same time promoting the effective application of the obligations established by Law 19/2013, of 9 December, on Transparency, Access to Information and Good Governance, by all responsible bodies and subjects bound by it, safeguarding the legal limits to the right of access to public information and the personal data protection regulations.
- Establish an evaluation system of the health centres and hospital services management from a multidimensional point of view, with a long-term vision, centred in the NHS principles and the results in health of the users of the services.
- Reconsider the organisation and priorities of the hospital within the framework of the general recommendations of the models of care for patients with chronic diseases.

- Advance in a physical and technological conception that facilitates cooperation between different hospital services and with other levels of care, particularly primary care.
- Evaluate the experiences of integrated care models and interlevel cooperation and disseminate good practices in this field.

Guaranteeing interterritorial equality and mobility of patients

As the ESC has pointed out, it is necessary to plan health resources rationally and in accordance with the health needs of each territory, so as to guarantee equality of access and quality of care regardless of place of residence. However, as a starting limitation, the report shows that there are great disparities between the regions in terms of per capita health spending, budgetary effort, the relative weight of spending on hospital care versus primary care, the size of pharmaceutical spending, and also in terms of the importance of spending on health care agreements with the private sector.

The CSURs (Centres, Services and Reference Units, y its initials in Spanish) are important instruments for guaranteeing cohesion and equal opportunities in access to healthcare regardless of place of residence, as are the other cases of patient mobility in the NHS as a whole. However, it is necessary to optimise coordination and cooperation between health services, improve and streamline administrative procedures and optimise the use of existing budgetary instruments to ensure interterritorial equity in access to health infrastructures, equipment and technologies.

Throughout this report, other notable differences have also been observed that may be affecting equity from a territorial perspective. Thus, there are territorial significant differences both in cancer mortality and in terms of prevention, human resources, access to early diagnosis programmes, advanced therapies and quality of care, which demonstrate the need to improve the functioning of cancer care. Likewise, there are still differences in the application of the rational use of medicines policy in the different health services.

Proposals:

- Undertake the reform of the financing system of the communities of common regime, in order to correct some of its main weaknesses, in particular, the relative underfinancing of some of them.
- Guarantee the functioning and effective contribution of the Health Cohesion Fund and the Care Guarantee Fund to equal access to public health services, compensating the costs incurred by the regional health services for the care of displaced or referred patients, as well as developing accompanying measures to meet the costs of displacement for patients' families.

- Facilitate the permeability of the different health services, given the unequal provision of infrastructures and resources for complex pathologies.
- Improve the evaluation and monitoring of the CSUR organisational model based on health outcomes. Assess its extension to other areas, beyond care for rare and highly complex diseases.
- Guarantee interterritorial equity in the care of all complex pathologies, regardless of their incorporation into the CSUR system.
- Institutionalise cooperation mechanisms between health services for when the critical situation of the patient does not make it advisable for them to travel, but rather for them to use the equipment and technological resources.
- Establish minimum quality standards for the provision of oncological care throughout the NHS.

Maintaining and strengthening the quality of attention, centred in the patient

Analysis of the system from the perspective of quality requires a dual approach in which both the excellence of services and their focus on patients and their needs are assessed. The quality indicators collected by the NHS information system are not as exhaustive in this dimension. In general terms, the indicators are more robust in measuring issues of effectiveness, efficiency or safety, and somewhat weaker in measuring the patient-centred dimension of the system.

On the other hand, the system has important areas for improvement. Among them, one of the most striking has to do with palliative care, which is, in turn, one of the most qualitative dimensions of the system, as it addresses issues such as the right to relief of suffering or the quality of end-of-life care. The lack of agreement between the different administrations to establish homogeneous criteria for monitoring and evaluation prevents the INCLASNS (Key Indicators National Health Systems, by its initials in Spanish) from including indicators on palliative care and, despite the fact that monitoring reports continue to be drawn up, the Palliative Care Strategy has not been updated since 2014.

However, despite the challenges facing the NHS in guaranteeing universality and improving accessibility to the system, aspects such as the high rates of vaccination against influenza in people over 65 years of age or breast, uterine and colon cancer screening as a strategy for minimising risk factors show the more positive dimension of the system in this area. These indicators, which in perspective compare with the European Union average, demonstrate not only the quality that the system is capable of offering, but also the population's confidence in the NHS.

