World Health Organization
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THIRTY-YEAR RETROSPECTIVE of CATALAN HEALTH PLANNING

Driver of Health System Transformation

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Abstract

After 30 years of health system planning, the Department of Health in Catalonia, Spain, jointly with WHO has embarked on an evaluation of the evolution, results and impact of the health planning process and health plans. The results of assessment will inform the next planning cycles for greater impact on health outcomes aligned to the spirit of the Sustainable Development Goal (SDG) era. The health plans constitute a valued institution in the Catalan health system. The health planning process in Catalonia has been carried forward with remarkable consistency over a thirty-year period while adjusting to the changing needs over time. Clear leadership, well-assigned institutional roles and relationships, inclusive and open dialogue, and consistent application of a full policy cycle have contributed to a large extent to the success of the Catalan health plans. In order to evolve to meet new challenges in the SDG era, the report makes 15 recommendations to strengthen the health planning process.

Keywords
HEALTH SYSTEMS
HEALTH POLICIES AND PLANNING
REGIONAL HEALTH PLANS
SOCIAL DETERMINANTS OF HEALTH

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Book design and cover design: Christophe Lanoux, France

Contents

List of figures, tables, boxes

Figures

Tables

Boxes

Acknowledgements

This report was produced through a fruitful collaboration between the Department of Health of Catalonia under the guidance of Alba Vergés (Regional Minister of Health) and the WHO Regional Office for Europe under the guidance of Tamás Evetovits (Head, WHO Barcelona Office for Health Systems Strengthening).

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The Department of Health and WHO assessment team are grateful to all experts interviewed in the course of the missions.

Juan García Domínguez and Isabel Gené (both of the WHO Regional Office for Europe) provided administrative support. The report was edited by Nancy Gravesen and the layout was designed by Christophe Lanoux.

Abbreviations

AC	Autonomous Community
AQuAS	Agència de Qualitat i Avaluació en Salut de Catalunya (Agency for Health Quality and Assessment of Catalonia)
CatSalut	Catalan Health Service
CMBD	Conjunt Mínim Bàsic de Dades (minimum basic dataset)
ComSalut	Community Health Programme
ICS	Institut Català de la Salut (Catalan Institute of Health)
LGS	Ley General de Sanidad (General Health Care Act)
LOSC	Llei d'Ordenació Sanitària de Catalunya (Catalan Healthcare Order Act)
PAFES	Promoció d'Activitat Física Saludable (Promotion of Healthy Physical Activity)
PAISS	Pla d'Atenció Integrada Social i Sanitària (Integrated Health and Social Care Plan)
PIAISS	Pla Interdepartamental d'atenció i interacció social i sanitària (Interministerial Health and Social Care and Interaction Plan)
PINSAP	Pla Interdepartamental de Salut Pública (Interdepartmental Public Health Plan)
PISMA	Pla de Salut Mental i Addiccions (Mental Health and Addiction Plan)
RAP	Reforma d'Atenció Primària (Primary Care Reform)
SDG	Sustainable Development Goal
XHUP	Network of Hospitals for Public Utilization

Executive summary

After 30 years of health system planning, the Department of Health in Catalonia, Spain jointly with the WHO Regional Office for Europe has embarked on an evaluation of the evolution, results and impact of the health planning process and health plans. The goal of this assessment was to take stock of strengths and weaknesses of health planning from an international European perspective to inform and adjust the design of the next health planning cycle for 2021-2025 for greater policy effectiveness and greater impact on health outcomes aligned to the spirit of the Sustainable Development Goals (SDGs).

A tailored methodology was developed for the assessment drawing on international good practices in health planning and health system performance assessment. The assessment was based on a multi-disciplinary approach, inclusive stakeholder selection and consensus among international and local experts. A systematic analytical framework was developed consisting of 5 dimensions and 21 attributes. Three technical missions were undertaken by joint teams including Catalan and WHO experts between February and November 2019.

Health planning in Spain takes place in the context of devolution enacted by the 1978 Spanish Constitution and initiated with the first transfer of competencies from the central government to Generalitat de Catalunya. In 1990, the Parliament of Catalonia approved the Catalan Healthcare Order Act (LOSC), a legislation landmark that redefined the roles of planning, purchasing and provision of health care, calling to create the Catalan Health Service and the Health Plan as the main health planning tool. From 1991 to the present, seven consecutive health planning cycles have been completed.

The Catalan health plans constitute a valued institution in the genome of the Catalan health system. The health plans receive high level political support and commitment and accountability instruments are in place at the highest level. The health plans are well known by all stakeholders and respected for setting a vision and a direction for the improvement of health and wellbeing. There is a well-stablished and clearly articulated mandate and well-regulated process for health planning outlined in the LOSC. The Department of Health has demonstrated strong leadership over three decades of the health planning process with inclusive and open dialogue. In the next planning cycles, the health planning process could be enriched by putting in place bottom-up initiatives to channel stakeholder involvement for health regions, health care providers, and citizens for accelerated uptake of local innovations.

Health plans are internally consistent in the five key steps of the policy cycle: situation analysis, priority setting, alignment of resources, implementation, and monitoring and evaluation. New health plans are formulated based on sound situation analysis and monitoring. Health plans set out clear priorities, goals and expected results to contribute to improving health outcomes and health equity through time-bound specific measurable targets. There is consistency across health plans in some of the goals and directions requiring a long-term perspective while new priorities are also accommodated. The Catalan Health Service (CatSalut) through regional health plans

and alignment of the contracting process operationalizes health plan priorities and ensures timely implementation. This partnership between the Department of Health and CatSalut is fundamental to the success of health planning in Catalonia. However, an increasing share of health plan priorities fall outside the CatSalut contractual processes. Implementation mechanisms, priority setting for operating expenditures, capital, human, and digital resources for the remaining priorities seem less explicit and systematic. Moreover, while health plans monitoring is well developed, specific evaluation tools are used less systematically to understand variation in health plan implementation.

There has been an increasing focus on health equity in the Catalan health planning process with remarkable commitment to equity and solidarity at the level of values. The predominant approach to tackling health inequalities is through territorial approaches, with particular successes in primary health care. A key asset for addressing and reducing inequities in Catalonia is the richness of the available data, which allows linking the socio-economic status of basic health areas with resource allocation through the health service contracting process and resources for particular initiatives. Opportunities remain to move from values to further action in the next health planning cycle through strengthening planning, implementation, evaluation and accountability for health equity. Incorporating a gender perspective in all phases of health planning is not yet a reality. The richness of the available data is not used to use to its full potential, since it is not always presented disaggregated and when it is it remains at the level of differences without looking at the fairness or causes of these differences. Additionally, there are further opportunities to strengthen the alignment of financial, human and other resources with equity goals and equity-enhancing health action. Finally, participation of different stakeholders throughout the planning policy cycle is one of the key elements for addressing inequities and this is an opportunity to further exploit in the future.

Catalonia has a long commitment to intersectoral working, a strong legal mandate enshrined in the Catalan Public Health law of 2009 and high levels of trust exhibited from partners sectors towards health. Examples of health-in-all policies and interdepartmental plans include public health (PINSAP), integrated health and social care (PAISS), mental health and addictions (PISMA), gender violence against women, children and elders, foreign unaccompanied minors, and food safety plan. A number of these can be considered good practice for the European region. Intersectoral action has been most successful when two parts of the Catalan system have been able to operate on areas with visible co-benefits, with different sectors working together but on parallel tracks. Although there is a high volume of activity, there remain implementation gaps both across territories (e.g. areas with low commitment) but also in relation to key public health objectives (e.g. tobacco control). To narrow implementation gaps, an increasing range of institutionalized approaches can be explored such as joint planning, shared/pooled budgets, shared staff and shared accountability for outcomes.

There is a long history and evolution of collaboration at different levels of the government (Catalan, regional and local level). Health plan operationalization and implementation has relied much on intergovernmental action which has allowed localization of health plan priorities and integration of local priorities. There are

inspiring examples of local action turning into regional policies and regional policies inspiring local action and innovation. However, considering the complexity and degree of fragmentation in public administration, evenness of implementation and sustainability of local public health action has been a challenge. The PINSAP has played a catalytic role for local public health action attempting to bridge the gap in institutionalized implementation arrangements. To even out variation in implementation, local governments highlighted the need for greater direct engagement and resources in support for engagement in planning and implementation, as well as an annual forum for sharing information and good practices.

The health plans were found to be useful to push forward the public health agenda in the past three decades with good links to PINSAP encouraging intersectoral action at local levels. A number of major successes have been registered (reduction in premature CVD and stroke mortality, good health protection, and outbreak control). At the same time, next generation health plans could target more dramatic improvement in the areas of tobacco consumption and obesity where success has been moderate so far. In addition, next generation health plans need to evolve to tackle increasing global challenges like the climate change or the antimicrobial resistance. The Catalan Public Health Agency will have an important catalytic and priority setting role. To strengthen this role, it is worth reviewing accountability arrangements. Public health action is prone to 'accountability gaps' due to the complexities of the public health system in Catalonia, with responsibilities falling between responsible organizations. More attention is needed to public health workforce development since there are existing and emergent gaps that are impacting on the success of public health activities. Health planning can provide a good opportunity to link new priorities with the new public health profiles, competencies and skills required to meet the current and future public health challenges.

The health plans were found to be useful to push forward the agenda on the transformation of individual services with an increasing focus on multimorbidity and integrated care. Primary health care is at the heart of service delivery in Catalonia and a model for the European region. Through subsequent health plans, the model has evolved to include mental health, chronic and social care services. Services are delivered through multiprofile group practices supported by acute emergency and a network of community services with shared electronic record systems and risk stratification. The development of a cross-government PISMA is a positive step forward to promoting more general policy to support the development of improved mental health, consolidate the shift towards community services. Cross-sectoral action between health and social care has been a constant priority in health plans and the creation of the PAISS signposts the need of collaborative action to tackle the challenges of an increasing ageing and fragile population. However, despite the roll out of a number health and social care integration interventions and tools in the last decade, institutional and structural barriers such as fragmentation in resource allocation hamper progress. Much of the centralisation of highly specialised care required by modern clinical practice has been undertaken as part of previous planning processes. However, there are sustainability issues related to the number of hospitals providing acute inpatient services and optimal hospital configuration has a place in future policy dialogue processes.

Building on the strengths and richness of good practices in health planning over a thirty-year period, health planning needs to continuously evolve to meet new challenges of the SDG era. These include greater attention to addressing health equity, greater reliance on inter-sectoral action, and further synergized interaction across governmental level. To strengthen health planning in the next cycles, the following policy recommendations could be considered:

1. preserve the strengths of the Catalan health planning process as it evolves to meet new challenges;

2. strengthen institutional capacity of the Department of Health for new generation areas such as health equity and inter-sectoral action;

3. secure greater involvement of CatSalut in the planning phase considering its fundamental role in implementation of a large part of the health plan;

4. create opportunities for bottom-up participation, including citizens, providers and municipalities in the health planning process to capture and build on innovations;

5. preserve the current priority setting process focusing on areas of large amenable mortality but strengthen focus and action on remaining challenges and emerging new priorities in public health;

6. strengthen the focus on health equity in the next health plan and complement the strong territorial approach with other mechanisms;

7. strengthen implementation arrangements for areas that are not contractible by CatSalut by developing explicit multi-agency implementation plans;

8. align financial resources with health plan strategic priorities more explicitly to strengthen the impact of the health plan on the prioritization of the overall health budget and carry out retrospective reviews of funds allocation relative to strategic priorities;

9. align human resource policies with health plan priorities starting with focusing on the public health workforce;

10. complement already strong monitoring efforts with specific evaluation efforts in selected areas of the health plan to better understand variation in implementation and root causes;

11. implement structural and institutional changes to address the implementation gaps in inter-sectoral action building on the various strengths of the current intersectoral processes;

12. keep strengthening intergovernmental participation in health plan development and implementation to ensure localization of health plan priorities and integration of local priorities into the health plan;

13. review the scope and prioritization of public health services in line with the Sustainable Development Goals;

14. continue the move towards an efficient integrated health service delivery system by addressing institutional and funding barriers to action; and

15. consolidate the digital health and care system through a better harmonisation of existing health information systems.

Chapter 1.

INTRODUCTION

After 30 years of health system planning, the Department of Health in Catalonia, Spain, jointly with WHO has embarked on an evaluation of the evolution, results and impact of the health planning process and health plans. The impetus for this exercise is to take stock of strengths and weaknesses from an international European perspective to inform and adjust the design of the next health planning cycle for 2021–2025. These insights will lead to adjustments to the planning process for greater policy effectiveness and greater impact on health outcomes aligned to the spirit of the SDG era (*1*).

The health plan is the main strategic health planning instrument for all health interventions of the Government of Catalonia. Health planning in Spain takes place in the context of devolution enacted by the 1978 Spanish Constitution and initiated with the first competence transfers from the central government to the Government of Catalonia (Generalitat de Catalunya). Since then, the Government of Catalonia through the Department of Health, the Catalan Institute of Health (ICS) and the Catalan Health Service (CatSalut) have regulated, planned and organized health services delivery. In 1990, the Parliament of Catalonia approved the Catalan Healthcare Order Act (LOSC), landmark legislation that redefined the roles of planning, purchasing and provision of health care. From 1991 to the present, seven consecutive health planning cycles have been completed with different forms and orientation.

The specific objectives of the assessment are:

- **to review the process of the last three decades of health planning as an instrument of health system governance** providing policy coherence for health system strengthening in an evolving context;
- **to assess prospectively how fit for purpose the health planning process is for the SDG era** when key themes increasingly reflect addressing upstream health determinants such as social and environmental determinants, working across different governmental levels combining top-down and bottom-up approaches, co-producing across public–private boundaries and increasingly involving and interacting with the population;
- **to understand the transformative impact of health planning on health system strengthening** in Catalonia from the perspective of transformation of **public health services** to better address social and environmental determinants of health through intersectoral approaches; and **individual services** to reflect themes of integration and patient centeredness; and
- **to capture the views of key stakeholders** in the process and their recommendations for improvement in order to strengthen dimensions of inclusiveness and consensus.

The report is structured as follows. Chapter 2 outlines the methods of the analysis. Chapter 3 provides a description of the five phases of health planning in Catalonia. Chapter 4 outlines key findings and observations. Chapter 5 links the key observations on health planning to the transformation of public health services. Chapter 6 links the key observations on health planning to the transformation of individual health services. Chapter 7 concludes with policy recommendations.

Chapter 2. METHODS

A tailored methodology has been developed to respond to these objectives. The methodology draws on international good practices in health planning and health system performance assessment. The assessment has been based on a multidisciplinary approach, inclusive stakeholder selection and consensus among international and local experts.

The assessment has been structured in three interlinked parts: context, process and content. A contextual analysis situated health planning in the past 30-year evolution of the socioeconomic and health system context with a quantitative assessment of key outcomes and results. At the heart of the analysis was the assessment of the health planning process and content itself as a governance instrument. This was complemented by a "light" review of selected trends in public health and individual health services as applications to understand to what extent health plans have captured and inspired transformative change, and identify future health system challenges and opportunities.

A structured interview guide has been developed to assess the planning process. The planning process itself was viewed as an instrument of governance with an important role to ensure policy coherence in the health system. Thus, the interview guide focused on the entire policy cycle from planning, funding and implementation to evaluation. The interview guide has been tailor-made specifically for the need of the assessment corresponding to key issues raised by the key stakeholders and base on four foundational publications: Joint Assessment of National Health Strategies and Plans (*2*); evaluating the health equity impact of policies (*3*); a mapping exercise and evaluation methodology for multi- and intersectoral action (*4*); and a framework for engagement with civil society (*5*).

Five dimensions and 21 attributes were developed to frame the assessment of the planning process (Table 1). The first set of two dimensions focus on "core health plan features" considered internationally the hallmarks of good health plans. The second set of three dimensions can be thought of as new generation issues particularly relevant in the context of the SDGs with a greater emphasis on equity, a more holistic view of health policies, intersectoral, interagency and intergovernmental implementation mechanisms.

Between February and November 2019, joint teams including WHO advisers and representatives of the Department of Health undertook three technical missions, applying the above framework. The missions involved in this evaluation were based on:

- semi-structured interviews with health system policy-makers and stakeholders at the central, regional and local levels;
- field visits to health facilities;[1]
- a review of policy documents and studies undertaken in relation to the health plans such as national strategies, director plans or interdepartmental plans;
- a review for Catalonia of the health system functions defined by WHO in its health system framework (health governance, financial incentives, information systems, health workforce, medicines);
- two policy dialogues with policy-makers and health system experts held in July and November 2019 in Barcelona;
- quantitative analysis of monitoring indicators and related targets attached to the different health plans; and
- a review of the scientific and grey literature on the Catalan health system and, more broadly, on health system strengthening and strategic management.

