Country Report on patient/user oriented health promotion (POHP) in General Practice: Spain

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EUROPREV - European Review Group on Prevention and Health Promotion In Family Medicine and General Practice

March 2001
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Part A I: Framework for the description of initiatives, models, of good/best practice and collection of guidelines at national level

Initiatives/models of good/best practice

Effectiveness of smoking cessation in routine general practice

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Who commissioned the initiative/model?
Ministry of Health (Fondo de Investigación Sanitaria-FIS grant #95/0987) and Department of Health of the Basque Government.

Who has co-ordinated the initiative/model:
Dr. Gonzalo Grandes

What is the running time of the initiative/project:
September 11, 1995 to October 1, 1996.

What is the current state of the initiative/project:
finished

Short description of the initiative/model:

Which problem is being addressed?
Although there are data from clinical trials that have demonstrated the efficacy of smoking cessation recommendations for primary care physicians, the effectiveness of these recommendations in real clinical practice has not been assessed.

What are the goals, aims and targets?
To evaluate the results of a comprehensive smoking cessation programme in the routine primary care practice.
What are the specific strategies and measures applied?
Therapeutic plan delivered by family physician over three consultations and two telephone calls; printed guides for smoking cessation were also delivered to patients (see ‘Actions and strategies of the smoking cessation programme in primary care’, fig. 1)

What is the scope of the initiative/model:
primary health care centres of the Basque Health Service in the Basque Country (Spain).

Which partners have been involved in the development implementation?
General Practitioners from the Basque Society of Family Medicine, Epidemiologists from the Basque Health Service and Health Educators from the Department of Health of the Basque Country.

Has any systematic project evaluation been conducted on the model/initiative?
Yes, a nonrandomised controlled trial

What is the knowledge about project results so far?
Acceptability: the programme was well accepted by GPs. The time dedicated by GPs to the programme was measured in 50 recorded consultations resulting as follows: a mean of 23 seconds for recognising smokers, 3 minutes and 28 seconds for counselling, diagnosing motivation and offering the therapeutic plan.
Effectiveness: 7.1% of the intervention group and 2.1% of the control group achieved validated and sustained abstinence, being 5% (95% CI, 3.1% to 6.8%) the crude effect attributable to the programme.
Efficiency: On average, 20 smokers must be identified in practices in which the programme has been implemented to result in one abstainer attributable to the programme.

Which were the most important barriers concerning development and implementation?
General Practitioners selected were particularly motivated in helping patients to stop smoking. Some kind of training (although it was minimal in the case of this study) is needed to reproduce the results of the study. One of the reasons for excluding patients was the lack of a telephone home, and this represents a real barrier in the development of the programme, since without telephone contact, follow-up is more difficult to achieve, if not impossible.
Which specific aspects of the model/initiative would you consider especially well-developed or otherwise instructive and thus relevant for transfer to other EU member states?

Smoking cessation programmes can be incorporated into everyday practice of general practitioners without introducing major changes in the course of their daily work. Smokers were recruited without taking into consideration tobacco dependence or willingness to stop smoking. Less than four minutes are needed (on average) for identifying smokers and for counselling, diagnosing motivation and offering the therapeutic plan. These actions caused a five percent increase in the absolute probability of giving up among all smokers at one year. Two telephone calls (one on the day to stop and 15 days after smoking) and three consultations during 2 months, obtained a 20% of successes among those patients who were willing to stop and accepted the therapeutic plan.

Available publications:

**Effectiveness of brief intervention on non-dependant alcohol drinkers**

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Who commissioned the initiative/model?
Programme for prevention and health promotion (Spanish Society of Family and Community Medicine).

Who has co-ordinated the initiative/model:
Dr. Rodrigo Cordoba

What is the running time of the initiative/project:

What is the current state of the initiative/project:
finished

Short description of the initiative/model:

Which problem is being addressed?
Simple advice is insufficient for reducing the consumption of alcohol to below the risk levels.

What are the goals, aims and targets?
To evaluate the effectiveness of brief and systematic advice with support and reinforcement visits in reducing the consumption of alcohol to below the risk levels.

What are the specific strategies and measures applied?
Brief intervention included a condensed therapy of a cognitive-behavioural type, with the following elements: quantification of intake, a questionnaire on life-style (with 12 items, 4 of them formed the CAGE test), information about risks and limits of safe consumption, a informative booklet designed especially for self-study, individualized agreement of alcohol consumption in units/week, and offering follow-up and support. The entire intervention lasted approximately 15 minutes

Which partners have been involved in the development implementation?
General practitioners from the Spanish Society of Family and Community Medicine

Has any systematic project evaluation been conducted on the model/initiative?
Yes
What is the knowledge about project results so far?