However, waiting times, to which reference has already been made, are the indicator that most negatively affects the quality and accessibility of the system. Despite the fact that Law 14/1986 recognises the right of patients to have a healthcare response within

adequate timeframes, current waiting times have a negative impact on patients' health, but also on the efficiency of the system. In fact, although the rate of unmet medical needs in Spain is very low, lower than the EU average, waiting lists are the main factor explaining this. Moreover, the Health Barometer shows that seven out of every ten people who opted for private health insurance did so because of "the speed with which they are attended to".

The saturation of the public health system is symptomatic of the major challenges faced by the health system as a whole in guaranteeing the right to health, which is the responsibility of the public authorities, in terms of the adequacy and sufficiency of available resources, equity, quality of care and sustainability.

There are also a series of barriers that do not form part of the statistics, but which negatively affect the accessibility of certain groups to health services. Among them, architectural arrangements in health centres and hospitals, the need to travel to health centres in rural settings with a dispersed population, as well as the cultural and/or communicative barriers with migrant population, among others. In this context, age bias leads to problems of age discrimination or "ageism", which requires constant vigilance to avoid patterns such as limited late or missed treatments or diagnoses, reverse care practices, inappropriate polymedication with an unfavourable risk-benefit ratio, "rationing" of care for reasons of age or even the exclusion of older people in randomized clinical trials without well-justified reasons. It is therefore imperative to minimise ageism bias, as it has been shown to lead to serious health problems and even death.

Need to eliminate invisible barriers and guarantee patients' rights

The degree of participation of people in decisions about their own health is another important dimension of the quality of the system, which is not only linked to the medical opinion but also to the patient's experience, who will go through the therapeutical process and has the capacity of analysing the risks or benefits in terms of quality of life or possible adverse effects in the short, medium or long-term.

In addition to the right to participate in the management of one's own health, the NHS provides for different mechanisms for the collective participation of citizens in the planning, implementation and management decisions of the health system. This way, individual participation contributes to bridging the gaps between the perspective of policy makers and the experiences and needs of communities.

Proposals:

- Improve patient-centred quality indicators. In this regard, the health information system should compile and publish official figures on the number of complaints and suggestions made by citizens, with data disaggregated by gender,

socio-demographic profile, level of care, reason for complaint and average response time, both in public and in private centres.

- Update the NHS Palliative Care Strategy and promote the necessary dialogue to include quantitative and qualitative indicators in the INCLASNS on the degree of compliance with the objectives related to palliative care treatments.
- With regard to the provision of voluntary termination of pregnancy, it should be recalled that there is a certain disparity and territorial inequity in access to this service, and that the public network must have the appropriate resources to guarantee the accessibility, cost-effectiveness and proximity of this service included in the common portfolio, without prejudice to public-private collaboration in this area and the safeguarding of the individual right to conscientious objection on the part of healthcare personnel.
- To improve the quality of patient-centres care, advance in the evaluation of clinical practice from the point of view of preventing possible biases of all kinds, including age or gender, among others, integrating into management and service provision models the experiences, both physical and emotional, of different groups, including vulnerable groups or those about whom there are stigmas or stereotypes.

Advancing towards a resilient and fair gender-sensitive health system

As it has been shown in this report, the feminisation of health professions is a growing reality. More than half the professionals of medicine and more than 70 per cent of nursing professionals in the NHS are women. This trend will increase in the coming years, taking into account the number of women among the new incorporations into health professions, what should be taken into account in the context of health planning and management. However, they are a minority in management and strategic posts in the NHS.

Women underpin the health and health care system in our country, not only because of their preponderance among health personnel and health researchers, but also because of their continuing role in the informal health care system within the household, which implies that they are *de facto* responsible for the health of all their members as a result of the inequality in the distribution of care roles in society, as analysed by the ESC in its Report 1/2022, an inequality which must continue to be overcome. Moreover, the ageing of the population and the greater longevity of women means that women predominate among older patients, with a large part of the burden of illness, chronicity and frailty associated with age falling on them, on the one hand, as well as, on the other hand, the care, attention to illness and accompaniment of members of the family environment in their journey through healthcare establishments. The resilience of the health system is largely linked to the recognition of this reality and to the adoption of a gender approach that does justice to it in all its dimensions.

The persistence of inequalities in health, in access to the health system between women and men, continues to make it necessary to improve knowledge and the dissemination of information on these issues, as well as to tackle the specific problems that affect women both as users of the health system (such as difficulties in access to reproductive health or differences in the consumption of medicines and the over-prescription of psychotropic drugs among women), or as professionals of the system (such as violence against health personnel, mostly suffered by women, or the difficulties in reconciling personal, family and working life).