[1] The health facilities visited were mental health services unit of Edifici "Els Til·lers" in Salt (Girona) of the Institute of Health Care (*Institut d'Assistència Sanitària*); primary care centre (*Centre d'Atenció Primària*; CAP) La Mina in Sant Adrià de Besòs (Barcelona) and CAP Les Indianes in Montcada i Reixac (Barcelona), which are part of ICS; the long-term care centre Centre Sociosanitari El Carme in Badalona (Barcelona) of Badalona Serveis Assistencials; the mental health services unit of CAP Gran Sol (CSM4A 2) in Badalona (Barcelona) of ICS; and Àrea Bàsica de Salut Gavarra in Cornellà de Llobregat (Barcelona) of ICS.

Table 1. Dimensions and attributes of the assessment of health planning process

Dimensions	Attributes
1. Well-managed inclusive planning processes ensure internal consistency	1.1. Mandate, regulated process and leadership 1.2. Stakeholder involvement and participation 1.3. Political commitment, accountability and, alignment with government policies 1.4. Internal consistency with subsectoral plans
2. Health plan content is internally consistent and reflects a connected policy cycle	2.1. Sound situation analysis and response analysis (including equity) 2.2. Clear priorities, goals, objectives and expected results 2.3. Link between goals, planned policies and interventions based on evidence and good practice 2.4. Alignment of funding and other resources with health plan priorities 2.5. Clarity and fit-for-purpose implementation arrangements
3. Equity dimensions are prioritized and mainstreamed	3.1. Prioritization of equity goals and equity-enhancing health action 3.2. Use of evidence and disaggregation of analysis 3.3. Mechanisms for participation and accountability 3.4. Alignment of resources
4. Health plan and planning process reflect cross-sectoral external coherence to address health determinants	4.1. Cross-sectoral interactions and engagement are mandated and integrated in the policy cycle 4.2. Prioritization of cross-sectoral action and its policy coherence 4.3. Resources available for joint action 4.4. Implementation arrangements are in place to catalyse and lead cross-sectional action
5. Health plan and planning process reflect external coherence to align Catalan government action with regional and local government action in health	5.1. Interactions and engagement across regional and local governments are integrated in the policy cycle 5.2. Contextualizing health plan priorities to local needs 5.3. Resources available for joint action 5.4. Implementation arrangements are in place to engage with local government

Chapter 3.

HEALTH PLANNING IN CATALONIA

From 1991 to the present, seven consecutive health planning cycles have been completed. Five eras or periods of health planning structure this evolution: (i) 1979–1990; (ii) 1991–2001; (iii) 2002–2010; (iv) 2011–2015; and (v) 2016–2020 (Table 2). Health planning in Spain takes place in the context of devolution enacted by the 1978 Spanish Constitution and initiated with the first competence transfers from the central government to the Government of Catalonia. In the first period, the Government of Catalonia through the Department of Health, ICS and other service providers regulated, planned and organized health services delivery. In 1990, the Parliament of Catalonia approved the LOSC, a legislation landmark that redefined the roles of planning, purchasing and provision of health care, calling to create CatSalut and the health plan as the main health planning tool.

Table 2. Health planning timeline

Period	Description	Planning cycle	Health plans	Duration (years)
1979-1990	Devolution of health competencies	–	None	-
1991-2001	First health plans	0 1 2 3	1991 1993-1995 1996-1998 1999-2001	3 years
2002-2010	Consolidation of health planning	4 5	2002-2005 2006-2010	4 years
2011-2015	Oriented to health services	6	2011-2015	5 years
2016-2020	Oriented to health services and health policy	7	2016-2020	5 years

3.1 | First period: devolution of health competences (1979-1990)

The first period is characterized by implementing the devolution of health competencies. Spain is a state decentralized in 17 autonomous communities (ACs). Health jurisdiction is shared between the central government that keeps the general

coordination of the Spanish National Health System and the ACs responsible for regional health care organization. Catalonia has spearheaded the devolution process since 1981. Most ACs concluded this process in 2002.

In the 1980s, health planning was based on territorial planning[2] of health care resources with the first health map – *carte sanitaire* – as a key landmark. Other remarkable milestones were the development of the accreditation of health facilities, specific plans for territories with special geographic and population needs, and the creation of several health programmes ranging from a long-term care plan called *Vida als anys*, mental health, prevention and control of AIDS, drug addiction, and renal insufficiency to blood transfusions.

During this period, two relevant health policies determined the quality of care in the provision of public health care services: the Primary Care Reform (RAP) in 1985 and the creation of the Network of Hospitals for Public Utilization (XHUP) along with the programme of hospital reorganing in 1986. RAP changed the territorial organization of primary health centres and created primary care teams as a new form of teamwork that consolidated the gatekeeping function. Deploying this reform took more than 20 years. At specialized care level, XHUP meant the modernization of hospitals and the setup of a network of regional centres. Both reforms aimed to increase accessibility to health services based on providing care closer to people and their needs.

In 1986, the General Health Care Act (LGS) in Spain introduced two critical aspects for the evolution of health planning in Catalonia. First, it defined the mandate to create an autonomous health service with the available resources in each AC. Second, it proposed the production of a health plan as a defining instrument of health policy for each AC.

3.2 | Second period: first health plans (1991–2001)

Following the LGS, in 1990 the Parliament of Catalonia approved the LOSC from which CatSalut emanated as an autonomous health service and public health insurance entity for the entire population of the region. In addition, LOSC prompted the elaboration of the health plan of Catalonia as "*an indicative instrument and a reference framework for all public actions in the health field, within the jurisdiction of the Generalitat de Catalunya*".[3] This law coincided with the Department of Health adopting the WHO *Global Strategy for Health for All by the Year 2000* (1981) (*6*).

These processes led to a drastic shift in the orientation of health planning moving from services-based planning to health goals planning based on population health needs *(6–8)***.** This new orientation meant that the purpose of the health plan of Catalonia was to increase healthy life expectancy as a long-term project. Planning the supply of health services became an instrument to achieve this.

[2] In the context of health planning, territorial includes regional or subregional. Catalonia has seven health regions.
[3] Catalan Health Care Order Law (1991).

In addition to the Department of Health, CatSalut has become an important institutional player in health planning and implementation. CatSalut provides universal health coverage to citizens with tax-based public funding. However, the model of health care provision in Catalonia is mixed as it integrates all health resources in a single public provision network regardless of their titularity. Therefore, funding remains public, but health care production is carried out by a mix of public, not-for-profit and for-profit private entities. This model is based on a split of two sets of functions: (i) the functions of planning, evaluation, funding and purchasing; and (ii) the provision and management of health services. A health service contract binds CatSalut with each health care provider. One of the functions of the health service contract is to operationalize goals and priorities explicitly defined by CatSalut through the health plan formulation.

Three health plans were formulated during this period. First, the framework document for the elaboration of the health plan of Catalonia produced by the Department of Health during 1990 and published in 1991. Based on this document, CatSalut, both at the central and territorial levels, produced in 1993 the Catalan Health Plan 1993–1995. It was a collaborative effort of the eight existing health regions with the participation of 3000 health professionals. In compliance with the LOSC, health regions must produce a locally-adapted health plan. Regional health plans have been produced during the entire period. In the beginning, a bottom-up approach was used to elaborate on the health plan based on regional information. Nowadays, regional plans adopt top-down the general document and regional planning units have switched to service monitoring. Concepts such as health inequalities and intersectoral action have been discussed from the first plans but were seldom developed until several planning cycles ahead. Although they formally appeared in the documents, it was hard to formalise their effective execution.

Orientation towards disease prevention and health promotion at primary level predominate in these first three health plans. From these plans, other technical documents emerged aimed at creating protocols for the preventive activities to be developed into services and other activities oriented to explore the most effective way of including them in service contracts (*9,10*). These "secondary" documents also served to define the priorities in the production of health information and education materials, guidelines and protocols. Evaluation documents were also produced in addition to the formal evaluation of the previous period included in each health plan.

This period ends with the publication of the report "Evaluation of the objectives for 2000 of the Health Plan of Catalonia" (*11*), which was until then the major evaluative effort of the Department of Health and CatSalut. It involved the analysis of several systematic information sources, but also others specifically developed for that purpose. It is important to point out that during this period, a great effort was made to improve the clinical, management and epidemiological information systems that contributed to start and consolidate initiatives such as the electronic medical record, the shared electronic health record, various activity registries (CMBDs)[4] and the Health Survey of Catalonia (*12*) whose first edition was carried out in 1994.

[4] CMBD (*Conjunt Minim Basic de Dades*) is a minimum basic dataset built by aggregating the information collected by health providers in their respective health information systems. A CMBD describes the activity of a health level (acute hospitals, long-term care, primary care or mental health) in a given year.

3.3 | Third period: consolidation of health planning (2002-2010)

In the first decade of the new millennium, the health planning process consolidated. Since 2002, health planning exercises have expanded from a three-year to a four-year cycle following the recommendations from the previous evaluation. The excessive time pressure that the evaluation process placed on the upcoming plan motivated this extension. As a result, Health Plan 2002–2005 served as a new framework document setting goals for a decade divided into two 4-year periods and two respective health plans: 2002–2005 and 2006–2010.

This planning period maintained the philosophy and the general context of the objectives but sought to find ways to improve the implementation of the recommendations made by the current health plan. Disease-specific masterplans called "director plans" emerged as a response to this motivation. Director plans had a positive impact from the implementation perspective but were also supposed to reinforce a biomedical approach. Seven director plans were created: five disease-oriented – cancer, circulatory system, respiratory system, mental health and addictions, and rheumatic diseases and the locomotor system – and two non-disease related – immigration and long-term care. Furthermore, at this time, the Catalan health map was developed (*13*).

New themes began to emerge taking into account a broader set of health determinants and ways to address them through greater cross-sectoral action and professional and public participation. In fact, the propositions for this decade 2002–2010 were: (i) intersectoral commitment for health; (ii) community actions for health; (iii) health care, long-term care and public health oriented to health needs; (iv) health professionals; and (v) the role of citizens. It became clear that while the axis of action related to health care services was closely linked to the services contract, the other axis implied the development of different types of policies that often required the participation of other sectors, following the 2009 Public Health Law (*14*). Although these themes were beginning to emerge, their integration into health planning and implementation remained incomplete.

3.4 | Fourth period: health services orientation (2011-2015)

The Health Plan 2011–2015 markedly increased the focus on improving individual health services and created a stronger link to health services delivery through the implementation of prioritized health care projects. Improving implementation effectiveness underpinned projects like the reorganization of tertiary care or the generalization of projects like the rapid action codes such as heart attack, stroke, suicide, polytrauma or sepsis. However, it is also the period in which interdepartmental and intersectoral projects crystallized, along with patient safety

programmes, the renewal of the hospital accreditation system and the creation of the accreditation system for primary care centres. Examples of these projects include the Interdepartmental Public Health Plan (PINSAP), Community Health Programme (COMSalut) and the Interministerial Health and Social Care and Interaction Plan (PIAISS) for complex chronic patient care. This period marked the transition from a health plan to a health and services plan.

During these years, the Results Centre – a unit of health system reporting under the Agency for Health Quality and Assessment of Catalonia (AQuAS) – generated reports from which general health system results were published.

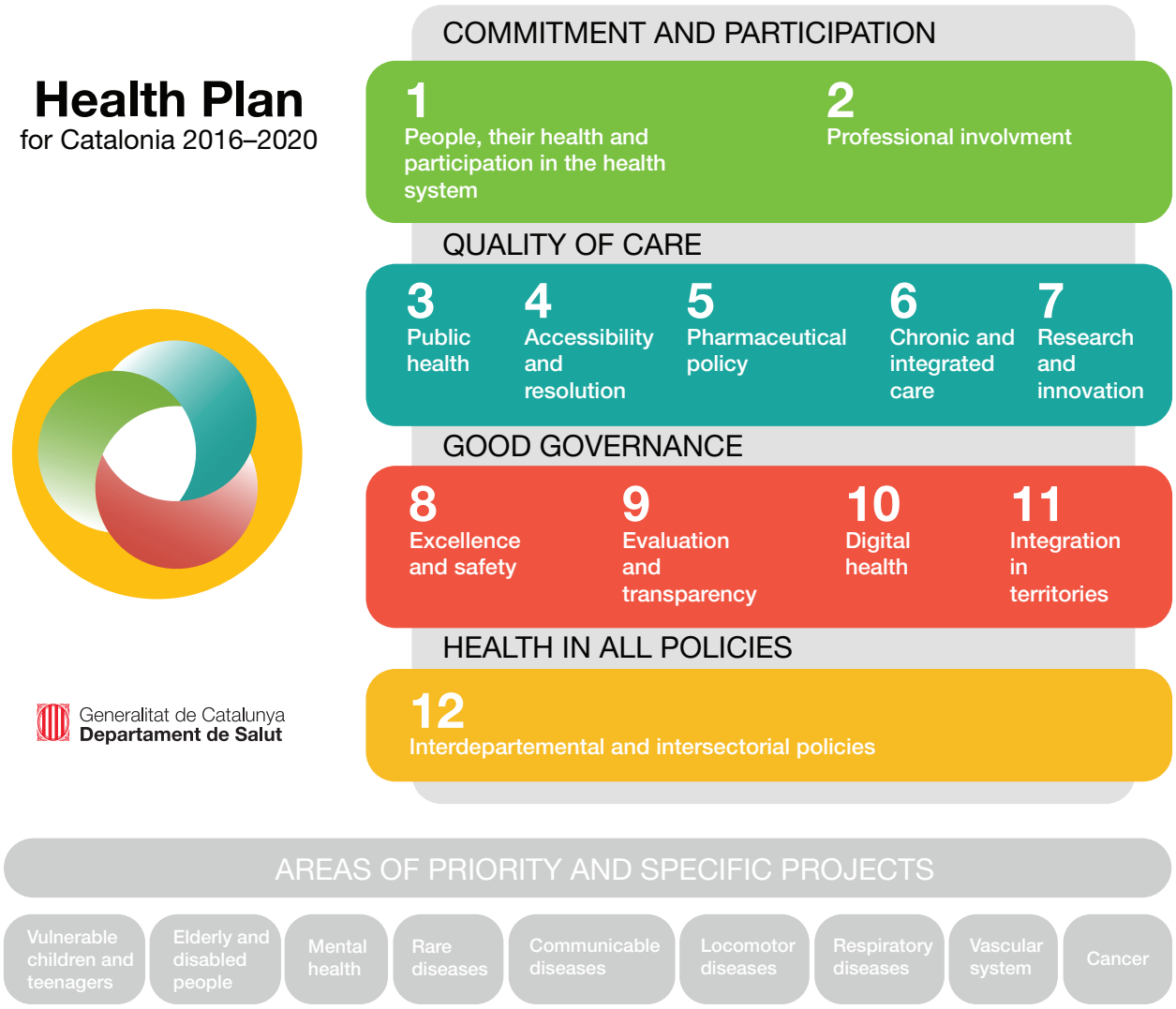
3.5 | Fifth period: health services and health policy orientation (2016-2020)

The current health planning cycle 2016–2020 is firmly committed to reinforcing strategic health policy to tackle social determinants of health through intersectoral action. Health services policies that dominated the previous plan give room to transversal and systemic health policies. There is an effort to raise the health plan to a more strategic position along with significant structural and organizational changes such as the creation of a Participation Secretariat and the Directorate General of Health Professionals, both responsible for areas of highest priority in the current Health Plan 2016–2020. As health plans set the health policy strategy of the Government of Catalonia, all departments (equivalent to ministries) are formally involved. A strategic line on interdepartmental and intersectoral policies (line 12) was included for the first time in the Health Plan 2016–2020 as an incipient first step to achieve a consistent Health in All Policies approach. The production of the Health Plan 2016–2020 was the responsibility of the Directorate General of Health Planning and the extensive work of its Health Planning unit, following a similar pattern found in former plans.

Varied input was gathered from different stakeholders, namely the Government of Catalonia, other technical divisions in the Department of Health, health services organizations represented in CatSalut's commission of health providers, health professionals involved in several Department of Health programmes, and patient associations and citizens through the participatory body Patients' Consultative Council of Catalonia. This combination ensured a balanced mix of political vision with technical and epidemiological analysis of health needs, health resources and patient expectations through several meetings and workgroups.

The Health Plan 2016–2020 was built around 12 strategic lines, areas of priority and specific projects. All in all, it includes more than 50 strategic projects of change. Every strategic line (Fig. 1) has a Department of Health, CatSalut, Public Health Agency of Catalonia or AQuAS representative as a leader. Regular meetings are chaired by these leaders to monitor and evaluate the implementation projects.

Figure 1. Health Plan 2016–2020 strategic lines



Source: Department of Health, Government of Catalonia (*15*).

