# *Service Concepts And Service Integration In Costa Del Sol*

# SERVICE CONCEPTS AND SERVICE INTEGRATION IN COSTA DEL SOL

# Table of Contents

# INTRODUCTION CHAPTER

# Introduction

According to the specialized literature, health and well-being services are a holistic definition that comprises health, doctor, nursing, social, household management, and any other alternative services. Therefore, health and well-being services are divided into social and health services but can also include other kind of services such as culture or community well-being.

Nevertheless, in the frame of this research and due to the characteristics of the Spanish, and more concretely the Andalusian and Costa del Sol system, the analysis will focus on the following sectors:

1. Health.
2. Social Affairs.
3. Dependency.

In order to put into context the Andalusian and Costa del Sol system, the first chapter of this report offers a general approach and overview on the characteristics of these three sectors in the region (health services, social affairs and dependency: sociosanitary services).

It is important to bear in mind that the Spanish decentralization of competences and power implies a division of the territorial organization between the various levels of government (State level, Regional level – Autonomous Communities- and local level). In this scenario, some competences or faculties belong completely to the State; in other cases, they belong to the Autonomous Communities (Regions); and it is also possible that some competences or facilities belong exclusively to the local governments.

Therefore, the description of the three sectors circumscribes to the level of government applying to each one of them. From a general point of view, most of the information is referred to the territorial sphere of competences where the sectors are circumscribed (mainly to Andalusian Autonomous Region) but, when existing, specific data or information will refer particularly to Costa del Sol district.

## 1. Objectives

The main aim of the project is to analyse, describe and assess well-being sector's services, service integration and service chains in Andalusia and Costa de Sol.

In order to achieve it, this objective has been set on the following specific ones:

- Analysis of well-being services in Andalusia and Costa del Sol (chains and integration, development, cooperation, resources, efficiency, effectiveness, sustainability, etc.).

- Analysis of the extent of well-being services integration (Health, Social affairs and Dependency)
- Evaluation, from customers' perspective: Degree of satisfaction, needs, obstacles or difficulties in relation to an effective access to services, driving forces (legal, institutional, contextual factors, etc.) main demands, etc.
- Identification of a series of most interesting practices, according to their content, efficiency or effectiveness in relation to service chains and integration.
- Identification of guidelines to strength and improve well-being services (short and mid- term)

## 2. Methodology

The assignment of this project has been developed in various steps and with different methodological techniques. This mixed approach has allowed the use of the most convenient methodological tool for each step.

### *Phase I. Well-being sector in Andalusia/Costa del Sol (Description)*

Methodology used during this phase of the study has been mainly based on a wide Literature Review. This methodological approach has helped to get accurate information about service integration and service chains.

During this phase of the study, literature review has been used as secondary source. This methodological approach has helped to synthesize and to analyse the critical points of current situation of Health, Social Affairs and Dependency. Questionnaire for the interviews (phase 2, 3 and 4) has also being designed using this methodological tool and information.

Also, through the literature review it has been made a selection of practices and information has been complimented through interviews with main stakeholders and customers.

### *Phase II. Service concept and service integration (Institutional and customers' perspectives)*

During this phase of the project, information has been obtained by primary sources (interviews and/or information provided by each selected agent) and also by secondary sources (bibliography, literature review and Internet).

In order to get accurate information from the interviewees, a structured interview guide was designed and sent by e-mail to the participants before the date of the interview. The design of the guide helped to get information about the topic and, at the same time, it made easier to classify the information provided by the agents (Figure 1).

Information about customer's degree of satisfaction has been complemented with the information obtained by the annual survey of customer's satisfaction carried out by the Andalusian Health Service (SAS) from the Andalusian Regional Government.

**Figure 1.** Participation extent on the field. Actors and institutions selected and interviewed.

| |
|---|
| AFIMARS (Association for Fibromyalgia patients - Marbella y San Pedro Alcántara-) |
| AFA Fuengirola-Mijas(Association of Alzheimer patient's relatives) |
| ALCER (Association for renal disease patients -Málaga-) |
| Andalusian Agency for Social Services and Dependency (ASSDA)- Andalusian Government |
| Andalusian Association of Sjögren's Syndrome |
| Andalusian Patient Safety Observatory - Andalusian Government |
| Association for anti-coagulated and coronary patients (Málaga) |
| CUDECA (Cancer Hospice in Costa del Sol) |
| Expert on Hospital Management and Health Cooperation Models |
| Expert on Primary Care |
| IDIS Foundation- Institute for the Development and Integration of Private Health |
| Primary Care Centre "La Lobilla"(Estepona) |
| Social Rights Area (Programme Management)- Málaga |
| Social Rights Area (Community and Dependency Services) - Málaga |
| Social Rights Area (Social Services)- Málaga |
| Social Worker - Public Health Company Costa del Sol |
| Social Worker -Primary Care Health Centres (Málaga Region) |

Source: Own elaboration

## Phase III. Resources, effectiveness and efficiency

Information provided in this chapter is based on the public information compiled by the Public Andalusian System of Health (Please check chapter 4). It is important to note that there is no assessment about the social and dependency services and, therefore, this chapter only refers to the health sector.

***Phase IV. Selection of Best Practices***

During this step a selection of best practices has been made. Best practices were chosen according to their holistic integration and their possibility to be transferred into other contexts.

As aforementioned, selection of these practices has been made through the information gathered by Literature Review and information provided by main stakeholders and customers. After this selection, a general description of study cases has been written for each single practice.

Study cases are based on an in-depth investigation of a single individual, group, or event and due to their dynamism; it has been considered the most suitable methodological tool for this phase of the study. Study cases can be defined by their characteristics into three different types: explanatory; exploratory or descriptive. In this case, we have opted for a descriptive approach using qualitative methods for gathering information in order to reach a holistic view of each practice.

## 3. Document structure

This document has been divided into chapters that, mainly, belong to the different phases of the project. First chapter makes a brief description about the three sectors analysed; second chapter analyses service integration and service chains from the point of view of the main institutional stakeholders (literature review and interviews); third one presents the perspective of the customers, especially in relation to their degree of satisfaction; fourth chapter compiles information about resources, effectiveness and efficiency of the system and finally, fifth chapter, finally brings together a selection of best practices selected.

# CHAPTER 1. DESCRIPTION

# 1. Health

## 1.1. Management models in Andalusian Health System

In Spain, healthcare provision is universal coverage, financed from taxes and mainly operates within the public sector. Provision is free of charge at the point of delivery with the exception of the pharmaceuticals (40% co-shared payment) prescribed to people aged under 65.

As an introduction to the health system in Costa del Sol, it is important to highlight that health competences in Spain are transferred to the Regional level (in this case to the Andalusian Autonomous Community) and, therefore, the organization, functions and management of the system depends on the Andalusian Government, also applying to the specific case of Costa del Sol.

In order to understand the Andalusian Health System, first of all, it is important to highlight the coexistence of three different models of management of the Public health system:

- Direct management model by Public Law, such as
  - Andalusian Health Service (SAS) (Servicio Andaluz de Salud).
  - Agencies and institutions with autonomy in their management (I.e., Andalusian Agency for Health Technology Assessment).
- Direct management model by Private Law.-New public management model, restructuring publicly owned hospitals or other services into semi-independently managed public firms (semi-autonomous management):
  - Public entities (I.e., Costa del Sol Health Agency; Andalusian Emergency Service, Andalusian School of Public Health, etc.)
  - Consortiums (I.e., Public Health Consortium Aljarafe).
- Indirect management model
  - In Andalusia, the most common way of partnership with the private sector is by:
    a. Outsourcing non-health services. (i.e.: restaurant, laundry, cleaning services, etc.) and purchase of products (goods and services). SAS has developed several strategies to increase efficiency in the Health Service Supply Chain (please check Chapter 2, Section 2).
    b. Partnership (public-private agreements) for the provision of health services and specific public-private agreements such as medical transport, dialysis specialists; specific agreed assistance (Oxygen therapy, rehabilitation, surgery therapies, cancer treatment, etc.) and diagnostic services. This type of indirect management model only represents the 3.7% of the services provided.

There is also an important presence of the private sector in the Autonomous Region (especially high in Málaga province and Costa del Sol). There are 57 private hospi-

tals and centres in the region (Junta de Andalucía, 2011) and approximately around 17.5% of the population has a private health insurance (IDI, 2012)[1] but not all of the private hospitals interrelate with the public sector (SAS and Public Entities)[2]. Private Health Insurances are completely independent from the public system and usually complements the services (customers mainly use their services to reduce waiting times in the public system for specialist care, to have some extra comfort during their hospital stay (individual rooms) or to access to services such as dental care, which is very limited in the public system). In order to give a general impression of the Andalusian Health System, next section of this first chapter make a first approach to its structure, figures and numbers.

### 1.1.1 Andalusian Health Service (Servicio Andaluz de Salud)[3]

Andalusian Health Service (Servicio Andaluz de Salud -SAS), was born in 1986 under the Ley 8/1986, 6th of May (Ley 8/1986 de 6 de mayo) as an autonomous body inside the Ministry for Healthcare of Andalusia and it belongs to the Andalusian Public Health System, run by the regional government. Its mission is to guarantee health care to all citizens of Andalusia, offering "quality public health services, ensuring its accessibility and fairness and the satisfaction of its users, and aspiring to be efficient and take maximum advantage of available resources". All Health Centres, Specialised Treatment Centres and Hospitals belong to the SAS[4].

Its responsibilities and functions are regulated by the Law 2/1998 of 15th June, of Health in Andalusia, and the precepts in effect under the Law 8/1986 of 6th May which created the Andalusian Health Service.

On 2004, Decree 241/2004 of 18 May establishes the organization chart and functions of the Andalusian Health System and the SAS (Andalusian Health System).

Decree 241/2004 establishes the basic organic structure of the Ministry of Health and the SAS. It is compose of the following directive centres:

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1    http://www.fundacionidis.com/wp-content/uploads/2012/11/COMUNICADO_Informe_de_Eficiencia_2012_Andalucia.pdf

2    Public sector is the main health service provider in Andalusia and Costa del Sol and the development of service integration has been leaded by SAS and Ministry for Health and Social Well-being. As already mentioned, Andalusian health management is mostly public and under the direct management model. However it should be noted that in order to complement the assistance and given geographical amplitude and dispersion of Andalusia, in certain areas there have been signed agreements with certain health care providers outside the public sector. Therefore, the next chapters of this report will be mainly focused on the public system.

3    In Spain, health competences are transferred to the Autonomous Communities (Regions).

4    http://www.juntadeandalucia.es/servicioandaluzdesalud/principal/documentosAcc.asp?pagina=gr_conocerelSAS

- Direction-Management
- General Secretariat
- Directorate General of Health Services
- Directorate General of Personnel and of Professional Development
- Directorate General of Economic Management

And following Agencies belong to SAS (Figure 2):

- Public company of Health Emergencies
- Costa del Sol Public Health Company Public
- Andalusian Agency for Social Services and Dependency
- Andalusian Agency for Health Technology Assessment
- Andalusian School of Public Health

**Figure 2.** SAS Structure and Agencies
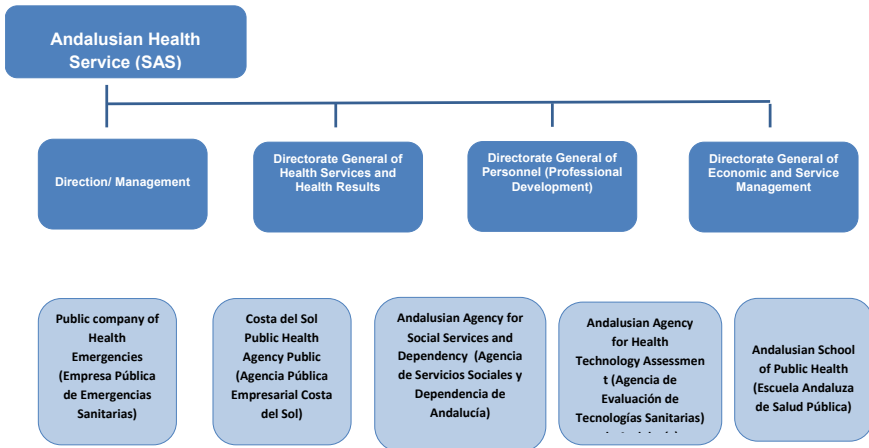


Source. Servicio Andaluz de Salud. Junta de Andalucía

And article 13.3 of Decree 241/2004 of 18 May establishes the functions of the SAS[5]:

- Management of health services in the field of promotion and protection of health, prevention of disease, health care and rehabilitation as applicable to the territory of the Autonomous Community of Andalusia
- Administration and management of the institutions, centres and of those health services that are under their dependency, organically and functionally.

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5    http://en.wikipedia.org/wiki/Andalusian_Health_Service

- Management of the financial, material and human resources needed to fulfil these functions.

Its functions are further delineated by:

- Ley 2/1998 de Salud de Andalucía (Law 2/1998 on the Health of Andalusia).
- III Plan Andaluz de Salud 2003-2008 (Andalusian Health Plan III).
- The quality plan of the Andalusian Public Health System (SSPA).
- The SAS's own strategic plan.

In 2011, there were approximately 1,500 primary care centres, 48 public hospitals (General Hospitals, High Resolution Centres and other kind of specific Hospitals) and 36 Speciality Centres (Figure 3) and around 102,000 employees working in SAS. The general budget (2010) was 9,3906M€ (7.2% of Andalusian GDP). In order to put into context these figures, it is important to highlight that Andalusia is the most populated autonomous community in Spain (around 8,5 million inhabitants, 14.8% of them older than 65).

**Figure 3.** Health Centres in Andalusia by provinces and type of Centre (2011)

| | Almería | Cádiz | Córdoba | Granada | Huelva | Jaén | Málaga | Sevilla | Andalusia |
|---|---|---|---|---|---|---|---|---|---|
| **Primary Health Care** | **233** | **129** | **142** | **328** | **118** | **197** | **181** | **191** | **1.519** |
| Health Centres | 41 | 53 | 39 | 50 | 28 | 42 | 65 | 90 | **408** |
| Local Practice | 95 | 51 | 73 | 163 | 61 | 87 | 75 | 91 | **696** |
| Auxilary Practice | 97 | 25 | 30 | 115 | 29 | 68 | 41 | 10 | **415** |
| **Specialized Attention** | **5** | **14** | **8** | **10** | **4** | **12** | **11** | **20** | **84** |
| Speciality Centres | 1 | 9 | 2 | 5 | 1 | 5 | 3 | 10 | **36** |
| Hospitals (SAS) | 2 | 5 | 3 | 4 | 3 | 3 | 5 | 5 | **30** |
| High Resolution Centres | 1 | - | 2 | 1 | - | 3 | 2 | 4 | **13** |
| Other kind of Hospitals | 1 | - | 1 | - | - | 1 | 1 | 1 | **5** |

Source. Consejería de Salud y Bienestar Social. Sistema de Información de Centros y Establecimientos Sanitarios (SICESS). Dated December 31st 2011. Junta de Andalucía

Therefore, from the public sector, health attention is carried out by the Andalusian Service of Health (SAS), as main provider, but also by Health Public companies (Ministry of Health) and by private centres in agreement with the SAS.

SAS has an integrated network of care services organized to guarantee its accessibility for the population. Services are divided into two different levels:

**1. Primary Health Care,** which includes preventative and curative care, rehabilitation and the promotion of health among the population. Primary health care is an integrated system composed by primary care centres (family doctors, nurses, etc.) and multidisciplinary teams (ambulatory specialists.). In Andalusia Primary Health Care is organized by districts (Figure 4).

The districts of primary health care are organizational structures (territorial) in charge of the operative planning, direction and management and administration in the area of primary health care. Some of their tasks are described as follows: organization of the activities of health assistance; promotion of health; prevention of diseases; health care recovery; management of environmental and food health risks; training for teachers and researchers, etc.

**Figure 4.** Division by Primary Health Care districts in Andalusia



Source: Servicio Andaluz de Salud. Junta de Andalucía

**2. Specialised Care** (hospitals), attends users that require hospitalization, and it has ambulatory services and out-patients departments in hospitals and in peripheral centres.

In Andalusia, there are 48 hospital and 36 specialised centres (Figure 5) (some of them are integrated into Areas of Sanitary Management). The rest of the public hospitals are:

- Centres managed by Public companies (H. Costa del Sol, H. West, H. Montilla, H. Andujar);
- A network of High Resolution Hospitals in charge of major ambulatory surgery (slightly invasive technologies) where customers can receive in only one visit all the necessary medical analysis and treatment (day-care hospitals). High Resolution Hospitals were created by the Ministry of Health of the Regional of the Government of Andalusia and they are a new model of hospital, oriented to outpatient surgery and surgery that requires a very short period of hospitalization. Diagnosis, emergency units, rehabilitation and, in some cases, primary care are provided too in these centres. The objective

is that citizens have access to an integrated and high-resolution health care service in less than 30 minutes (appointment management) (García, I and Carrillo, M., 2008)[6].

- Psychiatric penitentiary hospital; and
- Hospital - Public Consortium (H. Bormujos – Aljarafe).

Currently, there are also already existing 9 Areas of Sanitary Management: model of organization that integrates the management of both levels (Primary care and Specialised Care) in a territorial specific demarcation.

**Figure 5.** Public hospitals in Andalusia by province (2011)
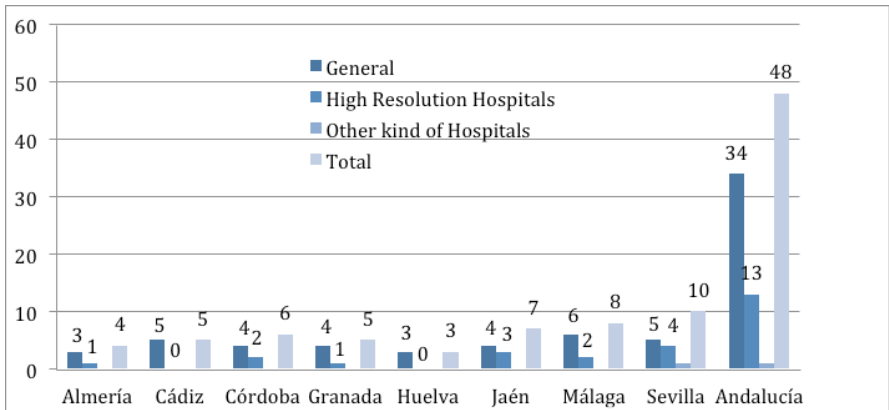
It is also important to highlight, as above mentioned, that there another 57 private hospitals or specialized centres in Andalusian region, most of them located in Málaga province (Figure 6 and Figure 7) and some interacting with all these public organizations (to a greater or lesser extent) in the provision of services to customers in the field of health and well-being (Andalusian government has agreements with 17 private hospitals in relation to service provision).

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6   This is a new management model that attempts to solve the problem of waiting lists, improve access for people who live far away from large cities, reduce the ever-increasing costs of hospitalisation and address medical problems whilst causing minimal inconvenience to patients(García, I and Carrillo, M., 2008.)

**Figure 6.** Private hospitals in Andalusia by province (2011)
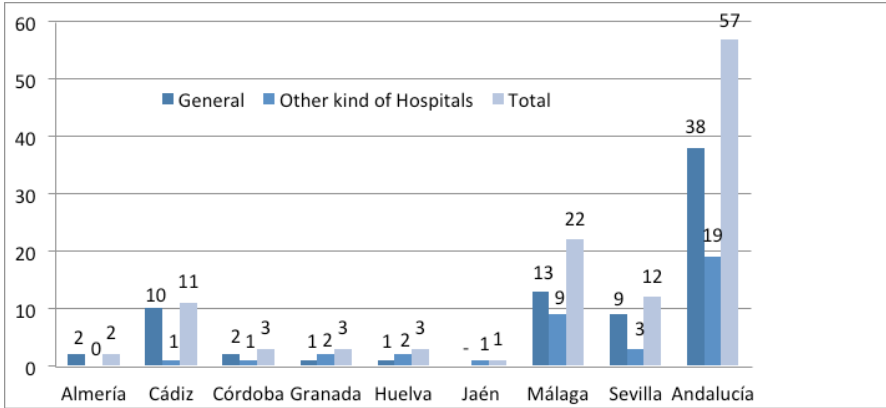
More concretely, following figure shows the private entities in agreement with the public sector (Figure 7)

**Figure 7.** Private entities in agreement with the public sector

And SAS has also other care entities such as[7]:

- Public Company for Health Emergencies of Andalusia (EPES). It covers the process from the emergency call (inbound) until the patient arrives to the hospital.
- Salud Responde - Telephone appointment and information system (24hs/7ds). It is a health care and information service accessible through different communication channels. This service provides immediate responses that are customized to each person's needs, providing a more accessible, comprehensive and high quality health information on their health situation, as well as assessment tools
- Andalusian Public Foundation for Social Integration of the People with Mental Disorders- Public foundation created to provide complementary services (besides the service provided by the ordinary Health sector) to people with mental disorders.
- Network of Centres for blood transfusion

There are also other actors that, in a greater or lesser extent, are an important part of the system and that play a key role in the service concepts and service integration, both from the institutional and customer point of view. Therefore, and in order to understand the functioning of the system, a short description of some of the more relevant actors is now presented.

- **Andalusian School of Public Health**. It is a public institution (Private Law) supported by the Ministry of Health and Social Well-being, which provides training, consultancy and research services for the healthcare sector.
- **Andalusian Agency for Health Technology Assessment.** It is a public institution supported by the Ministry of Health and Social Well-being, created to facilitate information to health professionals on the more efficient use of clinical resources. Among other tasks, the Agency is involved in the development of strategic plans to enhance the quality of care in Hospitals and Primary Health Care Centres (introducing technology and Information and Communication Technologies).
- **Andalusian Agency for Healthcare Quality**. Organization that belongs to the Ministry of. Health and Social Well-being, assuming the supervision and management of the processes of accreditation (Health centres). According to the Andalusian Agency for Healthcare quality, accreditation process is developed in:
  - Care Centres.
  - Clinical Management Units.
  - Health districts.
  - Research units.

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7     More specific information about these entities will be provided along this report

- Professional skills.
- Continuous training (lifelong training)
- Health webpages, etc.
- The **Andalusian Health Council** is the body for citizen's participation in the formulation of health policy and the control of its implementation. Among others, its function is to advise on this matter to the Ministry of Health about the development of actions related to the promotion of citizen's participation.
- **Patient School** is composed by patients, carers, relatives, associations and citizenship who participate in the training activities for active care. Includes an Patient Safety Observatory
  - Patient Safety Observatory is an observatory designed to improve the management, training and information health systems (best practices, improvement actions, incidence in the service, etc.). The observatory also has expert groups composed by professionals specialized in different disease. It is an initiative within the framework of the World Alliance for Patient Safety, aimed to contribute to professional discussion and dissemination of safe practices related to health care and sociosanitary care. The observatory is in charge to identify those critical points in the service chain where the customer is more vulnerable and to provide solutions in order to increase their safety along the sociosanitary process.

Last but not least, it is important to highlight the figure of the **Social workers in healthcare**. Social workers in the healthcare have been defined as the professional continuum of services designed to help patients, families and groups to improve or maintain optimal functioning in relation to their health (Barker, 2003). Social work activities are focused on the biopsychosocial components of health and/or mental health from a strengths perspective. Social workers in the Andalusian healthcare system are the ones in charge of seeking the potential psychosocial factors that influence the health / disease process of the customers and the objectives of their work is to promote customer's resources to overpass and recover from the sociosanitary problem and treatment to solve the problems encountered in relation to situations of illness. Social workers can be found in both primary attention and secondary (hospitals, high resolution centres-hospitals, etc.) one.

## 1.1.2. Costa del Sol Health District

Costa del Sol has a population of almost half a million citizens, (including more than 50,000 people over 65 years old), and more than 160,000 foreigners from more than 55 different nationalities, mainly from United Kingdom, France, Germany, Netherlands and Scandinavian countries, many of them retired people and people with disabilities with few family and/or social support and living independently.