Proposals:

- Include the gender perspective in any type of analysis aimed at policy design and decision-making in the health sector, starting with its necessary inclusion in the system of indicators for measuring, monitoring and evaluating this reality.
- Promote the activity of the Women's Health Observatory and the translation of these findings into the practice of research, medicine, health care and management.
- Incorporate the gender perspective in clinical practice and in the quality criteria for prescriptions.

Strengthening trust in the system and making the patient's participation effective

Part of the population has a high degree of confidence in the National Health System, with high rates of satisfaction and sense of belonging, and a very positive consideration of its functioning. However, in spite of the strengths the system showed to face the pandemic, its impact, added to the challenges it already faced before, became a weakening of the assessment of the population in primary and specialised care. Although the provisional data of 2023 show a slight rise, it is necessary to pay attention to the growing dissatisfaction of the population with the system, with the aim to determine whether this indicator respond to a critical situation such as the pandemic or whether there are deeper reasons for dissatisfaction. In this regard, it is appropriate to bear in mind that the Spanish population has historically conferred a high value to the NHS and, in general, considers it works well or fairly well. This has positive effects on questions such as the therapeutic adherence or on the possibilities of return in the event of a new episode of illness or disease. But an institution with good reputation also has talent, cohesion and enough efficiency to make innovative decisions and consolidate its support in society. Therefore, it is necessary to recover and improve the levels of satisfaction and positive assessment of the NHS, prior to the pandemic, both in primary care and in specialised care.

In this same sense, when it comes to assessing patient autonomy in their therapeutic process, the impact of the pandemic has led to a breakdown in the citizens' perception of their participation in decisions related to their illness and treatment. This

Making patient's rights linked to information and autonomy effective

aspect is of great importance in terms of the quality of the system, because to the extent that participation is diluted, not only is the principle of a patient-centred health violated, but the system loses its capacity to promote improvements that incorporate the patient's perception of their own pain, their sense of physical and mental wellbeing, or their satisfaction with the result achieved. Moreover, even assuming that the population is comprehensively informed, this does not translate in them considering that they have actively participated in the decision-making process of their illness.

Proposal:

- Insofar as the information and participation of citizens during a health problem and treatment are rights enshrined in the legal system, it would be useful to have official data that allow us to measure the degree of compliance with the duty to inform and the right to participate in the provision of private health services.

In contrast to the drop in the citizens' perception of their participation in the therapeutic process, it is worth noting that, in the area of specialist care, the patient's assessment of the information received about his or her health problem is good and, more importantly, the impact of the pandemic has not translated into greater dissatisfaction with it. In the primary care setting, satisfaction with the information is equally good, although the pandemic did result in a drop, although not very pronounced, in the indicator.

It should be remembered that the Law on Patient Autonomy incorporated informed consent into medical practice, an instrument that represented an important advance in patients' rights, improving decision-making in their own health and knowledge of the nature of the objectives, potential consequences and risks involved in a given treatment or intervention. However, bearing in mind that the greatest number of claims for health-related harm are due to the violation of informed consent, it is necessary to articulate mechanisms for improving doctor-patient communication that favour the correct transmission of the information contained in the document, guaranteeing its adaptation, so that there is no language, cultural or any other kind of barriers.

On the other hand, further reflection, analysis and research into the consequences of the pandemic in terms of the possible violation of patients' rights should be pursued. As has been stressed, COVID-19 not only highlighted the cracks in the system when it comes to responding to health emergencies such as this one, but also left valuable lessons on scenarios which, although assumed to be unlikely, may be repeated. In this sense, it is necessary to make progress on a regulatory framework that, on the one hand, guarantees rights recognised in the legal system even in the most adverse situations and, on the other, delimits issues present in the public debate such as the obligatory

nature of vaccination, the limitation –if any, under what circumstances and with what justification– of rights as patients or fundamental rights, social and healthcare coordination in these cases, the rights of the families or deceased, or even the consideration of the professional contingency of infections caused by a pandemic in the case of healthcare personnel, among many other examples.

The contribution of the private for-profit and not-for-profit sector

Throughout the report, the close relationship between the public and private health sector in its different manifestations has been noted. Private provision of public services can be socially convenient when the public system is limited, as long as the public guarantee of the quality of the contracted service is established and competition and efficiency in the use of public resources are encouraged.