Chapter

4. SUMMARY FINDINGS AND OBSERVATIONS

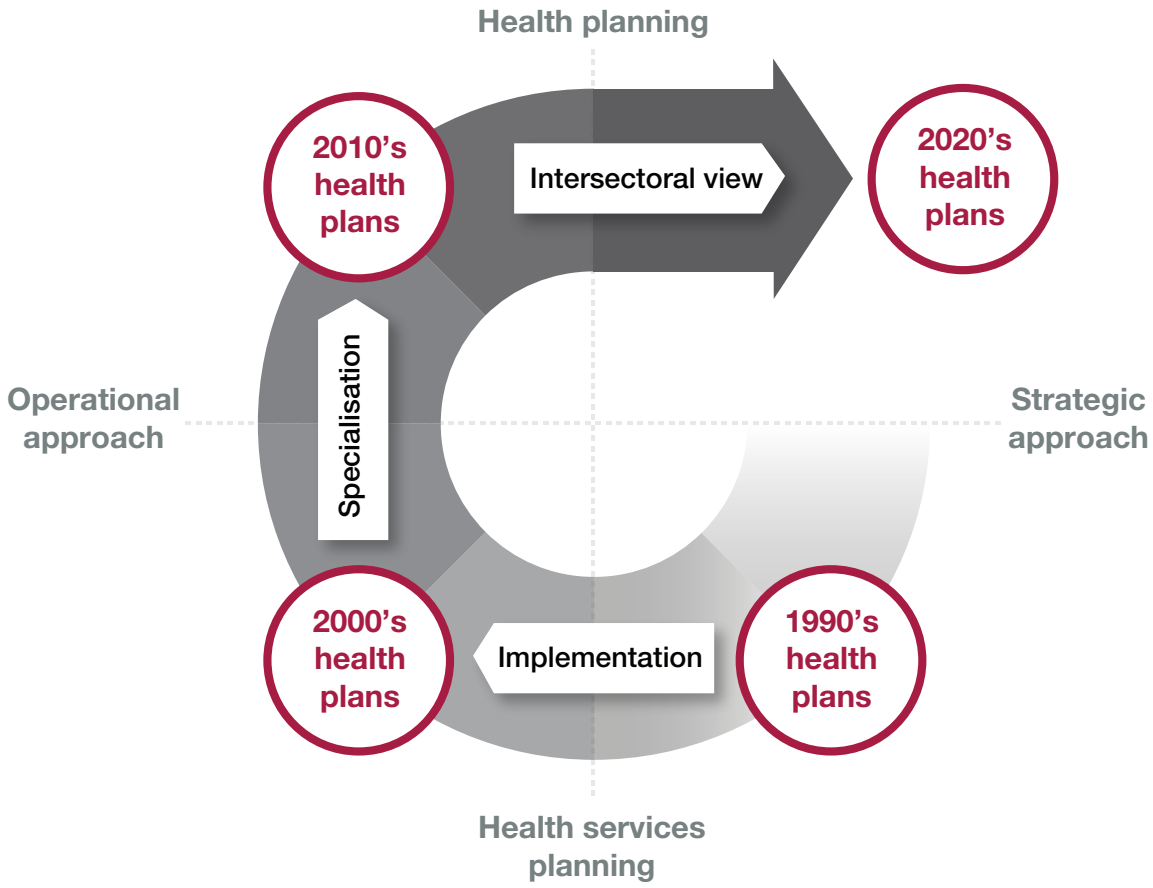
Catalonia boasts excellent health outcomes achieved at reasonable health system costs. Standardized mortality rates are decreasing and life expectancy is continuously growing. In 2010–2013, mortality was reduced by 8.5% while life expectancy increased in 1 year both for males (80.8 years) and females (86.3 years). In 2016, life expectancy at birth was 83.6 years, among the best in Europe (*16*). In 2016, public health expenditure per capita was US$ 2137 (purchasing power parity); total health expenditure was 7.6% of gross domestic product (*17*) and Catalonia had 1.7 hospital beds per 1000 population well below the average of 3.7 beds per 1000 population in the EU15 (*18*).[5] The past 30 years of health planning has targeted improvement of outcomes while keeping health system costs at reasonable levels through strengthening the health system.

During the past 30 years, the health plans have developed into a valued institution in the genome of the Catalan health system. The health planning process in Catalonia has been carried forward with remarkable consistency over a thirty-year period while adjusting to the changing needs over time. New generation topics have been consistently integrated although implementation challenges arose specifically for new generation policies. The health plans are well known by all stakeholders and respected for setting a vision and a direction for the improvement of health and well-being. A key informant likened the health plans to "a compass setting directions for health actions at various levels". Clear leadership, well-assigned institutional roles and relationships, inclusive and open dialogue, and consistent application of a full policy cycle have contributed to a large extent to the success of the Catalan health plans to fulfil this foundational role in the Catalan health system.

However, the health planning process has been facing challenges as health action has become more pluralistic across sectors and government levels. With growing attention to intersectoral action to address a more comprehensive range of health determinants, the health planning process has been able to capture key themes and policies but implementation and funding mechanisms need to be further identified and strengthened. Catalonia has been a greenhouse of innovation at local level (municipalities and health institutions), challenging health planners to create platforms and processes to capture and legitimize effective innovations for scale up and accelerated development. Thus, health planning now faces the challenge to become the nexus of intersectoral and intergovernmental action for health (Fig. 2).

[5] EU15 refers to the 15 member countries of the European Union before 1 May 2004.

Figure 2. Evolution of health plans and drivers of change



This chapter of the report explores these themes more systematically following the five dimensions and 21 attributes identified for strong health plans outlined in Chapter 2.

Dimension 1 | Management and inclusiveness of the planning process for internal consistency

Attribute 1.1 Mandate, regulated process and leadership

There is a well-established and clearly articulated mandate and well-regulated process for health planning outlined in the 1991 LOSC. Title 5 "The Health Plan of Catalonia" (articles 62–64) defines the essence, contents and procedure of five-year health plans.[6] The law provides the mandate to the Department of Health to initiate and lead the process of health planning by establishing general criteria, setting goals and targets, and outlining a methodological approach and timeframe. Building on local priorities has been in the focus early on, and the law provides the mandate to health regions to localize priorities and develop regional health plans jointly with CatSalut. At regional level, CatSalut reviews and aggregates regional health plans. The Department of Health ensures alignment of different plans with goals subject to economic constraints and leads priority setting (Table 3).

[6] Catalan Health Care Order Law (1991) (op.cit.)

Table 3. Five-step process for the elaboration of the health plan

Step	Responsibility	Process
1.	Department of Health	• Formulation of health care planning general criteria • Goal-setting and selection of targets and measures • Setting of methodology and elaboration calendar
2.	Health regions	• Formulation of draft regional health plan • Submission to Steering Council of CatSalut
3.	CatSalut Consell de Direcció (Steering Council)	• Review adequacy of regional health plans • Elaboration of the aggregated health care services plan
4.	Department of Health	• Integration of different plans and adjustment of the health plan to health and economic policies.
5.	Government of Catalonia (Executive Board)	• Approval of the health plan • Submission to the Parliament of Catalonia

Source: LOSC 1991, Title 5, Article 64

Executive boards of the Department of Health and CatSalut are responsible for the first approval of the health plan. Then, health councils from CatSalut at the central and regional levels endorse the plan and approve their respective regional health plans. Once this process is done, the Government of Catalan approves the health plan, and the Parliament is informed about health priorities and targets. Sometimes, this approval provides high institutional visibility with the President of the Government of Catalonia presenting the plan officially as it happened in the last two editions (*19*). Since 2011, the Department of Health has produced the Health Report providing updates about health indicators (*20, 21*).

The Department of Health has demonstrated strong leadership over three decades in leading the process of health planning, and this is openly acknowledged and recognized by key stakeholders at different levels of the health system. The Department of Health has institutionalized and formalized the functions of health planning using dedicated capacity from the Health Planning unit staffed with five health policy professionals under the Directorate General of Health Planning. The Department of Health has clearly operationalized the health planning mandate in seven subsequent policy cycles each of which logically builds on the achievements and shortcomings of the previous health plan. The Department of Health has sought well-defined contributions from key stakeholders, and organized dialogues and policy dialogue platforms around various aspects of health planning to build consensus over key directions. As a result, key informants overwhelmingly regarded the health plan as a foundational instrument of health policy with full legitimacy.

The institutional partnership between the Department of Health and CatSalut is fundamental to the success of health planning in Catalonia. As later described in more detail, CatSalut through regional health plans and alignment of the contracting process operationalizes health plan priorities and ensures that they are implemented. These strong links between the health plan, regional plans and service contracts can be considered an international good practice for countries that have good plans but lack implementation mechanisms. CatSalut is the main implementation mechanism of the health plans. In the planning phase, CatSalut plays an important role, which has varied over the 30 years reviewed and fluctuated between a more participatory approach and a more hands-off approach in anticipation of fulfilling an executive function of operationalization and implementation through contracts. Key informants regarded it important that CatSalut remains actively engaged not only in the operationalization phase but also in the planning phase, providing inputs to identify and select strategic health plan objectives and priorities. In particular, CatSalut is viewed to have solid mechanisms to coordinate, collect, synthetize internally and then bring to the planning negotiation table the key issues faced by regional branches, building on the good practices at territorial/regional level (strategic territorial plans) and extending them to other local health sectors and regions.

Health regions play an important role in health planning. According to the LOSC, regional health councils must approve and adopt regional-adapted versions of the health plan. Health regions are the first level of territorial organization in health administrative terms. Subregional levels (municipalities and counties) have a less clear function concerning the implementation of the health plan activities except for capital cities where municipalities play a major role in collaboration with the regional authority as in Barcelona. Some municipalities develop a local health plan that is often oriented to health promotion and intersectoral collaboration. These local plans tend to be inspired by and linked to the health plan, with an emphasis on public health and health promotion framework. The Barcelona Health Plan is the most relevant and is aligned with the regional health plan.

Moving forward, it is possible to build on and broaden these well-functioning mandates, regulated processes and legitimate leadership, and integrate new health policy issues into the current approach rather than develop new ones. As the focus of the health plan is moving towards addressing a broader set of health determinants, health planning needs to accommodate intersectoral approaches to a greater extent (see Dimension 4). An important area to further investigate is the institutional capacity of the Department of Health to be fit for purpose, and build stronger relationships and collaboration with different actors.

Attribute 1.2 Stakeholder involvement and participation

The development of the Catalan health plan is characterized by multistakeholder involvement predominantly using top-down approaches. Stakeholders use three main instruments to participate in and shape the development of the health plans. The first one is using institutional roles through governing bodies of the Department of Health, CatSalut and ICS, which include a broad range of stakeholders. This approach captures the views of senior executives in the health system predominantly and institutional positions of larger health service providers. The second one

is through the Catalan and territorial (regional) health councils who have also participated with their plurality of representatives from unions, provider and patient associations, scientific societies and third sector organizations. The third mechanism of participation at expert level is through thematic working groups. Working groups are established around key health plan priorities. Some are historically formed and continued; others are formed based on evaluation of the previous health plan, and some follow new priorities established by the political leadership. In general, key stakeholders at higher policy levels and senior experts felt that they had ways to shape the health plans either through these working groups, health councils or their institutional roles.

There is less reliance on bottom-up initiatives to channel stakeholder involvement from health regions and health care providers for accelerated uptake of local innovations. At the regional and provider levels, there was less consensus about the extent of inclusiveness of the health planning process, and less clarity about criteria for establishing working groups and the inclusion of stakeholders. These levels were clearly involved in operational and action planning based on the Catalan health plan but less involved in shaping its overall priorities. The significance of bottom-up processes is that there is a great degree of innovation and many good practices identified during these assessments, and channelling them to the planning process would enable accelerated implementation. There was general enthusiasm for larger more participative forums in the health planning process that would also create opportunities for learning from each other. There is a general acknowledgment of the challenges around organizing stakeholders' participation in practice and the need to improve those mechanisms making them more transparent, inclusive and effective.

The principle of participation is legally enshrined in the LOSC and also in the Catalan Public Health Law (*14*), although from the interviews conducted this varies in how citizens and communities are engaged and what function they play. Civil society and community engagement was identified in the processes around the mental health director plan particularly – with the preparation of community plans being led by mental health boards, which include patient/family groups, and the planning of services being undertaken based on local research as an outcome of this participatory dialogue at local level. Yet concerns were raised about the breadth of engagement from the civil society actors who tend to represent patient groups or families of patients; therefore, there is a representation gap in voices from health promotion or public interest nongovernmental organizations. The Catalan "Framework for citizen participation in health" published in 2018 deepens the role of citizens and provides an opportunity to step up engagement in this regard (*22*).

It is not clear to what extent citizens and communities are engaged in planning or priority setting, however. In oversight functions participation is dominated by professionals and representatives of institutions. Mental health boards exist at local level, with a role to prepare community plans and ostensibly to provide coordination of the different institutions; however, they have an advisory role in processes coordinated by local authorities and where the main actors and implementers are the health services. Different forms of lay committees channelling citizen voice – such as health and well-being boards – do not seem to exist. It is not clear that the (annual) reporting of the implementation of the Catalan health plan is discussed in the Parliament of Catalonia or in a public forum. This suggests that although participatory governance is in place, its actual implementation is not fully operationalized.

Attribute 1.3 Political commitment, accountability and alignment with government policies

The Catalan health plans have received high-level political support and commitment, and accountability instruments are in place at the highest level. Executive boards of the Department of Health and CatSalut are responsible for the first approval of the health plan. Then, health councils from CatSalut at the central and regional levels endorse the plan and approve their respective regional health plans. Once this process is done, the Government of Catalonia approves the health plan, and the Health Commission at the Parliament is informed about health priorities and targets. This approval provides high institutional visibility with the President of the Government of Catalonia presenting the plan officially as it happened in the last two editions (*19*). As a result, reporting and accountability for plan goals and targets are at the highest possible political levels. This high-level attention corresponds to the core values of well-being and solidarity, which have been important in government policies in Catalonia, providing the health plans a natural priority in governmental discourse. Further, since health is one of the key competencies allocated to autonomous communities, 31% of the overall governmental expenditure is allocated to health in Catalonia. This creates an overall interest and incentive for the government to ensure an orientation to producing good outcomes at low cost. High-level political support creates a good foundation for further incorporation of intersectoral directions to address health determinants.

Attribute 1.4 Internal consistency with subsectoral plans

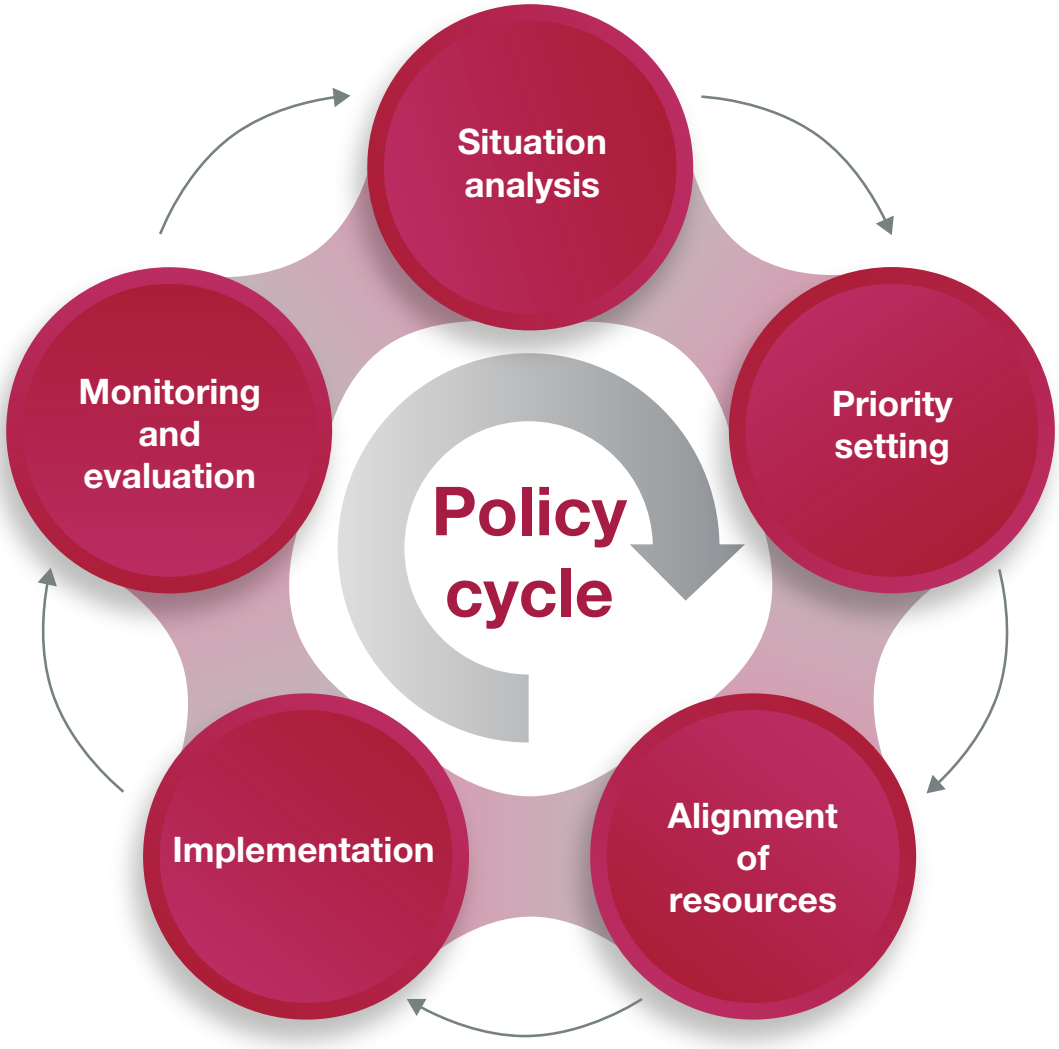
There is solid internal consistency between the health plan and subsectoral plans in the health system. This is achieved through disease-specific masterplans (referred to as director plans). Director plans were introduced in the 2002–2005 planning cycle. Director plans also fulfil the function of further specifying selected priority areas of health improvement, and thereby contribute to operationalization of the Catalan health plan.