As it shows the Figure 5, Costal del Sol is a Health District (DSCS) covering the west coast of Malaga province (from Torremolinos to Sabinillas, with an approximate extension of 100 square kilometres and four Basic Zones of Health (Torremolinos-Benalmádena, Fuengirola-Mijas, Marbella and Estepona) that includes 20 Units of Clinical Management (100% of well-being centres of the District).

DSCS offers a comprehensive portfolio of services of primary care in each health centre (well-being, preventive services, services related to promotion of health and services addressed to protection and rehabilitation).

In DSCS there are 24 Health Centres (2011) organised in 12 Clinical Management Units (Please check Chapter 2 for a detail description of this concept) and it has around 1,000 employees. Among other services, these health centres provide[8]:

- Medical consultations.
- Specific clinical care of chronic illness.
- Home care.
- Nursing care.
- Child and Adolescent care.
- Elderly Care.
- Sexual Health Care.
- Women Care (Cancer screening and pregnancy).
- Accidents and emergencies.

More concretely, DSCS has:

- 6 units for critics and urgencies care.
- 8 units for radiological exploration.
- 6 units for physical therapy and rehabilitation.
- 5 offices for oral attention.
- 7 units for maternal training/education.
- 13 units to come off nicotine poisoning.
- 4 units for mental health (Torrequebrada, Las Lagunas, Las Albarizas y Estepona).
- 1 unit for environmental and food health.
- 1 residential unit (supervising the care of the elderly in Residential Homes).
- 1 epidemiology unit.
- 3 units for early detection of breast cancer.

Inside Costa del Sol geographical territory, there are also several specialized centres and hospitals (both public and private). The most relevant organization (according to the aim of this report) is the Public Health Company Costa del Sol (Empresa Pública Hospital Costa del Sol), established in Marbella in 1993 (Disposición

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8   http://www.juntadeandalucia.es/servicioandaluzdesalud/dcostadelsol/web/?page_id=447

adicional Decimoctava de la Ley 4/1992 de 30 de Diciembre de Presupuestos de la Comunidad Autónoma de Andalucía).

From the creation of this public entity (its statutes were approved by the Decree 104/1993 de 3 de Agosto) a new model of management was designed, with the final objective of granting more managerial freedom to hospital managers (For more information, please check chapter 2 of this report).

The Public Health company Costa del Sol Hospital manages Hospital Costa del Sol (open in 1993), the High Resolution Specialty Centre (CARE) in Mijas (open on October 17th, 2005) and the High Resolution Hospital in Benalmádena, (open on November 8th, 2007), providing 348 beds (2009) and an average staff around 1.500 workers.

## 2. Social Well-being

In Spain, social assistance is a regional power of 'exclusive competence' of the Autonomous Communities (regions) (art. 148; 1.20; 1978 Spanish Constitution). The Andalusian Autonomous Community has exclusive competence in assistance and social services matters and family planning and counselling.

It is important to bear in mind that social services are mostly organized by the Autonomous Communities, in many cases, with special collaboration with the third sector. Social initiatives, through profit and non-profit making organizations, cooperate with the Public Social Services System to provide social services (mainly related to residential and day centres for elderly and people with disabilities) but not only. Also social services administration can subsidize private companies in order to develop programmes, such as the building and equipping of residential and day centres.

Nevertheless, in 1985 Andalusian Law 7/1985 of 2nd April (Ley 7/1985 de 2 de abril) established the need of decentralization of the social services in order to approach the services to the customer and, therefore, Andalusian Government delegated to the city councils- municipalities (for towns and cities with more than 20,000 inhabitants) and county councils (for towns and cities less than 20,000 inhabitants), responsibility for:

- Management of Community Social services Centres.
- Management of Specialized Social Services Centres.
- Execution of Social Services Programmes.

This distribution of competences has enabled decentralisation of power, bringing these services to cities and towns and allocating different levels of responsibility to the different levels of government.

From a legal point of view, the Andalusian Statute prioritize the social protection by regulating a variety of topics, such as the protection of minors (art. 13.23) and the promotion of activities and services for youth and the elderly. Also, from a legislative point of view, it is important to highlight that Law 2/1988 (Ley 2/1998 de 4 de abril) on Andalusian Social Services established the need of optimizing the organization of the social services by unifying dispersed units and eliminating duplicated structures. This Law also divides the structure of Social Services into two types of services:

- **Community social services or primary care services** that aimed to promote citizen's, groups and communities participation; boosting associationism (especially volunteer services) and coordinating different entities and professionals that work in the same district or area. Community Social services are organised into Social Work Areas (geographically divided) that are divided into sections called Social Work Units (the scope of these units is geographically smaller than the city) aimed to provide service to the customers related to information, advise, guidance and assessment.
- **Specialized Social Services** are aimed at specific population groups that need specific care. Specialized Social Services are organized into different areas such as: Promotion and development of individuals, groups and communities, enhancing participation; fostering alliances in social services, as a channel for increasing social volunteering; establishing channels of coordination between agencies and professionals that act and interact in social work within the same town, city or area.

Primary Care or Community Social Services aim to provide a general service to the entire population and are generally provided locally (in a similar territorial division than health areas). Community social services are organized into **Social Work Area** as their territorial demarcation. The current Zoning Map of Social Work in Andalusia is inside the Plan for Basic Services in Social Work where Zone boundaries are divided into what it has been called "**Social Work Units**": an administrative and territorial unit whose primary duty is to provide access to social services for the citizens, mainly through Information and Guidance Service.

This basic level within the structure of the Public Social Services (Social Work Unit) allows carrying out actions related to the promotion and social awareness in its area of intervention and it also allows a more systematic and close knowledge of the social needs of the population, technical cooperation in any comprehensive promotion and social integration.

Málaga province has 32 Social Work Areas and 127 Social Work Units, divided as follows:

**Figure 8.** Geographical division of Social Work Area and Social Work Units (Málaga Province)

| Id | Area | Units | Population |
|----|------|-------|------------|
| 1 | S.W.Z Málaga capital | 43 | 547.731 |
| 2 | S.W.Z Alhaurín de la Torre | 2 | 26.764 |
| 3 | S.W.Z Antequera | 4 | 42.378 |
| 4 | S.W.Z Archidona | 4 | 24.821 |
| 5 | S.W.Z Axarquía Occidental | 5 | 21.781 |
| 6 | S.W.Z Benalmádena | 3 | 42.437 |
| 7 | S.W.Z Campillos | 4 | 35.474 |
| 8 | S.W.Z Coín | 1 | 19.295 |
| 9 | S.W.Z Costa del Sol Occidental | 2 | 18.067 |
| 10 | S.W.Z El Rincón de la Victoria | 3 | 30.169 |
| 11 | S.W.Z Estepona | 4 | 50.488 |
| 12 | S.W.Z Fuengirola | 4 | 58.957 |
| 13 | S.W.Z Guadalhorce Alto | 2 | 18.582 |
| 14 | S.W.Z Guadalhorce Bajo | 4 | 41.962 |
| 15 | S.W.Z Los Alhaurines | 1 | 19.324 |
| 16 | S.W.Z Marbella | 10 | 117.353 |
| 17 | S.W.Z Mijas | 4 | 52.573 |
| 18 | S.W.Z Ríogordo | 3 | 18.609 |
| 19 | S.W.Z Ronda | 4 | 34.948 |
| 20 | S.W.Z Serranía | 5 | 18.386 |
| 21 | S.W.Z Torremolinos | 4 | 52.354 |
| 22 | S.W.Z Axarquia Oriental | 4 | 45.911 |
| 23 | S.W.Z Vélez-Málaga | 7 | 61.797 |

Source. Consejería de Bienestar Social. Junta de Andalucía, 2011

In each Social Work Area, there is a **Social Services Centre** (usually located in the capital of the province), which provides the basic infrastructure for the provision of these services Social Services.

**Social Services Centres** (local level) provide some of the following services:

- Information, Assessment, Guidance and Counselling. Centres for Social Services are the primary care and benefits centres for the population, as well as the link with other social resources.
-  Home Care (dependent people). Providing a series of care services in order to support individuals and families to facilitate their autonomy. These services are mainly focused on the provision of domestic (personal hygiene, cleaning, food, laundry, etc.), social (keeping and enhancing communication between people in a dependent situation and their communities) and personal support (solving specific situations of difficulty for interpersonal relations and/or serious problems of isolation).
- Coexistence and Social Integration. Focused on the inclusion of all citizens into community life, with particular emphasis on preventive actions.
- Social Cooperation. Its function is the promotion and enhancement of community life.
- Supplementary services. Economic benefits and economic help for certain disadvantaged individuals, families or groups.

At the same time, currently, the department for Social Well-being (inside the Andalusian Ministry for Health and Social well-being) has also developed some services related to social well-being (**Specialized Services**). These services are structured in seven areas, each one of them addressing different population groups who are (or can be) in a situation of vulnerability, and whose integration and prosperity in the society might require the effort of the public system in order to guarantee their access to rights and social resources in equality of conditions. These areas are:

- **Retirement and pensions** - Management of social economic help (addressing people without sufficient economic resources).
- **Elderly people -** Services for dependents; specific telephone attention for elderly people; economic help; elderly people's homes and active aging.
- **Dependency -** Development of the Law on Promotion of Personal Autonomy and Care for people on a dependent situation and the provision of services for dependent people (for people who cannot live independent lives for reasons of illness, disability or age).
- **People with disabilities** - Services and guides for people with disabilities.
- **Social services and inclusion -** Improvement of social well-being and life quality of the Andalusian population; Prevention of social exclusion.
- **Family and childhood -** Promotion of children's rights; services to children and adolescences; adoption and family help.
- **Drug dependency -** Sociosanitary attention and social inclusion of drug addicts; prevention of drug consumption.

Nevertheless, as we will see in the next chapter of this report, service concepts and service integration has been more developed in the health area than in the social sphere.

In this context, the Law on Promotion of Personal Autonomy and Care for people on a dependent situation has meant an important improvement on the integration of services. In relation to the scope of this report, special attention will be paid to the services related to customer's well-being, particularly to the services for dependents, disabled and elderly people and people with chronicle or long-term diseases.

## 2.1. Dependency

The term dependence refers to a permanent situation in which people, for reasons of age, illness of disability, need to be cared for by one or more persons, or need significant help to carry out daily basic activities or, in the case of people with a learning disability or mental illness, need other types of support to be independent.

The development of the Spanish National Long-Term Care System is one of the most important reforms in the field of health and social care. The "*Law 39/2006 of 14th December on Promotion of Personal Autonomy and Care for people on a dependent situation*" guarantees the right to long-term care services. This law has helped the introduction of the System of Attention to Dependence during 2007, which introduces different criteria to determine the degree of dependence:

**Level 1 - Moderate dependence** is when a person needs help once a day to carry out basic daily activities, or occasionally needs a limited amount of support to be personally independent.

**Level 2 - High dependence** is when a person needs help two or three times a day to carry out a variety of basic daily activities, but does not require a carer to be present at all times, or needs a high degree of support to be personally independent.

**Level 3 - Very high dependence** is when a person needs help various times throughout the day to carry out daily activities, or needs a carer to be present at all times due to loss of mental or physical independence, or needs all round support to be personally independent.

Thus, dependence attention and care scheme is formed as a network of public utilisation that integrates and coordinates the centres together with both public and private services.

In this context, in Andalusia was recently created the **Andalusian Agency for Social Services and Dependency, (ASSDA)** a Public (non-profit) Agency that works as instrumental entity of the Andalusian Regional Government (Junta de Andalucía, Ministry of Health and Social Well-being). ASSDA headquarters are located in Seville and Málaga, and it has delegations in the 8 provinces of Andalusia. The current number of employees is over 1.500 people and provides services to around 200.000 people.

Its aims are the promotion, development and management of social care resources directed to individuals, families and disadvantaged groups to promote and improve their welfare. It also provides a wide range of social services and assistance to elderly people in a dependent situation (15% of elderly population); disabled people (9% of the population) and population at risk of exclusion and/or substance addiction problems.

In order to achieve these goals, ASSDA provides support, training and employment interventions and services together with other social agents.[9]

Thus, ASSDA is the entity that manages the System for Personal Autonomy and Care for Dependent People in Andalusia.

According to the National Law these measures need to be developed[10]:

- Assistance in kind (tele-care, home helps, day centres and residential care).
- Economic assistance linked to services (when impossible to utilise the public service or in case of high degree of patient dependence).
- Cash payments to assist family carers. In exceptional circumstances, the formalisation of non-professional carers is required.
- Under certain circumstances, the government will pay a grant to enable dependent persons to receive care at home. In that case, the main carer (usually a relative) must be registered in the social security system.

Another form of assistance concerns 'major dependence'. In these cases, the state envisages the need of a carer for the dependent person. The dependent – or his or her legal representative – can choose the person in charge of the care and the caring methods.

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9    http://www.juntadeandalucia.es/fundaciondeserviciossociales/

10   Services for dependent people have been transferred to the regional level (autonomous regions).

In the scope of the national Law and among others, ASSDA offers some of the following **services related** to dependency[11]:

- **Services to promote personal autonomy** aimed to provide services to people in a situation of moderated dependency such as: occupational therapy, early attention; cognitive stimulation therapy, psychological and social support for mental handicap people or people with mental illness, provision of care for people in assisted living (sheltered housing), etc.
- **Community alarm service and tele-care service**[12]. The objective of ASSDA tele-care service is to improve senior citizens' quality of life by giving more autonomy and independence, bringing fast attention in case of emergency, and by supporting families with elderly people. Tele-care provides immediate attention for health emergencies and information to customer's relatives of any emergency. It also offers conversation and companionship for elderly people in situations of loneliness and information about the benefits and services offered by the Andalusian Social Services. Tele-care has a device that includes a loudspeaker and microphone installed both in the telephone of the elderly person and in a wireless unit (necklace) that directly connects the elderly person with a call-centre[13].
- **Home-care service**, providing help related to diet (cooking, shopping – shopping expenses are paid by the customer, etc.); eating habits, clothing (cleaning, ironing, shopping – shopping expenses paid by the customer.-, etc.); housekeeping, personal hygiene; mobility (help for standing up and lying down); special care (night accompaniment, coordination with health services for the medicine doses, etc. ) and social and family support (leisure activities at home and outside, activities focused on increasing their social participation, etc.).
- **Day-care and nigh-care services,** for disabled people and for elderly people (dependent). Centres for elderly people or disabled people on day or night bases.
- **Residence services** for high or very high dependent people. Residences where dependent people (elderly or disabled people) live and are attended 24 hours, 7 days a week. These residences provide, among others, health care, psychological and social stimulation and aid in the daily-life activities.
- **Economic support for non-professional carers.** For some cases in which the dependent person is being attended by his/her family.
- **Economic support to hire a professional carer.**

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11  Andalusia is the Spanish region that receives the highest number of application for recognition of dependence (around 350,000 applications) but only 145,00 were declared dependent in 2010 (receiving benefits and assistance).

12  This model is described in next chapters of this report

13  This project is part of the Commonwell Platform Services for Aging Well in Europe http://commonwell.eu/about-commonwell/the-commonwell-services/

In addition, ASSDA integrates activities which focus on the families (carers) of the dependent people such as:

**Support Plan for Carers**, aimed at relieving the burden of the informal carers (Please Check Best Practice Chapter for more information about this Plan).

The programme **"Family Respite"** (Respiro Familiar) consisting on a temporary residential service for dependent people (providing them comprehensive care accommodation and services, full support, help with activities of daily living, supervision, occupational therapy, leisure activities and community integration activities), aiming to give temporary relief to those who are caring (relatives) of the dependent person[14]. In some cases it is also possible In-Home Respite Care (short-term care in a person's home) mainly provided by private non-profit agencies and volunteer groups.

ASSDA also has a service called **"Cuidabús"** aimed to offer practical advice to those who are caring dependent people in order to facilitate to carry out their care tasks. Cuidabús is a bus service that travels through the whole territory offering training (workshops and lessons) for carers.

It is also important to highlight the services provided to elderly people related to the active aging, as a tool to postpone or even to avoid dependency. Keeping elderly people healthy and active has also an impact on society as a whole and programmes aimed to improve active aging are highly sustainable due to the fact that investments in these programmes yield savings in terms of other very expensive resources, such as health-care. Following services are provided by the Andalusian Ministry of Health and Social Well-being:

- **Senior university classrooms** for citizens above 55 years old. Senior university classes are a training, educational, participation, and fellowship programme, aimed to provide an opportunity for elderly people to join educational, scientific, cultural, technological and social programmes.
- **Discounts on public transport.** 50 per cent of discount on the ticket price for elderly people in those long distance trips (origin and destination inside Andalusia).

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14  At the moment, according to the information obtained through the interviews, this service is no longer being provided due to the cuts of public social expenditures. As an alternative, some entities from the Third Sector (mainly Foundations and Associations) are providing some similar services but in a very limited and short scale).
It is important to highlight that, due to the current economic crisis, the budget for the implementation of Dependency Law has been cut and therefore the development of the dependency services has been stopped.

- **Active Participation Centres**. Centres for promoting elderly people (60 years old or more) well-being, aimed at promoting coexistence, integration, participation, solidarity and social relationship amongst them.
- **Senior Social Tourism**. Financing tourism activities for elderly people.

# CHAPTER 2. SERVICE CHAIN AND SERVICE INTEGRATION. INSTITUTIONAL INFORMATION AND PERSPECTIVE

# 1. Introduction

Service integration is a concept that implies the organization and interrelation of health and well-being issues, activities and prevention programs, in order to create a chain of integral delivery of services. The main objective of service concepts and service integration is to satisfy the customer needs and expectation and, therefore, this aim should guide all the activities and resources to meet high quality standards.

In that sense, it is essential the interrelation between customer's (citizens), public administration, private entities and health and social affairs professionals. Service integration and service chains should meet, at least, the following principles:

- Engaging the users in an effective way.
- Enabling people to be happier, healthier, and independent for longer.
- Supporting people to take personal responsibility and make good lifestyle choices.
- Achieving evidence-based outcomes within a holistic vision of health and well-being.

According to the definition provided by Andalusian Regional Government, the region has developed a sociosanitary archetype that locates the customer (citizen) in the centre of the system, establishing a model based on the following principles: quality, accessibility, equity and efficiency.

The main objective of the service integration in the sociosanitary sphere is to transform a system where the customer requests and receives the social and sanitary services in a system where the services are coordinated, establishing an integrated chain of service for the customer.

In that sense, Andalusia **has developed several strategies to improve the service integration, most of them related to the health system** but, in some cases, establishing strong interrelations with other spheres (social sector), especially related to attention to dependents. Nevertheless, it is important to bear in mind that service integration and service chains have been highly developed in the health system but this integration has not been as much developed in the social and community sphere.

In order to understand the limited development of social services, it is important to note that the Spanish Welfare State is a recent creation (in comparison to other European Union Countries) and, therefore, it is less developed. The model of the Social Services in Spain and Andalusia correspond to what it has been called the "*Southern European Welfare State Model*". Its main characteristics are:

- Two tier or dualistic (segmented) social benefits based on insider–outsider labour market.
- Weak or lack of a public net for secure incomes.
- Strong reliance on families for care (mainly women).
- High reliance on hand-outs with a strong participation of the private sector (mainly third sector and religious organisations).

Nevertheless, in the case of the Andalusian Autonomous Community, the institutional stakeholders interviewed declared that the process of organization and unification of the public system of social services, completed by creating the Andalusian Ministry for Social Affairs (Consejería de Asuntos Sociales) in 1990 and, more recently (2011), the unification of Health and Social Well-being in the **Ministry for Health and Social well-being** (Consejería de Salud y Bienestar Social) will be a great improvement on the service integration for the sociosanitary sector.

In this sense, some of the relevant stakeholders interviewed point out the intention (in a near future) of the Ministry for Health and Social Well-being of transferring Health model into Social Services in order to provide the citizens an integral care but, by the moment, service integration is limited to certain specific cases (population groups)[15].

Besides, it is also important to bear in mind that even when the sanitary sphere has been much more developed than the sociosanitary sector, in any case, there have been made several steps to provide the users/customers a holistic service such as the ones related to Dependency (as above mentioned The Dependency Law has implied a strong development on the service integration in this concrete area) or the services offered for certain vulnerable groups (such as chronicle patients; people with mental illness or disabled people).

In order to better understand the service concepts and service integration in the health, social and dependency sectors, next sections of this chapter explains, on the one hand the health model and on the other the social and dependency one, by using the information provided through the interviews carried out with the main stakeholders and through the literature review.


## 2. Healthcare services

## 2.1. Standard customer's pathway through the system

In order to better understand the service chain and service integration strategies carried out by the Andalusian Public Health System, first of all it is important to

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15   The recent creation of ASSDA (as mentioned in firs chapter of this report) has meant an important step in order to coordinate and integrate health services and social services.

know how it is the **common or standard pathway** for customers through the different attention or care levels (García-Armesto, S., 2010).

Usually, the entrance door for health customers is the primary centre (except in emergency cases) and the family doctor. The family doctor will determine:

- If the customer's need can be managed and resolved by direct prescription or recommendation,
- If the customer requires further diagnostic procedures (test). In this case, the customer will get an appointment for carrying out prescribed tests and another to return to family doctor, who will determine:
    - If the problem can be solved by the primary care services (family doctor).
    - If there is a need to send the customer to specialized care (ambulatory) and, in this case, the customer will get an appointment for the specialist needed. Once the specialist has diagnosed the problem, the specialist can:
        - Prescribe further test and further specialist consultation.
        - Prescribe the treatment and sent the customer back to the primary care services.
        - Prescribe hospital care or high resolution hospital care. In the cases where there is a need of hospital stay and once the customer is discharged from the hospital, he/she will be sent back either to the specialist (ambulatory) or to primary care family doctor.

In the cases where a patient has a chronicle condition, he/she will require the services of a primary health care nurse for support and coordinated continuous follow-up and, depending on his/her social situation, assessment by social services.

In the cases where the customer is a **health emergency situation** there are three entrance doors depending on the episode and its seriousness:

1. Primary health care emergency centres.
2. Hospital emergencies.
3. Home visits for patients with mobility difficulties.

Andalusian Autonomous Community has developed several strategies in order to coordinate these healthcare services provided to citizens, aiming to increase the customer's safety through the whole process and, at the same time, to increase the customer's degree of satisfaction with the services provided by the Public Health System through this levels distribution (primary and specialized care) and areas of attention, in which several actors play different roles to provide services to customers (Figure 9).

**Figure 9.** Service Chain (Health System)
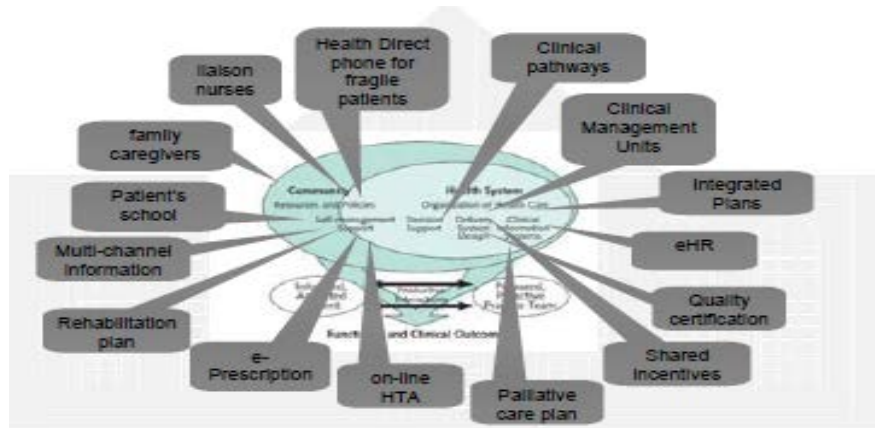
Besides the common pathway, this distribution implies different entrance doors for customers (depending on the customer needs) and, therefore, it is highly important the coordination of all the elements of the system in order to provide the customer a comprehensive and integral service.

