Health System Reform and the Rise of Family Medicine in Spain

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Spain's health care system is currently undergoing a paradigm shift in design. The transition is from a model emphasizing the traditional hospital for curative acute care to a newer model with emphasis on ambulatory and preventive care. The creation and ongoing development of a family and community medicine specialty have played a central role in this transition.[1] This paper addresses the rise of primary care and family practice within Spain's health care reform during the past 15 years. Issues of cost control, access to care, and patient satisfaction are discussed with regard to their importance in the health care model transition.

Relevant Past of the Spanish Health Care System

The contemporary Spanish health care system began during the post-Civil War era with the creation of the Seguro Obligatorio de Enfermedad (SOE; Compulsory National Health Insurance). The process, which began in 1942, was not completed until nearly a half-century later (in 1988) with the Ley General de Sanidad (LGS; National Health Care Act) and development of the Sistema Nacional de Salud (SNS; National Health System).[2]

The national health insurance system was organized as part of the Ministry of Labor for the first 30 years. It was linked to social security programs for pensions, family subsidies, and unemployment benefits but not to other health care institutions. The program was initially focused toward industrial workers. A series of reforms, most importantly the 1972 reform, expanded the role of the Seguro Obligatorio de Enfermadad and resulted in the renaming of the program to simply the Seguridad Social (Social Security) system. The focus of the program was expanded to include white-collar workers and some professional groups,[3] and during the 1970s there was rapid growth in the hospital capacity of the social security system.

From its inception, the system used a mixed approach of operating state-owned hospital beds and contracting with private hospitals for beds. During the 1970s an increase of more than 32,000 state-owned beds provided the social security system with 23.2 percent of beds in the country, up from 9.1 percent in 1963.[4] With the increased number of beds, there was a concomitant increase in sophisticated and modern hospital facilities. Curative medicine, with strong support from the medical profession, was the dominant paradigm. During this time there was a distinct concentration of illness-focused and hospital-based care. Ambulatory care, which was available at large centers (ambulatories) and smaller satellite centers (consultorios), did not experience similar growth, nor were prevention and health promotion emphasized in any specific manner.

Worthy of note is that, despite increasing public control over health care services, medical schools were relatively free from regulation. Little effort was made to ensure that the physician workforce represented public needs. Meanwhile, the number of students who matriculated into Spain's 6-year medical education system rose sharply.

The health care model progressed toward universal coverage and assumed a centralized development pattern. The responsibility and authority of the regional health care administration decreased during this period. At the time of Franco's death in 1976, the government had extended health benefits to more than 80 percent of the Spanish population. Infant mortality was reduced, life expectancy improved, and Spain's health care moved into the statistical ranges of developed nations. Nevertheless, the crisis of the curative restorative health model (its inability to

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address the broader health needs of the public), the slowdown of the economy, and rapid increases in health care expenditures began to threaten the stability of the system. During the 5 years directly after Franco's death (1976-1981), the system was scrutinized, yet it persisted despite many legislative reform efforts.

The arrival of the first socialist government in 1981 brought with it the first real change in the social security system, enlarging its coverage and decentralizing its structure into autonomous areas. The ambulatory care system was revised dramatically. Each of the autonomous communities was segregated into units called health areas. Each unit had 10 to 25 primary health centers (PHCs). The typical PHC was staffed with physicians, nurses, and social workers and delivered care to between 5000 and 20,000 patients. These centers differed from the traditional ambulatory care facilities, which were managed vertically and served populations of about 200,000. In 1982 training PHCs providing postgraduate medical training in family and community health were established in several locations in Spain.[5] During this time family practice began to gain considerable momentum.

The Emergence of Family Medicine

Although no definitive reform occurred in the Spanish health care system between the time of Franco's death (1976) and the arrival of the first socialist government (1981), the debate on the health care sector did set the stage for later developments. An interministerial commission for health care reform recognized the need for a generalist medical specialty and suggested that such a specialty would serve as the spearhead for system-wide reform. Thus, via the Real Decreto (Royal Decree) 3303 of December 1978, the specialty of Family and Community Medicine was officially created in Spain.[6] The Royal Decree states, "The family physician shall constitute the fundamental figure of the health system and shall have the mission of bringing complete and integrated medical care to members of the community." The next several years were dedicated to planning and developing the specialty training. A scheme modeled after the family medicine residency program in the United States was developed and began functioning with the arrival of the first socialist government in 1981.