Acceptability: The time dedicated by GPs to the entire intervention was approximately 15 minutes. No scheduled visits were needed.

Effectiveness: 67% of the brief intervention group (BI) and 44% of the simple advice group (SA) reduced their consumption to below the risk limit (35 units/week), while targeted reduction to below 21 units/week was reached by 46% of the BI group and by 24% of the SA group.

Efficiency: 4 drinkers must be identified in practices in which the BI programme has been implemented to result in one drinker reducing consumption to below 21 units/week.

Which were the most important barriers concerning development and implementation?

General Practitioners who finalized the study were probably the most motivated in helping patients to reduce alcohol consumption. Time dedicated to the BI is approximately ten minutes longer than to the SA.

Which specific aspects of the model/initiative would you consider especially well-developed or otherwise instructive and thus relevant for transfer to other EU member states?

Brief and systematic advice is more effective than simple advice (which usually includes only quantification of the intake, a questionnaire on lifestyle, and information about the risks and limits of safe consumption) and can be easily incorporated into everyday practice of general practitioners. As opposed to the simple advice group, the BI group received a booklet designed specifically for the study. Also, patients from this group received an individual and customised agreement of alcohol consumption, below the level of risk, in units/week.

Available publications:

**Intervention strategies to improve adherence among hypertensive patients**

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Who commissioned the initiative/model?
Ministry of Health, FIS (Fondo de Investigación Sanitaria, #98/1464).

Who has co-ordinated the initiative/model:
Dr. Emilio Marquez

What is the running time of the initiative/project:

What is the current state of the initiative/project:
finished

Short description of the initiative/model:

Which problem is being addressed?
How to improve therapeutic compliance in hypertensive patients.

What are the goals, aims and targets?
To assess the efficacy of a health education intervention through a group session and reinforcement with postcards in improving therapeutic compliance in hypertensives patients.

What are the specific strategies and measures applied?
Health education intervention in group sessions and reinforcement with postcards the first, third and fifth months after the visit, and then every three months over two years. At the end of this period, hypertensive patients were visited three times: the first one at the health center with a prior appointment, the second was done 9-10 months later at home (not expected by the patient), and the third one was done 1 month later, also at home (and not expected by the patient). During these visits, blood pressure was measured and all the pills were counted.
Which partners have been involved in the development implementation?
General practitioners from the Spanish Society of Family and Community Medicine, and an independent investigator who was in charge of making the telephone calls, of developing the group sessions and sending the postcard reinforcement.

Has any systematic project evaluation been conducted on the model/initiative?
Yes

What is the knowledge about project results so far?
Effectiveness: 96% of the hypertensive patients in the intervention group complied with the medication, while only 56% of the patients in the control group complied with the medication. The relative benefit increase was 90%, and the absolute benefit increase was 40%.
Efficiency: The number of patients needed to treat to avoid one case of non-compliance was 2.54 (between 2 and 3).

Which were the most important barriers concerning development and implementation?
Group sessions and postcards reinforcement are time consuming, and it is unlikely that GPs could have carried out this process by themselves without the support of other health professionals.

Which specific aspects of the model/initiative would you consider especially well-developed or otherwise instructive and thus relevant for transfer to other EU member states?
Health education intervention in group sessions was very structured and thought out (based on Glanz K, and Scholl TO. Intervention strategies to improve adherence among hypertensives: review and recommendations. Patients Counselling and Health Education 1982;1:124-128).
An informative booklet was also sent by mail to all patients as a reminder of the group session, including messages of positive reinforcement to comply with the treatment.

Available publications:

The effect of an office-based physicians' advice on adolescent exercise behaviour

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Who commissioned the initiative/model?
Programme for prevention and health promotion (Spanish Society of Family and Community Medicine)

Who has co-ordinated the initiative/model:
Dr. Ricardo Ortega

What is the running time of the initiative/project:
1995-1997

What is the current state of the initiative/project:
finished

Short description of the initiative/model:

Which problem is being addressed?
How to increase physical activity in adolescents.

What are the goals, aims and targets?
To assess the effectiveness of a health education intervention in increasing the levels of physical activity through physicians' advice provided in the office.