According the Ministry for Health and Social well-being the goals of the Andalusian Health are[16]:

> *"Improve the public healthcare system, based on the values of universality, access to good quality care, equity and solidarity.*
>
> *Modernize health organizations, making them more flexible and citizen – centred, ensuring clinical governance and transparency.*
>
> *Increase the value of the public service system".*

Related to the functioning and organization of the system and the service integration, the last two Plans for Quality of the Public Health System in Andalusia are focused on the organization and, especially, in the welfare and well-being continuum (seamless)/integration, aiming to achieve a more comprehensive and cus-

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16   http://www.juntadeandalucia.es/salud/channels/temas/temas_es/___QUIENES_SOMOS/C_7_
     Healthy_Andalucia/healthy_andalucia_navegable?perfil=ciud&desplegar=/temas_es/___
     QUIENES_SOMOS/&idioma=es&tema=/temas_es/___QUIENES_SOMOS/C_7_Healthy_
     Andalucia/&contenido=/channels/temas/temas_es/___QUIENES_SOMOS/C_7_Healthy_Andalu-
     cia/healthy_andalucia_navegable

tomer orientated system. That is to say, it aims to set a prototype for service and define it as how the organization would like to have its services perceived by its customers, employees, shareholders and lenders.

In this sense, it is important to note that the last Plan for Quality bases the service concepts on three different scenarios or central issues[17].

1. **Citizens.** Citizen participation is essential for the well-being, as self-care plays an essential role in the prevention of diseases and in the management of chronic illness. For this reason, it is crucial to reinforce the autonomy of citizens and support training for them to take on greater control and responsibility for their well-being. Better-informed citizens have more freedom to make decisions and to take greater responsibility over their own health and well-being. Several actions have been taken in this direction such as: the creation of the Patient School and the Patient Safety Observatory; Continuous assessment of the system from the customer's point of view[18]; Citizen Participation Commissions in the development of the Clinical Management Units; Specific Care Plans and Programs for customers and carers, etc. (Please, check Figure in Annex 1 for the list of services and measures designed by Andalusian Regional Government in relation to the citizen's rights on healthcare provisions).
2. **Professionals.** Involvement of health professional in the planning and execution of the Healthcare is one of the pillars of the system. Professionals are also involved in the design of accreditation manuals (professional skills manuals have been designed for each health speciality). Thus, health professionals are one of the bases of clinical management, management based on integrated procedures and competence based management.
3. **Shared or common space.** Enhancing meeting points for citizens and professionals, such as the Citizen's Participation Commissions, is the third pillar of the Andalusian Healthcare system.

These central concepts are articulated in a quite complex system, where different actors from same or different institutions play a key role in one or more parts of the system.

## 2.2. Strategies of Andalusian Public Health system to improve service concepts and service integration

In this sense, several strategies have been used to improve the service concepts and integration of the services provided to the customers. All these strategies might be synthesised on four pillars or organizational procedures (Marcenaro, O.D, 2012):

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17  http://www.juntadeandalucia.es/

18  http://www.calidadsaludandalucia.es/

1. Management of the system based on integrated procedures.
2. Clinical management and clinical management units.
3. Competence based Management (Skills).
4. Continuous improvement and accreditation.

## 1. Management of the system based on integrated procedures (Process Management)

The management by integrated procedures is based on the vision of the process from the customer perspective, taking into account the existence of different itineraries through the health system and the need of the customer to get a single response. Integrated procedures means a set of activities carried out by different healthcare providers (preventive strategies, diagnostic tests and therapeutic activities), aiming to increase the customer's level of health and satisfaction (organizational, well-being, etc.). **This strategy seeks to build a permanent link between customers and professionals basing all the actions on the following criteria**:

- Customer is the key in every action.
- Professionals must be implied in every action.
- Health practices must be in accordance with updated scientific knowledge.
- Continuity and integration of well-being and care is the centre of the system.
- Results and outcomes must be assessed and improved.

The introduction and development of Process Management is an essential key point to understand the service integration as Process Management adds a high potential related to the horizontality of the health attention. It implies to modify the traditional conception of services, divided and segmented by levels, specifics services, professionals and environments. Process Management integrates all the elements and actions involved in each process (regardless the level of attention) in order to provide and secure the continuity in the assistance.

Thus, Process Management has been proved a useful tool (from the customer's point of view) in the integration and continuous assistance of the different attention levels.

Service integration and service chain, in the case of Process Management, implies the continuity in the attention, care and customer's well-being and, therefore, it has been designed taking into account three key actors: Customers (patients and carers), environment (services, primary care, services, units, health district areas, customer's residence, etc.) and information (resources, health information, well-being information, etc.).

But, from the management of the resources point of view, the organization of this complex strategy needs an adaptation of the way resources traditionally were ma-

naged, by incorporating a more flexible and efficient management. Thus, Process Management is based on some of the following principles[19]:

a) Development of clinical management. Development of Clinical Management Units (Please check next section of this chapter for a detailed description).

b) Guide actions to ensure access to health resources in equal opportunities, integrating the gender dimension (gender mainstreaming) in the Integrated Assistance Process (IAP is following described): The guidelines should include alternatives (from a medical and assistance point of view) and Integrated Assistance Process must investigate new explanations for the processes of health, well-being and disease taking into account the gender perspective (how women/men perceive health, value assigned to health and well-being, beliefs about health issues, motivations, healthy or harmful behaviours, etc.)

c) Consideration, during all the care and recovery process, of customer or user as an active subject that has specific and individual needs, rights and duties established by law.

d) Customize the service in order to integrate, as a significant part of the care and well-being process, the characteristics and situations of each customer, his/her living environment. This characteristics should not only attend the physical sphere but also to have in consideration other kind of elements such as customer values; his/her assigned social role, his/her living conditions, his/her social networks, etc. as these elements are also key determinants for the health.

e). Approach the process from the "recovery" point of view. Customer needs to recover his/her life project and social inclusion, especially, in the case of long-term disease processes or elements of disability or loss of autonomy (dependency).

f) Continuity and service chain in the care process. Processes that imply the services of different specialist, units, working in different places and different times need to be organized in a highly coordinated way in order to provide quality services to the customers. Integrated Assistance Process and a Unified Service Portfolio (please see below) are key elements in the service integration.

g). Specific Skills and Competences. Competence based management is the strategy used for continuous improvement of professionals and services. Specific skills are developed to meet the technical or functional professional skills in order to ensure the patient needs in the care process development.

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19  http://www.juntadeandalucia.es/salud/export/sites/csalud/galerias/documentos/p_3_p_3_procesos_asistenciales_integrados/

h). Updating and innovating the Integrated Assistance Process

**Integrated Assistance Process** consists on the development of protocoled assistance guidelines that include recommendations from the beginning of the process until the customer is discharged from the hospital.

In order to develop the Integrated Assistance Process is necessary to establish a strong coordination of the attention; carry out continuous assessment by continuous registry and information of different action levels; design and update clinical guideline and adjust the process to the existing resources and environment.

According to the Andalusian Ministry of Health and Social Well-being[20], the main characteristics of an Integrated Assistance Process are:

- User-centred approach,
- Involve professionals,
- Focus on the best clinical practice through Guides of Practice and development of clinical routes,
- Development of an integrated information system. According to the specialized literature and the institutional actors interviewed, a key element for a proper implementation of healthcare processes is to have necessary information to monitor each of the lines previously defined. Updated and appropriate information make possible to identify problematic situations and to make changes, aimed at improving service quality and effectiveness. Therefore, the following up of the integrated care processes must be based on an integrated information system that facilitates continuity of care through a shared health history, and to systematize the collection and analysis of information on procedures; recommendations and results related to health care as established by healthcare integrated processes. In this context, the development of digital health records (Diraya[21]) and its extension to the whole system by computerizing medical history recorded and unifying a care processes record (among the different levels of attention) has been an important step that has strongly contributed to a better integration of the services.
- The continuity of the care.
- Integration of the information is essential.

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20  http://www.juntadeandalucia.es/salud

21  Diraya is the system used by the public health system of Andalusia as the tool that collects all the electronic medical records and it is used as an information and care management support tool. Diraya integrates all the health and care information of every citizen and it is available at any place and time for the professionals related to sociosanitary assistance. Diraya is also a tool that contributes to the management of the health system.
http://www.juntadeandalucia.es/servicioandaluzdesalud/library/plantillas/externa.asp?pag=/contenidos/gestioncalidad/diraya/DossierDiraya2010_En.pdf

The participation of different actors, units and levels in the same process requires a previous knowledge of the internal relations that already exist and work to transform them into integrated relations. This is a necessary step in the integration process to guarantee a customer orientated holistic service.

Therefore, a specific model has been created where professionals, as experts, have designed (for each specific pathology or sociosanitary problem) the logical chain to provide an integral well-being and assistance action. This sequence needs to be based on the best possible practices (clinical attention) and the chain should also comprehend welfare and care procedures. Following figure show the architecture of integrated process (Figure 10).

**Figure 10.** Architecture of integrated care process (Level 0)
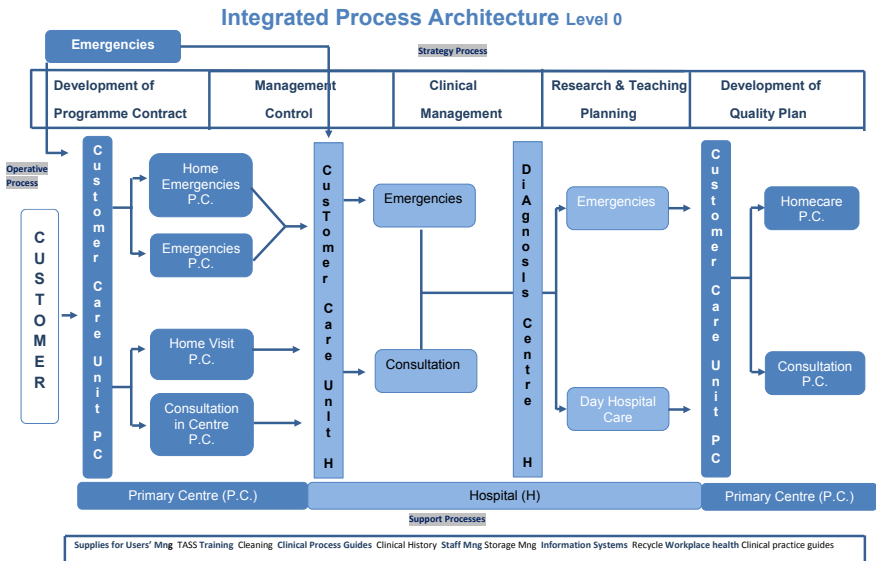


Source. Servicio Andaluz de Salud, 2009

The customer is the centre of IAP and therefore, his/her needs and expectations and crucial for the development of the IAP. A typical customer's pathway is described in the next figure (Figure 11)

**Figure 11.** Customer's general pathway in the Integrated Assistance Process

## Integrated Process (Customer's pathway)
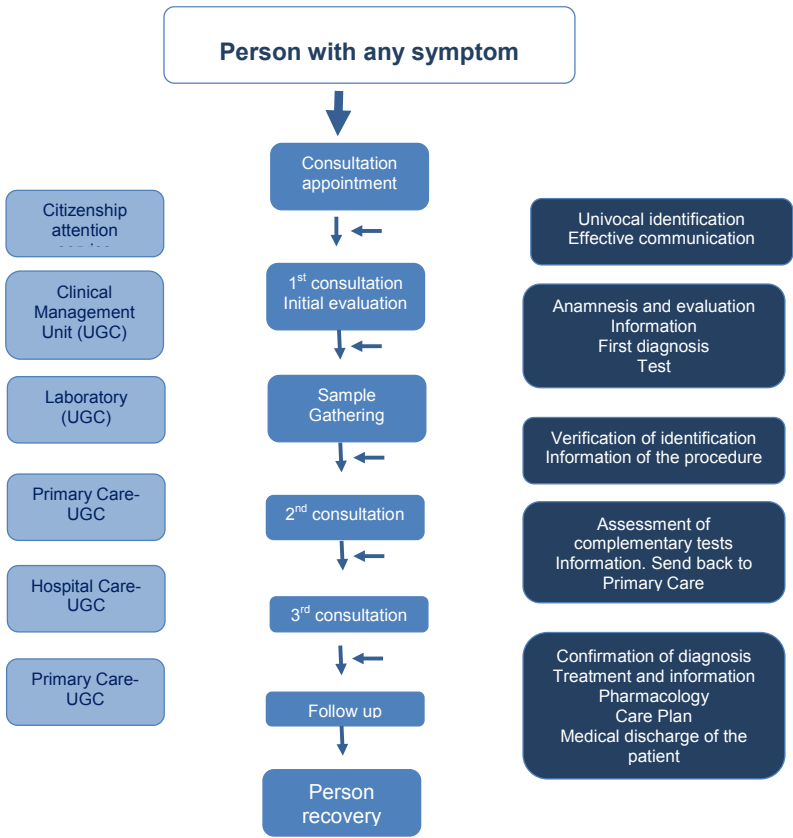
Also, several indicators have been taken into account in order to incorporate customers perspective: Primary indicators (satisfaction surveys, patient school, opinar.es saludable –webpage where customers can get information and express their opinion, download available researches, and ask queries related to the sociosanitary services); Qualitative information (focus groups have been conducted to get information from the customers in order to update and improve the system).

Structuring health care in **integrated assistance processes** meant an important step in relation to the **Unified Service Portfolio**[22] as this process seeks to overcome the difficulties related to the organizations by function or levels. Integrated processes are focused on identifying and integrating the needs of customers and on coordinating care attention and care responses. Ensuring continuity of care is the intended purpose in a portfolio process oriented both, to healthcare services, and customer needs[23].

The main objectives of Integrated Process are:

- Understanding IAP and Service Portfolio for Special Care (SPSC)[24] as a management tool that allows direct service supply according to demand (offering specific and proper attention for a particular problem).
- Ensuring compatibility of IAP and SPSC with the current development of the portfolio of services and offer clinical and care attention from different perspectives (facilities, services, processes, procedures, etc.).
- Defining the basic structure of the SPSC to ensure an updated and agile inclusion of the integrated processes.
- Setting the range of services involved in the development of each process. For example: Process implementation for Breast Cancer requires and early detection program; a system to identify and classify groups of women with a family history of breast cancer (Potential target risk group), confirmation diagnosis by single act including radiology and pathology, treatment, following-up etc.
- Ensuring consistence of content with the strategic lines of Andalusian Health Service (SAS) and explicit commitments in contracts corresponding program.
- Providing continuity of care with a special focus on the inter-phases between service levels (Contract SAS Program - Hospitals and health districts).
- Ensuring consistency of content with the strategic lines of AHS and explicit commitments in contracts corresponding program.

Thus, Integrated Assistance Process together with the approval of comprehensive Plans have been designed to improve the services and actions provided by different actors as an answer to major health problems from a holistic point of view that includes customer's well-being integrating social support and educational actions. Integrated and comprehensive plans have been designed to compile the different

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22  Please, check next point of this section.

23  Andalusian Health Service (2008)

24  Please, check next point of this section.

measures and actions adopted in a wide range of fields, in respond to major health and well-being situations[25].

## 2. Clinical management and clinical management units

Clinical management is an organizational process that seeks the integration, coordination and regulation of the resources needed on the clinical procedures, (including the professionals) in the management of these resources. It is a meeting-space for citizens and professionals to promote the autonomy and responsibility of the professional in service management. As already mentioned, process management and integrated processes requires the development of clinical management units.

In this sense, the most important progress is the cross-cutting strategies that are being carried out through comprehensive plans (from the process management point of view), as an element of strategic planning is the development of **Clinical Management Units (CMU)** by implementing and incorporating various instruments in the practice of the health and well-being assistance, articulating an integral system through partnership between professional, patients and families. Clinical Management Unit is an organizational model focused on the customer, which allows the professional more autonomy and responsibility in relation to the resource management.

Thus, Clinical Management Unit (CMU) is the environment where multidisciplinary teams addresses integrated actions of prevention, promotion, support, care and rehabilitation for the individual and family, emphasizing the effectiveness of clinical practice, the clinical leadership development, incorporating customer's views, paying attention to an efficient use of resources, transparency, boosting research and developing integrated care processes..

This approach works from the perspective of well-being as a compound, where the key factor is not only prevention and recovery but the "well-being feeling" of the customer. And this requires a transversal planning (Unifying Clinic Management and creating Integrated Assistance Processes). The final intention of this approach is to improve the recovery and well-being, always bearing in mind the customer perspective and all the elements that can be important for the customer and his/her relatives, in order to provide them the tools to establish a life project.

Following are described the key elements that are essential in this process and that are addressed in every specific program:

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25   Some highlights of the different Plans are detailed in Annex 2

- Review of the basic concepts and information (together with the patient, relatives and professionals) in order to facilitate the understanding of the situation and how to cope with it (for customers and relatives).
- Work on specific itineraries for each customer (attending to his/her profile, environment, conditions, etc.), identifying the different stages of the disease, from the diagnosis until the recovery (physical and psychological) of the customer and/or the carer.

From a general point of view, CMU system seeks to combine the knowledge of different professionals from diverse areas or working fields in order to avoid the fragmentation of the service. Therefore, it is planned and designed pursuing to concentrate and join every single area or field related to the provision of care and well-being for the customer.

Related to Andalusian Health Service division there are several levels of Clinic Management:

- Primary Care Clinic Management. Activities performed in the Primary Care level in a specific centre.
- Specialized Care Clinic Management. Activities performed at a hospital level in a specific centre/hospital.
- Mental health Clinic Management.
- Inter-centres Clinic Management. Activities performed into the same care level but in more than one district, hospital or area.
- Inter-level Clinic Management. Activities performed at different levels (primary and specialized care).

Since March 2012, a new element has been included in every CMU "Citizen Participation Commissions" (Comisiones de Participación Ciudadana). These Commissions are in charge of promoting actions related to the continuous improvement of the services and to guarantee the citizen's rights. Citizens participating in these Commissions are chosen randomly and the participation is not compulsory.

More specifically, in Costa del Sol Health District, 160 citizens are involved in 14 Citizen Participation Commissions (2012). In each Commission there are 10 people, including citizens, professionals (health and care) and the manager of the CMU.

In Costa del Sol Health District already exists: 1 "inter attention levels" CMU (Osteoarticular system); 14 CMU in Primary Health Care Centres and 6 CMU in emergency and Intensive Care Units (Junta de Andalucía, 2012).

It is also important to note that CMU have a service portfolio related to the level of assistance.

*Development of a Service portfolio*

Definition of the services portfolio can be classified from different points of view: health care and well-being services; services that are intermediate products; support services, and liaison or coordinating services.

From the perspective of the level of attention and the clinical point of view, the sector distinguishes between two levels:

- Service Portfolio for Primary Attention
- Service Portfolio for Specialized Attention

In both cases, selection criteria are similar and are the basis of the catalogue of services supplied in the well-being and sociosanitary attention. Therefore, the catalogue of services consist in the scientific, technical, administrative and providers activities that guarantee the service integration on the health and well-being sector.

- **Service Portfolio for Primary Care (SPPC).** It is articulated in the Health Programs and this Portfolio includes following criteria: target population, coverage and follow-up indicators; quality standards and specification about the information; and record system that contribute to the correct functioning of the services. It is distributed by Districts (as abovementioned in the introduction chapter). The structure of the (SPPC) is designed aiming to facilitate customer and users consultation (customers, professionals, managers, etc.) and it is focused on the care and attention homogeneity. Service Portfolio for Primary Care includes:
  - Health Care (Doctor surgery)
  - Health Care (Emergency surgery)
  - Sexual and reproductive Health Care
  - Pregnancy
  - Cardiovascular care
  - Nicotine poisoning
  - Chronicle patient Care.
  - Cancer patient Care.
  - Care for people with special needs.
  - Immunization (adults)
  - Dietetic counselling
  - Minor surgery procedures.
  - Health test for elderly people (65 years or more)
  - Health and Care assistance for gender based violence victims.
  - Care (infancy and adolescence).
- **Service Portfolio for Specialized Care (SPSC)** describes the service, clinical unites, functional units or dependent units related to each hospital or specialized centre by specialties of attention and service supply. SPSC is more complex. The structure is designed to show the availability of technologies

or knowledge areas, being more useful for professionals and managers than for the customers[26].

In this context, the introduction of the **Integrated Assistance Process**[27] (also called Assistance Process Implantation –PAI-) has been a very important step on the service integration and on the creation of a **Unified Service Portfolio (USP)** where services are no longer organized by level of attention, area or functionality. The objective of the USP is to create integral service chains by identifying the needs of the customers (and their relatives) and to coordinate the response provided by the sector in in a coordinated way.

Service integration and continuity in the assistance is the final aim of the Unified Service Portfolio, through the concept and strategy of designing Integrated Assistance Process, in which the customer and his/her necessities should be the centre of the system.

The design of a Unified Service Portfolio needs to incorporate elements for improving those aspects of the operational side, and thus the USP would be useful for a wide range of possible users and it would meet the requirements of transparency and accessibility of information.

The USP also helps the manager facilitates as it provides detailed knowledge of how professional are working in each care and assistance process and if customers are treated in an appropriate way, addressing each specific customer case.

For professionals in direct contact with the customer, the establishment of protocoled guides helps them to control the variability of the customer's situations and it also allows placing the contribution of each professional in the final outcome.

Thus, the USP acts as a helpful tool to orientate the service into a customer centred system as each process is also integrated in Process Maps (identifying customers, products and services) that complement and integrate USP with other service portfolio (SPPC, SPSC).


## 3. Competence based Management

Competency management seeks the continuous training ("lifelong") of health professional as an essential tool for the continuous improvement of the health service. Andalusian competence based management is articulated through three main processes:

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26   Annex 3 contains the Service Portfolio of the Public Health Company Costa del Sol

27   Please check previous section

- Training for professionals (Comprehensive Training Plans) to reach aiming all professional levels (undergraduates, specialists and lifelong training).
- Assessment of the results of the activity carried out by the professionals and orientation and self-assessment.
- Recognition of skills developed by professional (Skills accreditation and career accreditation).

Competence based Management encompass instruments and methods to assess current and future competencies required for the work to be performed, and to assess available competencies of the workforce and it is based on **maps of competences.**

Maps of competences are the result of the review of the Competency Maps developed by different professionals (SAS and Public Health Enterprises). These maps list exhaustively the knowledge, skills and attitudes to be considered in each professional level. The model followed by the SAS is based on Miller's Model of Competence (Figure 12).

**Figure 12.** Miller's Model of Competence
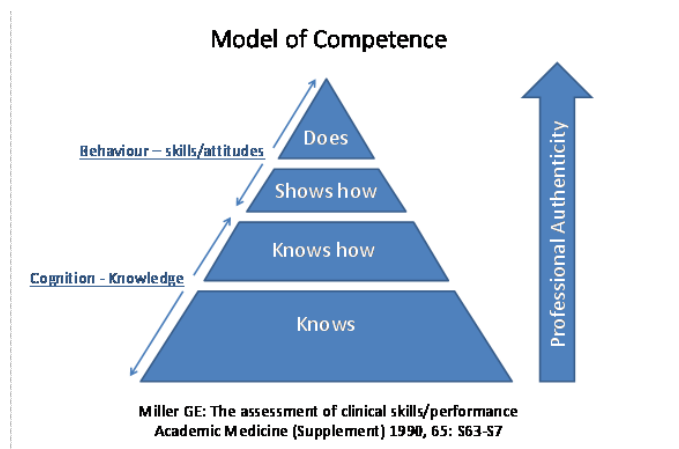


Source. Miller, G.E., 1990.