Residency training in family medicine involves 3 years during which the resident spends 2 years doing hospital rotations in internal medicine, pediatrics, gynecology, surgery, and psychiatry, and a 3rd year in a PHC, where the resident assumes responsibility for a defined patient population. During the 3 years continuity experiences are provided in the theory of primary care, statistics, epidemiology, health care planning and administration, research methodology, and health education.[6]

By 1982 the PHC model became the basis for health care reform. Family and community medicine training became formally integrated with pilot PHCs. Also in 1982 the Spanish Society of Family and Community Medicine (Sociedad Española de Medicina de Familia y Comunitaria; SEMFYC) was begun. Its six functions are similar to those of the American Academy of Family Physicians and include continuing education, research exchange, and academic development. Thus, in 4 short years after its inception, the family practice specialty had an official scientific assembly and had been positioned by the new government in the driver's seat of health care reform.

Family Medicine During an Era of Ongoing Reform

During the first socialist government SEMFYC actively and consistently supported the reforms of the Spanish health service. The specialty enjoyed growth and within 5 years had trained about 2500 family physicians. During this era other medical specialties did not experience such warm relations with the government. Indeed, some of the most serious physician strikes of the century occurred among hospital-based physicians in 1987. At the end of the first socialist government tenure, the National Health System was created with passage of the National Health Care Act (1988). With this legislation, all Spanish citizens are guaranteed access to health care. In addition, decentralization of health care and the move toward PHCs were further established. Medical education became more regulated in an effort to address better the physician supply and distribution issues. Given the primacy of the PHCs in family medicine training and the dependence of the PHCs on family physicians for personnel, the National Health Care Act served to strengthen and further institutionalize the specialty.

The Spanish economy weakened throughout the 1980s. Following passage of the National Health Care Act, the Spanish government wrestled with the quandary of increasing public expectations in an environment of diminishing economic resources. The PHC model was adopted to assure all citizens access to basic primary care services. Discussion centered on defining what services should be considered basic and included in the benefits package. There was also much interest in citizen satisfaction with the system, which resulted in the first quality-assurance programs in the primary care sector.[7] The family physician has continued to occupy a strategic position throughout the spectrum of activities surrounding assured access to basic services and maintenance of patient satisfaction and high-quality care.

A product of these dynamics has been a fundamental change in the nature of general practice. In the old system of public ambulatory care, generalists, including family physicians, worked a 2.5-hour session per day at high speed. The number of patients seen in this period averaged 45 in Madrid and as high as 70 to 80 in other areas.[5] Consultation time in this setting is said to have averaged 3 minutes. The remainder of the generalist's day was typically filled with private practice. Some physicians in the old system held two or three salaried positions. Continuing education had been largely absent in this setting.

The transition to the PHC model and the advent of family practice training programs have brought change to the nature of ambulatory care. In contrast to the old system, the PHC physicians typically work a 6- or 7-hour shift per day and hold no other practices. They also perform off-duty rotation work. Salaries are calculated based upon clinic time, off-duty work, and populations at risk. The new system focuses more on continuity and a holistic approach to the patient. Most of the health centers hold regular staff meetings and provide continuing medical education. Among the articles found in the Spanish primary care journal *Atención Primaria*, about 80 percent come from health center physicians. The majority of these authors have trained in a family medicine residency. The health centers share some of the problems with the old ambulatory centers, including understaffing and excessive patient lists. It is generally agreed, however, that the PHC model offers considerable improvement when compared with the old system.