From the point of view of coverage, the NHS reaches practically the entire population, while the penetration of private healthcare, mainly through health insurance, is a minority phenomenon, although growing in recent decades, concentrated in terms of territory, age and socio-economic level, and accentuated since the pandemic. Mixed coverage shows significant territorial differences and is more frequent among the population with higher incomes, intermediate ages and higher level of education. This evolution is related to factors such as the continuation of administrative mutualism, demographic evolution, the increase in the level of education and income, higher patient expectations, population density and regional public spending policies. According to the Health Barometer, speed of care is the main reason for taking out health insurance, far ahead of any other type of motivation.

The interconnection between the public and private systems is manifested in multiple dimensions of the healthcare environment, starting with the training of its professionals. Since the beginning of the century, the range of healthcare degree courses on offer in private universities has continued to grow, in parallel with the increase in interest in them and the difficulties of access marked by the numerus clausus in public universities. However, the vast majority of resident posts for specialised training are in public centres and hospitals.

The coexistence of professionals is particularly intense at the specialised and hospital care level. Sixty per cent of all hospitals belong to the NHS network and forty per cent to the private sector. In fact, in recent decades the expansion of the public hospital network has taken place mainly through the development of the so-called public utilisation, that is, privately run centres that devote more than 80 % of their resources to the provision of NHS-financed services. In the public utilisation network, activities linked to private healthcare are carried out, in the same way that professionals in the service of public healthcare institutions may work for the private sector or on a freelance basis. Thirty per cent of the health professionals working in the private hospital

sector work in private hospitals that have a substitute agreement or belong to a public network.

The private sector increasingly shares with the public sector the difficulties in recruiting and retaining healthcare personnel. Although the vast majority of NHS medical staff perform their duties on an exclusive basis, most regional health services allow them to combine public health care with their private activities, provided that they meet a series of regulatory requirements.

On the other hand, according to AIReF, the NHS's investment in continuous training for hospital medical staff is very low and uneven across the country, the pharmaceutical industry plays a significant role in the continuous training of this staff, albeit outside the scope of what would be planning based on the objectives and needs of the professionals identified by the healthcare administration.

For their part, agreements with the private health sector for the provision of different NHS services, a type of mixed management formula that is widespread in Catalonia, are also becoming increasingly important in other regions, such as Madrid and the Balearic Islands. This type of public-private collaboration absorbs a growing volume of public resources which, in turn, sustain the business model of the private hospital sector. In any case, there is room for improvement in the design of the specifications, the conditions specified in the contracts and the supervision of the contracts.

Public-private collaboration is particularly fruitful in the biomedical research ecosystem, contributing to Spain's good position in this field, as we have seen in the corresponding section of this report.

In any case, the complementarity of the private sector with the public sector and the existence of formulas for collaboration between the two should not serve to dilute the obligation of the public authorities to guarantee the right to health and a high level of quality in the healthcare provided through the public network, which should be reinforced.

Proposal:

- Given the economic importance and complexity of the different types of existing agreements with the private sector, all public administrations should commit themselves to carrying out systematic, transparent and independent evaluations of the efficiency, effectiveness and equity of the different public-private management formulas adopted.

Improvement of management and assessment of the system

The healthcare system is a large and complex organisation in which millions of management decisions are taken every day that influence the resources available and the efficiency of their use, the working conditions of the staff and the quality of patient

care itself. Throughout the course of the report, numerous improvements in the NHS information system have been noted, but there are also important gaps that make it difficult to approach the system as a whole. It is not so much a lack of indicators as the existence of an organisational substratum that addresses their continuous use from the perspective of their adaptation to the health profile of the population and to health outcomes.

For example, the information offered through the Primary Care Information System (SIAP, by its initials in Spanish) and the Primary Care Clinical Database (BDCAP, by its initials in Spanish) is limited to the number of consultations, professionals, interconsultations and number of people per quota, but does not offer references to the health outcomes resulting from the activity carried out, which hinders the evaluation of its functioning. Nor does it accurately show the real volume of activity as it does not take into account the lack of coverage for professional absences, whose agendas are often assumed by other professionals who add them to their own.

The same is true of the specialised care system, where, although information on private sector activity is incorporated, it is not easily interpretable. Moreover, it is difficult to understand the degree of coordination between levels, there is a lack of information on experiences of integrated care models and numerous other aspects that affect the qualitative aspect of the activity and the efficient use of resources. Social-health care coordination in the NHS, for example, so often mentioned as one of the levers for improving the quality of care, lacks substance in the form of information and continuous monitoring tools that facilitate the visibility of the experiences that are being carried out.