## 4. Continuous improvement and accreditation

According to the Second Healthcare Quality Plan for the Andalusian Public Health System, continuous improvement is based on the following principles:

- Assuming the needs and expectations of citizens;
- Ensuring quality management of health services;
- Ensuring quality of public health policy;

- Managing knowledge and stimulating innovation and
- Modernization of the system.

In order to achieve and improve the system, the Andalusian Health Quality Agency[28] has implemented a system of accreditation (both for entities and professionals) as a tool for continuous improvement.

These strategies are the basis of Andalusian (and therefore Costa del Sol) public health system and all of them are aimed to provide an integral and holistic service to the customers, increasing their health and well-being situation. As we will see in next chapter, this concept of service integration has a clear positive impact on how population perceive the service provided.

All these strategies are necessary in order to understand Andalusian Healthcare System and its functioning (from a general point of view and always related to the clinical and healthcare sphere) and how service integration and service concepts have been introduced and developed to provide customers and integral care and **they are also the basis of the Costa del Sol district** (as part of the Andalusian region system). Nevertheless, it is important to note that, in the case of the Public Health Company Costa del Sol, there are some special features in relation to the **management model** (not in the service concepts provision). This new management model is following described.

## 2.3. Public Health Company Costa del Sol. The new management model as a further step in the service concepts

Public Health company Costa del Sol was born as a pilot project of the Ministry of Health (Government of Andalusia) aiming to introduce different forms of hospital organization. The project is based on the application of business management tools to the public hospital sector, seeking to improve the efficiency and quality of their services and to update its organizational structure.

Nowadays, Public health company Costa del Sol manages Costa del Sol Hospital; High Resolution Centre Mijas and High Resolution Hospital in Benalmádena and its main particularity is its legal form as a public enterprise regulated by private law, meaning that even when it is a public entity (owned by the regional government), the human and material resources are managed according to the private law (for example, staff working in the hospital is not civil servants).

Also the funding of the Agency depends on contracts signed periodically with the Ministry of Health and Social Well-being (initially payment and funds are related to service provisions and service quality). Thus, Agency funding is done through

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28   http://www.juntadeandalucia.es/agenciadecalidadsanitaria/

agreement of a contract-programme between the Agency and the Ministry of Health and Social Well-being, which sets out the objectives to be achieved by the Agency and relates financing to these objectives.

The economic and finance system of the agency is focused on achieving maximum return (monetary and financial) meeting the highest levels of quality and production. The more relevant element in this area is the organizational structure.

The organizational structure of the Agency is articulated by centres, dividing each Hospital into Integrated Management Areas. Each area is in charge of the clinical management of a certain clinical sphere. Public Health company Costa del Sol was the first entity introducing the concept of Integrated Management Areas (IMA)[29]'' depending organically and functionally of the medical direction (management) and of the medical divisions, where different welfare and assistance specialities with common aims or objectives are grouped (usually by Clinical Management Units). Each one of these groups has autonomy on the management of their economic and personnel resources.

In relation to human resources a management by objectives- performance-related salary for the clinical staff has also been introduced by the Costa del Sol Public Health Company. This performance related salary scheme for the clinical staff (introducing human resources management tools as in the private sector) aimed to lead to more productivity, better quality of care and higher patient and workers satisfaction. Wages of directors (management of the hospitals) and directors of Integrated Management Areas are set by the objectives established by their contract programme (around 40% of the salary in the case of the Managing director and 35% in the case of Directors of Integrated Management Areas).

This public-private structure of the Agency allows a more flexible managerial organization, especially, in relation to some of these aspects:

- The Agency is the one in charge of the management and distribution of its liquid assets, allowing the Agency to deal with suppliers and providers payment conditions and terms.
- Budget can be distributed according the necessities of the Agency, avoiding typical restrictions and limitations related to public expenses of the public sector.
- Facilities services are provided and managed by external companies (private sector).
- Goods and services are purchased according the private law rules (free competition).

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29  This model has already been described in previous section of this chapter

A recent study that compared Costa del Sol model with a regular hospital (both depending from the Andalusian Public Health System) has found out that Costa del Sol model is "more economical and efficient" in the management of available resources, with a total cost of healthcare assistance per capita of 58 per cent less than the "non-public company" (Cámara de Cuentas de Andalucía, 2010).

## 2.4. Relation between public and private sector

As above mentioned, cooperation and relation between public and private sectors (in relation to health and care issues) in Andalusia is merely circumscribed to service provisions (Figure 13). This relation is established by two different chains:

**a. Outsourcing non-health services.** (i.e.: restaurant, laundry, cleaning services, etc.) and **purchase of supplies** (goods and services).

SAS has developed several strategies to increase efficiency in the Health Service Supply Chain. The most relevant strategies are the introduction of GS1 and SIGLO:

- The introduction of the **GS1** standards for the supply and demand chain. GS1 is a global (international) healthcare standard system that seeks to increase customer's safety (avoiding, among other questions, the provision of forged products). The final aim is to integrate the available logistic resources under a common operating model aiming to get an effective and efficient coordination in the supply and demand chain. In order to do so, the Andalusian Health Service (SAS) has carried out the following actions (Gavira, J., (2009-2010):

1. Create infrastructures to allow traceability and efficient logistics management as, for example:

- Defining and establishing requirements and symbol coding (using GS1 standards) for all the products purchased by SAS (allowing all Andalusian health centres the identification of products and provides within the supply chain).
- Creating a product (services and goods) portfolio. SAS has a product portfolio (based on an Internet Platform) where providers can access and check the relevant information.
- Validation of the coding and symbols structures used by providers in order to, on the one hand, ensure the consistency and validity of logistics information provided by suppliers, and on the other hand, to check and ensure the technical adaptation of symbols (bar codes) used by providers in their packaging and packaged.
- Purchasing policy based on prior approval of suppliers and products.
- Purchasing policy based on updated and continuous information.

2. Standardization and generalization of the requirements relating to logistics services for purchases. Reaching agreements and consensus with the main organizations representing SAS suppliers about the conditions needed for the store of products (Storage Management Agreements) and products supply (agreements about Logistic Development).

3. Identification and inventory of facilities, materials, professional resources and organizational means.

4. Identification and standardization of processes and management procedures.

- The design of **SIGLO** Platform for providers. SIGLO is a corporate (SAS) platform aimed to integrate logistic management of goods and services purchased by SAS. SIGLO helps to manage all the relationships and communications with suppliers. SIGLO is nowadays being implemented in the region (process is not finished yet). Once completely implemented, SAS providers must be registered.

**b. Partnership** (public-private agreements) for the provision of health services and specific public-private agreements such as medical transport, dialysis specialists; specific agreed assistance (Oxygen therapy, rehabilitation, surgery therapies, cancer treatment, etc.) and diagnostic services.

Partnership between public and private sector for the provision of health services is common in Andalusia but it only represents the 3.7% of the services provided by the Public System. The partnerships are mainly focused on:

- The provision of certain specific services that cannot be offered by the public system (due to several factors such as geographical dispersion or customer's special needs).
- The provision of healthcare (mainly related to major or minor surgery procedures) in the cases where it is existing a waiting list in the Public centres. (Decree 209/2001, of 18 September of the Andalusian Government – Ministry of Health and Social Well-being- establishes maximum timeouts for public healthcare service provisions –surgery-).

In both cases, the patient that needs this type of services can be referred to the private provider by the professionals of the Public Health System. The private provider delivers the intervention and sends the patient back to the Public System.

**Figure 13.** Most common cooperation (public-private) models in Andalusia (hospitals)

| Model | Private sector responsability | Public sector responsability |
|---|---|---|
| Private management of a public hospital (Public Health company Costa del Sol) | There is not private responsibility but the hospital is managed using private management tools Non clinical services are often outsourced. | Public sector finances (mainly) the hospital and its staff but staff hiring and hospital management is independent from the SAS. |
| Service Outsourcing (non-clinical services) | Provide services (including staff) for non-clinical services: Cleaning, catering, security, etc. | Public sector finance clinical services and staff (mainly civil servants) and manage the hospital |
| Service Outsourcing (clinical support services) | Provide clinical support services (radiology, laboratory, etc.) | Public sector finance clinical specialized services and staff (mainly civil servants) and manage the hospital |
| Service Outsourcing (specialized clinical services) | Provide clinical specialized or common services in those cases/situation where these services cannot be provided by the public sector | Public sector finance clinical common and specialized services and staff (mainly civil servants) and manage the hospital and provide most of the services |

Source. Own elaboration (adaptation from Cabo, S., 2012 classification)

Last, it is also relevant to note the important role that some associations have (mainly patient association[30]). Patient organizations aim to improve the quality of life for people and their families who are affected by certain health conditions. In Andalusia and Costa del Sol there is an important number of patient and patient families associations, mainly affected by a chronic diseases that are playing a key role in the system by providing advice, psychological assistance and information to patients suffering the same disease and by making information campaigns, workshops and seminars for the whole society, aimed to prevent diseases. From a general point of view, patient associations interact with the public health system (as services providers) in 4 different ways[31]:

1. Information to patients. As patients need accurate information provided by accredited professionals (associations are often advised by doctors and experts) they provide information to citizens, patients and citizens.

2. Providing services to patients that are not cover by the Public System. In some cases, associations offer care services (mainly psychological support, physiotherapy and, in some cases, residence centres) for situations where the Public Health do not offer enough assistance.

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30  Associations usually receive some subsidies from the Andalusian Government.

31  As we have already mentioned, associations also play a key role as customer's representatives in clinical decision-making and improving relationships between doctors and patients.

## 3. Social and dependency services

Most of the integrated care and well-being processes, especially those ones related to chronicle diseases, not only include the health perspective but also social and well-being aspects of the customers. This is special relevant in processes where the customer is a dependent person or he/she has a long-term disease that requires from specialized services that comprehend socioeconomic factors (as in the case of elderly citizens).

Nevertheless, while the service concepts and service integration has been highly developed in the healthcare sector, the social side of the service integration and service chains has not experienced the same itinerary (according to the literature reviewed and the perspective of the institutional stakeholder).

However, there have been several improvements in the service concepts and service integration for certain collectives, especially for elderly people and people with disability. Andalusia has developed various plans, programs and projects where there is a special emphasis on the sociosanitary care integration and coordination.

- The Act 6 of 1999 on care and protection for the elderly has regulated and ensured a comprehensive system of care and protection for the elderly.
- The I Comprehensive Care Plan for People with Disabilities of Andalucía 2003-2006 (PAIPDA) horizontal and interdepartmental plan that tries to cover all the areas of administrative intervention for people with disabilities: health, education, employment, social services, housing, accessibility, culture, sports, etc.
- The Andalusian Plan 2007-2010 for people with Alzheimer addressing patients and families affected by Alzheimer's disease from an integral perspective (social and health care). The Plan was designed together with the Association of relatives of people affected by Alzheimer or any other kind of dementia.
- The II Comprehensive Mental Health Plan in Andalusia (2008-2012) which incorporates the importance of inter-sectorial action, promoting actions at all health levels to facilitate cooperation with other sectors that play a key role in promoting mental health and in the treatment and recovery of individuals suffering mental health problems and their relatives (including social and labour topics).

More concretely, ASSDA (Andalusian Agency for Social Services and Dependency) has developed several programmes aimed at providing those groups with special services as a continuum of the health services provided. Currently, protection measures have been developed at Autonomous Community level (regional level) and local level. More concretely in Andalusia some specific programmes and

resources coexist integrating health services, social services in relation to active aging and dependency.

Among the services abovementioned, a very important step on the well-being service integration and the continuum in the service chain has been the **Integration of Social Care Records and Emergency Services**, combining social and health care for elderly and dependent people. According to ASSDA this combination includes[32]:

- A more efficient and quick system when dealing with emergency calls: reducing the time dedicated by the dispatcher centres to attend and follow up the calls and minimising the follow-up calls per case. The time saved can be dedicated to attend other users and response to additional users in need for the service.
- Avoidance of information duplication, so that the existing information can be used by both institutions (with a coordinated update of this information).
- Improved ability to detect a social care need through more effective cooperation protocols between EPES (Public Emergency Agency) and ASSDA.
- The need for providing valuable information about the user as regards health status, personal data, and further administrative emergency protocols is addressed by an automatic voice and data transfer.
- This improves the quality of the service provided to the users who receive the appropriate service as quickly as possible and who can have contact to both services (social and health) with just one call.

This integration has been completed by providing **Tele-care services** to certain groups of people (mainly elderly and dependent people) to support their independent living and granting care and safety and, therefore, improving their life quality, offering support and immediate attention to people in need of support in case of, for example, emergencies or any other attention such as help with medication or medical appointments[33] (currently provides services to approximately 200.000 users).

Tele-care is a service (which, by means of specific devices connected to the telephone network) enables, in this case, elderly people and dependent people to be permanently connected to a team of professionals to deal with their needs at all times, 24 hours a day, 365 days a year.[34]

The devices are designed for elderly people and are very easy to use. They have a fixed terminal which includes loudspeaker and microphone, normally positioned

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32   http://commonwell.eu/about-commonwell/the-commonwell-services/

33   Operators help customers with medication and medical appointments by phoning them to remind them to take their medicines or by arranging appointments with family doctors/specialists

34   http://commonwell.eu/commonwell-home/

below the user's own telephone, and a wireless terminal in the form of a pendant, both with their respective buttons. Pressing either of the two buttons (the fixed terminal button or the wireless terminal button), the elderly people make contact with a centre staffed by professionals, the telephone operators, trained to correctly attend to this group. The communication between the users and the telephone operator is 'Hand Free', i.e. when the users press the button they do not need to pick up the phone to be able to speak to the professionals, but they can communicate perfectly well remotely. The characteristics of the wireless device enables it to have sufficient scope so that the users can make contact from any part of their home, e.g. in the case of falls.

In April, 2004, the Andalusian Ministry of Health and Social Well-being has launched "Independent" a European Union pilot project launched the Independent European project, which allows access to the services of "Salud Responde"[35] to all registered tele-care customers, by pressing tele-care button. This programme integrates social and health services and provides health answers to the users and to the carers. It also allows:

- Management of appointments with the health centres (mainly primary and specialized health centres),
- Access to health advice from tele-care services
- Provide tracking service to people who require care after hospital discharge, (it has been called tele-care-continuity.

By September 2012, "Salud Responde" has already managed 1.742 cases that came from the tele-care service. It is important, in this case, to highlight the "Independent programme" user's profile: 64% of the users are older than 65 years old; 35.3% are in a dependent situation and 0.5% is people with disability. 76.1% are women and 66.3% of the users live alone.

## 3.1. Service concepts and service integration originated or improved by the approval of the dependency Law

Increasing life expectancy has led to higher expectations amongst people in the EU. Spain and Andalusia (as the rest of most of European Union Countries) is experiencing a high demographic ageing and, directly related to this population aging, the need for long-term care services has increased.

In this sense, as we have already seen, a significant step was taken in Spain to address the growing issue of dependency and to improve the quality of life of individuals relying on care and their carers by enacting rights and benefits in a dependency law - Promotion of Personal Autonomy and Care for Dependent Persons

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35   Please, check first chapter of this report

(law 39/2006). The new law established a Service Catalogue[36] (care services both at home and in care centres) and when these services are not available, dependent people may receive cash allowances. These are financial benefits linked to the service, for care in the family (if non-professional carers are hired) or for personalized care (Vaquerizo, 2010)

The integration of long-term care delivery involves creating single entry points (for customers) or local assessment teams, coordinating health and social services. These services are both offered by public and private sector (private sector usually offers chartered and non-chartered centres -previous accreditation-) and by family carers.

More concretely, in Andalusia the system has been developed together with the local level (municipalities) and especially with the involvement of Community Social Services, who are responsible to start the procedure for recognition of the dependence; the individual care proposal (ICP) and the management of home care services. Municipalities can also support with the delivery of other services from the catalogue.

Therefore, Community social services or primary care services (local level) are the ones in charge of:

- Starting the dependency recognition process (on customer request or *ex officio* or by law requirement) and they will be the Information, guidance, and advice and assessment point.
- Individual Care Proposal (ICP). Social Services make a social report of the situation of the dependent person, including:
  - Customer's background (taking into account services already provided to the customer and new services that can be provided).
  - Family situation (living in a residence centre or at home – care level provided by family or other carers), etc.
  - Environment where the customer is living (social relations of the customers, support provided by the community where he/she is living or existence of architectonic barrier/hindrance, etc.).
  - Perception of the user about his/her own situation (preferences of the customer in relation of his/her future way of living: at home/residence)
  - Social report (Conclusions about the dependent person situation and services required/suitable for him/her: The dependent person participates in all the different phases of the ICP (or family or legal mentors when the person is declared as incapable).

36   Please Check Chapter 1 for Service Catalogue

- ICP would also include information about the compatibility of the services recommended for the dependent person.

Once the ICP and Social Report are done, the Province Delegation of the Ministry of Health and Social Well-being assesses each case. The Province Delegation of the Ministry of Health and Social Well-being is in charge of:

- Requirement of the documentation prepared and completed by the Community Social Services.
- Communication on availability, if any, in Residential and Day Centres.
- If applicable, determination of the degree of cost-sharing (percentage) of the services provided assumed by the customer.
- Approval or revision of the ICP.
- Ending of procedure without resolution (death of the person before the ICP or customer's withdrawal).

When ICP is finally approved, some of the following services might be provided to the customers (Figure 14) and the service costs are shared by the user and the public administration (the percentage of co-sharing is determined by the Provincial Delegation of the Ministry of Health and Social Well-being).

**Figure 14.** Service chain for dependent people (ICP approved)
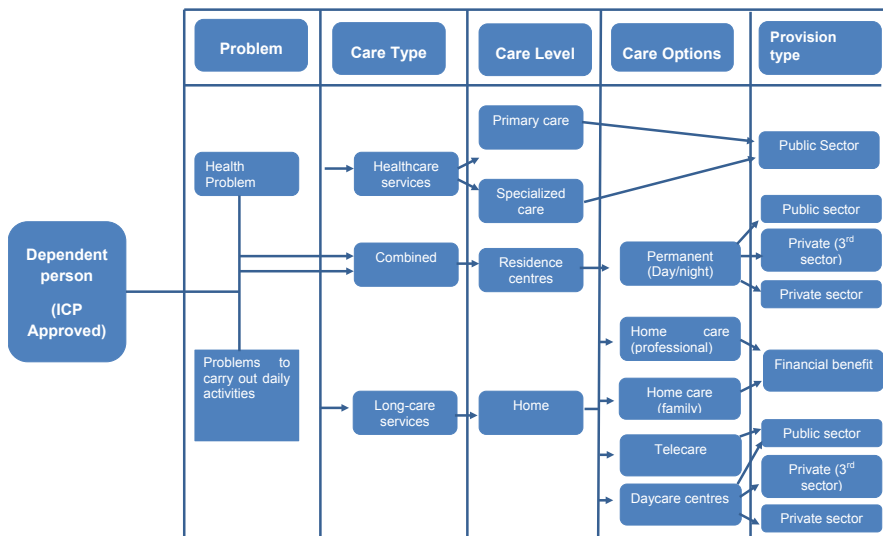


Source. Own elaboration

And Figure 15 show the service provision by customer's dependency level.

**Figure 15.** Service provision by dependency level

| Moderate dependence | High dependence | Very high dependence |
|---|---|---|
| Tele-care | Tele-care | |
| Home care (30-40 hours/week) | Home care (40-55 hours/week) | Home care (55-90 hours/week) |
| Day and night residence centres | Day and night residence centres | Day and night residence centres |
| | Residence Care | Residence Care |
| Economic benefits related to service provisions | Economic benefits related to service provisions | Economic benefits related to service provisions |
| Economic benefits related to home care services (provided by relatives) | Economic benefits related to home care services (provided by relatives) | Economic benefits related to home care services (provided by relatives) |
| | | Economic benefits related to personal care |

Source. Own elaboration

Day and night centres offer comprehensive care during the day or night to the dependent person, aiming to improve or maintain the highest possible level of personal autonomy and supporting families or carers, covering the needs of counselling, prevention, rehabilitation, guidance for the promotion of autonomy, enablement or assistance and personal care, and include (Gutiérrez, M.F. et al, 2010):

- Day centres for elderly people.
- Day centres for dependent (disabled) persons under the age of 65 years.
- Day centres with specialized care.
- Night Centres.

Residence care might be provided on a permanent or temporary basis. It includes:

- Residence for dependent elderly people.
- Residence care adapted to the type and dependency degree and the intensity of care required by the person.

When the Andalusian Public System (Autonomous Community) is not able to offer these services, the dependent person is entitled to receive **financial benefits**. There are three types of financial benefits:

**1. Economic benefits linked to the service**, received on a regular basis, are only granted when access to a public or subsidised care service is not available, and depends on the degree and level of dependency and on the beneficiary's economic status.

**2. Economic benefits for care in the family** (support for non-professional carers). A financial benefit for family care is granted when the beneficiary is being cared by a relative at home and as long as the home meets requirements regarding co-habitation and habitability.

**3. Economic benefits for personalised care**. Its objective is to contribute to the hiring of a personal assistant, for a number of hours, in order to provide the beneficiary with access to education and employment, as well as a more autonomous life in the exercise of basic daily living activities.

## 3.2. Relations between public and private sector

As above mentioned in the first chapter of this report, social services can be offered from different administration levels (regional, province or local) and from the public and private sector. Andalusian and Spanish Social Services is a public responsibility system that combines public and private service provision. Therefore, the relations between public and private sector are more intense in the social sphere than in the health sector but mainly characterized by a high private participation but contracted by the public administration.

Mainly, the most common way of establishing relation with private sector (non-third sector) is by outsourcing services to private providers (providers must be accredited by the regional government and meet, at least, the same quality standards than services provided by the public sector). The relations, then, are mainly customer-provider based. Responsibility for service provided is not shared as the public sector is the one designing and implementing the service conditions and, finally, it is the one responsible of customer's well-being and security, while the private sector it is only responsible for providing the material aspects related to the provision of the public service (or part of the service) contracted, meeting the quality standards already established by the public system.

More interesting is the relation between the third sector and the public system. Third sector (associations, foundations, NGO's, etc.) is playing a key role in the provision of services that the public sector is not covering/offering, mainly referred to most vulnerable society groups. As we have already seen, the construction and development of the social welfare state in Spain (and, therefore, in Andalusia) is recent (90's decade). Previously, most of the services were provided by charity entities and this fact has an important effect on the evolution of the social service sector, as some of these charity entities have been integrated into the social affairs system (by private-public relationship) as, in the beginning of the construction of the public social sector, the public system was underdeveloped and needed to incorporate these entities.

Third sector entities related to the social matters are highly heterogeneous (customer associations, religious entities, civil society, trade-unions, NGO's, social corporative actions carried out by some companies, etc.). In order to articulate this relation, on the one hand, respecting the diversity of entities and their characteristics but, at the same time, securing a minimum quality standard of the services offered by them, the relations have been usually established by collaboration agreements as an instrument to set out the minimum requirements for the service provisions.

But there are also other factors why the service provision of social services made by the Third Sector is highly important and compliments the Public Sector Service provision:

- Proximity: The Third Sector organizations are embedded in the social reality of towns and cities, and they are highly well-known and recognized contributing the citizens feeling of proximity.
- The insertion of Third Sector into social networks: The existence of social networks of cooperation, both formal and informal is more visible in the Third Sector than in the Public one.

Nevertheless, in Andalusia (and Spain), Third Sector is mainly funded by the own Public Sector (Autonomous and National government) and therefore, in the current economic situation, there is a great concern about their sustainability. Some academic studies note that 85% dot the associations and 69% of the foundations receive public funding and in most of the cases, this public funding is their main economic resource (Espadas, M.A, 2006)[37].

This way of relation between public and private (both third and non-third sector) also applies in relation to dependency, where services are configured as a network for public use that integrates public and private services, especially in relation to the centres, on a coordinated basis. Thus, centres can be owned and managed by:

- The regional government.
- Provincial and local government.
- Third sector entities (approved and accredited by the regional government).
- Private sector entities (approved and accredited by the regional government).