What are the specific strategies and measures applied?
Health education intervention is offered to individuals according to a specific protocol: first, individuals are classified as active, partially active and inactive using a specific and validated questionnaire. Patients in the intervention group were provided with reinforcement, increase or initiation counselling, depending on the baseline status. Individuals in the control group were provided with no intervention. Individuals were visited again six months later, in order to classify them according to the three categories and to provide them with the appropriate, counselling. Once again, the controls were provided with no intervention. The study ended a year
after the first visit with both groups being given the same questionnaires, reclassifying and comparing the three categories between them.

Which partners have been involved in the development implementation?
6 General practitioners working in the public health system (INSALUD-ICS)

Has any systematic project evaluation been conducted on the model/initiative?
Yes

What is the knowledge about project results so far?
Effectiveness: 53.5% and 36.3% individuals in the intervention and control group respectively were classified as active, with higher duration, frequency and intensity of the physical activity. The relative benefit increase was 47%, and the absolute benefit increase was 17%.
Efficiency: the number of individuals needed to counsel to get one more active adolescent at one year is 6.
Cost-effectiveness: the cost of physician’s advice to get one additional active adolescent at one year was estimated to be $13.40-$26.80.

Which were the most important barriers concerning development and implementation?
Assessment of a behaviour such as physical activity is a complex task.
GPs are sometimes not motivated to advise patients to change physical activity behaviour.
To find the best moment to give some advice to adolescents whenever they come to the office.

Which specific aspects of the model/initiative would you consider especially well-developed or otherwise instructive and thus relevant for transfer to other EU member states?
The questionnaire used for physical activity assessment had the following characteristics: “non-reactiveness” (it does not alter the behaviour of the individual being surveyed), practicability, applicability and accuracy (it is both reliable and valid). As opposed to many other exercise advice studies where the questionnaire could classify individuals as active/inactive, in this study the questionnaire could classify individuals within four categories. The intervention carried out in this study is one step further than other studies about the effectiveness of exercise counselling, because those adolescents who were physically active but not manifesting sufficient duration, frequency, and intensity of exercise were provided with the increase, rather than the reinforcement counselling. Also in this study, adolescents were contacted directly in the office and the entire intervention was carried out by their own General Practitioners.

The duration of follow-up is another important strength of this study, allowing sufficient time for the adolescent to consider the advice and to look for the opportunity to either begin exercising or to increase his/her activity levels.
Available publications:

Analysis of the effectiveness of a comprehensive programme of prevention and health promotion in Spain

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Who commissioned the initiative(/model)?
Spanish Programme of Prevention and Health Promotion (Spanish Society of Family and Community Medicine)

Who has co-ordinated the initiative(/model):
Dr. Pedro Subias

What is the running time of the initiative(/project):
1998

What is the current state of the initiative(/project):
finished

Short description of the initiative(/model)

Which problem is being addressed?
The impact of a comprehensive programme in clinical practice.

What are the goals, aims and targets?
To assess the effectiveness of a comprehensive prevention and health promotion programme in reducing smoking, hypertension and alcohol consumption.

What are the specific strategies and measures applied?
85 primary health centers involved in the Programme of Prevention and Health Promotion using a specific questionnaire recording data on age, sex, tobacco habit, alcohol consumption and blood pressure of patients visited in the centres from May 1995 to April 1997. Specifically, the following data was recorded: preventive activity-measurement or counselling carried out, time of diagnosis, initial and final assessment.

Which partners have been involved in the development implementation?
378 basic care units (each basic care unit composed of a physician and nurse), from 85 health centres from all over Spain.
Has any systematic project evaluation been conducted on the model/initiative?
Yes

What is the knowledge about project results so far?
28.3% of the patients were tobacco dependents, 6.9% were heavy drinkers and 22.2% had hypertension. About 20% of cases for each condition were detected through the programme during that period of time.
Effectiveness: 7.6% of the smokers and 19.7% of the drinkers stopped during these two years and 78.6% of hypertensive patients had acceptable - optimum control.

Which were the most important barriers concerning development and implementation?
Those health centres involved in the programme and participating in this study were volunteers, so the results could be overestimated and therefore cannot be extrapolated to all the health centres of Spain.

Which specific aspects of the model/initiative would you consider especially well developed or otherwise instructive and thus relevant for transfer to other EU member states?
A comprehensive programme in prevention and health promotion can have an impact in clinical practice, reducing negative health behaviours and risk factors. One of the most relevant features of this programme is the existence of a chart form to be used within the medical record, that can be used as a reminder of the preventive and health promotion activities and also, as a useful tool for the evaluation of the programme.
Recommendations of the programme are evidence-based, with some adaptations based on the Spanish reality.
Implementation of the Programme has been increasing since the beginning, and currently more than 590 hundred health centres - more than 10% of the Spanish population is covered by these centres - are included in the Programme.