Director plans have had a positive impact from the implementation perspective and have been actively used in the design and priority-setting phases. Director plans on cancer, the circulatory system, respiratory system, mental health and addictions, and rheumatic diseases and the locomotor system cover the most prevalent burden of disease. Two non-disease related director plans on immigration and long-term care target health priorities of vulnerable groups. It is not clear, however, to what extent director plans are linked to service contracts and are aligned with resources.

Dimension 2 | Health plan content is internally consistent and reflects a connected policy cycle

Overall, there are strong connections in the five key steps of the policy cycle creating good internal consistency between aspirations and actions (Fig. 3). Evaluation and situation analysis feed into priority setting and programming. For many areas of the health plan, implementation arrangements are clear and contractual approaches through CatSalut translate activities into services. Regular monitoring and evaluation feed into the new health planning cycle. Potentially, the weakest link in the policy cycle is the alignment of resources (financial, capital, human, and digital) with health plan priorities, particularly in new generation health improvement areas, which may not easily translate into contracts (e.g. policies to address childhood obesity). These areas are explored further below.

Figure 3. Policy cycle of health planning



Attribute 2.1 Situation and response analysis as foundation of health planning

New health plans are formulated based on sound situation analysis and tracking of progress against goals and targets in the previous health plan, with strong monitoring functions and capacity developed in the Department of Health. Contextual analysis is based on epidemiological, demographic, socioeconomic and equity issues. Tracking progress against goals and targets in the previous health plan is carried out by the Department of Health's Directorate General of Health Planning, involving experts in the analysis of trends as needed. Roughly every 10 years (e.g. in 2000, 2010), a more comprehensive analytical exercise is carried out to examine long-term trends. Data sources for the indicators are varied including vital registration, surveys and other data sources. Monitoring capacity has been strengthened over time. For instance, the first Health Plan (1991) anticipated conducting the Health Survey of Catalonia to monitor health status and people's health-related behaviours. Since 2011, the Health Survey has been continuously conducted annually. Monitoring results are published and widely disseminated regardless of whether goals were achieved. The publications of these indicators gain political and popular attention.

Table 4. Health goals and risk reduction evaluation results 2000–2015

Level of achievement	2000		2010		2015	
	Health goals	Risk reduction (%)	Health goals	Risk reduction (%)	Health goals	Risk reduction (%)
Totally achieved	69	68.3	94	53.7	13	50
Partially achieved (>50%)[a]	8	7.9	24	13.7	8	30.8
Not achieved	24	23.8	57	32.6	5	19.2
Evaluated goals	101	91.8	175	79.6	26	96.3
Non-evaluated goals[b]	10	–	45	–	1	–
Total goals	111	–	220	–	27	–

[a] At least 50% of the expected change was achieved.
[b] Non-evaluated goals are due to unavailable data, register or deficient definition of goals and indicators.
Source: Department of Health, Government of Catalonia.

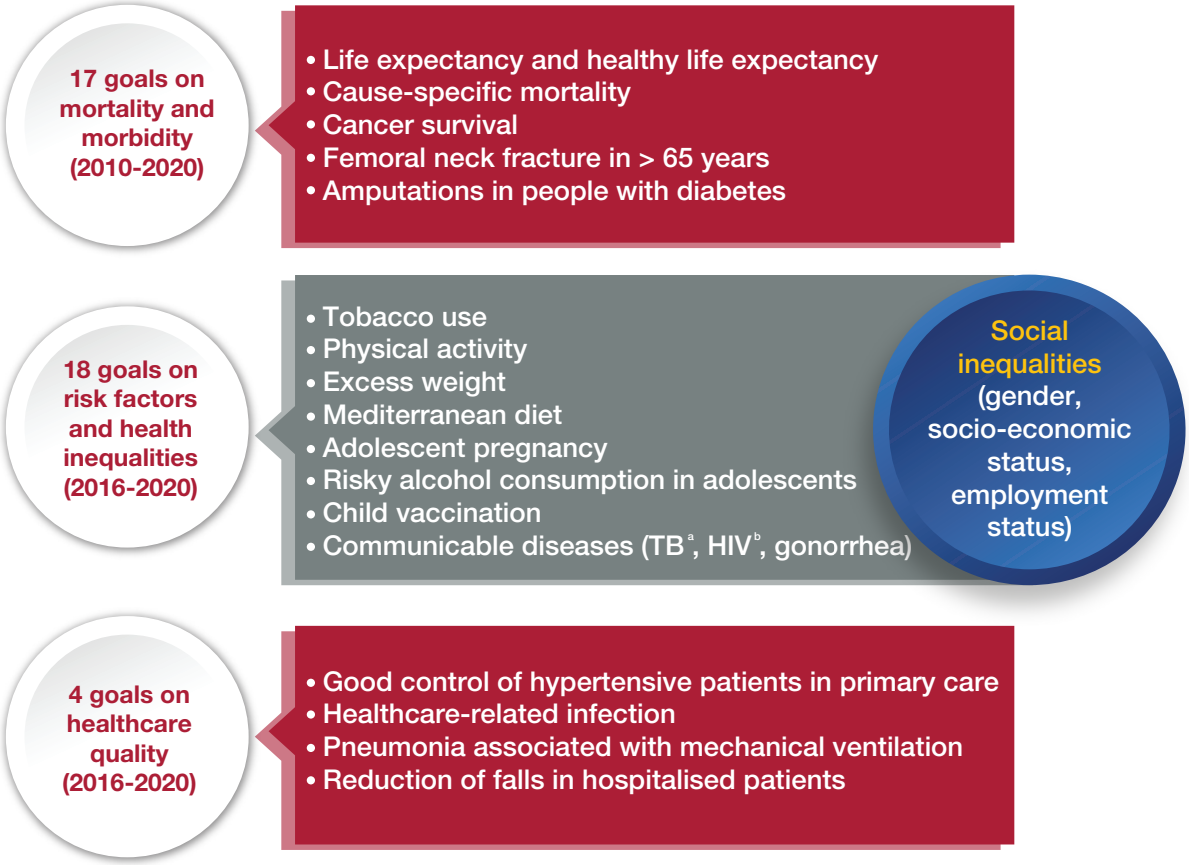
While health plan monitoring is well developed, specific evaluation tools are used less systematically to understand variations in areas of health plan implementation and identify key factors behind it. Monitoring of indicators enables the Department of Health to track whether desired progress is happening,

and evaluation would enable the Department to better understand the driving factors behind successes and gaps. In many countries, such functions are routinely contracted out to policy analysis institutes and academia. Several stakeholders have commented that the role of AQuAS has evolved from technology assessment to broader health policy analysis and could better fulfil this role in partnership with others.

Attribute 2.2 Clear priorities, goals, objectives and expected results

The health plan sets out clear priorities, goals and expected results that aim to contribute to improving health outcomes and health equity, and it does so through time-bound specific measurable targets. Improving life expectancy in good health is the ultimate objective with intermediate objectives related to reducing mortality, disability, morbidity and risk factors. Health care quality goals were included in 2011–2015, and the reduction of the social divide connected with several risk factors was introduced in 2016–2020. Since 2011, gender, age group, territory, socioeconomic status and level of education have also been considered (Fig. 4).

Figure 4. Health goals of the Health Plan 2016–2020

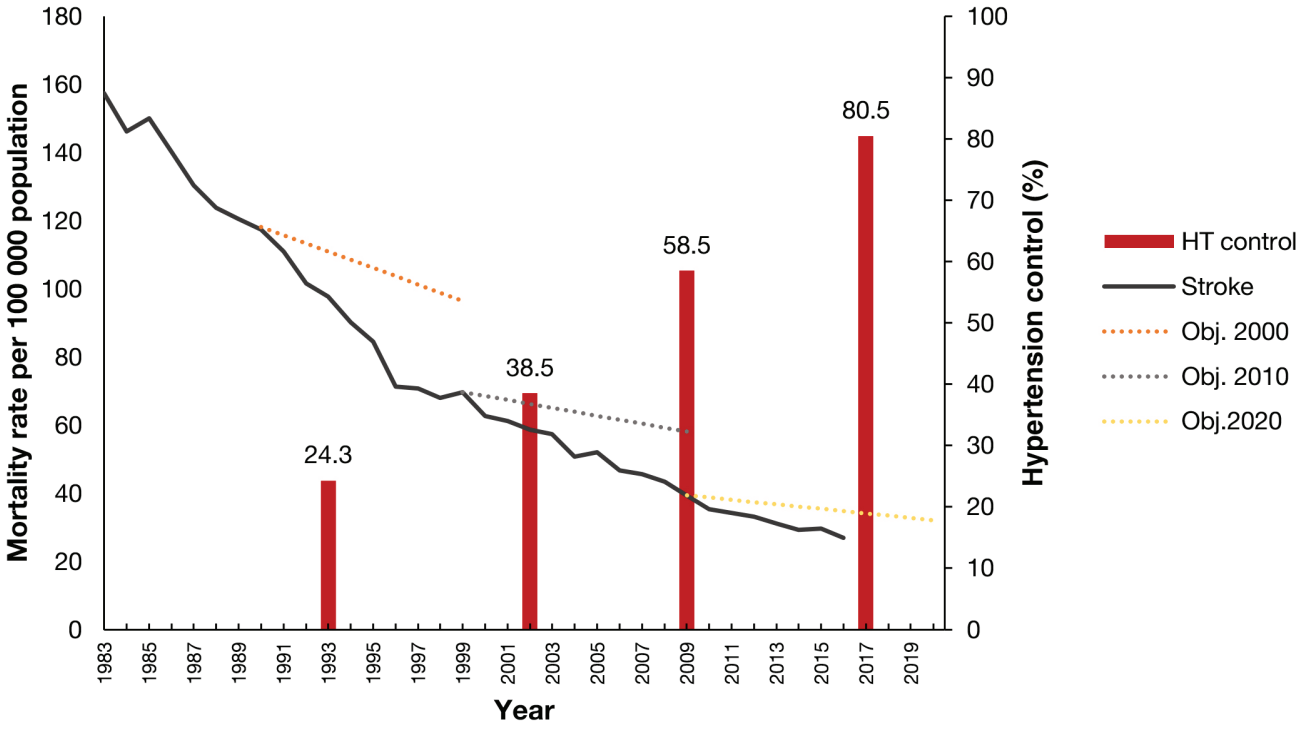


[a] TB: tuberculosis.
[b] HIV: human immunodeficiency viruses.

There is consistency across health plans in goals and directions while also accommodating new priorities, continually challenging the health system to move forward. The current 2016–2020 Health Plan has 39 health and risk reduction goals. Roughly half of these (20 goals) were identical in the previous health plan but targets have been modified. Nineteen targets are completely new reflecting recently emerging priorities such as: excess weight in children, Mediterranean diet, consumption of high-calorie products, adolescent pregnancies, vaccination of children aged under 5 years, tuberculosis, HIV, gonorrhoea, binge drinking and falls in hospitalized patients. Further, the current Health Plan 2016–2020 has strengthened the focus on equity with some goals with gender targets and a breakdown of social inequalities.

The example below on stroke mortality shows that the health plans have continued to put focus on large amenable areas of mortality and through subsequent health plans have established ambitious targets (Fig. 5). It also shows the importance of linking goals at the level of health outcomes to more concrete outcome targets that directly contribute. The reduction in stroke mortality coincided with improved control of hypertension. This in turn was achieved by increasing the focus and strengthening the resolute capacity of primary health care, which remains a strategic area even in the current Health Plan 2016–2020. This in turn is translated into services, service targets captured in CatSalut and primary health care provider contracts and indicators for measuring primary health care performance as well as pay for performance bonuses. A fully connected chain underlines several of the goals, indicators and targets particularly in those areas, which can be addressed through individual health services.

Figure 5. Stroke mortality, health plans' goals and hypertension control, Catalonia



Source: reproduced by permission of the Department of Health, Government of Catalonia.

Prioritization across goals and interventions has moved from a highly technocratic towards a more flexible multidimensional approach allowing broadening of the vision for health improvement. Until 2011, prioritization took place through a Hanlon-adapted ranking method of health interventions considering the following factors: problem magnitude, intervention existence and efficacy, feasibility and the potential for improving healthy life expectancy. Since 2011, with the introduction of strategic lines and projects, prioritization by health problems has not been exclusively applied. Transversal criteria like accessibility, equity, research, chronicity and information technologies are also incorporated, and expert and professional opinion play a larger role. This allows a widening vision beyond health problems.

Attribute 2.3 Link between goals, planned policies and interventions

Largely, planned policies and interventions have evolved over time and have responded well to priorities and objectives. Overall, the health plans are comprehensive and address varied areas of health system strengthening. Over the past 30 years, the focus of policies and activities promoted in the health plans has gone through an evolution. Initial health plans focused much on health promotion and prevention in line with ambitions in the WHO Global Strategy for Health for All by the Year 2000 (*6*). In the new millennium, health plans became more oriented towards strengthening health care services, in particular to implement a stronger primary health care model, and regionalized and fit-for-purpose specialized and hospital services while moving forward with the integrated care agenda. The latest health plan has returned to strategic and higher-level policy orientation, increasingly taking into account the social determinants of health (Table 5).

Development of policies and interventions for the health plans take into account evidence and European good practice, including consideration of effectiveness, efficiency and sustainability.

There is a striking wealth of innovation and good practices encountered at the community and provider levels. The health plans could do more to integrate and scale evaluated, evidence-based good practices. This is particularly the case for the new generation health actions such as strengthening mental health services at community level, vertical integration of care, integration of health and social care, gender-sensitive approaches, etc. This requires systematizing and evaluating innovations existing in Catalonia, creating a process with a greater exchange about innovations and feeding them into the health planning process. This has to be balanced, however, with the very reason why Catalonia has such a wealth of innovative approaches: plurality in service delivery and provider autonomy.

Table 5. Evolution of health planning design and implementation

Period	Planning cycle	Health plans	Responsibility	Planning axes	Orientation	Focal areas	Implementation
1979–1990	–	None	Department of Health	Productivity	Health services reforms	Territorial development and health care quality	–
1991–2001	0 1 2 3	1991 1993–1995 1996–1998 1999–2001	CatSalut	WHO health goals 2000[a]	Preventive activities	Primary care and prevention	Services contract for primary care and hospitals
2002–2010	4 5	2002–2005 2006–2010	Department of Health	Main health problems	Specific programmes	Primary care and prevention, specialized care and diseases	Director plans
2011–2015	6	2011–2015	Department of Health	Health services	Reordering health services	Specialized care	Reordering health services
2016–2020	7	2016–2020	Department of Health	Health inequalities, participation and intersectoral collaboration	Strategic health policies	System view	Equity, participation and intersectoral policies

[a] *Global Strategy for Health for All by the Year 2000 (6).*

Attribute 2.4 Alignment of funding and other resources with health plan priorities

An important strength of the policy cycle is the translation of health plan priorities into service contracts and, thus, to budget allocation processes through CatSalut's contractual mechanisms. CatSalut, which leads on the plan implementation for individual services, has put in place a system to translate the strategic objectives of the plan into actions by (i) orienting resources allocation according to these priorities and by (ii) reflecting them in the contracts negotiated with the providers. Service delivery contracts mirror goals and targets in the health plan. Additionally, 5% of the budget is explicitly allocated through payments for performance at the primary care and hospital levels, linking performance to the achievement of health plan priorities. Provider incentives are also translated into individual incentives through the variable part of health professionals' salaries (Box 1).