To conclude, Associations, Foundations and NGO's are satisfying necessities that are not being provided by the public sector and detecting new needs of the population well-being, mainly the provision of services to the most vulnerable groups but the dependency on public funding questions the future of this kind of partnership (in relation to sustainability of the system) in a context where Andalusian public sector has serious economic and financial problems.

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37  Some exceptions can be found in relation to the funding of certain Foundations and Associations as the case of CUDECA, described in the Best Practice Chapter.

# CHAPTER 3. CUSTOMERS PERSPECTIVE

## 1. Introduction

Quality not only implies that customers receive a secure and scientific founded attention, but also, it implies (among other considerations) that this attention is provided in time, in a coordinated way, taking into account the customer's point of view and preserving the equity. Therefore, there are several dimensions to be achieved in order to be able to articulate a wide and global concept of quality in the sanitary and social attention and of the well-being system.

Before, during, and after service delivery, service organizations set customer expectations. These expectations relate to the service, as well as to the nature, duration, and flexibility during the service process

Thus, customer experience is one of the key points in order to assess quality of services provided. In relation to this topic, Andalusian government has designed and developed a series of tools aimed to address customer's degree of satisfaction (assessment). In order to complete and complement the quantitative methodology (customer's satisfaction degree) qualitative information obtained by in-depth interviews with customer's and main customer's associations have been carried out.

## 2. Quantitative approach. Quality assessment of Andalusian healthcare system.

### 2.1. Measuring the quality

In order to measure the quality of health services provided to customers (customer's perception and customer's degree of satisfaction), the Ministry for Health and Well-being makes periodically (once per year) satisfaction surveys. These surveys provide quantitative information, offering objective quantification and assessment of the quality perceived by the users. These surveys are also the basis for the construction of synthetic indicators, which contribute to identify weaknesses and areas to improve in the system.

Thus, the Andalusian Health Service has incorporated the quality perceived by the users as a management and evaluation line of healthcare institutions, as survey results are a powerful tool to get information about user's demands and centres and system results, and to introduce specific improvement plans.

Measuring the user's satisfaction regarding the healthcare public sector was a project that started on 1.999 and since then, these are its main objectives:

- Getting updated information about the opinions, attitudes and expectations of the Andalusian population about the Andalusian Health System (in general terms).

- Andalusian Public Health System user's assessment (primary care services and hospital care services).
- Building specific indicators and general indexes in order to get accurate information about the strengths and weaknesses of the whole system from the point of view of the different types of users and patients.
- Observing and assessing the different aspects of the system, considering its main organizational units: primary care and hospital care.
- Classifying and locating each unit attending the user's assessment.
- Analysing the influence of different organizational and socio-demographic variables of the users in relation to their opinions and satisfaction with health services.
- Construction of a system for collecting and analysing information adaptable to periodic management mechanisms of the SSPA (Andalusian Public Health System), by using homogeneous and stable criteria in order to observe the evolution of the system.

Instruments and data collection mechanisms have been synthetized into three different surveys: primary care services users' survey, another survey addressing users who have required hospital admission/stay and, finally, survey to citizens that have used the services provided by high resolution hospital.

**a. Primary care survey**. Target population is people who have used any of the clinics or health centres in any Primary Care District. Survey was carried out in 939 sample points (regardless the type of primary care health centre). Data collection was compiled inside the primary care centres once the user finished his/her visit to:

- family doctor,
- paediatrician or
- nurse,

In 2011 a total of **14,610 personal interviews were carried out** (proportionally distributed according to the type of facility, municipality population size and users profile (age and gender).

**b. Hospitals**. Target group are users who have been admitted in a hospital and stayed for at least one night. In 2011, the number of sample points (hospitals) was 38 and a total of 7,443 interviews were carried out (computer-assisted telephone interviews).

**c. High resolution hospitals**. A specific questionnaire has been designed for this survey. Target group are users who have been admitted in a high resolution hospital and stayed at least one night. In 2011, the number of sample points (high resolution hospitals) was 10 and 1,339 interviews were carried out (computer-assisted telephone interviews).

## 2.2. Managing the quality system

The purpose of these surveys is not only focused on obtaining user's opinions and perception about until what extent they are satisfied with the public health services they have received but also, these surveys are used to set goals to improve the system management by establishing accurate measures to increase customer's degree of satisfaction in the cases when they were significantly low, and by solving the problems that are causing negative evaluations.

In order to clearly identify areas for improvement, different synthetic indicators have been developed by using a selection of the items collected in the surveys. As an example, following you can find how the information is selected and used in the case of primary care centres surveys (Figure 16).

**Figure 16.** Synthetic indicator of user satisfaction (for primary care users)

| SYNTHETIC INDICATOR OF USER SATISFACTION | | | | |
|---|---|---|---|---|
| **Synthetic indicator of Primary Care User** (Using SERVQUAL MODEL (1). 5 dimensions and 27 statistical weight items) | | | | |
| Category | Variable | Weight | | % Satisfaction |
| **Tangible elements** | Q7 | 3 | Building and facilities comfort | |
| | Q8_1 | 3 | Area/space (centre) | |
| | Q8_2 | 3 | Cleanliness (centre) | |
| | Q8_3 | 3 | Ventilation (centre) | |
| | Q8_4 | 3 | Comfort of the seats (centres) | |
| | Q10 | 3 | Preservation (centres) | |
| | | 18 | **INDEX OF TANGIBLE ELEMENTS** | |
| **Empathy** | Q26 | 2 | Centre organization | |
| | Q28 | 4 | Respect (behaviour) | |
| | Q29 | 4 | Willingness to active listen | |
| | Q30_4 | 4 | Staff Assessment (administrative staff) | |
| | Q45_4 | 3 | Information provided (by administrative staff) | |
| | Q45_5 | 4 | User's treatment and attention (administrative staff) | |
| | | 21 | **INDEX OF EMPATHY** | |

| | | | | |
|---|---|---|---|---|
| | Q2 | 3 | Satisfaction with the service provided | |
| | Q12 | 4 | Satisfaction with medical consultation length | |
| | Q17 | 2 | Information provided (by doctor or paediatrician) | |
| **Reliability** | Q30_1 | 4 | Staff Assessment (family doctors) | |
| | Q54 | 3 | Would you recommend this centre? | |
| | Q55 | 5 | Would you recommend your doctor/paediatrician? | |
| | | 21 | **INDEX OF RELIABILITY** | |
| | Q5 | 4 | Easiness related to paperwork | |
| | Q45_1 | 5 | Doctor's appointment system (administrative staff) | |
| **Response capability** | Q45_2 | 6 | Specialist doctor's appointment system (administrative staff) | |
| | Q45_3 | 5 | Administrative paperwork (administrative staff) | |
| | | 20 | **INDEX OF RESPONSE CAPABILITY** | |
| | Q13 | 3 | Degree of privacy | |
| | Q20 | 3 | Trust in care and assistance | |
| | Q27 | 6 | Confidentiality and professional secret | |
| **Security** | Q31 | 3 | Information about services and medical treatment | |
| | Q32 | 5 | User's opinion is asked | |
| | | 20 | **INDEX OF SECURITY** | |
| | | | **INDEX OF USERS' SATISFACTION (GENERAL)** | |

Source. Servicio Andaluz de Salud, 2011

(1) There is a diagram on Annex 4 explaining SERVQUAL MODEL

These indicators are essential to give information to each centre about the weaknesses that must be improved. For example, a centre might perform well in the categories related to tangible elements and reliability but needs to improve in security, empathy and response capability categories. And, therefore, the actions and improvement plans designed by this centre should address these specific areas to raise user's satisfaction levels. Improvement plans should at least contain: actions and tasks to be done; schedule for actions and tasks and assessment procedures for actions and tasks.

## 2.3. Results in Costa del Sol Health District

This section presents the main results obtained by the satisfaction surveys conducted in primary care centres and hospitals in Costa del Sol. Each survey provides information on a large number of variables related to user satisfaction (see complete tables in Annex 5), and allows comparing Costa del Sol Health District results with the average results obtained for the whole Autonomous Community (Andalusia).

Based on the results of satisfaction surveys, the main conclusions regarding the quality of care received by users are (Figure 17) [38]:

1. The **satisfaction levels of users of primary care services are lower than average levels of Andalusia** in almost all variables considered. Nevertheless, it is important to note that the average levels of user's satisfaction with the services are very high in Andalusia. In fact, 92.8% would recommend their assigned primary centre (85.5% in the District Costa del Sol) and 91.5% of users are satisfied with the service received (86.9% in Costa del Sol). These two indicators summarize the high level of user's satisfaction.

The greatest differences between Costa del Sol Health District user's satisfaction and Andalusian ones are related to the low score given to:

- Facilities,
- The degree of reliability on the assistance (service provided),
- Staff (administrative staff) assessment,
- Staff (social workers) assessment,
- Staff (nurses) assessment.

**Figure 17.** Costa del Sol user's degree of satisfaction. Primary Care Services. 2011
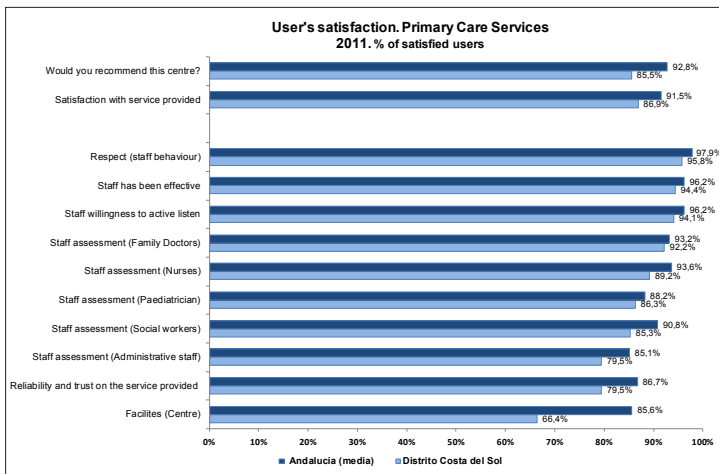


Source. Servicio Andaluz de Salud, 2011

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38  There are other studies that offer different (more modest) results, regarding to user's degree of satisfaction for Andalusian Autonomous Community. For more information please check this link: http://www.aeval.es/export/sites/aeval/comun/pdf/calidad/informes/agenda_publica_2010.pdf

2. The **user satisfaction with health services provided at the Hospital Costa del Sol is very high and superior in almost every aspect** analysed than the percentage obtained by the average of Andalusian hospitals. 94.9% of Hospital Costa del Sol users would recommend the hospital (92.3% in Andalusia) and 90.2% are satisfied with the service received (89.4% in Andalusia). Among the specific services, it is important to highlight the services received during childbirth (delivery) as the percentage of users satisfied with the service reached 94.2% versus 87.5% in Andalusia.

In general, assessment about all health and non-sanitary professionals (staff) is very high and above average in comparison to the Andalusian general one, but the most significant differences are found in the general assessment of the facilities and the confidence in the care received (Figure 18).

**Figure 18.** Costa del Sol user's degree of satisfaction. Hospital Costa del Sol. 2011



User's satisfaction. Hospital Services
2011. % of satisfied users

| | Andalucía (media hospitales) | Hospital Costa del Sol |
|---|---|---|
| Would you recommend this hospital? | 92,3% | 94,9% |
| Satisfaction with service provided (in relation to delivery/birth) | 87,5% | 94,2% |
| Satisfaction with service provided | 89,4% | 90,2% |
| Staff assessment (Doctors) | 90,8% | 92,4% |
| Staff assessment (Orderly) | 87,5% | 92,4% |
| Staff assessment (Nursing assistants) | 88,8% | 92,3% |
| Respect (staff behaviour) | 90,1% | 90,9% |
| Staff assessment (Nurses) | 88,1% | 89,7% |
| Staff assessment (Administrative staff) | 85,6% | 88,3% |
| Facilites (Centre) | 80,0% | 86,6% |
| Reliability and trust on the service provided | 76,3% | 82,8% |

Source. Servicio Andaluz de Salud, 2011

3. The degree of **user satisfaction in relation to High Resolution Hospitals is the highest of all the analysed services from the Andalusian Health System** (both in Costa del Sol Hospital and in the whole Andalusian region). 98.5% of users would recommend the High Resolution Hospital of Benalmádena and 97.8% said they were satisfied with the service received (these percentages were 93.5% and 94.1% in the case of Andalusian region).

Like in the Costa del Sol Hospital, the assessment of health and non-sanitary staff is very high and, in any case, higher than that obtained in similar Andalusian hospitals. Again, the largest differences are observed in the confidence and trust about the care and assistance provided (82.8% in Benalmádena HAR compared to 76.3% on Andalusian average) and in the facilities assessment (Figure 19).

**Figure 19.** Costa del Sol user's degree of satisfaction. High Resolution Hospital (Benalmádena). 2011
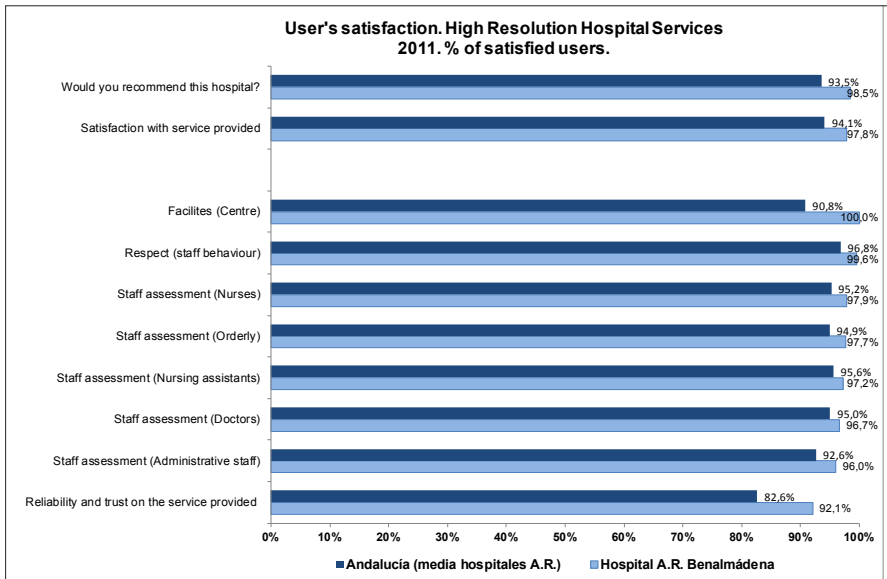
## 3. Quantitative approach.
## Quality assessment of Andalusian Social Services

In relation to social sphere, less development of the social protection system is also noted in relation to the assessment of services provided. There are few data available about the customer's degree satisfaction and these data only refer to certain services.

Actually, public information about customer's degree of satisfaction with social services received only refers to tele-care service and the available information only presents a general overview about the regional results. In any case, and according to this data, the results are:

- Tele-care service is evaluated with 9.8 point (10 is the maximum) by the users. Among others, users highlight the care and attention provided by tele-care staff during the service and the frequency they are contacted by tele-care professionals. They also make a positive assessment about the technical questions and the easiness to use and access the service.
- Moreover, 83% of the users declare that they are satisfied with the service provided, mainly, because they feel more secure and accompanied at home. Also, 94% of them think that service is easy to use and whenever they have required any help, they have been properly attended.

Commonwell programme[39] has also assessed tele-care (ASSDA) user´s degree of satisfaction in relation to two questions: Feeling of assistance during emergency call and Degree of satisfaction with emergency call handling. Figure 20 and Figure 21 show the very positive results.

**Figure 20.** Feeling of assistance during emergency call
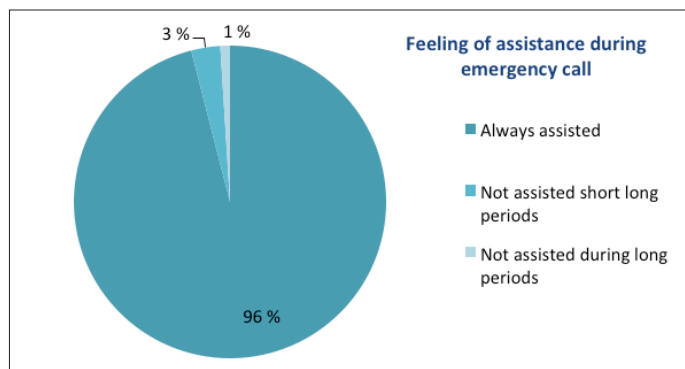


Source. Common Platform Services for Aging Well in Europe

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39   http://commonwell.eu/fileadmin/CommonWell/documents/CommonWell_CBA_Andalucia.pdf

**Figure 21.** Satisfaction with emergency call handling
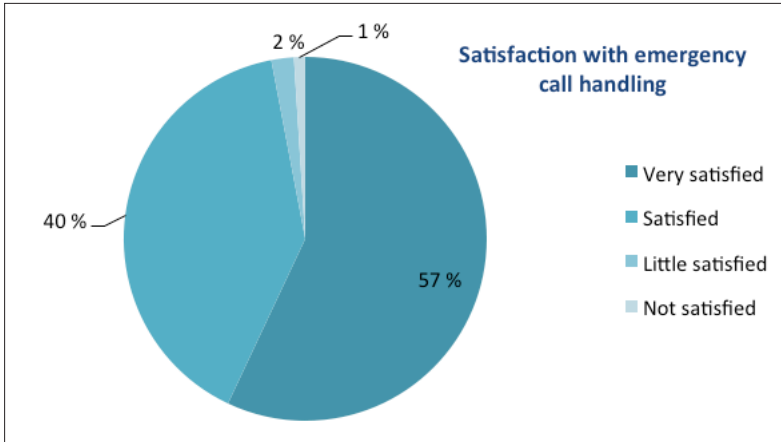


Source. Common Platform Services for Aging Well in Europe

There is also very little information about the degree of satisfaction of the dependency service but, in this case, the only information available is that these services are very positively evaluated, the public services better considered by the citizens (ASSDA, Junta de Andalucía[40]), especially in relation to the service provision (tele-care, residence, day and night centres). Even though, economic support is not as well considered as the other measures.

From the local level, Malaga's city council assesses user's degree of satisfaction from a general point of view. Following figure shows the good assessment results obtained in the last two years (Figure 22).

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40  http://www.juntadeandalucia.es/agenciadeserviciossocialesydependencia/es/noticias/not_040511/
   wfnews_view_pub

**Figure 22.** Social Services user's degree of satisfaction. Málaga
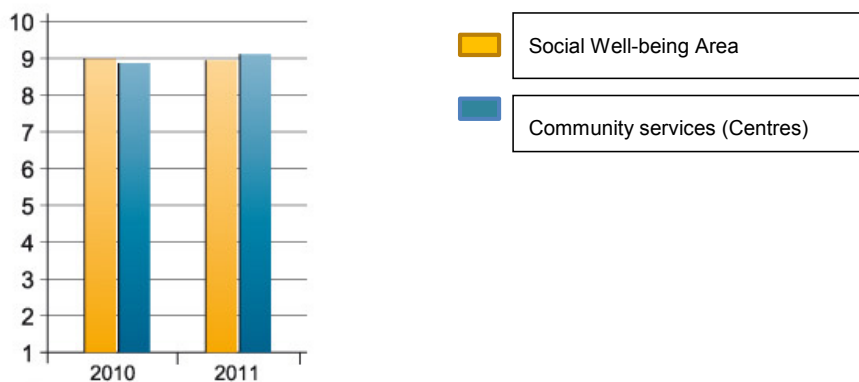


Source. Málaga City Council, 2011[41]

## 4. Qualitative approach.
## Quality assessment of Andalusian Well-being Services

From a qualitative point of view, information about degree of satisfaction has been gathered during the interviews with customers and user's associations. The information provided by the actors interviewed is complementary to the quantitative analysis and, in this case, it confirms the good results that surveys shows about the customer's degree of satisfaction provided by the Health System.

There is consensus among the actors interviewed about the high degree of satisfaction with the services provided by the Healthcare System in relation to the clinical care. They considered that population clinical health needs are covered by the system and they do not detect any difference when the service is provided directly by the Public Health System or when they are diverted to the private sector.

It is different when we talk about a more comprehensive care which would include the psychological and social aspects of the health care. Customers think that psychological care is not really well integrated into the Health System, except in the cases where there is a serious mental disorder. From their point of view, third sector (especially patient associations but not only) are the ones that are really supporting the psychological and social aspects and there is a break in the service chain as third sector is not always capable (due to the lack of resources) to provide those services to the whole society or to reach certain type of customers who, due to their profile (rural habitants, elderly people with few access to information about

41   http://www.malaga.eu/recursos/sociales/bsocial/memoria_2011/

existing resources, vulnerable groups such as migrants in an illegal situation, etc.) do not accede to associations services easily. Thus, social services are not being offered on equity bases as they are not covering all the population needs.

Customers interviewed in general agreed about the important and positive step that meant the introduction of the Integrated Assistance Process (IAP) as it unifies all the clinical care process by type of problem. But it is also important to note that some interviewees point out that the IAP has not been extended yet to all health situations (diseases) and, therefore, the attention for those diseases that do not have an Integrated Assistance Process are not being provided in such a coordinated and integral way.

On the other hand, customers highlight the good results of the High Resolution Hospitals as they have introduced a new way of understanding the care provision and they have contributed to the equity in the effective access to services of the population (especially for residents in rural areas). High Resolution Hospitals are also very positively assessed by the healthcare professionals interviewed.

On the other hand they positively assess some initiatives carried out to support customer's and their families but they also considered that they are not covering all the population necessities as they are addressing only certain customer's profiles and/or sicknesses (a selection of Best Practices identified by the interviews and through Literature Review is presented in Chapter 5).

From the social aspect, there is a general shared opinion about the minor development of the social sector but this feeling is mitigated by the lower expectations (in comparison to the health services expectations) that the customer's interviewed have about the provision of this kind of services. That is to say, the interviewees have a clear perspective about the necessity of increase the number and the quality of social services but, at the same time, they declare that Andalusian society, in general, have lower expectation about public social services. The critics about social services are not so much related to their quality (when they are delivered) but about the lack of resources to provide services to the whole population or the total absence of some kind of services (except the ones provided directly by the private profit market).

Still the system is not providing an integral care to the customers as they declare that even when the clinical part of the attention is highly covered by the existing resources and for the whole society, the social and psychological aspects of the well-being are not being attended in the same way.

Nevertheless, several actions have been carried out in order to move from a fragmented framework, in which the customer receives the social services and health

separately, to a new model of shared responsibility. The most important development on this area has been related to the approval of the Law on Promotion of Personal Autonomy and Care for People in a Dependent situation, which has implied a higher coordination of the Sociosanitary services provided to the dependent people and their carers.

In relation to services provided for dependent people, there is a general feeling about the improvement that the Law on Promotion of Personal Autonomy and Care for People in a Dependent has introduced and, actually, these are service best assessed by customers in the social sector. Nevertheless, interviewees say that even when the system and the service portfolio has clearly been improved for those ones that have been officially declared as dependent; they find a notable obstacle in the process to obtain the certification (that allows the customer to access to services), motivated by the long waiting times (lack of resources) and the paperwork related to the certification. Also there is a general concern about the future as, at this moment, the economic situation has implied a paralysation of the cases that are in the process to be certificated.

As in the case of Health services, when we asked about the provision of services by private entities, the interviewees declare that they do not find any difference in the quality of the delivery.

As a conclusion, it is important to note that there is a big concern about the effects that the economic crisis will have on the well-being sector. The current Spanish and Andalusian economic and financial situation has been present in the discourse of all the interviewees and, sometimes, it introduced some difficulties to get information about other matters (especially in relation to the sustainability of the system, but not only) as it is articulating and creating a new discursive scenario.