The primacy of family medicine was explicitly recognized by the April Committee, an ad hoc group formed in 1990 under the auspices of the Spanish Commission on Analysis and Evaluation of the National Health System.[8] The committee was established in the wake of a study, performed by the Harvard School of Public Health, which showed substantial dissatisfaction among the Spanish citizenry with certain aspects of their health care.[9] The official charge to the committee was to analyze the structure, organization, and function of the system in relation to the quality and effectiveness of services provided. The committee was also to propose changes in the context of future economic and social scenarios the country would face.

The result of the April Committee was a voluminous report containing many suggestions in support of high-quality primary care and the decentralized PHC model of the health system. The report specifically states, "Medical care must include activities of prevention, health promotion, and education with defined objectives and incentives." Specific budgets for health promotion and disease prevention activities are suggested. The report states the following in regard to training health professionals:

> The curriculums should be oriented towards content more adequate in the professional practice of health care in Western countries, including teamwork, teaching of management principles, the understanding of the necessities of community health and the new ethical demands of modern medicine, which combine scientific content with societal dimensions.

The report represents a landmark federal study that strongly validates the family medicine prototype, and as such, furthers the specialty both in the public image and in the minds of policy makers.

Conclusions

Spain has reason to be proud of its success in achieving more equitable access to high-quality care for all its citizens. The family medicine specialty should be applauded for its primacy in that process. Family physicians currently provide a full range of acute and preventive primary care

services to patients in the PHCs. They additionally supervise the treatment of their patients requiring hospitalization. The changes in ambulatory care, including the recent interest in quality control in that sector, underscore the strong emphasis placed on primary care, health promotion, and disease prevention in Spain and hold implications for US health care reform. The April Committee report suggested developing specific budgets, separate from other health care services, for the provision of preventive care. If universal coverage were to become a reality in this country, the core of any basic benefits package would be strong efforts at health promotion and disease prevention through a reinforced primary care network. This lesson was learned by the Spanish, and the logic and economies surrounding that experience are important to the United States.

The Spanish experience illustrates the need for a strong primary care physician workforce. This workforce must be capable of providing contemporary clinical care, caring for the community's health, practicing prevention and promotion of healthy lifestyles, and accommodating expanded accountability. In Spain the family medicine specialty is rising successfully to that challenge. For a large portion of their training, the residency programs in Spain use the equivalent of our community health centers (CHCs). Research into the financing mechanisms of this process might yield useful insight into the issues surrounding direct funding to CHCs for residency training in the United States. In addition, research into efforts being made in medical education to engender interest in family practice and primary care medicine (ie, the primary care pipeline) could also be useful.

References

1. Borrelli CF. El reforme de atención primaria en Espana: Perspectivas de un siglo de la medicina familiar and communitaria. Atención Primaria 1994;13:277-8.
2. Rodriguez JA. Struggle and revolt in the Spanish health policy process: the changing role of the medical profession. Int J Health Serv 1992;22:19-44.
3. Drane JF. Spanish medicine: trying to heal itself. JAMA 1988;260:1219-20.
4. Saturno PJ. What you need to know about the Spanish health system. Aust Clin Rev 1989;9(2):54-9.
5. Hart JT. Primary medical care in Spain. Br J Gen Pract 1990;40:255-8.
6. Gascon TG. La medicina familiar y comunitaria en Espana. Rev Int Med Fam 1991;3:167-70.
7. Ruiz U. Acedo K, Buenaventura R. Coll J. Coronado S. Rivero A, et al. Implementing total quality management in the Spanish health care system. Qual Assur Health Care 1992;4:43-59.
8. Cruz AF. El informe Abril y sus implicaciones medicas. Rev Clin Espanola 1992;9:437-3.
9. Blendon RJ, Donelan K, Jovell AJ, Pellise L, Lombardia EC. Spain's citizens assess their health care system. Health Aff Millwood 1991;10:216-28.

Correction

An error in wording appeared in "Myxedema Coma in the Elderly," by Cynthia G. Olsen, which was published in the September–October issue of the *Journal* (JABFP 1995; 8:376-83). We offer the following correction:

Page 379: right-hand column, first complete paragraph, line 15:
"A thyroid-releasing hormone administration assay would be useful in that no detectable rise in base-line serum TSH would occur."