Box 1. Good practice of transferring health plan priorities through CatSalut's health services contracts

CatSalut's health services contracts are the key implementation mechanism to transfer health plan priorities into health provider interventions. Through the different CatSalut contract lines, encompassing primary care, acute and long-term hospitalization, mental health and emergencies, health priorities are incorporated as annual objectives under the pay for performance scheme that represents up to 5% of health providers' turnover. These goals are further transferred to health professionals as the variable part of their salary, connecting health policies with individual incentives and behaviours. All in all, CatSalut's health services contracts represent a strong instrument for aligning the health system, integrating health services delivery and orienting care to long-term health priorities.

At the same time, the impact of the health plan on the prioritization of the overall health budget seems weak. While the noted contractual process provides an excellent vehicle to match resources to priorities, it is more likely to work for those areas that fall into contractible individual services delivered by current provider structures. However, an increasingly smaller share of health plan priorities falls into these categories of contractible services. In the current Health Plan 2016–2020, for example, just three of the 12 strategic lines (lines 4–6) fall into the category of these easily contractible services (Section 3.5, Fig. 1). Similar priority setting for operating expenditures, capital and human resources for the remaining priorities seem less explicit and systematic. The review team did not encounter examples of budget impact analysis or retrospective reviews of public spending relative to strategic priorities of the health plan. The monitoring and evaluation process of health plan implementation does not appear to focus on these areas.

Attribute 2.5 Clarity and fit-for-purpose implementation arrangements

Many key informants noted the implementation gap between aspirations of the health plan and its actual results. Interestingly this terminology was used consistently. However, there were divergent descriptions of this implementation gap and its cause in key informant interviews. The underlying thread is the increasing complexity and ambition of health planning to address a wide range of health determinants to continue to push for increased health outcomes and health equity while keeping costs low. This discussion has also translated into dilemmas about the extent to which the health plan ought to be more strategic and visionary versus more pragmatic and operational. Fig. 2 illustrates how the last three decades of health planning have evolved from a strategic perspective in the 1990s, towards greater operationality in the 2000s and again back towards a strategic vision-setting level in the current era.

As the focus of the plan has evolved over time, its implementation arrangements have also evolved and it now includes a complex set of actors and a wide range of implementation arrangements. For example, the most salient implementation arrangements include:

- **direct implementation** by core government agencies such as the Department of Health, CatSalut and the Public Health Agency of Catalonia through their own institutional capacity;
- **strategic purchasing and contracting** of service providers
- **regulatory policies** in which some interventions, such as criteria for complementary benefits, require legal developments through CatSalut's instructions;
- **intersectoral collaboration** in which some goals need interdepartmental projects involving other sectors such as PINSAP for public health, PIAISS for health and social integration or PISMA for mental health and addiction;
- **intergovernmental collaboration** for local and community health action; and
- **clinical governance** in which the health plan promotes excellence in clinical practice through clinical guidelines, care pathways, protocols and evidence-based recommendations to avoid over-diagnosis and overtreatment (*24*).

Pragmatic but possibly incomplete approaches are in place to translate the health plan into implementation plans or operational plans. Multiple instruments are in place, which cover a large share of health action but not all.

- Since the Health Plan 2002–2005, these specific plans have been known as **director plans**, masterplans led by eminent clinicians appointed by the Department of Health. They are defined around a health problem or disease system and involve the collaboration of various health system actors, including prominent scientific societies. The implementation of the Health Plan 2016–2020 involves a plurality of Department of Health and CatSalut units, health care organizations and professionals, without a hierarchical structure. A leader for each strategic line and project is appointed and reports progress periodically. The Health Planning unit follows up projects and the evolution of health goals.
- Territories have different sizes and diverse compositions of health providers making homogeneous implementation a challenge. That is why health plans are planned at health region level to incorporate local conditions. Through its regional branches, CatSalut develops **health region service plans**: territorial planning and implementation instruments that reflect the priorities of the health plan and provide professional participation environments for developing local projects. Health plan priorities, purchasing, incentives and service delivery planning comes together at the regional and territorial levels for coherence. This is an enormous strength to preserve and build on. An example for this expansion is the integration of selected social services.

However, not all priorities of the health plan can be implemented through disease-specific director plans and CatSalut contractual processes. Implementation mechanisms for new generation areas need to be examined, in particular, for

intersectoral and intergovernmental action as described under Dimensions 4 and 5. Multistakeholder implementation plans were not in place for these areas at the time of this assessment.

Particularly, opportunities remain to identify and narrow implementation gaps in intersectoral action (see Dimension 4). Most intersectoral work is undertaken at project level, where there are strong and immediately visible co-benefits. Under such circumstances, different sectors work together but in parallel using their own budgets and separate activities (such as through PAISS with the social sector). The experience gained from PINSAP has become a core element for intersectoral working in Catalonia. The strength of the PINSAP implementation mechanism is enabling voluntary action within a strong strategic framework. However, there are no multiagency implementation mechanisms developed for intersectoral actions at the Catalan level and for those types of intersectoral action where voluntarism and co-benefits are insufficient (e.g. tobacco control).

Localizing implementation to health regions and territories is an important direction but engagement has been variable and accountability gaps exist (see Dimension 5). Consistent implementation is sometimes hampered by the complexity of governance and accountability arrangements. Governance across different public administrative bodies and agencies is quite fragmented. Joint outcomes and shared responsibility for joint outcomes are not always specified. Accountability remains internal rather than distributed and jointly owned, and is largely carried out by the Department of Health through formal accountability mechanisms and reporting to the government and Parliament.

Dimension 3 | Equity dimensions in health planning

There has been an increasing focus on health equity in the Catalan health planning process with remarkable commitment to equity and solidarity at the level of values. Opportunities remain to move from values to action through strengthening planning, implementation, evaluation and accountability for health equity. Working towards health equity is key to implementing the 2030 Agenda for Sustainable Development (*25*), one of the strategic objectives of the WHO Policy framework in the European Region, Health 2020 (*26*) and part of the WHO Health Equity Status Report Initiative (*27*).

Attribute 3.1 Prioritization of equity goals and equity-enhancing health action

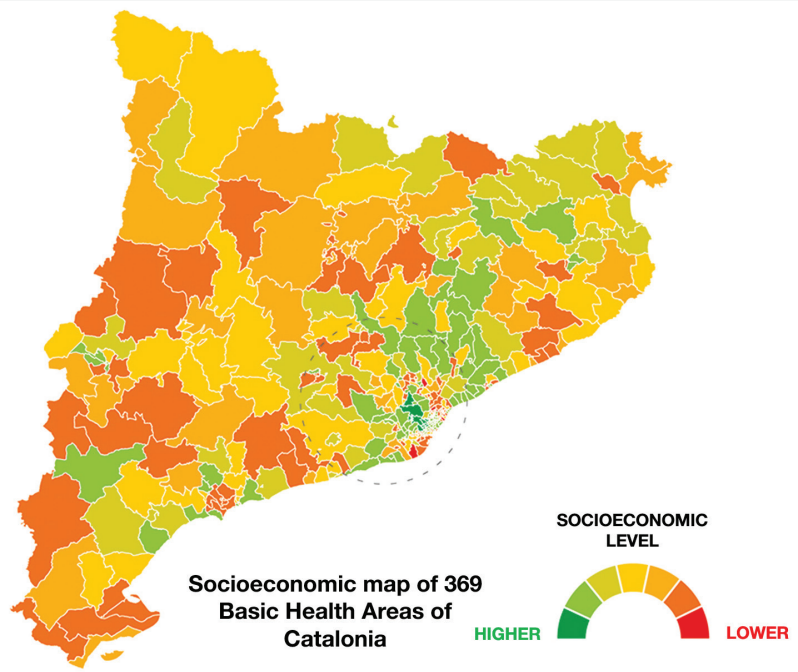
Leadership and political commitment to identify and reduce gender and socioeconomic inequities are now high on the agenda, and the health plans present a good framework to move forward. Since 2011, gender, age group, territory, socioeconomic status and level of education have been considered in

health plans. The reduction of inequalities in health by social class, education and employment are linked to several risk factors in the Health Plan 2016–2020. Equity is also included as a guiding principle as a guarantee for social justice and gender is mostly referred to under the projects related to sexual and reproductive health and violence against women.

In the Catalan health plan and health system, the strongest approach to tackling health inequalities is a territorial one, in particular, related to primary health care. Enabled by excellent data, variation in socioeconomic status is understood with good precision at the level of basic health areas. The analytical tools have been linked to policy follow-up in several ways making this an area of a European good practice (Box 2). First, the socioeconomic variation has triggered an adjustment in the capitation payment of primary care providers. Second, it has influenced the risk-stratification approach used in primary care to identify complex and high-risk patients. Third, it supports the social work dimension in primary health care. Fourth, it informs community health action and funding allocated to it.

Box 2. Good practice of tackling socioeconomic inequalities

Addressing social determinants of health and reducing health inequalities are principles and goals of the current Health Plan 2016–2020.



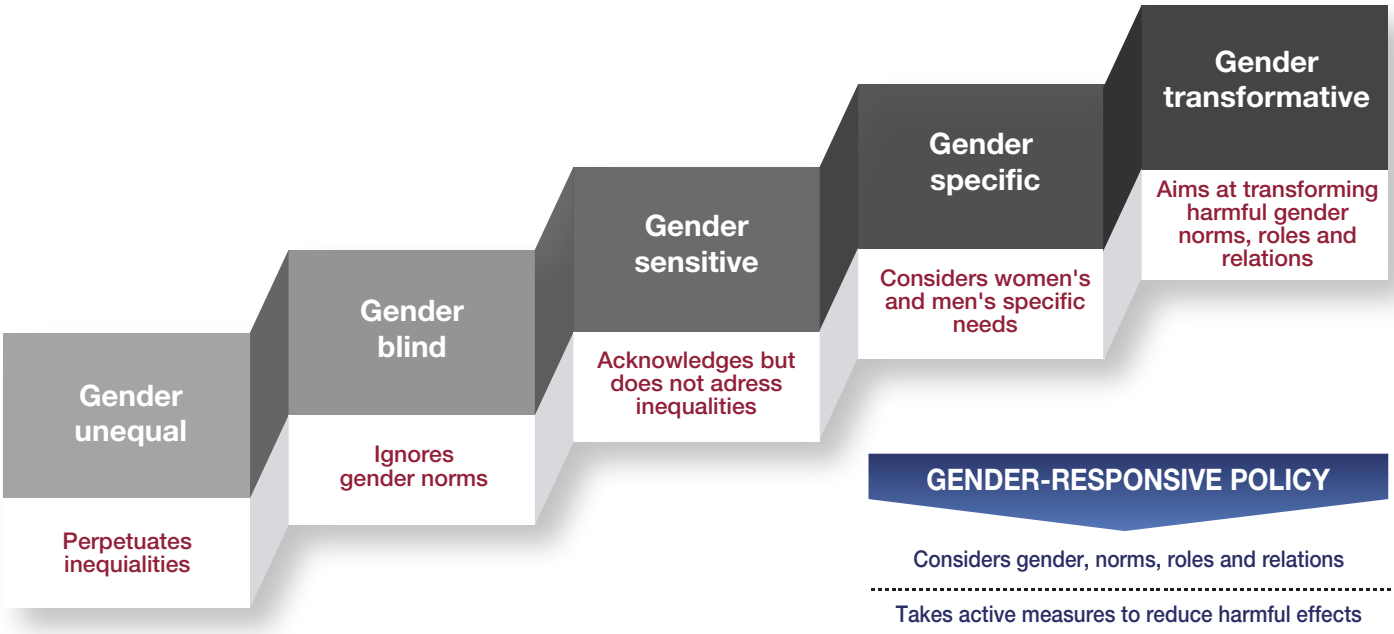
In 2016, AQuAS produced a socioeconomic index to measure deprivation at the level of basic health areas. This index has been incorporated in the funding mechanism of primary health care services, and now it is used to adjust resource allocation for each primary health care team based on the socioeconomic level of its served population.

Primary care teams can use this additional funding to provide additional or reinforced services to the most vulnerable populations.

Source: Department of Health, Government of Catalonia.

Regarding gender equality, Article 48 of the Law 17/2015 on gender equality includes the need to incorporate a gender perspective in all phases of health planning, but this is not yet a reality and remains an opportunity for the next health planning cycle. Using WHO's assessment scale on the degree of gender responsiveness (*28*), the Catalan health plans reflect on average gender-sensitive approaches (Fig. 6). The latest health plans have gender-specific health targets. There is room for improvement, however. It is difficult to see if these targets have been driven by a gender analysis. Sex differences in results or use of services are neither used to redefine priorities or design interventions. Therefore, actions to improve gender equity are implicit and voluntary without hard policy instruments such as additional funding, service delivery mechanisms and capacity building for example.

Figure 6. WHO Gender Responsive Assessment Scale



Source: Gender mainstreaming for health managers: a practical approach (28).

Attribute 3.2 Use of evidence and disaggregation of analysis

The strongest asset for addressing and reducing inequities in Catalonia is the rich level of disaggregation of data. The good overall health indicators in Catalonia, which remained stable even during the economic crisis, may mask socioeconomic and gender inequities. The data allow gender and equity analysis of almost any health outcome, access and use of services, access to medicines, inequities within the workforce, etc. The yearly health status reports and the national health survey present sex, age and socioeconomic disaggregation of data, and services collect these data at the primary health care and hospital levels.

Despite this richness, data are not always presented disaggregated and when they are, they remain at the level of differences without looking at the fairness of these differences or the causes. For example, the same percentage is applied to male and female ischaemic heart disease targets while the differences between both are significant. Similarly, targets in the current Health Plan 2016–2020 to reduce socioeconomic inequalities are not disaggregated by sex: target 1.2 reduce social inequalities in good self-perceived health; target 15.1 on healthy physical activity; or target 16.1 on excess weight. The Health Survey of Catalonia and yearly health reports are a good basis for priority identification although further inclusions of gender- and equity-sensitive indicators could be integrated. Beyond monitoring efforts, specifically commissioned evaluations could help to identify reasons behind successes on some dimensions and understand barriers to making greater progress on others (see Attribute 2.5). For example, a 10% gap between the actual and target outcomes may appear small, but there also needs to be an understanding of who these populations are and how to involve and reach them in order to not leave anyone behind.

Attribute 3.3 Mechanisms for participation and accountability

Participation of different stakeholders throughout the planning policy cycle is one of the key elements for addressing inequities, and this is an opportunity to further exploit in the future. Engaging with different actors to develop the Catalan Health Plan 2016–2020 was broadly focused on professional associations, patients and territorial representation through institutional bodies with quite rigid participation. Currently, there is great interest to more directly involve citizens in various dimensions of policy formulation, and this is an important equity-enhancing instrument. There are explicit institutionalized teams established both in the Department of Health (Secretary General of Health Care and Participation) and at intergovernmental level (Directorate General of Citizen Participation and Electoral Processes). These steps demonstrate commitment to this approach. It will be important to link these efforts to priority setting in terms of resource allocation and staffing plans.

Several mechanisms for multisectoral collaboration and for participation of different groups can be further used to reduce inequities. Stakeholders mapping as a prerequisite for intersectoral collaboration and participation can be done through the Health Council of Catalonia, regional health councils, the Patients Advisory Council of Catalonia and the Advisory Board of Gender Health Policies, all under the steering of the Department of Health. Other relevant participation bodies are the *Consell* (Council) 2030, *Nova Agenda Urbana* (New Urban Agenda), *Consell de Dones* (Women's Council), etc. It would be important to learn from multiple experiences at regional level and strengthen participation mechanisms at the three levels: Catalan, regions and municipalities.

Attribute 3.4 Alignment of resources

The socioeconomic status of basic health areas and resource allocation are linked through the health service contracting process and resources for particular initiatives. As described above (Attribute 3.1), resource allocation at primary care level is particularly sensitive to socioeconomic, status, and policy responses to these data can be considered a European good practice. Also, there are several individual initiatives and good understanding at service level of gender-based inequities, which are mostly related to thematic areas or population groups: violence against women, sexual and reproductive health, protocol of services for vulnerable groups, etc.

There are further opportunities to strengthen the alignment of resources (financial, human, other) with equity goals and equity-enhancing health action. In particular, the following areas stand out for further exploration.

- Resources are not distributed based on equity targets, and no gender budgeting is identified in the health plan as a planning and management tool.
- The capacity of health providers and in the Department of Health to address gender and equity is scarce. Capacity-building efforts are ad hoc and not mainstreamed. New tools such as the draft guide for gender planning is not yet resourced.
- Some initiatives that are not yet operational, such as the Observatory of Health Inequalities (which is under AQuAS) could be a good opportunity to strengthen the equity dimension.