# CHAPTER 4. RESOURCES AND EFFICENCY

# 1. Resources

It is obvious to say that effectiveness has a strong relation to the resources (economic, material and human) allocated. Information (when available) about human and material resources allocated to well-being sector have already been mentioned on previous chapter of this report. Therefore, as a general orientation and before assessing Andalusian public well-being polices, next figures show the economic resources allocated (general budget) by the regional government to the different sectors/areas.

Figure 23 presents the general budget approved for 2013 and figure 24 the detail for the sectors analysed in this study.

As we can see, best assessed areas (by customers and institutional agents) have allocated more economic resources. Thus, health area represents 27.3% of the total expenditure of Andalusian Regional Government, being the most funded area. On the contrary, Social Protection only represents 6.6% of the budget.

**Figure 23.** Andalusian General Budget by main areas. 2013

| AREA | | TOTAL (EUROS) | % |
|------|------|------|------|
| 0.1 | Public Debt | 3.581.617.880 | 11,66 |
| 1.1 | High Managers of Andalusian Regional Government | 124.376.793 | 0,41 |
| 1.2 | General Civil Service (Regional Government) | 37.408.772 | 0,12 |
| 1.4 | Justice | 417.168.130 | 1,36 |
| 2.2 | Civil protection and security | 55.437.258 | 0,18 |
| 3.1 | Social Security and Social Protection | 2.037.259.382 | 6,63 |
| 3.2 | Social promotion (Employment) | 825.266.703 | 2,69 |
| 4.1 | Health | 8.384.670.968 | 27,31 |
| 4.2 | Education | 6.573.354.253 | 21,41 |
| 4.3 | Urbanism and Dwelling | 143.505.608 | 0,47 |
| 4.4 | Community Welfare | 411.270.711 | 1,34 |
| 4.5 | Culture | 180.576.334 | 0,59 |
| 4.6 | Sports | 39.087.666 | 0,13 |
| 5.1 | Basic infrastructures and transport | 826.577.033 | 2,69 |
| 5.2 | Communication | 151.401.073 | 0,49 |
| 5.4 | Research, Innovation and Knowledge Society | 588.497.497 | 1,92 |
| 6.1 | Economic Regulation | 377.729.441 | 1,23 |

| 6.3 | Finance Regulation | 28.435.927 | 0,09 |
|------|------|------|------|
| 7.1 | Agriculture, Cattle industry and Fisheries | 2.313.209.689 | 7,53 |
| 7.2 | Corporate and Business Help | 271.973.165 | 0,89 |
| 7.3 | Energy and Mining | 82.513.262 | 0,27 |
| 7.5 | Tourism | 105.270.237 | 0,34 |
| 7.6 | Commerce | 13.847.527 | 0,05 |
| 8.1 | Local governments relationships | 3.084.813.641 | 10,05 |
| 8.2 | European Union relationships and support to developing countries | 51.433.876 | 0,17 |
| **TOTAL** | | 30.706.702.826 | 100,00 |

Source. Consejería de Salud y Bienestar. Junta de Andalucía, 2013

Analysis by subareas shows the budget distribution of health and social sector areas. Thus, the main expenditure in the Health sector refers to Healthcare service provision and in the case of the Social Services, Dependency, Disability and Active Aging represent more than the half of the budget (as we have seen dependency related services are the one better assessed by customers in the social sphere) (Figure 24).

**Figure 24.** Health and Social Protection Budget (subareas). 2012.

| HEALTH | | |
|------|------|------|
| General Services and Management (Health Area) | 71.175.658 | 0,76 |
| Education, training and lifelong training | 179.813.179 | 1,9 |
| Healthcare | 7.001.873.214 | 75,0 |
| Public Health and Participation | 28.244.654 | 0,3 |
| Hemotherapy | 49.226.381 | 0,5 |
| Organ transplant | 9.188.460 | 0,1 |
| Complementary services and pharmacology services | 1.930.751.191 | 20,7 |
| Finance and Planning | 8.785.201 | 0,1 |
| Healthcare services inspections | 10.116.959 | 0,1 |
| Quality and modernization policy | 40.870.904 | 0,4 |
| **TOTAL** | 9.330.045.801 | 100,00 |
| **SOCIAL PROTECTION** | **EUROS** | **%** |
| General services and management (Equality and Social Well-being sub-area) | 74.640.699 | 3,4 |
| Drug addiction Plan. | 43.976.064 | 2,0 |
| Infancy | 168.044.624 | 7,6 |

| | | |
|---|---|---|
| Pensions (retirement) | 39.660.740 | 1,8 |
| Social Well-being | 102.416.551 | 4,6 |
| Voluntary work and "Andalusian citizens around the world" programme | 4.640.842 | 0,2 |
| Migrant Policies Coordination | 15.883.320 | 0,7 |
| Youth justice and juridical services | 91.827.768 | 4,1 |
| Family support services | 484.562.773 | 21,8 |
| Dependency, active aging and disability | 1.187.048.145 | 53,4 |
| Prevention and integral protection against gender based violence | 8.637.358 | 0,4 |
| **TOTAL** | 2.221.338.884 | 100,0 |

Source. Consejería de Salud y Bienestar. Junta de Andalucía, 2013

## 2. Assessment of Andalusian Health Public Policies

Andalusia Government assess periodically [42] (Junta de Andalucía, 2012) the Public Andalusian System of Health from a quality point of view. The latest results have been recently published (2012). For the evaluation 9 criteria are taking into account:

1. Equity
2. Efficiency
3. Accessibility
4. Effectiveness
5. Customer experience
6. Security
7. Coordination
8. System's capability (sustainability).
9. Innovation

Each of these 9 criteria is composed by around a dozen indicators, comparing each indicator with the ones obtained by in the Spanish system (average) and in some cases with International data. In that way, it is possible to assess the Andalusian health system in relative terms.

A selection of indicators used to measure three basic areas or criteria considered as basic for the health system service provision: efficiency, effectiveness and equity are following presented.[43]. These indicators have been selected as, from our point

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42  http://www.calidadsaludandalucia.es/docs/resultados_y_calidad_del_sistema_sanitario_publico_ de_andalucia_2012.pdf

43   Although this chapter only provides information about selected indicators, more information can be found about the rest of indicators used by the Andalusian Health Quality Agency on the following link: http://www.calidadsaludandalucia.es/es/index.html

of view, they might be the more relevant ones for the objectives of this report (either because these indicators allow international comparison or because the possibility to check their temporal evolution).

## 2.1. Efficiency

In order to assess the efficiency of the Andalusian Public Health System, several perspectives can be taken into account. In this sense, a set of indicators have been developed in relation to:

- Dimension of public health expenditure;
- More rational use of resources;
- Resolution of processes in environments with a lower cost;
- Development of information systems that enable improvements in process management and professional's productivity.

These indicators offer an overview of the effort that has been done in recent years to increase efficiency in relation to a rational use of resources, while ensuring the maintenance of quality in healthcare. The information is also complemented with the customer's assessment about the system efficiency and sustainability of the public health system.

a) From the point of view **of public health expenditure**, efficiency is assessed using indicators that measure:

- The expenditure of Andalusian Public Health system (on GDP basis and per protected person);
- The percentage that goes to general administration; or other indicators that relate public health spending with activity levels in the primary or specialized services or with effective results (Figure 25).

**Figure 25.** Public Health Expenditure in relation to GDP. Andalusia, Spain, International countries (2009)
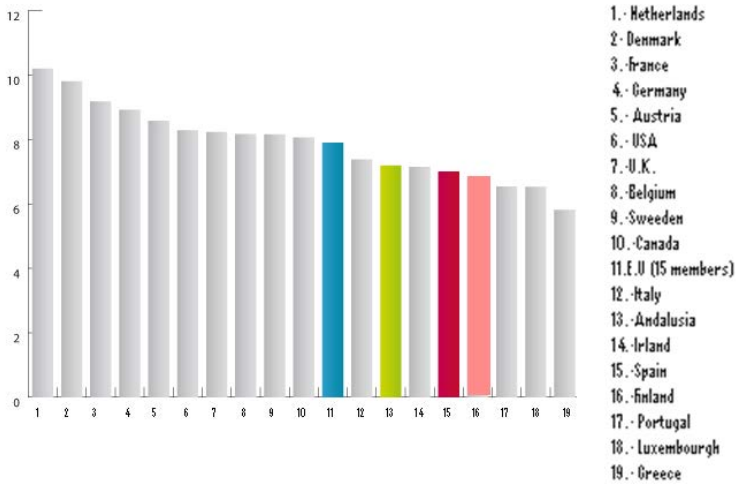
b) Efficiency assessment using the approach of the **rational use of resources** is obtained by using indicators related to pharmaceutical expenditure and the substance prescription. The incorporation of new information systems that promote efficient management of processes is assessed using indicators that show the costs and benefits arising from the implementation of the Integrated Management System (Process Management and Clinical Management) and Information for Healthcare.

c) Efficiency assessment from the point of view of **resolution of processes in environments with a lower cost** is obtained by using indicators such as outpatient surgery and its contribution to the efficiency of surgical operations, from the point of view of improving the productivity of professionals but also, in terms of management of sick leave related to temporary disabilities (Figure 26).

**Figure 26.** Outpatient surgery in Andalusia 2000-2010
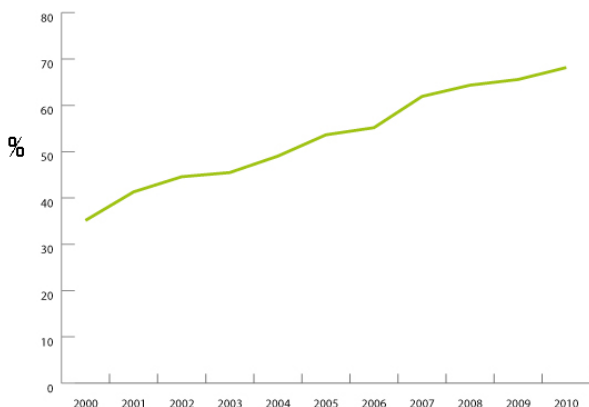
d) Finally, the view and perception of citizens about healthcare efficiency and sustainability of the public health system is also taken into account. (Figure 27)

**Figure 27.** To what extent do you think healthcare is efficient? Andalusia, Spain, International. 2008-2009
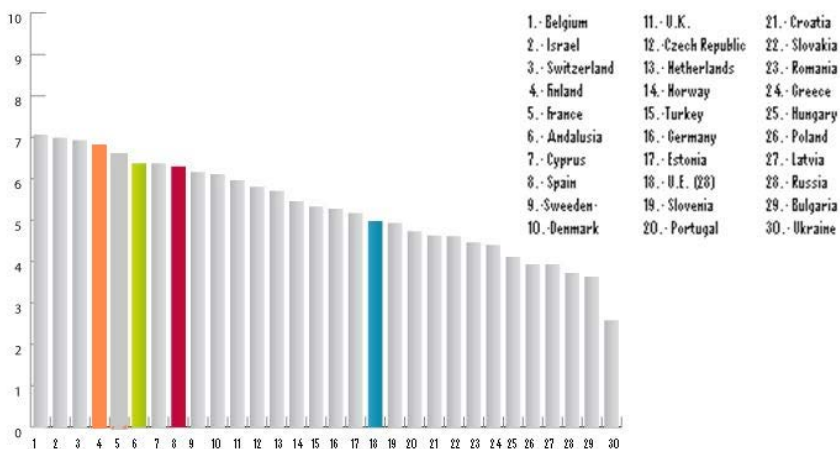
## 2.2. Effectiveness

The healthcare effectiveness refers to what extent the intervention (service, process, method, diagnosis, test or treatment) has produced the desired result. Therefore, the concept of effectiveness includes the level of adequacy of the care service in relation to the customers and the way the benefit from the services received.

In order to measure effectiveness a selection of indicators has been selected. These indicators present priority areas for improvement referring specific population groups:

a) Indicators of common interest about the population or population groups. These indicators show life expectancy at birth and at age 65 by gender (Figure 28), life expectancy in good health and without disability, the-standardized mortality age by gender and, the infant and perinatal mortality.

**Figure 28.** Life expectancy (women) at birth. Andalusia, Spain and International. 2008
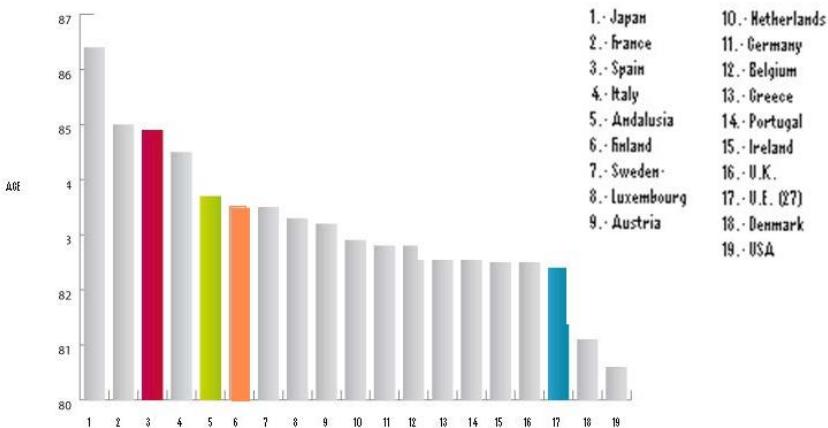


Source. Movimiento Natural de Población – INE OCDE

b) Indicators of the quality of the service, offering results of the care services during pregnancy, childbirth and the postpartum period; results of vaccination programs, and hospital readmission as an indicator of quality of clinical care. In addition, there is also an indicator about the perception of health status as a measure of health status compared with the population general one. (Figure 29).

**Figure 29.** Perinatal mortality. Andalusia, Spain, International.1999-2009
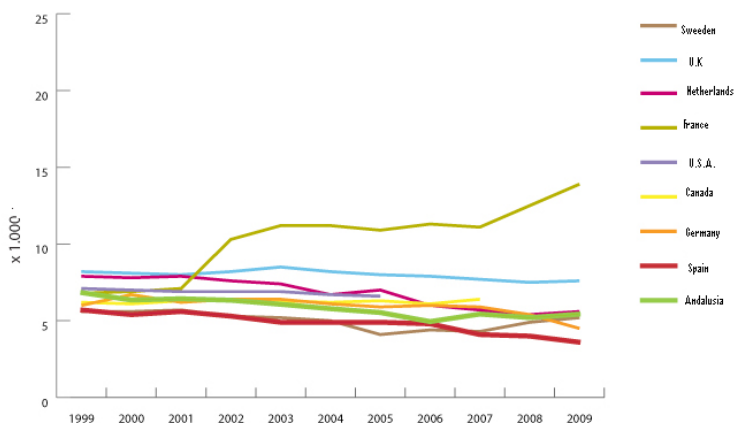
c. Indicators about the main causes of morbidity and mortality related to cancer, cardiovascular disease and stroke, mental health, and AIDS.

d. Indicators of health determinants (habits) whose prevalence could be positively or negatively affected by an effective service delivery (tobacco consumption, overweight and obesity, alcohol consumption, sedentary lifestyle and consumption of fruit and vegetables).

## 2.3. Equity

Equity related to healthcare refers to the provision of health services on an equalitarian basis, regardless of geographic location, gender, income, age or any other dimension. It also relates to serve and promote the health of all the citizens, understanding healthcare from the point of view of an equal access to available healthcare for equal needs, equal utilization for equal needs, and equal quality for all the citizens. Thus, equity can be measured from different perspectives:

1. - Indicators related to income and self-assessed health status by income level; the use of medical consultation or access to medical consultation in primary care or paediatric nurse comparing general population and population living in areas of social transformation (with less economic resources) and the perception of the population according to socioeconomic status about equity issues.

2. Indicators of equity from the point of view of the geographical location of both: activity (ambulatory surgery) and early detection (screening for breast cancer); outcomes (low weight at birth, mortality from breast cancer), accessibility (surgical waiting time or diagnostic waiting time), and perception of the population about accessibility to public health services (population living in rural[44] or urban areas). (Figure 30).

**Figure 30.** Perception of the population about equity on healthcare service provision (rural and urban areas residents) and economic and social situation
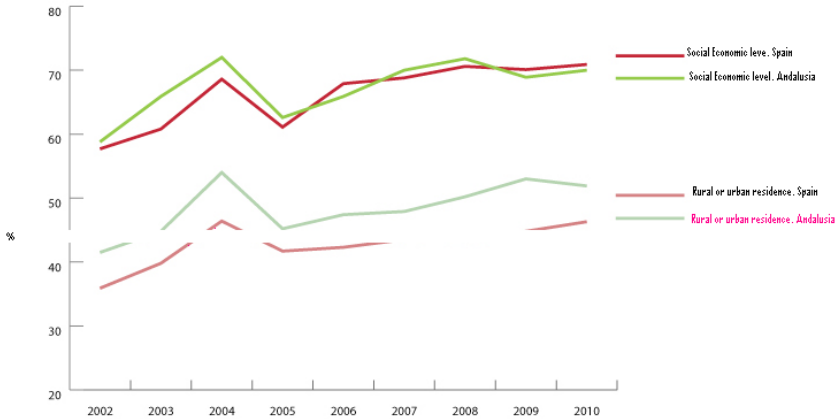


Source. Barómetro Sanitario - Ministerio de Sanidad, Servicios Sociales e Igualdad

3. Indicators of equity from the point of view of gender as self-perceived health status or mortality from lung cancer.

4. Finally, the perspective of equity from the point of view of age is addressed by indicators related to patient experience about accessibility (timetable and opening hours) to services (Figure 31).

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44   Please, note the important advance and service improvement for rural population that High Resolution Hospitals have introduced (already mentioned in previous Chapters of this report).

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**Figure 31. Satisfaction with opening hours in primary care centres. Andalusia (groups by age). (1999-2009)**
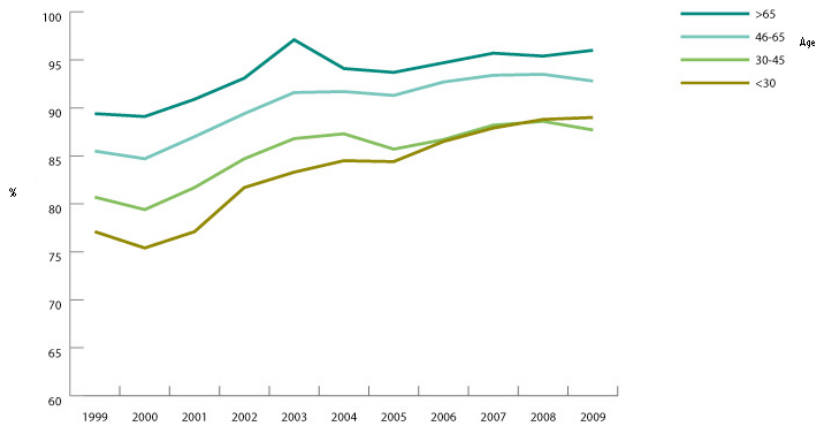


Source. Encuestas de satisfacción a usuarios – SSPA. Junta de Andalucía, 2012

# CHAPTER 5. SELECTION OF BEST PRACTICES

# 1. Introduction

Best practices do not have a universally accepted definition. Even a same organization such as the United Nations considers different concepts to describe them. For example, one definition used by this organization describes best practices such as

> *"The new ways of acting to face new challenges and problems, whether they be social, economic or environmental. These practices are characterized by an itemized approach which is aimed at resolving the population's specific problems and is founded on the knowledge of reality and its local specificities, but with a global vision or planning of the problems and the interventions".*

Taking this definition as a starting point, the action, in order to qualify as and be called best practice, must possess certain characteristics[45]:

- To have a demonstrable, tangible impact on the improvement in people's living conditions.
- To have a result of a joint effort between different sectors that act and live in a town: the Administration, citizens through their associations, etc.
- To be socially, culturally, economically and environmentally sustainable and long-lasting.
- To contribute to the strengthening of the community and its organizational capacity.
- To pay special attention in order to solve social exclusion problems.

An additional definition is provided by the United Nations Population Fund Glossary of Monitoring and Evaluation Terms, which defines best practices as "*planning or operational practices that have proven successful in particular circumstances and which are used to demonstrate what works and what does not and to accumulate and apply knowledge about how and why they work in different situations and contexts*". On the other hand, UNESCO[46] prefers to describe best practices not by providing a definition but by determining the four common characteristics that any best practice contains, which are:

- To be *innovative;*
- *To make a difference;*
- *To have a sustainable effect; and*
- *To have the potential to be replicated and to serve as a model for generating initiatives elsewhere.*

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45   Arco Latino (2007): "Best Practices Manual for Public Decentralized Cooperation", http://www. arcolatino.org/index.php?method=section&action=zoom&id=2028

46   http://www.unesco.org/most/bphome.htm

All the above mentioned definitions should be considered complementary to each other and they should be taken into account together, due to the fact that each one offers a particular characteristic of best practices that is not reflected in others. However, for the aim of this chapter UNESCO approach matches better because it considers that best practices must be sustainable, to have the potential to be replicated and to be the basis for following initiatives. In other words, it emphasizes that best practices must have a high potential effect, as temporal as geographical, because they must have potential to be set anywhere and to contribute to generate new initiatives.

To end, we can add a functional definition, provided by Bendixsen & Guchteniere (2003), who define best practices as a term that "relates to successful initiatives or model projects that make an outstanding, sustainable, and innovative contribution to an issue at hand". According to this definition, best practices are not only successful, in a general way, but also contribute to the purpose that is relevant in a specific context. In other words, and following to Jennings (2007), best practices carry a tripartite function: identifying successful initiatives addressing important issues, learning what works and does not work in different contexts, and inspirational guidelines for decision making.

In this sense, a selection of most relevant Best Practice (in relation to the integration of socio-sanitary services) is presented in this chapter. It is important to bear in mind that these practices or programmes might refer to specific customer groups but they have been selected due to their potential transferability to other customer groups/sectors/places.

## 2. "AL lado con"

According to the data provided by the Andalusian Government, 25% of the total population would have some mental illness or disorder through their lifetime[47.]. Moreover, specialized literature identifies mental health as one of the essential components that determine individuals and community well-being.

It is important to bear in mind that people with mental disorders are a collective with special needs for care, over long periods of time, in significant and diverse areas of their social, personal and family functioning. These difficulties may be accompanied by varying degrees of disability and dependence[48].

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47    http://www.1decada4.es/Ingles/volvamosapensar/

48    http://www.faisem.es/ (Andalusian Public Foundation for Social Integration of the People with Mental Disorders Disorders)

In Andalusia, the Andalusian Public Foundation for Social Integration of the People with Mental Disorders was created in 1993, aiming to develop and manage the existing resources to provide social support for individuals with disabilities caused by serious mental illness, through the coordination with the general health and social service networks and other existing services. Among others and in collaboration with other agents (associations, foundations, NGO's and the Ministry of Health and Social Well-being), this public foundation provides some of the following services:

- Residential programmes.
- Occupational programmes.
- Employment programmes
- Leisure and free time programmes.
- Support to the Andalusian Federation of Relatives of People with Mental Disorders (FEAFES-ANDALUCIA) and Andalusian Platform of Associations of Users of Mental Health.

But there are also other organization, associations and foundation working in the territory to provide services to people with mental disorders and their families and carers that are playing an essential role in the service chain for this group of people, such as: the Andalusian Federation of Mental Health Users (En primera persona[49]).

In relation to this multiplicity of institutions and actors, the II Comprehensive Mental Health Plan in Andalusia (2008-2012) realizes the importance of inter-sectorial action, promoting actions at all health levels to facilitate cooperation with other sectors. This II Plan also put an emphasis on empowering citizens, to assume greater self-management capacity in all aspects of their health, and incorporates the perspective of the users, their families and other relatives in all initiatives undertaken.

In this context, the programme **Together with (Al lado con)** has been recently launched by the regional government together with the main civil society actors. This program is designed and developed in collaboration with the Foundations and Association of mental health service users, carers and families and it aims to integrate the different resources existing, identifying the most suitable service or resource for each user.