Available publications:
Part A II: National Guidelines Documents for POHP

GUIA BASICA sobre consejo de los profesionales sanitarios dirigidos a modificar hábitos de vida. Documento nº 0.
Year of publication: 1995.
Commissioned: Spanish Programme of Prevention and Health Promotion (PAPPS), Spanish Society of Family and Community Medicine (semFYC).
Actors involved in its development: members of the Health Education group of PAPPS.
Knowledge about utilization: No

GUIA para la intervención sobre el consumo excesivo de alcohol. Documento nº 1. PAPPS. SemFYC (translated into English. A copy is attached)
Year of publication: 1995.
Commissioned: Spanish Programme of Prevention and Health Promotion (PAPPS), Spanish Society of Family and Community Medicine (semFYC).
Actors involved in its development: members of the Health Education group of PAPPS.
Knowledge about utilization: No

GUIA de educación sanitaria sobre actividad física de tiempo libre. Documento nº 2. PAPPS. SemFYC.
Year of publication: 1995.
Commissioned: Spanish Programme of Prevention and Health Promotion (PAPPS), Spanish Society of Family and Community Medicine (semFYC).
Actors involved in its development: members of the Health Education group of PAPPS.
Knowledge about utilization: No

GUIA para ayudar a la gente a dejar de fumar. PAPPS. Documento nº 3. SemFYC (translated into English. A copy is attached).
Year of publication: 1995.
Commissioned: Spanish Programme of Prevention and Health Promotion (PAPPS), Spanish Society of Family and Community Medicine (semFYC).
Actors involved in its development: members of the Health Education group of PAPPS.
Knowledge about utilization: No

GUIA para ayudar a promover una alimentación saludable. Documento nº 4. SemFYC.
Year of publication: 1996.
Commissioned: Spanish Programme of Prevention and Health Promotion (PAPPS), Spanish Society of Family and Community Medicine (semFYC).
Actors involved in its development: members of the Health Education group of PAPPS.
Knowledge about utilization: No
Efectividad de la educación sanitaria en grupo en el marco de la atención primaria. PAPPs. SemFYC.
Year of publication: 1997.
Commissioned: Spanish Programme of Prevention and Health Promotion (PAPPs). Spanish Society of Family and Community Medicine (semFYC).
Actors involved in its development: members of the Health Education group of PAPPs.
Knowledge about utilization: No

GUIA de prevención del cáncer en atención primaria. PAPPs. SemFYC.
Year of publication: 2000.
Commissioned: Spanish Programme of Prevention and Health Promotion (PAPPs). Spanish Society of Family and Community Medicine (semFYC).
Actors involved in its development: members of the Health Education group of PAPPs.
Knowledge about utilization: No

Year of publication: 2000.
Commissioned: Spanish Programme of Prevention and Health Promotion (PAPPs). Spanish Society of Family and Community Medicine (semFYC).
Actors involved in its development: members of the Health Education group of PAPPs.
Knowledge about utilization: No
Part B: Framework for the description of relevant preconditions for POHP in General Practice (GP)

What are the general characteristics of the health care system and specific characteristics of General Practice relevant for POHP in your country?

General overview of the Health Care System

Insurance coverage in Spain is uniform, universal and requires no patient cost-sharing. All the primary health care centres are part of the National Health Service. The population is geographically assigned to each health centre.

Specific situation of General Practice in Spain

How is General Practice organised in Spain?

The speciality of family and community medicine began in Spain in 1978 and the first group of Family Physicians finished their training in 1981.

The name of family and community medicine defines some of the essential characteristics of this type of training and the subsequent work the Family Physician does.

It is "family" because it treats not only the individual as an isolated person who can become ill, but also because it treats the patient in relation to his/her family environment. The family has its own illnesses and these can notably influence the individual. Some obvious examples are psychological and social problems, such as in the alcoholism of one's partner/spouse or in the drug addiction of a child, etc. These problems must also be solved within medical possibilities.