Dimension 4 | Intersectoral action and external policy coherence to address health determinants

Catalonia has a long commitment to intersectoral working with recent health plans integrating this theme, but priority-setting arrangements need to be examined vis-à-vis key public health challenges (e.g. smoking, obesity) and implementation arrangements need to be strengthened. Catalonia has demonstrated through both policy and practice an understanding of the need to bring in other sectors as part of a modern public health approach to improving population health outcomes. Examples of health-in-all policies and interdepartmental plans include PINSAP; PAISS; PISMA; gender violence against women, children and elders; foreign unaccompanied minors; and a food safety plan. A number of these can be considered good practice for the WHO European Region[7] demonstrating cooperation with different sectors (notably education, social services, finance and

[7] For example, the strategic axes of PINSAP include a health test (a health impact assessment following the phrase "first do no harm"), social prescribing, asset mapping, a cooperation agreement and working relationship with the Ministry of Education and Vocational Training of Spain and extra-fiscal action for social objectives (*29*).

the interior) to make a larger impact on health determinants. Although the volume of activity is high, implementation gaps remain both across territories (e.g. areas with low commitment) but also in relation to key public health objectives (e.g. tobacco control). Thus, opportunities remain to identify and narrow implementation gaps.

Of particular importance is the experience of PINSAP, which has evolved over time from a Horizon 2020 project to a core element for the implementation of the health plan and intersectoral working in Catalonia. The activities are undertaken through a cooperative approach, backed by significant investment, with 1226 actions identified and the strong focus on the social determinants of health as the dimension for further action. The strategic axes of PINSAP (*29*) are very strong and are examples of good practice for the European Region with an implementation strategy relying on voluntary action at territorial levels (both within and beyond the health service). This dual approach to priority setting and implementation has both advantages and some shortcomings as highlighted below.

Attribute 4.1 Mandated intersectoral action and engagement is integrated into policy cycle

The context for cooperation across sectors in Catalonia is favourable with a strong legal mandate – an important facilitator. The Catalan Public Health Law of 2009 provides this legal mandate, which enables government and public administrative action in the field of public health, work across sectors and participation. It also underscores a strong rights-based equity foundation in relation to the provision of public health services providing a powerful impetus to address social determinants of health. Political support at different levels of government is strong and demonstrated through action. There is a strong working culture of cooperation and consensus building, focusing on co-benefits and using evidence-based approaches. There are high levels of social and institutional trust, including towards the health sector. Technical staff are motivated and committed at different levels and within different agencies particularly in relation to PINSAP where there is no legal obligation for implementation.

High levels of trust are exhibited from partner sectors towards the health sector, which is an important facilitator of good governance. The health sector is perceived as highly professional and organized, with political weight across governmental departments and towards the public. This can be explained partly due to the dominance of the health budget in terms of overall government expenditure. However, it is also due to the strong history of collaboration exhibited by the health sector as a partner; its professional approach to planning and processes; the strength of and trust in the health professions at social level; and trust in the universality and values-based approach of the system. This power and trust from the health sector is seen as an asset. Interviewees identified that it could be used further, for example, in support of

- raising awareness of the social determinants of health, both among health professionals as well as in the wider public sphere;

- developing a universal social services system; and
- professionalizing social policy including the social professions.

Mechanisms to support governance of intersectoral working appear well-developed at the highest level as provided for by the Catalan Public Health Law, with the Intersectoral Ministerial Health Council supported by the Public Health Secretary, and are present through to the departmental and territorial levels, with both political councils and technical commissions. These are established to facilitate coordination and participatory and intersectoral approaches towards implementation. This provides an excellent basis to provide for governance of intersectoral action, although their function could be strengthened further. The dominance of health actors in these processes – although important to build buy in and support from within the health sector – could be addressed in the next stage of planning, through the inclusion of partner sectors in the planning and design of setting the agenda for action, the implementation mechanisms and joint action. Key informants expressed strong demand for a wider annual forum for coordination, continued development, innovation and maintaining support and buy-in for joint action to allow professionals from across the territories to meet, share experiences and identify common approaches and themes for further implementation.

Attribute 4.2 Prioritization of cross-sectoral action and its policy coherence

Policy coherence appears to be high across policies, mirroring overall development priorities. The health plans inform and are informed by key intersectoral projects such as PINSAP and PAISS, and demonstrate strong links to the Government Plan of Catalonia and *Agenda 2030: Transforming Catalonia, improving the world (30)*. For instance, the current Health Plan 2016–2020 has used PINSAP to develop its intersectoral component, and PINSAP is seen at territorial level as the implementation framework and sometimes vehicle for the intersectoral component of the health plan. This dual approach to setting public health priorities has some advantages such as providing a strong value-based framework for intersectoral action, and rewarding motivation, initiative and innovation for action. The interaction between PINSAP and a subsequent health plan will be important to maximize synergy in priorities and goals and ensure complementary actions.

Despite good policy coherence, it is concerning that important public health challenges may have fallen through the cracks of this dual approach to priority setting at Catalan level with voluntary implementation at territorial level. Despite excellent health outcomes in general, smoking and obesity rates are surprisingly high in Catalonia and recent trends are not improving fast enough. These areas may require a stronger top-down approach and greater reliance on regulatory instruments. A thorough evaluation of progress against top public health priorities in the European context would be helpful to understand some of the reasons for slow progress in these areas.

Attributes 4.3 and 4.4 Resources for joint action, and implementation arrangements to catalyse and lead intersectoral action

Intersectoral action has been most successful when two parts of the Catalan system have been able to operate on areas with visible co-benefits, with different sectors working together but on parallel tracks: each within their own mandate carrying out activities using their own budgets. Examples include the Inclusive Schools Project and through PAISS with the social sector. This approach to successful collaboration has been facilitated by high levels of social and institutional capital with high levels of trust at operational level. The focus on tools and the provision of a toolbox to support intersectoral action is a good practice. The health sector has been relying on co-benefits as natural entry points to joint working. These soft mechanisms are critically important to catalyse joint action.

Although the volume of intersectoral activity is high, implementation gaps remain both across territories (e.g. areas with low commitment) but also in relation to key public health objectives (e.g. tobacco control). These implementation gaps need to be systematically identified and narrowed through complementing so-called soft instruments based on voluntarism, and trust with so-called hard instruments of institutionalized processes aligned with resources. Institutionalization so far has consisted of the establishment of committees and working groups. This is an important first step to drive buy-in and culture change. However, institutionalization so far has lacked systematic alignment of human and financial resources and institutionalized multistakeholder implementation mechanisms (see Attribute 2.5).

To ensure sustainability of intersectoral approaches, moving towards further systematic and greater institutionalized actions will facilitate both the sustainability of the actions as well as strengthen their impact. In particular, this is most relevant where co-benefits are less immediate or even where conflicts arise. This can be achieved through structural integrated approaches, such as joint planning, shared/pooled budgets, shared staff and shared accountability for outcomes. However, there are a number of identified systemic and institutional barriers. There does not appear to be any evidence that this is currently occurring or even whether this is structurally possible: the legal base allows for the creation of mechanisms within the scope of the jurisdiction of sectors, and perhaps the possibility for new mechanisms that create facilitated approaches can be explored further. This can be seen, for example, in the implementation of the PISMA, with primary health care interventions in the school setting, and education interventions in the health care setting but with distinct budgets, reporting and accountability lines. This can also be seen in the Catalan-level suicide prevention strategy and the parallel but reinforcing activities including training from the Department of Health and the Department of Interior. Possible opportunities to strengthen this work include using Article 4 of the Catalan Public Health Law, which provisions for an intersectoral ministerial plan (PINSAP), as part of the Catalan health plan.

Moving towards new governance approaches is already included as one of PINSAP's instrumental objectives. It requires a revised approach that builds on the experiences from projects/specific actions, and moves towards systems and institutionalization of processes. This applies for intersectoral, intergovernmental and participatory governance including the use of communities and involvement of wider society. This is an ambitious agenda, which would benefit from a theory of change. The Public Health Agency of Barcelona can be an example here, with their theory of change: build internal capacity; promote culture change; and then change the paradigm. The cooperation between the Department of Health and the Department of Education is an example of good practice to institutionalize joint action, which grew out of the Inclusive Schools Project. With joint work planning, oversight and direct contributions from the Ministry of Education and Vocational Training into the relevant PINSAP components, the Inclusive Schools Project provides for an institutionalization of cooperation through a legal mandate (dating from 2017), delivery of education in health settings and health services in education settings while maintaining separate budgeting and accountability.

Alignment of human resources is particularly important for this agenda of strengthening governance for intersectoral action. The importance of the role of the public health profession in the process of developing intersectoral approaches, providing the evidence base and leadership for action was emphasized by the interviewees. High levels of trust in the health sector and health professions, both from other sectors and the wider population, have been identified as a critical factor in successful processes. There is a large gap in human resources between the central authorities, including the city of Barcelona, and those in the territories, and this unequal distribution of expertise creates a barrier. The Catalan Public Health Law provisions for high levels of multidisciplinarity in the public health teams. However, this does not yet appear to be reflected in the make-up of core public health staff, although efforts have been made to convene multidisciplinary teams at local level in the implementation of the Catalan health plan and PINSAP. Some dedicated financial resources, as well as continued investment in both the resourcing and capacities of the workforce, will be important to take this work further.

Dimension 5 | Alignment of Catalan government action with regional and local government action in health

Health plan operationalization and implementation has relied much on intergovernmental action which has allowed localization of health plan priorities and integration of local priorities. There is a strong and broad legal base for intergovernmental alignment demonstrated through the stakeholder interviews and evident in practice. There are inspiring examples of local action turning into regional policies and regional policies inspiring local action and innovation. However, considering the complexity and degree of fragmentation in public administration, even implementation and sustainability of local public health action has been a challenge.

Attribute 5.1 Intergovernmental working is integrated into the policy cycle

There is a long history and evolution of collaboration at government different levels (Catalan, regional and local level) and generally, intergovernmental alignment and cooperation is reported well in both the implementation of the Catalan health plan, through the PINSAP framework as well as in specific plans such as PISMA or the suicide prevention strategy. The context described under Dimension 4 also facilitates alignment between intergovernmental actors with the Catalan working culture of consensus, and collaboration facilitates cooperation and exploring of shared and joint approaches.

However, the complexity of public administration provides a challenge. Catalonia's Public Health Law (No. 18/2009) provisions for a strong alignment and cooperation between governmental departments and agencies (including at territorial level) with a mandate on the broader definition of public health. The separation of the political functions of public health – which remains with the Department of Health – and the service provision – which became the mandated function of the Public Health Agency of Catalonia was designed with legal intent to allow for a highly decentralized public health service delivery function. It has a broad understanding of public health departments and agencies, which extends to local government and mayors and mandates the health authorities to work with all government bodies necessary to deliver on its mandate. This is a strong and broad legal base for intergovernmental alignment, and there is evidence that the Catalan health authorities have gone some way to utilizing this breadth of mandate.

The distinct mandates for the delivery of public health services between the different actors are clear, including for municipalities. Although the relationships are clear in relation to those actors within the health system, the Catalan public health system does not provide for similar detail in relation to municipal public health services, with the exception in relation to participation in local public health teams (were appropriate). The strong institutional links between the Department of Health, the Public Health Agency of Catalonia and the Public Health Agency of Barcelona are very evident, with mutual accountability through officer participation on governing boards; territorial links are also evident, with direct funding of territorial functions.

Public administration at local level (municipalities, supramunicipal structures) is complex with over 900 municipalities in Catalonia alone, organized under four provinces and 42 counties with indirectly elected political representation. This is further complicated through regionalization and territorial decentralization within the health and public health sectors that are not aligned with public administrative bodies. The law provides for flexibility within this public architecture of both direct and indirect public health actors, and by virtue creates a complex mandate with ultimate responsibility falling to the Public Health Agency of Catalonia (in the form of a strong subsidiarity principle).

Attribute 5.2 Contextualizing health plan priorities to local needs

There is complexity in aligning the logic of PINSAP and the health plan into coherent action at local level. Although PINSAP is a government plan, the decision to keep the leadership of PINSAP with the Public Health Agency of Catalonia rather than at the level of the government has allowed for strong technical leadership and evidence-based focus. In addition to this, the lack of legal mandate for PINSAP and gaps in human resources at territorial level could be compounding factors to the challenges faced at that level. The next phase of PINSAP and the Catalan health plan may need to be more territorially-focused and territorially driven. In addition, building on the enormous coordination role and visibility to the importance of intersectoral action played by PINSAP, additional work is needed to support the operationalization of intergovernmental alignment at territorial level. This function could be provided by a strong public health system at territorial level, which is not demonstrated: its absence leaves a gap in knowledge and local capacity, but this could be mitigated through stronger local political leadership for PINSAP.

Attributes 5.3 and 5.4 Resource allocation and implementation

Consistent implementation is sometimes hampered by the complexity of governance and accountability arrangements. Governance across different public administrative bodies and agencies is largely fragmented and individualized; PAISS, PINSAP and the Catalan health plan all provision for different governance arrangements: there is no such provisions for integrated care. However, there is an absence of both joint outcomes, as well as joint accountability from across the system with accountability remaining internal. Despite high-level coordination mechanisms at both the Ministerial and Secretary General levels, there is an overlap between different government departments and even parts of the same department due to a fragmentation in the administration, leading to a lack of transparency.

The example of Tarragona in the localization of the Catalan health plan presents as good practice in terms of both methodology and process (Box 3). It emerged from an understanding that a regional adaptation and localization process was necessary. The process was participatory, responsive, engaging of senior management, providing a feedback loop, led by “middle out” (self-selected) technical staff that are at the front line of implementation and through a negotiation, which created buy in and promises both change in practice and creating the conditions for sustainability. The process created ownership, inspiration and motivation, and the cooperation with the central technical staff in the Department of Health was considered critical to the process. It appears that this has not been repeated in other regions of Catalonia, highlighting both the importance of local leadership as well as the limitations of bottom-up implementation: for the next phase of the Catalan health plan, provisioning for greater direct engagement and support from the centre to the regions in support of

the preparation for implementation, as well as providing an annual forum for sharing information and good practice across the regions could address this gap/unequal implementation across Catalonia.

Box 3. Good practice of the PINSAP Tarragona commission on leisure

In the PINSAP Tarragona commission on leisure, participation is dominated by the health community, with representation of target groups (such as youth) expected by the local government representatives (who did not participate actively). This risks skewing the purpose/objectives of the commission and preventing ownership from other sectors and target communities, particularly where the priorities have been set prior to the finalization of the composition of the committee. One way to address this could be through raising awareness and competence in the area of modern public health and social determinants (similar to the change theory undertaken by Barcelona) before engaging other sectors. If the commissions aim to leapfrog directly into intersectoral action, the balance of stakeholders and leadership of the process need to be carefully addressed, as the town hall is the driver and owner of the determinants and its engagement and ownership is critical for success. If the purpose of the committee is to create connectivity and alignment across public administration and agency, perhaps a different process may be better suited.

Chapter 5.

APPLICATION I – HEALTH PLANNING AND THE TRANSFORMATION OF PUBLIC HEALTH SERVICES

5.1 | Evolution of public health priorities and services for better population health outcomes

The delivery of public health services has evolved continuously over the last 30 years in Catalonia and has contributed to considerable successes in improving health outcomes. Life expectancy is good for women (86.3 years) and fairly good for men (80.8 years) (*16*). The gender difference disappears for healthy life expectancy (both just under 70 years). Premature cardiovascular disease and stroke mortality have declined rapidly in the past decades. Health promotion, disease prevention, early detection and good disease management practices have contributed. Infant mortality rates are below those for the whole of Spain and the European Union.

Health protection and infectious disease outbreak management are also areas of strength in the Catalan public health system. Health protection encompasses protection of the population from environmental hazards or related factors (e.g. food safety, air pollution, water quality, chemicals and toxins), and this area of public health seems well developed in the public health system in Catalonia. In general, good working relationships were described between staff of the Public Health Agency of Catalonia and relevant staff members at local/provincial level of government. Similarly, control of infectious diseases and management of outbreaks are areas that appear broadly well-covered. Staff conveyed that the modern health information systems in Catalonia support this important public health function well.

These results contrast with significant remaining public health challenges like tobacco consumption and obesity. Levels of overweight are high for adult men (43.2%) although less-so for women (27.3%). This gender difference is mirrored in obesity levels in young children. Tobacco consumption in those aged over 15 years is high at 25.6% (30.9% for men and 20.5% for women). Over the past two decades, rates have fallen for men but hardly at all for women. Interestingly, despite the concerning prevalence levels for smoking, stroke survival rates are strong, reflecting positive progress on hypertension reduction and good health services. Binge

drinking is a particular problem for those aged 14–18 years. These public health priorities would benefit from greater prioritization and strategic action combining top-down and bottom-up approaches.