According to the information and opinions provided by the interviewed actors, it is still too early to make a general assessment of the results of this project but this programme has been selected as best practice due to the high consensus about the importance of this kind of projects for the service integration (including the cus-

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49  http://www.enprimerapersona.org/

tomer and carers point of view) and for the inclusion and coordination of all the actors operating in the service provision.

Thus, the aim of the program is to create an instrument of cooperation between health services and associations in order to improve the user's health attention and to facilitate the work of the people taking care (carers) of the patients (mainly family or relatives).

"Al lado con" is a program based on the necessities of the customers and families, as customer's knowledge and families' knowledge about the disease is a necessary complement and reinforce the clinical one. The cooperation between the two-levels: professionals and families, is essential throughout the course of this type of disease. It is the so called **"shared care pathway'**.

This pathway includes the different stages of the disease (slight, moderated and advanced disease).

Thus, at an **early stage** of the disease, the goals are:
 a) raise awareness among professionals and the general public to get an early diagnosis;
 b) start working on personal autonomy and promote active aging,

In a **second stage** it is essential to work with the families and carers and how they manage the dedication to the patient in order to mitigate the sense of isolation and fatigue/tiredness.

In a **third stage**, the goal is to reach a consensus (form a medical and personal point of view) in order to face the last days of the patient and to support and facilitate the recovery of the carer/relative.

Therefore, **"shared care pathway' implies** mutual aid, and includes complementary action to the service provided by the health care and social affairs sector (including third sector), in order to enrich the quality of the care treatment. It is important to highlight that this is a complementary system where all the actions are interconnected but there is not replacement of the services provided by each one of the care sector (contributions are complementary): health and social services provide scientific and technical perspective, while relatives/carers can transmit the individual and familiar capacity to adapt and make decisions that are more favourable to the evolution of the well-being status of the user.

This approach is especially significant in serious diseases, because they require a holistic view of the care, implying not only a good attention but also a special sensitivity from the very first moment (how to inform about the diagnosis) up to

the monitoring of the dairy care and emphasizing in the understanding of quite complex medical treatments (such as food, pharmacology, mobility, etc.). This approach intends to adequate the person's life project to the disease. In this sense, it is essential to work on the acceptance of the disease, the effective management of treatment and care and active and positive coping and acceptance from the patient and his/her family.

Thus, as a pilot project, the programme has started to work with people affected by Alzheimer and their families and the itinerary has been designed taken as a model three biography narrative (qualitative research) where patients and their families gave information about the itinerary of the disease and this information was complemented with the clinical information about the patient's pathway.

From the biographical cases and through focal techniques and subsequent discussions carried out in working groups, project needs, ways of living and understanding the processes and similar factors and improvement areas have been identified. By this process, the contributions of each biographical case has been used to understand the real needs of patients and families and the areas where there is a necessity to improve the system.

Once identified the itinerary, the programme identifies the different models that are playing a key role in the support network, in order to better understand the path that a person and his/her family take. In this pathway there are two types of sources of support: natural support (individual and family/carers support) and organized one (associations and public services). The relationship between these actors (people affected, professionals and managers) is decisive for family's and patient's management of the situation. Thus, the programme final aim is to offer an instrument for healthcare for people and families affected, based on the coordination between health services and associations of people affected by creating a common, shared and integrated itinerary between public services and associations. In each one of the phases or stages of the disease, the resources provided by both the associations and public sector are clearly identified.

As we have already mentioned, the first section of this itinerary is called "Until the diagnosis moment" aimed to raise awareness among professional and society for an early detection of the symptoms.

The second phase is related to the family and how the cope with the new situation. Once the family has the confirmation of the diagnosis, their first step is usually a medical consultation. This phase includes a plan for the patient and the main carer to deal with the process. In order to do so, a more or less comprehensive assessment and a personal planning of care are developed by the primary care team. This

plan included the provision of initial information about disease and care resources available.

The last phase addresses the last moments of the patient and aims to mitigate both the patient suffering and his/her family suffering. In this phase, the aim of health interventions is to provide welfare for the customer, avoiding the elements that can cause suffering (on multiple occasions the family's opinion help the professional to decide on what aspects can be improved the patient's well-being). On the other hand, the aim for the Sociosanitary and associations intervention is to help carers and family in the psychological aspect related to the loss of the person and to help them to take decisions about patient last days. In this third phase it is essential that the carer receives the following assistance:

- Psychological support (individual or self-help groups), designed to recognize and accept their own feelings and to reduce or control the level of stress.
- Education, information about the disease and how to improve the skills related to the care in these last days.

In most situations, decisions will have to be taken together with the family, and it is necessary to note that decisions should be made on an individual basis, analysing every decision and taking into account the psychological state of the carer and the family.

## 3. Support Plan for Carers

Caring a sick or dependent person requires tireless effort, energy and empathy, and it has a very important impact on the daily lives of carers. Caring can have a major impact on work effort and health, especially for individuals providing a high intensity of care (OECD; 2011). The stress associated to care for chronic disease patients or dependent people may result in a condition commonly referred to as carer's syndrome that it is characterised by exhaustion, anger, rage, or guilt and that can cause serious mental and physical problems for the carer. But also, providing personal care is usually a demanding task that is incompatible with a full-time job or with any type of paid employment. Therefore, Plans to support and relief carers are highly important in the service chain provision.

In this sense, the plan for carers was implemented in 2005 by the Andalusian Health Service, and its main target group are women between 55 and 65, (majority profile of informal carers), who are facing high risk of physical and mental health burdens related to their role as carers. It includes an assessment of the target group and the adoption of more tailored health services, aimed at relieving the burden of the informal carers.

In order to support family carers, the Andalusian Health Service offers a variety of services to improve the home care assistance (including care for carers), prevention and attention to mitigate mobility problems related to the carer role, adaption to the problems caused by the disability and attention to social problems caused by the dependency problem. Among other the Plan establishes some of the following services:

- A service portfolio has been created in order to provide help and support services for carers (especially homecare). This portfolio includes:
  - Case Management Nurse (Please check section 4 of this chapter).
  - Inclusion of family carers in the homecare services provided.
  - Assessment of the situation of the carer and proposal of an integral and personalized attention Plan.
  - Workshops to help in the care process.
  - Promotion of informal networks (including workshops where the women can exchange stories, receive emotional support and build a social network with people in similar situations, as well as the provision of support materials to be used at home).
  - Telephone follow-up and support.
  - Actions aimed to arrange and organize health resources and material resources (orthopaedic material, special beds, etc.).
- Prevention and attention to mobility problems caused by the role as carer (rehabilitation and physiotherapy). Individual and group treatment.
- Adaption to the problems caused by the disability into daily life activities (both in primary care and in specialized care). Nurses are trained by physiotherapist to produce knowledge about how to cope with problems caused by the disability and how to maintain autonomy as long as possible.
- Social attention. Social workers are the ones in charge of assessing the social situation of the patient and his/her surrounding and of providing information about the resources available.
- Notebook for care continuum, where all the professionals can write down and check the information about the patient and the carer.
- Attention to carers in hospitals by hospital case management nurses, who coordinate all the services provided to the patient and the carer and, also, all the professionals interacting.
- Telephone follow-up (Salud responde) to carers. This follow-up is made regularly by Salud responde nurses.
- Specific services for carers of patients with serious mental disorders (assessment, training, respite programmes, etc.).
- Specific care for mourning situations.

This Plan also promotes cooperation with Third Sector association (especially in relation to the provision of respite services) and with the local entities (promoting leisure activities for carers).

There are also some specific measures carried out by the Andalusian Public System for certain type of carers such as the personal identification card for Carers. It is an I.D. that identifies carers of patients with Alzheimer's and other dementias and regular carers of patients with severe disabilities, establishing preferential treatment in the access and services provided by the well-being system.

## 4. CUDECA Foundation. Cancer Hospice in Costa del Sol[50]

CUDECA Foundation is a non-profit organisation that provides hospice services, focusing on the palliation of a terminally ill or serious disease, understanding the last moments of the patient and his/her relatives as a situation that affects all aspects of life at physical, psychological, social and spiritual levels.

In order to do so, CUDECA has multidisciplinary teams consisting of doctors, nurses, social worker, psychologist, physiotherapist and qualified volunteers who attend to patients both in CUDECA's residence centre and at home, offering care services (free of charge) in Málaga province and, especially in Costa del Sol region.

Patients may be referred to CUDECA Hospice by their hospital consultant, family doctor or other health professional. Referrals normally are for purposes of pain and symptom control, also for rehabilitation following radiotherapy, chemotherapy, surgery and other palliative interventions, psychological and social support. Referrals may also be for specialist respite or terminal care. Also, a patient and/or the family member can contact CUDECA directly and ask for help, in which case it is requested that all medical reports are presented at the first appointment in order to accurately assess the situation.

CUDECA provides to terminal patients and their families following services:

- Home care services: It is the main CUDECA care program for patients. The Home Care team consists of a nurse that coordinates the staff. Each team has a doctor and a nurse and, if necessary, it is complemented by psychologists and social workers. These services are also supported by the secretary of CUDECA centre and by qualified volunteers for home care. Home visits are carried out from Monday to Friday, mainly in the morning and in close coordination with primary care teams of the Public Health Service (SAS). In the

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50   All the information of this best practice case has been obtained using information available in CU-
     DECA's webpage and through an in-depth interview with a team member of the Foundation. The
     case has been selected as it was identified as a best practice by several interviewed actors.

province of Málaga, 150 patients receive these services. And it is important to note that since 2006, this program receives an annual grant/subsidy from the Andalusian Health Service representing 40% of the cost of CUDECA's staff (doctors and nurses that work in the Home Care teams).

The objective of this service is to offer quality care, relieve symptoms and provide emotional and social support to both patients and their families. This is achieved through a comprehensive initial assessment of the situation that allows designing a planning for a personalized treatment. During the process, a continuum follow-up is carried out not only by the visits but also by telephone contact, allowing the patient, if possible, to stay at home until the end. Family support is offered after the death of the patient and through all the mourning process as not only the patient needs assistance.

- Outpatient consultation offering patients and their families the opportunity to easily visit a multidisciplinary team of doctors, nurses, psychologists, social workers and physiotherapists in order to maintain the best possible quality of life for the patient and for his/her family as long as possible. This is achieved by an initial comprehensive assessment of the situation and a personalized treatment plan. When patients can no longer go to the outpatient, the Home Care Teams ensure continuation of care and support at patient's home.
- Admissions unit. Although the patient usually prefers to stay at home, sometimes it is necessary that he/she access to a residence centre because his/her physical or emotional situation requires intensive and continuous professional care or care at the end of life. Admissions unit has the technology and expertise of a hospital. In addition, the environment of the unit has been designed to create a warm feeling and quality in the palliative care. Admission unit has 9 rooms and each room has its own bathroom and a terrace overlooking a garden. The rooms allow that family and friends can visit the patient without restrictions on the number of people staying at the room. Each room has a recliner in case a family member wants to spend the night there. For those families with young children, there is also a special playroom for children.
- There is also a multi-faith chapel as CUDECA philosophy pay especial attention to the spiritual care, considering it as important as the physical, mental and emotional care of the patient. Volunteers also provide qualified assistance to patients. Carers also receive support from specialist staff.
- Day care unit that offers several non-clinical activities where patients have access to medical care or nursing care, spiritual support, physiotherapy, occupational therapy, hairdressing, beauty treatments in addition to a wide range of leisure and social activities. Day care activities include: include:
  - Creative therapies as decoration, collages or paint.

- Leisure activities such as outings to local attractions, entertainment and presentations.
- Complementary therapies such as reflexology, aromatherapy, massage and Reiki.
- Other type of activities such as relaxation therapies and beauty treatments.
- Psychosocial programme. One of the key aspects of palliative care is to address the psychosocial needs of a person with a terminal illness. These needs are related to the social context of the person and his/her family and the way they adapt to changing and critical circumstances. Patient's personality, emotions, and social circumstances, in addition to their physical situation, determine the way how the patient sees his/herself and how she/he copes with the situation. The psychosocial program focuses on finding and providing solutions to emotional or social context of patients and their families and also, provides support to staff and volunteers

Any person who is being treated by CUDECA, including family members, can access to this program and receive help from a psychologist and a social worker:

- Psychologist assesses the emotional needs of patients and incorporates these needs to the patients care Plan.
- Social worker attends to family, social or labour problems of patients and their families by helping them to find solutions to these problems that arise in the course of a terminal illness. The social worker can contact other health institutions; social services or other specialized NGOs.
- Rehabilitation programme.
- Counsel services.

CUDECA has also a research department that has published several guides about the palliative care process.

But, in the case of CUDECA it is also interesting to note the funding of the Foundation as they have created a system that allows them to be more independent than other Third Sector entities from the public grants and this is especially relevant on the current economic situation as the public resources are being significantly reduced.

CUDECA's main income comes from the inheritance that they receive, mainly from customer's that allocate their financial inheritance (or part of it) to the foundation (Figure 32). CUDECA also obtains an important percentage of its incomes from charity shops as they own several shops (as in the British model this kind of shops usually sells used goods that have been donated and are staffed by volunteers). Income from the sales is used to fund CUDECA (20% of their income).

Public grants still play an important role on the funding but in this case it only reaches 11% of the total incomes. This fact is very important for the sustainability of the Foundation as having several ways of subsidize their activities make CUDECA less dependent on the Public sector. Nevertheless, the current economic crisis has also affected CUDECA as the incomes coming from charity shops, inheritance, donations, etc. have decreased and, at this moment and according to the information provided during the interview, the Foundation is looking for new resources or ways to self-finance.

**Figure 32.** CUDECA's incomes by type of subsidizer (%). 2011
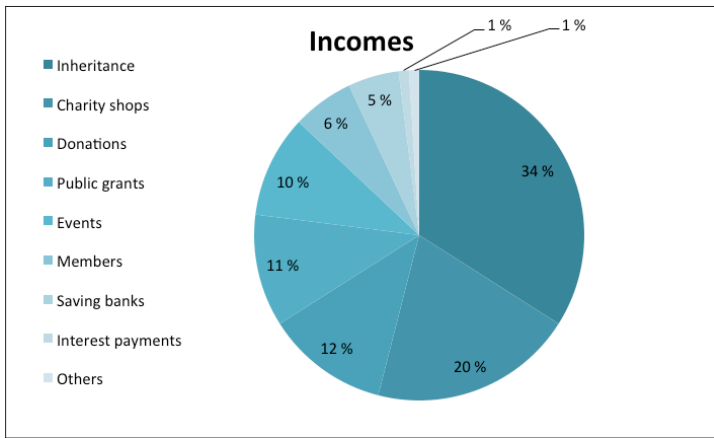


Source. CUDECA; 2011 (http://www.cudeca.org)

## 5. Case Management Nurse for people with chronicle diseases, long-term diseases, people with disabilities and elderly people

The population aging[51], complex chronicity of some type of illness, the increasing of dependence, the decreasing of the informal support (families and relatives) network and the inadequate use and attention to healthcare issues are factors that are creating new challenges in the service integration of well-being services (Sánchez, et al, 2004). In this context, some studies (Junta de Andalucía, 2005) set that approximately 15% of hospital admissions are avoidable through and adequate and time effective primary care (prevention, control and accurate treatment).

In this context, in 2002 the Andalusian Regional Government launched a Case Management (CM) programme for people with multiple chronic conditions, disabled

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51   More than 50% of the hospital stays in Spain are required by people over 65 years old.

and elderly people and their families, as some of these vulnerable patients have difficulties in getting appropriate health, social or rehabilitation care within the traditional model.

Care provision for people in situations of dependency or with multiple-pathology profiles – which is the case for a high percentage of elderly citizens – is an enormous challenge to comprehensive and integral health and social care (well-being), as demand for homecare services has increased considerably, along with the growing complexity of cases and variability among resources and providers.

Case Management is one of the better-known care coordination approaches and it is an essential integrated care tool. It is a comprehensive and systematic process of case finding, assessing, planning, arranging, coordinating and monitoring multiple services for customers with long-term care needs and other complex or high-risk conditions across time, setting and discipline (Kodner 1993).

Case Management is a collaborative process where all the agents related to delivering care are involved -including primary care, secondary care, specialist services, ambulance services, social care and community organizations- working together with the person that has multiple chronic conditions or has a complex need of sociosanitary attention. Therefore, the effectiveness of interventions in this approach requires the involvement of multidisciplinary teams which interact at the different care levels with the participation of the primary care network, and the specialised and emergency networks, all of them coordinated by the case manager (liaison) nurse (Figure 33).

**Figure 33.** Case Manager Service Provision. Care model adaption from Kaiser Organization model
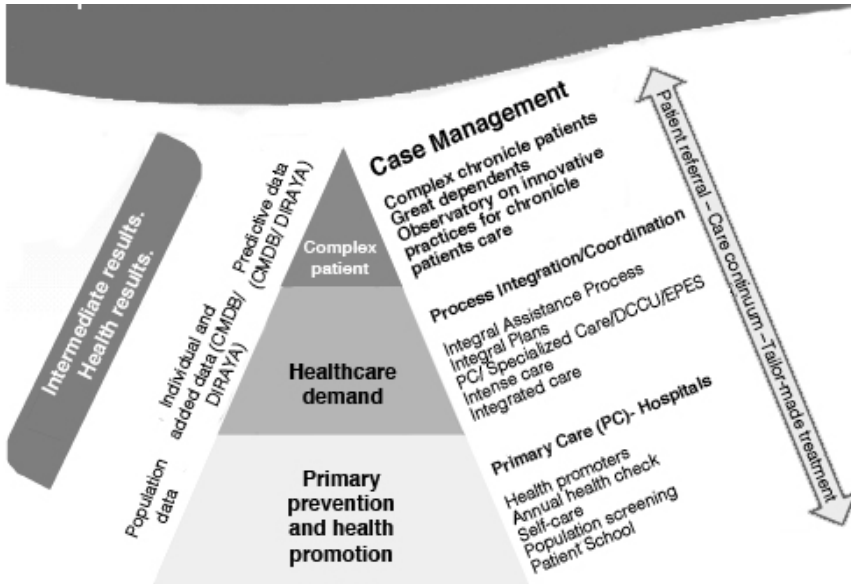


Source. "Desarrollo competencial en el modelo de gestión de casos del SSPA". Junta de Andalucía (Adaption from Morales Asencio Model), 2011

The aim of this practice is to provide personalized services in order to improve patient's life quality according to patient characteristics and patient profile. Therefore, case managers (liaison nurses) act as agents liaising between the various levels of the healthcare and social-care system, understanding case management as the collaborative process by which the nurse is in charge of the consecution of the objectives set in each patient care plan, coordinating with different professionals and mobilizing the necessary resources to ensure a comprehensive care. Thus, these nurses take care that patients receive a comprehensive evaluation of their situation and that their care plan is individualized, focusing on preventing health problems and alleviating the already existing ones.

Through this program, more than 300 nurses have been trained to be high-skilled case managers in Andalusia (Every Primary Health Care team has a case manager).

When a patient with a complex condition is discharged from hospital, case managers prepare a tailor-made plan for follow-up outpatient treatment. The case manager (nurse) proactively organizes treatment in accordance with the customer's needs and requirements and mobilizes the resources necessary to achieve this

plan. This entails coordinating the medical and social aspects of the treatment. In particular, case managers are expected to encourage the primary care teams to focus more closely on the specific needs of the individual customer.

As a quasi-experimental study has shown, (Morales, J.M, 2008) the project fulfils many of the predefined expectations and aims (from the customer's point of view) as a successful discharge process from hospital to homecare is identified as an essential factor to ensure the coping of the situation (at home) and the continuity of care. After a period of six months and when compared to the control group (Customers that have not received the case management services), the user from the intervention group showed evidence of:

– Higher levels of satisfaction and improved quality of life.
– Better access to rehabilitation facilities and social services.
– Less need for home care.
– Reduced burden on the carers.

Nevertheless, it is important to highlight that a minority of the actors interviewed, in the frame of this report, point out that the introduction of case management services has implied a duplicity of function and services provided, on the one hand by the liaison nurses and, on the other hand, the services provided by the primary care social workers. But, from the customer's point of view (patients and carers) the case management service is identified as a best practice related to the improvement of the service integration and service chains in the sociosanitary and well-being sector and it is very positively assessed.

# CONCLUSIONS

Through this report we have seen how service concepts, service chains and service integration in the well-being sector have been designed and interact (in a greater or lesser extent) in Andalusian Autonomous Community and in Costa del Sol area. As we have seen there is a great difference on the development of the health services in comparison with the social sphere. While health service integration is one of the main strong points of the sanitary system, it is scarcely developed in the Sociosanitary sector.

In order to conclude this report, main conclusions are following shortly summarised:

1. In relation to Healthcare the wide majority of services provided to customers are delivered by the Public Sector.

2. Andalusian Public Health system has a complex architecture both, from the organizational and management point of view and from the procedures and processes perspective.

3. In the last years, there has been (from the public health sector) a special interest on improving the service chains and service integration from:

- Different perspectives and areas: integration of procedures (process management); clinical management units, competence based management and accreditation and continuous improvement.
- Focusing on different actors and scenarios (customers, professionals and common spaces).

4. Also, this service concepts development is being carried out by developing private sector strategies (aimed to introduce more flexibility and to provide more autonomy to the clinical units) in the management of human resources and financial resources within the public health system,. This is the case of the Public Health Company Costa del Sol and it has meant an important improvement regarding the provision of more customer orientated services.

5. Public- private cooperation in the healthcare system is very limited and mainly related to the provision of services that cannot be offered by the public sector due to long waiting lists, customer's special needs or geographical dispersion of some population groups. In any case, if we consider the current economic situation, it is likely to prospect a higher cooperation in a near future (especially from a qualitative point of view) as it is expected an important development of the services provided by the private sector.

6. On the contrary, regarding to social sphere, private sector (Third sector mainly) has an important relation with the public system. This relation is mainly articulat-

ed mainly by collaboration agreements. From our point of view, these agreements have been proved as a valid tool to organize the cooperation with a Third sector (which is characterised by its heterogeneity), guaranteeing minimum quality standards in the provision of services to citizens. It is also important to note the essential role of Third sector on the public decision-making process as these entities also act as a link between citizens and public policy makers.

7. A special case in the well-being integration refers to services provided according to the Law on Promotion of Personal Autonomy and Care for People in a Dependent situation. This Law introduced an important step on the well-being service concepts and service integration and it has been assessed very positively by the users but, at this moment and due to the current economic situation, the development of the measures and services related to the Law has been stopped.

8. From the customer's perspective, it is also important to note that:

- The same as the healthcare organizational, procedural and management architecture has been highly formalised, the measurement of the quality perspective (from the user's point of view) has also been highly developed (quantitative measurement, periodicity, use of wide samples). Also, the information obtained by this quality measurement is being used to elaborate protocols and plans to improve the quality in the healthcare service delivery.
- In the Social sphere, there is a shortage of formalized public measures to assess the services provided, mainly due to the inferior development of the social sector but, also, probably caused by the heterogeneity of service providers that operate in the social system.

9. Costa del Sol region holds very high levels of users satisfaction in the healthcare provided by the specialized level (referring to Public Health Company Costa del Sol – Hospital Costa del Sol, Mijas Care and High Resolution Hospital Benalmádena). Thus, it is important to note that these positive results might be related to the management model.[52]

10. Regarding to the resources allocated to the Well-being sector, there is an important reduction caused by the economic crisis. This is the major concern for both institutional agents and customers.

11. In relation to efficiency and effectiveness, it is important to highlight the important effort carried out in the healthcare system to assess and measure the public sector. This report analyses only three aspects related to the efficiency and effectiveness of the services, but the Andalusian Ministry of Health of Social Well-being

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[52]   Other elements can also contribute to this high degree of satisfaction, such as material and economic resources allocated to the Public Company.

offers information related to 9 topics and more or less 12 indicators for each topic. According to this information, the issues here analysed (efficiency, effectiveness and equity) offer quite positive results.