A good information system is the base to drive the evaluative culture in the health system, in which it is necessary to explore all its aspects.

Proposals:

- Continue with the improvement of the health and health system information system with new tools and observatories that facilitate the continuous evaluation of the functioning of the NHS structures in all its dimensions, both primary care and specialised care and other areas of care (public health, mental health care, public health coordination, among others), incorporating registers about the results in health of their activity.
- Given the budgetary restrictions, all the agents of health expenditure, in particular the communities, should carry out or request rigorous evaluations, independent and transparent, of their policies and health services, and of the different management formulas established. This would allow for the detection of inefficiencies, inequities and shortages, but also identify good practices liable to be followed by the rest.

Boosting social participation in the NHS

One of the most diffuse, but no less important, dimensions of health system governance is related to the participation of civil society in the management of the NHS. This responds to a dual interest: on the one hand, to make participation effective as a democratic right that promotes greater citizen autonomy and social responsibility in the management of the public sector. On the other hand, it responds to a technical need, since without the presence of citizens in different health management bodies, the possibilities of resolving problems linked to therapeutic processes are limited. Thus, for example, a system that ignores social participation in the management of the system could boast the best life expectancy statistics at birth, but would limit its possibilities of knowing about and responding to actions that, by action or omission, could result in or be perceived as violent, abusive or vexatious.

The regulatory development of the NHS has gradually introduced different mechanisms for social participation in its management and governance model, at local, regional and national levels. However, as with some of the system's quality indicators, the nature of the organisations that form part of some participation bodies varies considerably between territories, especially at the local level.

At present, there are no official figures on the number of forums, councils, consultative committees or other bodies where civil society is represented. In addition, the institutional framework that the legislation recognises for social participation has significant limitations due to a certain opacity and confusion about its functions and competences. In contrast to the participation of patients in shared decision-making regarding their health, which seems much clearer and has a longer history, collective participation is articulated in a diffuse manner, with multiple instances of participation that together resemble a mosaic rather than a truly integrated and coherent system of participation. Finally, one of the most interesting spheres of civil society participation is in the area of patient and user organisations. Although it is not clear what role they play in the management of the system, this has not prevented the formation of a vast network of organisations that have an important political and social impact on the improvements required by the system, always from the perspective of patients and their family and care environment.

Apart from their institutional involvement and interest in participating in the governance of the NHS, patient organisations carry out special research, training and information dissemination work, but also on the empowerment of patients and relatives so that they can participate fully in the decisions affecting their illness or treatment.

Proposals:

- Incorporate into the SISNS (Health Information System of the National Health System, by its initials in Spanish) accessible, centralised and updated information from the different administrative units in which civil society is present, whether they are merely consultative bodies or decision-making spaces.

- Respecting the nature and legal powers of the different organisations and participatory bodies, improve and strengthen citizen participation and representation in the National Health System, promoting spheres such as the Area Health Councils, making the Open Health Forum permanent and, in general, promoting a greater of the most representative consumer and user associations in the different spheres of participation.

Boosting the investigation and innovation ecosystem and health digitalisation

The proper functioning of the biomedical and health research system is essential for developing effective treatments and advancing the scientific knowledge that underpins medical practice. Despite being an area of growing importance in our country, which has been promoted in different ways, it is necessary to continue making efforts to address it in a more cohesive, efficient, sustainable and ethical way, taking advantage of the enormous opportunities offered by the digitalisation of healthcare and artificial intelligence.

Fostering public and private investment in biomedical and Health Research

Spain is a benchmark in biomedical research, with a strong public health research system, although there is room for improvement in terms of R+D spending intensity, talent management and translation of results into real practice. Given that biomedicine is one of the sectors that will most change the future of society, there is a pressing need to address these challenges. The main challenges are to increase the human and technical resources available for research; to simplify the regulatory and administrative environment for research; and to ensure greater translation of research results.

Proposals:

- Increase financing and improve the taxation of biomedical R+D, establishing priorities in the General State and Autonomous Community Budgets, and seeking additional funding resources from the private sector and international research calls.
- Ensure adequate and agile execution of all or a large part of the European resources received.
- To do this, we should analyse the reasons for the slower rate of execution of funds by the private sector, and try to solve the problems detected, whether administrative, legal, organisational or economic in nature.
- Invest in key areas to increase the national critical mass, ensuring the continuity of projects after funding ends.