The health plan was found to be generally useful to push forward the public health agenda with good links to the intersectoral plan (PINSAP). The health plans have played an important role in setting strategic directions for public health action (also see Attribute 1.1). The health plans have championed ambitious health targets focusing on areas of large amenable mortality and have ensured that actions were linked to goals. Some important health goals were carried forward from health plan to health plan with increasingly ambitious targets (e.g. stroke mortality) while new health goals and priorities were also set in each health plan in a balanced manner (see Attribute 2.2).

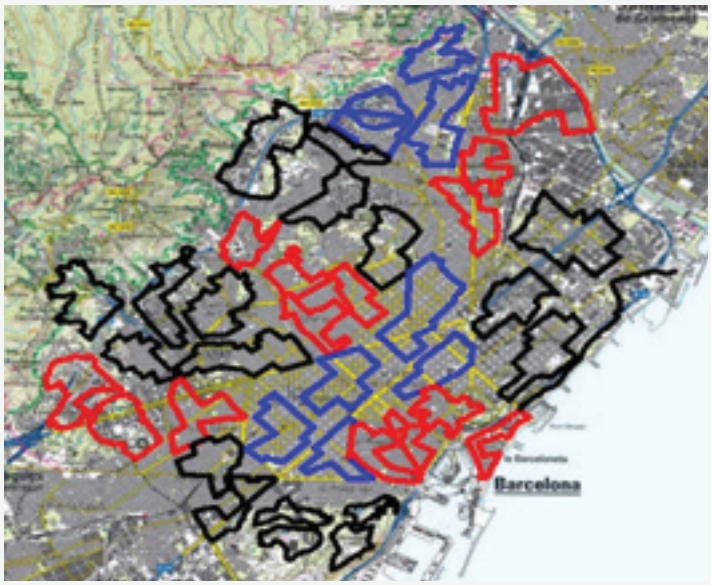
The role of the health plans to set an increasingly ambitious vision for public health action remains particularly important in the coming decade as the public health outlook is changing across the globe. The public health agency and system in Catalonia needs to adapt accordingly and health planning can spearhead this process of transformation. As of yet, the model of the public health agency, and the public health system, in Catalonia is quite traditional – not yet structured to deal with the public health problems of the future. The three broad areas of classical public health activities (health protection and communicable disease control; health education and health promotion; and population/community services) are covered and, as has been mentioned, seem broadly fit for purpose. However, the nature of public health challenges is changing, and public health priorities are shifting. For example, climate change is the biggest public health challenge of our time and the biggest threat to the planet's future, with an onus to act locally while thinking globally. Yet, there was relatively little to be seen of serious local/regional commitment to combating climate change, ensuring environmental sustainability and contributing to meeting the SDGs. The Catalan Strategy for Adapting to Climate Change (ESCACC) is good but, as the title indicates, is more about adaptation than mitigation – and it is unclear what has practically happened as a consequence of its creation. Other next generation areas that require further thinking include tackling the global threat of antimicrobial resistance and addressing social determinants of health.

It is important to continue to address knowledge development and evidence exchange. The creation of a web portal for publicly accessible public health related data (e.g. socio-demographic, health, education, health behaviours) at all geographical levels (like Public Health England's "Fingertips") would allow sharing evidence of what works in all areas of public health, including relevant guidance. Such a portal should be created and managed by the Public Health Agency of Catalonia, but developed with strong stakeholder involvement in the design and set-up. It is essential that the end user (local/regional public health staff, municipalities, stakeholders, members of the public), can easily interrogate the data and the public health experience of their locality, creating sound and easy access mechanisms for sharing good practice and innovating ways to celebrate public health successes (Box 4).

Box 4. Good practice of the Physical Activity, Sport and Health Plan

The Physical Activity, Sport and Health Plan (PAFES) is an interdepartmental project initiated as a pilot plan in 2005 by the Department of Health and the General Secretariat of Sport, and consolidated by a government agreement in 2007. PAFES aims to disseminate physical activity recommendations for good health and achieve a more active population. The target population is insufficiently active adults (aged 15–69 years), especially those with a cardiovascular risk factor: high blood pressure, type 2 diabetes mellitus, dyslipidaemia and overweight/obesity. Habits change is recorded in ECAP, the primary care electronic health record.

Risk reduction objectives related with physical activity were present since the first-generation health plans. In the Health Plan 2016–2020, two goals were set: (i) increase the prevalence of healthy physical activity in the population aged 15-69 years above 2016 levels: and (ii) monitor the prevalence of overweight in the population of 18–74 years from the perspective of social inequalities in health.



Healthy pathways in Barcelona

Healthy pathways

Many municipalities in Catalonia have created healthy pathways to facilitate the participation of people in activities such as those promoted by PAFES.

At present, it is considered that the municipalities that are affiliated with PAFES provide coverage to more than 80% of the population.

According to the evaluation of PAFES, in 2014, 100% of primary care teams in Catalonia implemented PAFES and 28.3% of people who receive advice, follow PAFES recommendations (*31*).

Source: Department of Health, Government of Catalonia (*32*).

5.2 | Cross-sectoral and cross-governmental policy coherence

The public health successes in Catalonia outlined above have been achieved in an institutionally highly complex public health system with a great degree of policy coherence across sector and across government levels (see Attribute 5.1). When compared with public health systems across the globe – including high- and low-income countries – the system in Catalonia is extremely complex. As in many other settings worldwide, the public health system in Catalonia comprises two main arms: (i) the health system component under the Department of Health, including the Public Health Agency of Catalonia whose professional workforce has operational reach into all four provinces; and (ii) the local government (municipality) component with staff at the urban, regional and local levels contributing to public health activities and projects. While health is essentially a devolved function (Catalonia can set its own health strategies, manage its own health services, and choose how to spend its devolved health budget), the municipal system across the whole region remains mainly overseen by Spain's national government, including the national setting of policies and control over budget.

The differential policy-setting and different funding streams between the two arms of the public health system are reasonably well aligned with strong underlying principles of solidarity and communitarianism providing the glue in a complex institutional set up. In practice, this is not least on account of the fairly ground-breaking Interministerial Public Health Plan (PINSAP), which helps bring together those two arms – as well as other government departments – in support of a shared public health agenda. The agenda covers the relationship between health and an array of factors including the environment, diet, employment, housing, town-planning, education, physical activity and culture. The intersectoral plan (PINSAP) is strong (world-leading in terms of ethos), and should be cultivated and shared as an example of good practice. In part, the success of public health action in Catalonia in this complex environment is due to extraordinary social networks, reflecting a great degree of communitarianism (see Attribute 4.1). This is seldom seen globally, illustrating a powerful community-spiritedness that plays an important role in supporting health and well-being. Indeed, it may well be this that explains improvements in public health outcomes through the recent period of economic challenge. These social networks need to be documented and celebrated even more.

There is impressive joint working between public health agency staff and community care staff on selected public health activities and in selected settings contributing to the noted policy coherence. Through group interviews as well as visits to integrated health care centres (Salt – Girona, La Mina – Barcelona), there was evidence of strong collaboration between public health agency staff, other health staff and non-health professionals all contributing collectively to various public health endeavours (e.g. mental health, drug addiction, physical activity). Signs of community appreciation of public health efforts and the involvement of local government authorities were observed in the field visits. However, further work is needed to check the level of variation in good working practice across the whole of

Catalonia, and thought needs to be given around how good practice examples can be shared between different geographical areas. In addition, such good practice fails to explain why there are high levels of adverse health behaviours across Catalonia e.g. smoking, obesity, and (in some parts) drug addiction, although these differences are mainly related to the unequal distribution of social determinants of health.

Nevertheless, public health action is prone to accountability gaps due to the complexities of the public health system in Catalonia, with responsibilities falling between responsible organizations. This is particularly true to health protection and communicable diseases. In several instances, there is no clarity in who is ultimately responsible and how the position carrying the responsibility can leverage their influence over those in charge of complex action. Governance could be improved in this regard.

5.3 | Alignment of human resources with public health goals

The staff working on public health activities in Catalonia are a wonderful asset in terms of skills and contribution, and this strong human resource foundation needs to be nurtured. Through group meetings, one-to-one interviews and visits to facilities, a stand-out issue was the passion, commitment, intellect and work ethic of staff – both within the public health agency and those contributing elsewhere to public health activities. This degree of enthusiasm and positive spirit is rarely seen with such vigour and needs to be cherished, built on and rewarded. There are signs that the economic situation (with its impact on available funds and staffing levels) may be starting to take its toll on the goodwill and positivity of the existing workforce, so care is needed to preserve what is there and not to take anything for granted.

At the same time, more attention is needed to public health workforce development: existing and emergent gaps are impacting on the success of public health activities. Health planning can provide a good opportunity to link new priorities with new competencies and skills. Resources within the public health agency for staff are low, and a modest increase could make a huge difference. The economic climate since 2009 has had an adverse impact and staff recruitment has been problematic, and this is affecting staff morale and needs addressing. The skill mix of staff within the agency has suffered as a consequence and also needs rectification. The fact that almost half of the agency staff are veterinarians is unusual and likely not appropriate or sustainable in the long run given public health priorities. There is also a lack of key public health speciality expertise that would make a real difference to the programmes of public health work (e.g. health economists, sociologists, health promotion experts, anthropologists). There also appears to be a need for fostering leadership development. Plans are already in process to increase public health leadership strengths and skills (e.g. strategic thinking, how to foster collective working, rapport and connection, getting the most out of other staff), considering that senior staff is already strong on technical skills.

Chapter 6.

APPLICATION II – HEALTH PLANNING AND THE TRANSFORMATION OF INDIVIDUAL HEALTH SERVICES

6.1 | Evolution of individual service delivery priorities and services for better population health outcomes

The planning process has had a significant and positive impact on the shape and effectiveness on the delivery of individual health services. There are a number of opportunities to capitalize on the progress that has already been made as well as to develop new approaches. This will help the health system continue on its path of adapting to the changing nature of demand for health services and the dynamics created by an aging population and the associated increases in multimorbidity.

6.1.1 Moving towards integrated primary care services

Primary health care is at the heart of service delivery in Catalonia and a model for the European Region. Through subsequent health plans, the primary care model has evolved to include mental health, chronic and social care services. Services are delivered through multiprofile group practices supported by acute emergency and a network of community services with shared electronic record systems and risk stratification. There are opportunities to increase the use of phone and web to replace a large proportion of face-to-face encounters, which could release professional time to further improve the management of more complex patients. The tools to do this are being developed but further work will be required to make the most of these new ways of delivering services (see Box 5).

There appears to be a lot of local innovation within primary care developed with the local support of ICS and CatSalut. However, there may be scope for increasing the autonomy available at the basic health area level. It would be worth considering the development of a system to provide small amounts of funding support and

methodological assistance to areas trying to innovate and create mechanisms for identifying and spreading good practice. This would also support a more bottom-up approach to the creation of the health plan as it goes into its next phase. There are also some approaches for coordinated working with specialists who deal with chronic disease although there are opportunities to do more in this area.

The development of large primary care networks to coordinate primary care basic health areas and other local providers could be an important step towards further integration of care. Models where all the provision is contained in a single organization, including mental health, long-term care and social services, (e. g. the Badalona Serveis Assistencials) tend to be much easier to contract with and will find it easier to coordinate care across settings. However, there are reasons to be cautious about concluding that structural change will be the answer to this. It would be worth returning to the question of how to develop a more integrated way of working between primary care and hospitals, and how to enable improved information exchange, capitated payment and contracts that enable integration.

Box 5. Case study of patient empowerment and alternatives to face-to-face meetings

Web-first model of general practioner appointments

As smart phone usage increases, it is likely that there will be growing demand from patients for some of their use of health services to be transacted virtually. Catalonia already has a patient portal that can provide a platform for this and link to the patient record although further adaption of it may be required. Examples of practice elsewhere are the following.

- Practices using askmyGP in the United Kingdom deal with an average 57% of demand online. Sixty-two per cent of patient requests are resolved by secure message or telephone and 20% of patients are directed to self-care. No patients are turned away.
- With eConsult – also in the United Kingdom – up to 70% of cases are resolved without a face-to-face consultation, which allows general practitioners to understand the problem in 2–3 minutes.
- General Health Cooperative of Puget Sound provides 60% of primary care via the phone or web.

These systems save time for the patients and the doctors although they can lead to an increase in demand that will partially off-set this benefit.

Support for long term condition management

There is also the opportunity to use smart phone apps or web browsers to support chronic disease management although at present these are generally in single disease areas. For example, myCOPD is an app that helps people with chronic obstructive pulmonary disease (COPD) to better manage their condition and:

- delivers a self-management programme;

Box 5 (contd)

- provides education, symptom tracking, inhaler technique coaching and pulmonary rehabilitation, 24-hours a day;
- enables clinicians, local health care providers and clinical commissioning groups to access a dashboard to:
  - monitor and manage their patients remotely;
  - monitor exacerbation burdens in real-time;
  - manage a population register; and
  - review inequalities in health care to plan support services effectively.

6.1.2 Regionalization of hospital services

The growth of multimorbidity means that there is a need to review the model of medical specialization. The development of more specialists in the management of the complex multimorbid patient and in particularly the frail and elderly – both in emergency presentations and in long-term management – seems to be a priority. Local programmes to develop these through additional training or opportunities for local doctors to acquire new qualifications should be considered, particularly if there continues to be a mismatch between what is required and what national programmes are producing.

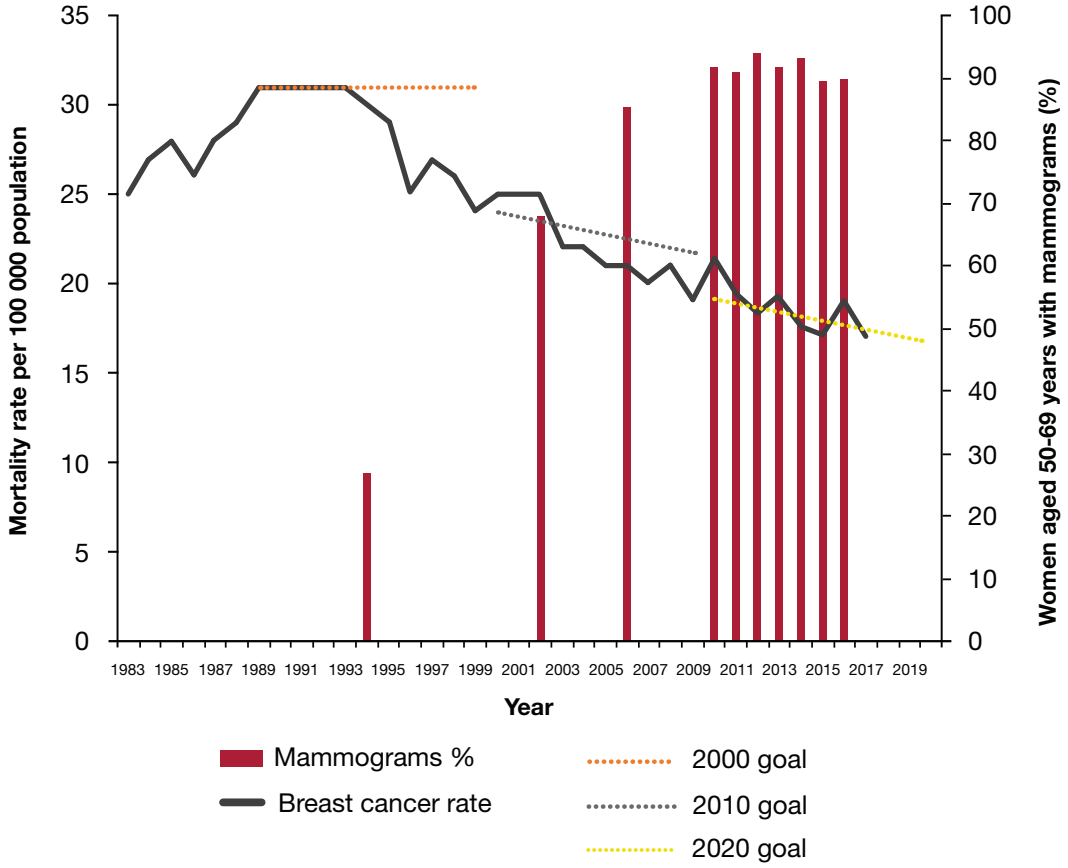
Much of the centralization of highly specialist work required by modern clinical practice has been undertaken as part of previous planning processes. Complex surgery, stroke and angioplasty to treat STEMI (ST-elevation myocardial infarction) for example have been regionalized. The process is complete for the moment; however, 69 hospitals provide acute inpatient services. These are proving difficult to staff. The model of medical training means that there are an inadequate number of doctors with general internal medicine and geriatric training who can provide first line response to emergency patients, particularly those with multimorbidity. Some of these hospitals are also too small to be economically viable. This means that there is a need to return to the question of optimal hospital configuration. Some units can be repurposed to provide subacute, step down, rehabilitation and end-of-life care. The fact that Catalonia already has a relatively low number of hospital beds may mean that some capital investment is required to move some services. This can be minimized by further action to improve the use of post-acute care, day procedures, ambulatory emergency care and by improvements in the management of chronic disease in primary care. Catalonia has experience of this type of master planning approach in earlier versions of the plan, which appear to have been successful (Box 6).