12. From a qualitative point of view, customer's opinions confirm the positive assessment of the healthcare system but they also highlight the problem related to the service chain fragmentation (health-social care).

13. To conclude, the recent unification of Health and Social Well-being in the **Ministry for Health and Social well-being** might suppose an important improvement on the service integration but it is still too soon to state so and, due to the current economic situation of Andalusia (and Spain in general) customers and main stakeholders share the uncertainty of the development of these services.

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# Index. Figures

**Annex 1.** Citizens and patient's rights related to Health Care

| |
|---|
| SECOND MEDICAL OPINION: in cases of serious illness, citizens have the right to demand a qualified second opinion, which is provided by experts within 30 days since of application. |
| LIVING WILLS: Andalusian citizens have the right to record their wills on a specific Registry regarding limits to health care in situations where communication is not possible. Physicians have the obligation to consult this registry before applying special treatment to patients who are unable to communicate. |
| DIGNITY IN THE PROCESS OF DEATH (DEATH WITH DIGNITY ACT): to guarantee adequate healthcare during life's final process based on suffering prevention and respect for each person's dignity and free choice. Includes: home palliative care, single rooms in hospitals or palliative sedation if necessary. |
| DENTAL CARE FOR CHILDREN AND PREGNANT WOMEN: free for 6 to 15 year-olds and women during pregnancy. |
| DENTAL CARE FOR HANDICAPPED: the coverage by the public dental care services has been extended to handicapped people. |
| SURGERY WAITING LISTS: the Andalusian government was the first in our country to introduce the legal right to a guaranteed maximum waiting period for surgery (180 days). Recently it has been updated, reducing the waiting time for the most common interventions to 120 days. The information is available at the Department of Health web page. |
| OUTPATIENT SPECIALIZED CARE AND DIAGNOSTIC PROCEDURES WAITING LISTS: legal rights have been extended to guarantee a maximum delay for outpatient specialized care (60 days for first referral from the primary health physician) and the most common diagnostic procedures (30 days). |
| PREIMPLANTATIONAL GENETIC DIAGNOSIS (PGD): the Public Health Care System has included PGD to avoid the transmission of genetic disorders. This service is offered in a public hospital. |
| GENETIC COUNSELING: new integrated genetic units providing genetic testing and counseling are being implemented. This is one a number of measures listed in the Andalusian Genetic Plan. |
| CHILDREN NEEDS IN HEALTH CARE FACILITIES AND SERVICES: health care facilities and services are being adapted to the special needs and requirements of children and newborns who are accompanied by a close relative (mother or father) during their stay in hospitals. |
| ELDERLY ANNUAL CHECK-UP: people over 65 years old are contacted to assess their health status and are offered the health services they may need. |
| PODIATRIC/CHIROPODIC CARE FOR PEOPLE WITH DIABETES, under the Diabetes Care Plan. |
| FREE MEDICATION FOR CHILDREN UNDER 1 YEAR OLD |
| PROTECTION OF TEENAGERS UNDERGOING AESTHETIC SURGERY: includes psychological test for maturity before the consent form is signed as well as the obligations for aesthetic units and centres. |

Source: Taken from http://www.juntadeandalucia.es/salud

**Annex 2.** List of Integrated and Comprehensive Plans

| |
|---|
| DIABETES CARE PLAN: Information for the public and patients, improved health care services, including early detection for major complications (retinopathy), prevention and health education, citizen participation, training and research. |
| ONCOLOGY PLAN: Health promotion activities, oncology day care in all hospitals, palliative care, new radiotherapy units, improved social and emotional support. Research and training. |
| CARDIOVASCULAR DISEASE CARE PLAN: Secondary prevention and rehabilitation programme, paediatric surgery, adult congenital cardiovascular disease unit, training and research. |
| MENTAL HEALTH PLAN: Mental welfare promotion, information for the public, increased accessibility, community mental health units, day care units, training and research. |
| TOBACCO PLAN: Media campaigns, web portal and telephone service supporting tobacco cessation, training programmes for health professionals, education and work, special smoking cessation units at primary and specialized care, special situations (mental health patients, prisons), training and research. Legal actions (suits) against tobacco companies. |
| DEPENDENT PEOPLE STRATEGY: designed to support people with special needs. Coordinated with the Social Welfare Department. |
| ALZHEIMER'S DISEASE PLAN: In collaboration with associations of relatives and caregivers, includes different programmes designed for the needs of these patients and their families, such as healthcare, family support, stimulation and re-education, training, volunteering and research. |
| PHYSICAL ACTIVITY AND HEALTHY FOOD PROMOTION PLAN: Promotes physical activities and healthy food through local interventions, mainly in four scenarios: healthcare services, schools, community and workplaces. |
| INFANT OBESITY PLAN: Includes more than a hundred preventive, healthcare, training and research measures. School dining rooms support services. |
| ACCIDENTS HEALTHCARE PLAN: Different measures in order to reduce accidents, and to minimize their consequences. |
| PATIENT SAFETY STRATEGY: Designed to improve management, training and information systems. It includes an Patient Safety Observatory and a registry on adverse events. |
| GENETICS PLAN: Establishes a network for providing genetic services for the population, identifying and optimizing the available resources, and opening new lines for the development for research and health care. |
| RARE DISEASES PLAN: Early identification of rare diseases, structured health care network within the health system, and coordination with different units involved. |
| PALLIATIVE CARE PLAN: Designed to attend patients at end stages of their diseases under a common protocol and to support their families and close carers. |
| PAIN CARE PLAN: Standardizes care and pain relief throughout the Andalusian health system. |
| ASSISTED REPRODUCTION PROGRAMME: Extension of public health care services of assisted reproduction techniques in the public hospitals and centres for those who need them, including women without male partners. |
| DELIVERY AND BIRTH PLAN: Promoting healthy and safe delivery based on international evidence and recommendations. |
| HIV/AIDS AND STD PLAN: Treatments closest to the patient, promoting early detection of infection and healthy lifestyles when HIV is diagnosed. |
| EARLY CHILDHOOD INTERVENTION PLAN: For children with developmental delays and/or disabilities and their families. Includes early detection and involves prevention and specialized therapy services for the child aimed at achieving personal autonomy; for motor, intellectual and sensory disabilities as well as autism spectrum disorders |

Source. Information has been taken from Healthy Andalusia (Ministry for Health and Social well-being) 53

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53  http://www.juntadeandalucia.es/salud

**Annex 3.** Service Portfolio Public Health Company Costa del Sol

| | Costa del Sol Hospital | High Resolution Hospital Benalmádena | Mijas CARE |
|---|---|---|---|
| Medical Services | Medicine Internal | Medicine Internal | Medicine Internal |
| | Cardiology | Cardiology | Cardiology |
| | Neumology | Neumology | Neumology |
| | Gastroenterologist | Gastroenterologist | Gastroenterologist |
| | Clinical Haematology | | |
| | Paediatrician and Neonatology | | |
| | Medical oncology | | |
| | Emergencies | Emergencies | Emergencies |
| | Clinical Pharmacology | | |
| Surgical Services | General and digestive surgery | General and digestive surgery | General and digestive surgery |
| | Urology | | Urology |
| | Otorhinolaryngology | Otorhinolaryngology | Otorhinolaryngology |
| | Ophthalmology | | Ophthalmology |
| | Orthopaedic surgery and traumatology | Orthopaedic surgery and traumatology | Orthopaedic surgery and traumatology |
| | Obstetrics and gynaecology | Obstetrics and gynaecology | Obstetrics and gynaecology |
| | Dermatology | Dermatology | Dermatology |
| Diagnosis General Services | Anaesthetic, Rehabilitation and Pain Therapy | Anaesthetic, Rehabilitation and Pain Therapy | |
| | Critical Care and Emergencies Care | | |
| | Intensive Medicine | | |
| | Haemodialysis | | |
| | Rehabilitation | | |
| | Clinical Test | Clinical Test | |
| | Haematology/Hemotherapy | | |
| | Microbiology | Microbiology | |
| | Pathology Anatomy | | |
| | Radio Diagnosis/ Radiology | | Radiology |
| | Ultrasonography/mammogram | Ultrasonography | |
| | TAC / RNM | TAC | |
| | Haemodynamic | | |
| | | Shot stay surgeries | |
| | | Eco-Doppler | |

| | | | |
|---|---|---|---|
| No invasive | No invasive cardiology | No invasive cardiology | No invasive cardiology |
| | Respiratory | Respiratory | Respiratory |
| | ORL | ORL | ORL |
| | Digestive | Digestive | Digestive |
| | Ophthalmology | | |
| | Urology | | Urology |
| | Obstetrics | Obstetrics | Obstetrics |
| | Gynaecology | Gynaecology | Gynaecology |
| | | | |
| | Endoscopy | Endoscopy | Endoscopy |
| | Respiratory | Respiratory | |
| | Digestive | Digestive | |
| | Gynaecology | Gynaecology | |
| | Urological | | |
| | | Arthroscopy | |
| | ORL | ORL | |
| | Endoscopy surgery | Laparoscopy | |
| Clinical Support Services | Preventive health | | |
| | Day Hospital | | |
| | Social Work Unit | | |
| | Clinical Documentation | | |
| | Clinical History Archive | | |
| | General Admission Emergencies | Admission | Admission |
| | Quality and Assessment Unit | | |
| | Research Unit | | |
| | | All the rest provided by Costa del Sol Hospital | All the rest provided by Costa del Sol Hospital |
| Nursing Services | Diagnosis and therapy procedures | | |
| | Education on Health and Prevention (Habits) | | |
| | Promotion of Self-care and health education education sanitaria | | Promotion of Self-care and health education education sanitaria |
| | Cooperation services -Follow up/ Problems control (confront and adaptation of the disease) | Cooperation services | Cooperation services |
| | | Patient care | Patient care |

| | | | |
|---|---|---|---|
| Logistic and management services | Information and Communication Technologies | Information and Communica-tion Technologies | |
| | Library | | |
| | Information | Information | |
| | Juridical Advice | | |
| | Sterilization | | |
| | Supplies (purchase) unit and storage | Supplies (purchase) unit and storage | |
| | Hospitality | Hospitality | |
| | Maintenance | Maintenance | |
| | Interpreter | Interpreter | Interpreter |
| | Economic and Management Control | | |
| | Treasury and Invoicing | | |
| | Human Resources | Human Resources | |
| | Staff administration and Labour Relation | Staff administration and Labour Relation | |
| | Prevention of Labour Risks | | |
| | Labour Health Unit | | |
| | Security and video-surveillance unit | | |
| | | Rest of the services provided by Costa del Sol Hospital | Rest of the services provided by Costa del Sol Hospital |

Source. Public Health Company Costa del Sol

**Annex 4.** Servqual Model
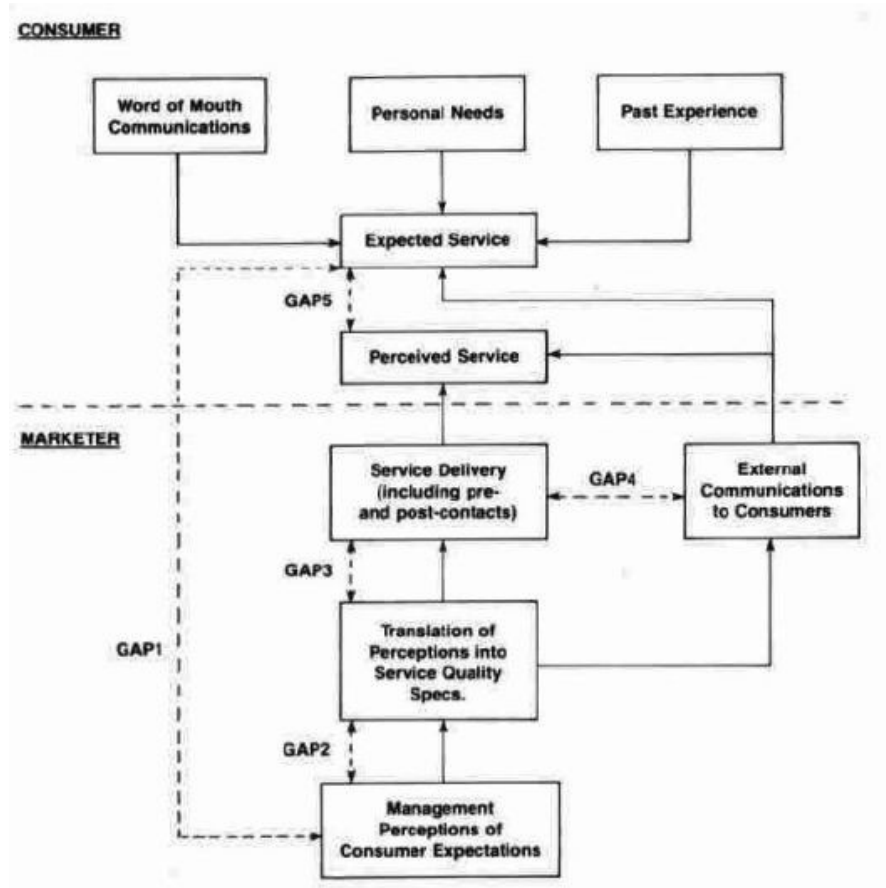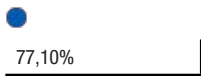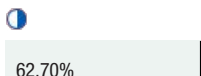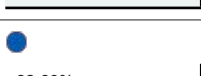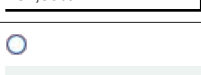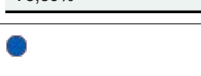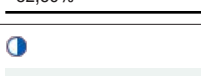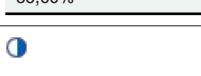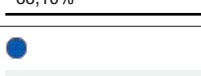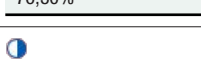
**Annex 5.** Satisfaction surveys (Costa del Sol District- Primary Care Centres and Public Health Company Costa del Sol
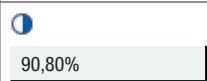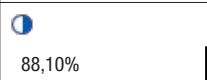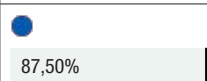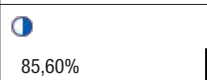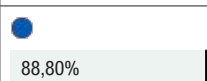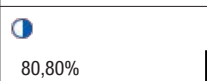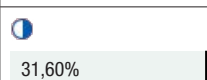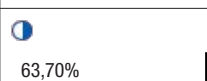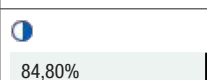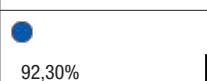
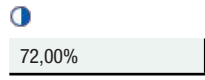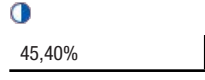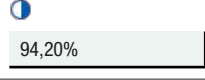| Costa del Sol District Primary Care | | | | |
|---|---|---|---|---|
| Code | Satisfaction Indicator | % satisfied / District | Answer rate | % satisfied (Andalusia average) |
| AP2 | Satisfaction with service provided | 83,8% - 89,9% | 100,0% | 91,50% |
| AP4 | Easiness to solve administrative issues | 68,2% - 75,9% | 94,0% | 81,50% |
| AP5.1 | Area/space (centre) | 57,0% - 64,4% | 99,9% | 83,70% |
| AP5.2 | Cleanliness (centre) | 83,5% - 89,5% | 99,9% | 92,90% |
| AP5.3 | Ventilation (centre) | 65,3% - 72,9% | 99,4% | 85,80% |
| AP5.4 | Comfort of the seats (centres) | 56,5% - 64,5% | 100,0% | 84,10% |
| AP5.5 | Preservation (centres) | 62,6% - 70,2% | 99,6% | 85,60% |
| AP6 | Proper identification of professionals | 85,7% - 91,3% | 92,7% | 90,40% |
| AP7 | Confidentiality of clinical data and history | 95,3% - 98,2% | 87,2% | 96,40% |
| AP8 | Centre organization | 67,9% - 75,7% | 96,3% | 80,90% |
| AP12 | Easiness to get an appointment (By telephone) | 94,9% - 99,2% | 34,0% | 94,90% |
| AP14 | Wafting time to access to consultation (under appointment) | 52,5% - 60,7% | 95,7% | 62,10% |

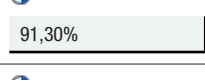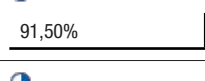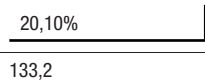| AP19 | Degree of satisfaction and reliability on care provided | 76,2% - 82,7% | 99,3% | 86,70% |
| AP24 | Easiness to change family doctor or paediatrician | 86,4% - 98,1% | 6,7% | 92,20% |
| AP25 | Satisfaction with the change of family doctor or paediatrician | 76,7% - 91,2% | 17,9% | 86,50% |
| AP1.0 | Satisfaction with consultation timetables* | 85,8% - 91,0% | 99,4% | 92,30% |
| AP3.0 | Respect (treated correctly)* | 93,9% - 97,6% | 99,9% | 97,90% |
| AP4.1 | Kindness (staff)* | 94,3% - 97,6% | 100,0% | 96,70% |
| AP4.2 | Efficiency (staff9* | 92,4% - 96,4% | 100,0% | 96,20% |
| AP4.3 | Active listening (staff)* | 91,9% - 96,2% | 100,0% | 96,20% |
| AP4.4 | Information provided was easily unders-tandable* | 95,9% - 98,4% | 100,0% | 96,70% |
| AP5.0 | Satisfaction with medical consultation length* | 91,8% - 95,9% | 100,0% | 95,30% |
| AP7.0 | Privacy in consultation* | 95,5% - 98,4% | 99,9% | 96,90% |
| AP8.0 | Assessment about the information and explanation provided (treatment)* | 93,3% - 96,9% | 95,6% | 95,90% |
| AP9.0 | Users opinion is asked * | 77,8% - 85,3% | 76,5% | 84,30% |
| AP11.1 | Family doctors assessment* | 89,9% - 94,5% | 98,0% | 93,20% |

| Code | Indicator | % Satisfied in the District | Answer rate | % Satisfied (Andalusia average) |
|---|---|---|---|---|
| AP11.2 | Paediatrician assessment* | 81,1% - 91,5% | 31,7% | ◑ 88,20% |
| AP11.3 | Nurses assessment* | 86,4% - 92,0% | 87,9% | ○ 93,60% |
| AP11.4 | Administrative staff assessment* | 76,0% - 82,9% | 96,6% | ○ 85,10% |
| AP11.5 | Social workers assessment* | 77,3% - 93,3% | 13,3% | ◑ 90,80% |
| AP10.1 | Would you recommend this professionals (staff)* | 89,0% - 93,8% | 97,7% | ○ 95,10% |
| AP10.2 | Would you recommend this centre* | 82,5% - 88,5% | 94,8% | ○ 92,80% |
| Code | Indicator uses and demand | % Satisfied in the District | Answer rate | % Satisfied (Andalusia average) |
| AP13 | Have you got and appointment on the date you asked for | 67,5% - 75,2% | 95,6% | ○ 86,20% |
| AP27 | Have you got an appointment with a specialist (managed by your Primary Care Centre) | 90,2% - 94,8% | 80,5% | ◑ 94,80% |
| AP28 | Have you been informed about the possibility of choosing the specialist | 22,4% - 30,7% | 79,3% | ○ 38,00% |
| AP15 | Waiting time (under appointment-days) | 15,0 - 18,2 | 95,7% | 15,7 |
| AP6.0 | Consultation time (minutes)* | 8,6 - 9,4 | 99,7% | 8,8 |

Source. SAS, 2011

| | Hospital Costa del Sol (APES Costa del Sol) | | | |
|---|---|---|---|---|
| Code | Satisfaction Indicator | % satisfied /District | Answer rate | % satisfied (Andalusia average) |
| HP1 | Satisfaction with service provided | 87,5% - 92,8% | 100,0% | 89,40% |
| HP3 | Assessment of visit hours | 79,9% - 86,7% | 96,5% | 77,10% |
| HP6 | Assessment of room comfort | 59,0% - 67,7% | 100,0% | 62,70% |
| HP8 | Easiness to solve paperwork | 83,3% - 89,6% | 97,0% | 82,60% |
| HP9 | General assessment of facilities | 83,5% - 89,7% | 97,7% | 80,00% |
| HP10 | Proper signs in the hospital | 78,8% - 85,8% | 93,7% | 81,90% |
| HP11 | Assessment of food quality | 65,9% - 74,2% | 97,7% | 75,50% |
| HP13 | Assessment of cleaning | 86,6% - 92,1% | 99,5% | 82,50% |
| HP15 | Satisfaction with the information provided by the doctors | 86,9% - 92,3% | 99,5% | 88,60% |
| HP17 | Satisfaction with the information provided by the nurses | 84,2% - 90,3% | 97,0% | 88,10% |
| HP19 | Trust and reliability on the service (care) provided | 79,4% - 86,2% | 98,2% | 76,30% |
| HP20 | Proper identification of profes-sionals | 78,8% - 85,8% | 97,2% | 81,30% |

| Code | | % Satisfied in the District | Answe rate | % Satisfied (Andalusia average) |
|---|---|---|---|---|
| HP21 | Respect (treated correctly) | 88,3% - 93,5% | 99,7% | 90,10% |
| HP22 | Privacy in the hospital | 53,1% - 62,1% | 96,0% | 50,40% |
| HP28.1 | Doctors assessment | 90,0% - 94,8% | 99,7% | 90,80% |
| HP28.2 | Nurses assessment | 86,9% - 92,4% | 99,5% | 88,10% |
| HP28.3 | Orderly assessment | 89,9% - 94,8% | 95,5% | 87,50% |
| HP28.4 | Administrative staff assessment | 85,2% - 91,4% | 88,1% | 85,60% |
| HP28.5 | Nursing assistants assessment | 89,8% - 94,7% | 97,7% | 88,80% |
| HP29 | Active listening (staff) | 79,0% - 85,8% | 99,0% | 80,80% |
| HP32 | Waiting time | 21,3% - 40,0% | 19,7% | 31,60% |
| HP37 | Waiting time from hospitalisation to surgery procedure | 50,3% - 64,5% | 39,1% | 63,70% |
| HP26 | Proper care to companion | 79,7% - 86,8% | 88,9% | 84,80% |
| HP43 | Would you recommend this hospital | 92,9% - 96,9% | 98,5% | 92,30% |
| Code | Indicator uses and demand | % Satisfied in the District | Answe rate | % Satisfied (Andalusia average) |
| HP4 | Information about visits pro-gramme | 45,0% - 54,3% | 93,4% | 51,90% |

| | | | | |
|---|---|---|---|---|
| HP5 | Companion permits | 97,4% - 99,6% | 98,7% | ● 96,90% |
| HP16 | Doctor assigned | 65,9% - 74,2% | 98,5% | ◑ 72,00% |
| HP18 | Nurse assigned | 41,5% - 50,6% | 96,5% | ◑ 45,40% |
| HP34 | Information about surgery procedure | 93,3% - 98,9% | 38,6% | ◑ 94,20% |
| HP35 | Written consent | 91,6% - 98,0% | 38,6% | ◑ 95,40% |
| HP38 | Have you got a medical report for your family doctor | 93,5% - 97,4% | 93,9% | ◑ 93,70% |
| HP39 | have you got a medical report for your nurse (primary care) | 61,8% - 70,8% | 88,4% | ◑ 69,60% |
| HP40.1 | Information about care | 89,2% - 94,3% | 95,2% | ◑ 91,30% |
| HP40.2 | Information about treatment | 89,8% - 94,7% | 94,7% | ◑ 91,50% |
| HP40.3 | Information about following up | 87,2% - 92,8% | 93,7% | ◑ 87,80% |
| HP41 | Hospital improvements | 13,6% - 20,7% | 91,2% | ◑ 20,10% |
| HP33 | Days in the waiting list | 102,3 - 157,2 | 18,4% | 133,2 |

Source. SAS, 2011