- Invest in the skills and competences of research staff, not only during the initial training stage but also throughout their professional career, including those related to digitalisation.
- Providing centres with the infrastructure and technical and human resources to adapt to the new scientific and regulatory requirements of the new European clinical trials regulation[2].
- Ensure a stable and predictable regulatory framework for research, avoiding frequent changes that could affect the continuity and planning of projects.
- Simplify the administrative procedures associated with obtaining funds and carrying out research projects, eliminating obstacles.
- Streamline procedures and response times in public calls for proposals.
- Introduce greater flexibility in the hiring of staff, fully subject to the current labour framework and the established definition of professional categories.
- The recruitment of administrative managers could ease the administrative burden on researchers.
- Improved frameworks for collaboration between basic and clinical research, as well as greater public-private collaboration, for a better translation of knowledge from academia to the real world.
- Review the conditions of access to calls for grants, assessing their accessibility according to the type and size of the companies, preventing them from being left deserted due to the existence of administrative barriers.
- Develop and promote forms of innovative public procurement by the public sector that make it possible to integrate solutions to meet their clinical and economic demands.
- Strengthen research and knowledge on public health interventions, as well as research on social and environmental determinants of health, through specific calls for proposals for these areas of research.
- Promote the inclusion of the gender perspective in biomedical research, with special emphasis on pathologies that have traditionally been understudied.

Seizing the opportunities offered by healthcare digitalisation

Healthcare digitalisation has the potential to improve the efficiency, accessibility and quality of healthcare, as well as to empower patients. However, in order to do so, unequal access to technologies, the development of new skills, the lack of integration of information systems, or the adequate control of patients' personal data, among other aspects. Reducing the digital gap among users and aligning capabilities with needs is a priority.

2 Regulation (EU) No. 536/2014 of the European Parliament and of the Council of 16 April 2014, on clinical trials on medicinal products for human use, and repealing Directive 2001/20/CE Text with EEA relevance.

Proposals:

- Provide adequate means of access and dialogue with the health system.
- Encourage the diversity of communication channels, and their adaptation to different levels of digital literacy.
- Enhance the technological capabilities of the most vulnerable population groups, with digital literacy programmes that teach basic technology skills.
- Collaborate with technology companies to develop innovative solutions and programmes to address the digital gap.
- Continue investing in the training, digital competences and skills necessary for healthcare professionals to be cyber-resilient in the use of digital tools.
- Incorporate new professional profiles in the healthcare system (bioinformatics, biophysics, mathematics, artificial intelligence, etc.), with an appropriate system of training and incentives, to be able to better cope with the digitalisation of healthcare.

Developing and integrating health information systems

In order to generate and use health information efficiently and securely, electronic systems must be developed to enable the collection and storage of health data in a structured and standardised way, while facilitating the exchange of information between systems. In addition, proper handling of personal data will be essential to ensure the privacy and security of patient information. Therefore, collecting, storing, processing and sharing information, as well as ensuring the correct handling of personal data are major challenges.

Proposals:

- Facilitate the integration and interoperability of information systems at regional and national level, with a single digital health record shared between primary and hospital care, and optimal and shared functionality of the electronic health card.
- Take steps towards greater interoperability of the public information system with the private health system, mutual societies and pharmacies.
- Promote the collection, storage, processing and analysis of data from different sources to improve prevention, diagnosis, treatment, monitoring and research.
- Develop tools that help to better use and apply health system information, avoiding statistical and social biases.
- Address the ethical challenges of handling patients' medical data as a source of information for artificial intelligence in medicine, taking into account privacy, informed consent and approved ethical standards.

- Address the legal challenges of handling patients' medical data, ensuring regulatory compliance and considering data ownership, legal liability and legal standards in AI development.
- Invest in cybersecurity and other information security measures to prevent cyber-attacks and protect personal data.
- Train staff who handle data on security and privacy best practices.

Improving the system coordination, cooperation and governance

Coordination, cooperation and governance in the health system are crucial to ensure efficiency, equity and quality in the delivery of health services. While there are no simple solutions for the complex institutional fabric of the health system, some general recommendations can be made to improve its functioning at the macro (health system as a whole) and meso (organisations, regions, communities) levels, incorporating the principles of good governance at all levels.