Extending the integrated care model should go hand in hand with developing a rationalization plan. This would provide an opportunity to offer hospitals a way of dealing with changes in their activity and financing resulting from reductions in hospital activity (admissions and bed days) that should be the result.

Box 6. Good practice of breast cancer screening programme

The Department of Health's Oncology Master Plan coordinates the breast cancer screening programme in Catalonia and evaluates its results. The programme is divided territorially into 16 technical screening offices, which send invitations to women in the target group, provide follow-up and coordinate activities. Mammograms are carried out in 58 different centres, mostly hospitals, but also some primary care centres. In 47 hospitals additional studies are conducted, and the diagnosis and treatment of breast cancer is done in 39 centres. The results of the programme show that 426 196 women (aged 50–69 years) were invited in 2017 and that 65.2% participated (277 925 women). A total of 15 672 women (5.6%) were given additional studies, and 941 invasive and 203 in situ breast cancers were detected. Participation in the programme has remained around 65% in recent years, which can reach 75–80% if women who do not participate in the population screening programme are counted because they already are screened in private centres.

Figure 7. Health plan goals and breast cancer mortality and mammography rates in women aged 50–69 years, Catalonia, 1983–2017



Source: Department of Health, Government of Catalonia.

6.1.3 Medicine policies

Earlier stages of the planning process have established systems for reporting and improving safety and prescribing practice, followed by the full adoption

of e-prescribing in primary care and information systems to support medicine management. Work has also been done to systematize and harmonize drug use in hospitals and primary care. The development of registries has also allowed the budgets for drug use to be set and managed in a more rational way.

The challenges that policy-makers now face are more to do with the sustainability of the system and the management of the budget in response to the growth in the number of new high-cost drugs that target small subgroups. This is a challenge faced by all health systems and will continue to be an issue in Catalonia. As with other aspects of planning and policy, there might be a case for increasing the dialogue with society and the media about some of the challenges being faced by the system from changes in the nature and cost of new drugs.

There appears to be good engagement by senior clinicians in the process of developing a value-based approach to assessing and paying for new high cost medicines. There is reported to be a shared understanding of the challenges and a commitment to address the threats to the sustainability of the system. Advice is provided by a single clinical forum, and AQuAS produces monitoring information that will support decisions on resource allocation and value-based decisions.

6.2 | Cross-sectoral and cross-governmental policy coherence in individual services

6.2.1 Mental health

The cross-governmental development of PISMA is a positive step forward to increase the potential of Catalonia to reduce stigma, increase inclusion and promote more general policy to support the development of improved mental health. It also supports individuals with mental health problems and their families. The strategy makes an important link to prisons and the criminal justice system, building on the work of earlier plans.

A key issue is the need to develop services for children and adolescents, and their transition to adult mental health. The proposal to create a separate specialty for child psychiatry is welcome. This will take time to have an impact, and there remains a shortage of staff with clinical psychology training. As is the case in many systems, transitions of care from adolescence to adulthood need to be improved. The strategic plan has a strong emphasis on developing improved services for children and adolescents. There are interesting ideas about the incorporation of mental health support into schools, which should improve early intervention as well as promoting better mental health.

At the other end of the age range are issues with mental health for older people, particularly where there is dementia and social problems.

The continued extension of mental health services into primary care is an important part of the strategy. Although some approaches coordinate work with specialists who deal with chronic disease, there exist opportunities to do more in this area like extending the model of including mental health staff in the primary care team.

There remains more to do to develop community services and to reduce the use of inpatient facilities for the treatment of more serious mental health conditions. Other ministries full cooperation will be required to create community solutions and to ensure that people with mental health problems can get and keep jobs, have access to housing and will be treated appropriately if arrested or convicted.

6.2.2 Strengthening health and social care integration

Cross-sectoral action between health and social care has been a constant priority in health plans and has been emphasized in the last two through interdepartmental plans. The creation of PAISS signposts the need for collaborative action between the health and social affairs departments to tackle the challenges of an increasing ageing and fragile population. Since 2011, a number of health and social care integration interventions and tools have been rolled out such as case finding of complex chronic patients with risk stratification tools or shared individual intervention plans. However, institutional and structural barriers hamper progress such as the fragmented purchasing agencies and the lack of interoperability between health and social information systems.

The employment of social workers is a very positive addition to the model, but it is worth noting that these are health care employees and there remain some significant issues with the variability in terms of funding and the services offered by different municipalities. There would be advantages in taking steps to create a uniform minimum package of social care benefits so that there is more uniformity between municipalities. This will help to remove barriers to developing more integrated approaches across Catalonia.

6.3 | Alignment of resources with service priorities

For individual services, CatSalut through regional health plans and alignment of the contracting process operationalizes health plan priorities. These strong links between the health plan, regional plans and service contracts is a critical implementation mechanism and reflects explicit prioritization of resources. However, the objective stated in earlier primary care plans of increasing the share of the total budget going to primary care from 15% to 21% has not been realized yet. There are a number of reasons for this some of which are related to the financial crisis and others to decisions taken by policy-makers. As finances become available, it is intended that the share will increase and this will require active management to ensure that this objective is achieved. In doing this, it will be important to ensure that the production of general practitioners and primary care nurses is sufficient to meet the requirements of the system although new expenditure might also be used to develop other types of staff working in primary care. This will be important even if central government can be influenced to increase the numbers of family doctors and nurses in training.

Chapter 7.

POLICY RECOMMENDATIONS

The Catalan health plans constitute a valued institution in the genome of the Catalan health system. The health planning process in Catalonia has been carried forward with remarkable consistency over a thirty-year period while adjusting to the changing needs over time. New generation topics have been consistently integrated although implementation challenges arose specifically for new generation policies. The health plans are well known by all stakeholders and respected for setting a vision and a direction for the improvement of health and well-being. Clear leadership, well-assigned institutional roles and relationships, inclusive and open dialogue, and consistent application of a full policy cycle have contributed to a large extent to the success of the Catalan health plans to fulfil this foundational role in the Catalan health system. However, health planning needs to continuously evolve to meet new challenges, which in the SDG era include greater attention to addressing health equity, greater reliance on intersectoral action and synergized interaction across governmental level. To strengthen health planning, the following policy recommendations could be considered.

Policy recommendation 1

Preserve the strengths of the Catalan health planning process as it evolves to meet new challenges. Health planning is a greatly valued institution in the Catalan health system. It is valued for setting the vision and direction for the system. It captures and legitimizes key directions to improve health of the population. The health planning process is based on a strong legal mandate and a well-regulated process. The Department of Health has played a strong leadership role in its development, implementation and evaluation. CatSalut and its contractual process has been an instrumental arm in implementation. Health plan development is characterized by stakeholder involvement and mandated roles for regions with inspiring examples. There is a wealth of innovation at the territorial and provider levels in public health and individual health services, which are facilitated by the values of pluralism, autonomy and voluntarism within a common framework. These are important strengths to preserve and build on in the evolution process.

Policy recommendation 2

Strengthen institutional capacity of the Department of Health for new generation areas such as health equity and intersectoral action. As the focus of the health plan moves towards addressing a broader set of health determinants, health planning needs to accommodate intersectoral approaches to a greater extent. This requires reviewing the institutional capacity of the Department of Health in these areas. Successful intersectoral action does not necessarily involve doing but rather stewardship to catalyse action carried out in partnership with other sectors. This requires a broader set of skills focused on vision setting, partnership building,

understanding of different public sectors, collaborating across public–private boundaries and strong communication skills.

Policy recommendation 3

Secure greater involvement of CatSalut in the planning phase, considering its fundamental role in implementing a large part of the health plan. In turn, this will require for CatSalut to establish a mechanism to coordinate, collect, synthetize internally and then bring to the planning negotiation table the key issues faced by the regional branches. It could build on the good practice at territorial/regional level (strategic territorial plans) and extend them to other local health sectors and regions. It could also provide inputs to identify and select health plan strategic objectives and priorities. The responsibilities of overseeing director plans and thematic working groups require more clarity to maximize their contribution to the plan.

Policy recommendation 4

Create opportunities for bottom-up participation, including citizens, providers and municipalities, in the health planning process to capture and build on innovations. Stakeholder involvement in the planning process is organized in a top-down manner, enabling consultations on expert-developed priorities and core themes. There are opportunities to move towards a more participatory process, which would enable to capture and build on local innovations. A striking wealth of innovation and good practices are encountered at the community and provider levels, and the health plans could do more to integrate and scale evaluated, evidence-based good practices. The health plan could be used as an instrument to scale successful innovations towards strategic priorities. Moving towards a more participatory process requires rethinking the contribution of the Department of Health, CatSalut and the regional-level stakeholders for participating in planning, implementation, monitoring and evaluation. A range of participatory platforms can be developed to engage a broader set of stakeholders. Currently, there is no formal way for the regions and providers to contribute to the health planning discussions although these had existed previously.

Policy recommendation 5

Preserve the current priority-setting process focusing on areas of large amenable mortality but strengthen focus and action on the remaining challenges and emerging new priorities in public health. Tobacco consumption and obesity continue to present significant public health challenges with variable degree of success demonstrated bringing rates down. More ambitious results are possible through more prominent prioritization of these issues and strategic action combining top-down and bottom-up approaches with alignment of resources. The nature of public health challenges is changing, and public health priorities are shifting. Climate change, antimicrobial resistance and addressing social determinants of health are key priorities and require new sets of policies combining global thinking with local action. Some of these new generation areas have not been strongly prioritized.

Policy recommendation 6

Strengthen the focus on health equity in the next health plan and complement the strong territorial approach with other mechanisms. This could include strengthening the underlying analysis of and evaluation of target setting to reflect different trajectories and resource needs to meet targets in different groups. A clearer strategic focus could create more clarity and consensus on whether an equity approach aims at reducing the gap or at reaching the most vulnerable. Beyond the strong focus on territorial approaches to reducing inequalities, a more explicit and direct approach addressing socioeconomic and gender dimensions could be explored and integrated. Similar mechanisms as are used for achieving territorial equity (e.g. participation platforms, incentives, budget distribution, use of data, service delivery, capacity building) could also be applied to more directly reduce socioeconomic inequities and define gender-responsive objectives. In addition, further strengthening and mainstreaming the intersectoral dimensions of health planning and public health action in the next health plan will also contribute to achieving this objective. In terms of designing actions, a so-called twin track approach could be adopted, embarking on a transversal approach to equity and gender mainstreaming across the different levels of policy and health service delivery while targeted interventions based on needs and priorities are strengthened. Mechanisms used for achieving territorial equity such as participation platforms, incentives, budget distribution, use of data, service delivery or capacity building could also be applied to reduce socioeconomic inequities and define gender-responsive objectives.

Policy recommendation 7

Strengthen implementation arrangements for areas that are not contractible by CatSalut by developing multiagency implementation plans. Implementation arrangements work well for those areas of the health plan that can be translated into service contracts through CatSalut. For these areas, health plan goals, priority actions and implementation arrangements are well aligned. However, not all health plan priorities can be translated into contracts. For these areas, implementation arrangements are unclear. For the next health plan, strategic priorities that do not fall under contractible services should have their own standalone multistakeholder implementation to spell out responsibilities for action and time-frames.

Policy recommendation 8

Align more explicitly financial resources with health plan strategic priorities to strengthen the impact of the health plan on the prioritization of the overall health budget, and carry out retrospective reviews of the allocation of funds relative to strategic priorities. The CatSalut contractual process provides an excellent vehicle to match resources to priorities. It is more likely to work for those areas that fall into contractible individual services delivered by current provider structures. However, an increasingly smaller share of health plan priorities falls into these categories of contractible services. This affects implementation and results that are beyond individual services. Going forward, it is important to create explicit and systematic

priority-setting processes for operating expenditures and capital resources for the remaining priorities. A good place to start is to carry out a retrospective review of budget impact analysis or retrospective reviews of public spending relative to strategic priorities of the health plan, and then integrate regularly in the monitoring and evaluation process of health plan implementation.

Policy recommendation 9

Align human resource policies with health plan priorities starting with focusing on the public health workforce. There did not appear to be a strong link between the human resource plan and health plan priorities, taking into account new generation skills and competencies in both population and individual services. Human resource policies for public health services are a very good illustration of this. The public health workforce development plan should address competencies, training, multidisciplinarity and working conditions of all public health staff across Catalonia, enabling the public health system to become fit for purpose for the future. To achieve this, funding of the public health workforce needs to be addressed, with modest investment required to future-proof the system. The workforce plan should be developed with inclusion of all relevant stakeholders. Leadership skills of senior public health staff across the system need development. Over the years, the emphasis within public health senior staff has been on technical abilities. However, tackling modern public health challenges requires leadership skills that are of a different nature and more generic across a range of sectors. For example, leaders will need to become skilled in change management, in galvanizing activity across different sectors and across professional boundaries, and in the ability to inspire and maximize effectiveness. Mechanisms to foster a culture of learning and cross-fertilization across the public health workforce need to be strengthened.

Policy recommendation 10

Complement already strong monitoring efforts with specific evaluation efforts in selected areas of the health plan to understand variations in implementation and root causes. Specifically commissioned evaluation tools could be used more systematically. Evaluation complements monitoring efforts to understand variations in areas of health plan implementation and identify key factors behind successes and gaps. In many countries, such functions are routinely contracted out to policy analysis institutes and academia. AQuAS and academic institutions could be involved in the evaluation process with a focus on cause-effect analysis. Several stakeholders have commented that the role of AQuAS has evolved from technology assessment to broader health policy analysis and could fulfil this role in partnership with others to a greater extent.

Policy recommendation 11

Implement structural and institutional changes to address the implementation gaps in intersectoral action, building on the various strengths of the current intersectoral processes. Although Catalonia is advanced and modern in planning and policy, addressing the implementation gaps will require changes. Coordination, continued development, innovation and maintaining support and buy-in could

be further facilitated through an annual forum to allow professionals from across the territories to meet, share experiences and identify common approaches and themes for further implementation. The informality, project origin and so-called soft nature of PINSAP – which are strengths in that this has contributed to the culture of consensus, co-benefits and strong cooperative approaches – could be supported through further systemization and institutionalization of intersectoral working. It will be challenging to continue to progress without this. Some dedicated financial resources, as well as continued investment in both the resourcing and capacities of the workforce will be important to take this work further. During subsequent planning processes in the development of a future Catalan health plan, further work could be undertaken to involve partner sectors in the process design, priority setting and design of implementation mechanisms.

Policy recommendation 12

Continue to strengthen intergovernmental participation in health plan development and implementation to ensure localization of health plan priorities and integration of local priorities into the health plan. Greater territorial consideration, including involving territorial participation in the development and planning process, was considered of great value and drew on the experience of technical staff in the field. Greater involvement of territorial actors from different governmental institutions in the planning process for a subsequent Catalan health plan could be considered. Maintaining an action-oriented plan but supported by tools and guidance (for example work sheets) is considered valuable – the latter is particularly important in the absence of human resources in the regions and to support a common understanding and access to the evidence.

Policy recommendation 13

Review the scope and prioritization of public health services in line with the SDGs. New intersectoral public health challenges like climate emergency require a structured response from public health services, bringing together efforts to improve public health information, generalize local good practices and reduce variability. Actions in that direction include strengthening of collaboration with local governments, increasing the multidisciplinarity of public health professionals and improving their skills through continuing education to further lead future community projects.

Policy recommendation 14

Continue the move towards an efficient integrated health service delivery system by addressing institutional and funding barriers to action. Building on past progress and innovations already in place in Catalonia, the next health plan could more systematically promote integration of services with a focus on policy coherence and resource alignment. Examples include facilitating the interface between primary care and public health through community services, providing higher autonomy to health centres, promoting research on innovation and organization of primary care services, or improving coordination and information exchange between health providers under new contractual arrangements. A better integration of community

mental health services and social services with primary care should be addressed through regional implementations of the health plan, defining a standard package of services. Continuing the hospital sector transformation will require adapting services and professional specialties to population health needs, including reprofiling acute beds to subacute, and rehabilitation and palliative care units.

Policy recommendation 15

Consolidate the digital health and care system through a better harmonization of existing health information systems. Effective cross-sectoral collaboration and integrated health and social care demand a smooth exchange of health information among health actors and the adoption of digital health and care solutions that empower patients and health professionals. Reducing the fragmentation of the current health information systems landscape will benefit not only a better coordination and integration of services but also a more accurate long-term planning, innovation management and health research at all system levels.

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