It is "community" because the community or population that Family Physician attends also has its own illnesses that must be recognized (such as drug addiction in youths, teenage pregnancy, HIV infections etc.) and solutions must be attempted, taking into account the active participation of the community itself. The community activities that family physicians might undertake could consist of numerous and varied interventions. One example is that family physicians might participate in periodic meetings with members of the community in order to look for and solve health problems. Putting a suggestion box in the health center, giving talks on health education to diabetics, (going to) visiting schools to talk about birth control or dental hygiene, implementing a door-to-door vaccination campaign, etc. are all ways the family physician can connect with the community.
In Spain, in order to become a Family Physician, a specific exam (MIR- Médico Interno Residente) must be passed and, as in the rest of the specialities, candidates undergo the requisite training, in this case for 3 years, with similar systems of education and evaluation.

In Spain there are about 25,000 GPs (although about 12,000 have been specially trained through a residency programme). The average number of patients per practice is about 1,800. They are employed by the (N)ational (H)ealth (S)ervice (i.e. they earn a government salary). Patients pay 40% of the medicines’ cost. Pensioners do not pay. Family physicians serve as gatekeepers (the referral to specialised care is always made via a Family Physician). In urban Spain, primary care for children is provided by paediatricians. FPs mostly work in a group setting (teamwork), except for rural areas. Also, FPs work together with other health professionals, such as nurses (mainly), physical therapists and social workers. There are two types of practice: the traditional (solo) model, where the physician is assisted by a nurse who is mainly dedicated to administrative duties, delivers two ours of primary care a day followed by domiciliary visits; the new model, which has been implemented since 1986, physicians and nurses are organised into primary care teams (group practice) providing primary care 7 hours a day. It is expected that the traditional model will be completely replaced in the future by the new model. There are some regions in Spain where 30% of the population is still attended by the old model.

Is health promotion a defined part of the professional role? How is health promotion being defined?

Prevention and Health Promotion are priorities for the primary care services in Spain. GPs have specific responsibility for preventive health or anticipatory care for adults and children. Since January 1989, the Spanish Society of Family and Community Medicine, the Spanish Society of Paediatricians and the Ministry of Health have been supporting the country-wide programme of Prevention and Health Promotion (PAPPS).

At the present time, there are more than 590 health centres enrolled in the PAPPS, covering a population of over 10 million inhabitants. An updated monograph has recently been published (PAPPS, 1999) addressing all the selected preventive conditions accompanied by clinical practice recommendations tailored to patient age and gender. A preventive chart listing all the activities within a specified period was designed to be used inside the medical record as a reminder and follow-up of each preventive recommendation.

Health promotion is defined as the process of empowering individuals and communities to increase their control over the determinants of health.
Current POHP in GP

- Has there been any (recent) scientific study (or systematic inquiry, respectively), exploring the extent and types of HP activities in routine GP in your country? If so, what where the main findings? No
- Has there been any (recent) scientific study (or systematic inquiry, respectively), exploring organisational factors relevant for POHP in GP? Yes. A recent study was carried out in Spain.

Summary of the study

The objectives were to identify the characteristics of the practices that are associated with the accomplishment of the three main preventive activities (tobacco, alcohol and hypertension).

A cross-sectional study, reviewing medical records, was performed in 378 practices from 85 health centers enrolled in the programme of Prevention and Health Promotion in Primary Care (PAPPS), in Spain. Each practice obtained a random sample of medical records, adding up to a total of 7,562 patients. The successful implementation of preventive recommendations related to tobacco, alcohol and hypertension, and characteristics of the physician, nurse and health organization were assessed.

The main findings were the following: a specific chart form for recording preventive activities, speciality in family medicine and a time-share for nurse and physician to implement the preventive recommendations, were associated with a more successful accomplishment of preventive activities. However, a heavy patient load and teaching health centers were associated with less successful results. (This last result raises two aspects of some concern. First, it might be that physicians during the residency training with no experience in delivering prevention and health promotion activities were responsible for carrying out preventive activities in these centers, and they might fail to introduce them in clinical practice. Second, it might also be true that teaching practices - as opposed to non-teaching practices - have an overload of activities including research, and this might interfere with the performance of the preventive activities). From this study, we may conclude that having followed a specific training in family practice and the use of a preventive chart form are important predictors of successful accomplishment of preventive recommendations. Also, nurses along with physicians, play an important role in the implementation of preventive activities in clinical practice.

Reference:

a.
Preferences and Expectations

Has there been any systematic inquiry (or survey, respectively) on GPs’ opinion of their role in HP and/or the extent of their involvement in HP activities?