Leadership and system governance

It is a priority to clarify the roles and responsibilities of the different institutions and actors in the health system in order to avoid duplication and ensure and efficient distribution of resources, providing the system with greater coherence and continuity.

Proposals:

- Provide the Ministry of Health with a greater strategic vision and leadership, reinforcing its role as a coordinating body, with an adequate organisation of personal, material and organisational resources.
- Clearly define the attributions and responsibilities of the different agents of the system, with adequate medium- and long-term planning.
- Establish internal regulations for the Permanent Pharmacy Commission, regulating its functions, composition and system for adopting agreements.
- Legally clarify the role of the CISNS and the scope of its coordination capacity, bearing in mind that the areas of inter-administrative cooperation need not only to respect the different functions and competences, but also the frameworks of institutional loyalty, with a common effort to try to meet shared objectives.
- Develop and publish clear procedures and methodologies, providing consistency, fairness and transparency for the different parties involved in the process.
- All this drive should be developed within the framework of a new social pact for public health that involves all political forces and all sectors of society, so that it is sustainable over time.

Harmonising the health technology assessment system

As has already been mentioned, the regulatory vacuum in which health technology assessment currently finds itself must be resolved, with assessments at European level that will have to be completed in those aspects that fall within national competence, which is the aim of the draft Royal Decree regulating health technology assessment, open to public consultation in October 2023. The need to regulate and harmonise health technology assessment has become more pressing following the ruling of the National High Court, which declares the agreement on which the current assessment of medicines was based to be null and void.

Proposals:

- Achieve a clear attribution of the functions of the different agents in the system, which avoids redundant and unnecessary evaluations.
- Set up the necessary internal administrative mechanisms to guarantee independence between the economic evaluation and the decision to finance health technologies, with a structure that allows clinical and economic information to be provided and that informs decision-making, but which is not the decision-making body itself.
- The evaluation bodies must be provided with sufficient personnel and material resources to develop this competence in a rigorous, agile, independent and sustainable manner over time.
- Introduce greater predictability and transparency into the evaluation system, increasing certainty about the methodology used and the time required for each phase of the process.
- Explore ways to speed up access to medicines, with parallel rather than sequential processes, provision of robust economic evaluation models by pharmaceutical companies, early start of price negotiations, or the setting of interim and time-bound prices.
- Provide the Health Cohesion Fund with continuous and sufficient funding to combat health inequalities.
- Regulate a health technology assessment system with clear mechanisms for participation at different levels, including representatives of patients' interests, consumer organisations, health professionals and the economic operators themselves, as well as any other interested party with a legitimate interest.

Improving coordination between institutions and actors in the system

On the other hand, continuous and harmonised coordination of the different agents in the system, including health services and functional areas, such as the public health environment, is essential to ensure comprehensive and effective care for patients.

Proposals:

- Execute the creation of the State Public Health Agency as a way to improve the governance of the NHS and promote cooperation mechanisms between the healthcare and public health services of the autonomous communities.
- Improve inter-institutional collaboration and coordination, effectively implementing a governance model based on *One Health*.
- Establish clear and efficient channels of communication between health professionals, social services and other stakeholders.
- Promote benchmarking competition between public sector entities as a way to stimulate accountability, with data to help reduce information asymmetry.
- Evaluate experiences in integrated care models across different levels of care and consider their extension as a possible way to improve prevention and quality of care.
- Promote independent and rigorous evaluation of the different healthcare management formulas implemented, as a way of ascertaining their real impact and guiding future decision-making.
- Deepen the professionalisation of healthcare management as a tool for transforming the healthcare system, using appropriate incentives, training and motivation of human resources at all levels.
- Strengthen and give continuity to coordination between the care and social and healthcare sector, with clear protocols for action in homes for the elderly and other vulnerable groups.
- Maintain also a coordination with the private health sector, as a growing way of health provision, in the framework of the public guarantee of the capacity and quality of the given care.
- Increase the population participation in the system governance, with a greater presence of the economic and social agents; the most representative consumer and user associations, as well as patients and scientific societies.

The point of inflection that the irruption of the pandemic meant in the health system led to important NHS strengthening commitments, which need to be materialised. The health system is in a favourable moment to consolidate universality, equity, quality and sustainability, making it more resilient and, at the same time, more centred in the user's needs, overcoming the mere reactive approach when facing illness to fully incorporate the paradigm of health prevention and promotion throughout life and in all its spheres.