A Delphi study was performed recently with the objective of knowing the profile, attitudes, and expectations of health professionals (GPs, nurses, pharmacists, pediatricians, and other specialists) working in primary care in the 21st century. Three hundred and seventy one (371) health professionals from all over Spain participated in the survey, and the response rate was 92%. Data was not analysed by type of health professional, thus it cannot assure that findings represent GPs opinions, although 50% of participants were GPs. The main results concerning health promotion activities were the following: 97.7% believed that it was important to increase preventive activities related to tobacco and alcohol cessation, and 93.5% believed that it was important to increase preventive activities related to illegal drug abuse. No consensus was found concerning increasing preventive activities in children (periodic health examinations, immunizations, etc.). 96.8% believed that it was important to increase preventive activities related to HIV infection and 91.5% believed that it was important to increase preventive activities related to sexually transmitted disease(s).

Publication:
Perfil, actitudes. Valores y expectativas de los profesionales de la Atención Primaria en el siglo XXI. Cuadernos de Gestión para el profesional de Atención Primaria 1995 (Supp.1).

A study of self-reported preventive activities in a stratified random sample of 700 primary care physicians was conducted from March to June, 1996, in the Basque Country, Spain. One of the objectives of the study was to determine how often they deliver effective interventions for the prevention of cardiovascular diseases, cancer, and acquired immunodeficiency syndrome. The response rate was 91%. More than 63% reported to ask about tobacco use or alcohol consumption or to check blood pressure to most of their new patients. On the other hand, only 33% asked about intravenous drug use, 14% about sexually transmitted diseases, and 6% about the number of sexual partners.

Has there been any systematic inquiry exploring patients'/users' expectations of or preferences for HP in GP? (or of the general public, respectively)

In 1994, a survey of 15,000 individuals, randomly selected from the population of Catalonia, was performed. The main results of the survey concerning perception of health are the following: excellent health 7.1%, very good 16%, good 52.7%, acceptable 19.9% and bad 4.3%.

87.8% of the those surveyed/interviewed had been visited by a health professional at least once in the previous year, and the frequency of the visits increased with age. 22% of those surveyed/interviewed said that they had been visited during the previous two weeks (or had had a telephone consultation) by a health professional.
GPs were the health professionals most often visited by the population (in 48.5% of the cases). The reasons of consultation were preventive examination in 10% of the cases. Only 11% of the population were physically active or over active. 31% of those surveyed were smokers (that is, 42% of males and 21% of females), 6.4% of men and 2.2% of females were heavy drinkers.

Publication:

**Structural preconditions for the development and current practice of POHP in GP**

**Laws, Rules and Regulations**

Have there been any specific laws (regulations, respectively) relevant for the development of POHP in GP? Are GPs obliged to document HP activities?

NO

Have there been any incentive schemes or specific remuneration/economic rewards for POHP activities set up in GP?

NO

**Education and training**

Have specific topics and key skills (e.g. prevention, epidemiology, public health, communication knowledge and skills) relevant for POHP been integrated in basic medical education, postgraduate training, and CME respectively?

YES, basically in postgraduate education and training.

**Policies, programmes and projects**

Is there any explicit policy/official statement concerning the professional role of physicians/GPs in health promotion?

YES.

Prevention and Health Promotion are priorities for the primary care services in Spain. GPs have specific responsibility for preventive health or anticipatory care for adults and children.

Have any specific programmes relevant for POHP in GP been set up?

Yes
What are the most important partners for the development and practice of POHP in GP in your country? GPs and nurses.

Are there any specific networks relevant for the development of POHP in GP? The Spanish Programme(s) for Prevention and Health Promotion has a network of more than fifty health professionals collaborating in 7 working groups (cardiovascular diseases, infectious diseases, health education, pediatrics, elderly, women, and mental health) were scientific evidence is reviewed and recommendations are discussed.

Is POHP in GP supported by discussion in journals/at conferences, newsletters, information campaigns, lobbying? A Spanish journal of primary care (Atención Primaria) publishes a (specific) special issue covering health promotion and prevention once a year. In it, recommendations are reviewed and updated, and results of the evaluation of the PAPPS programme are presented.

Other relevant preconditions for POHP in GP not explicitly addressed in this framework: No

List of references


Subías P , Brotons C, Perula L, Martín-Rabadan M, Iglesias Mª. Martín-Zurro A, on behalf of the Programme of Prevention and Health Promotion in Primary Care (PAPPS) in Spain. Compliance with preventive and health promotion recommendations in primary care practices in Spain.(Data not published)
