European Observatory on Health Care Systems

Health Care Systems in Transition

Spain





The European Observatory on Health Care Systems is a partnership between the World Health Organization Regional Office for Europe, the Government of Norway, the Government of Spain, the European Investment Bank, the World Bank, the London School of Economics and Political Science, and the London School of Hygiene & Tropical Medicine in association with the Open Society Institute.

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Foreword

The Health Care Systems in Transition (HiT) profiles are country-based reports that provide an analytical description of each health care system and of reform initiatives in progress or under development. The HiTs are a key element that underpins the work of the European Observatory on Health Care Systems.

The Observatory is a unique undertaking that brings together WHO Regional Office for Europe, the Governments of Norway and Spain, the European Investment Bank, the World Bank, the London School of Economics and Political Science, and the London School of Hygiene & Tropical Medicine in association with the Open Society Institute. This partnership supports and promotes evidence-based health policy-making through comprehensive and rigorous analysis of the dynamics of health care systems in Europe.

The aim of the HiT initiative is to provide relevant comparative information to support policy-makers and analysts in the development of health care systems and reforms in the countries of Europe and beyond. The HiT profiles are building blocks that can be used to:

- learn in detail about different approaches to the financing, organization and delivery of health care services;
- describe accurately the process and content of health care reform programmes and their implementation;
- highlight common challenges and areas that require more in-depth analysis;
- provide a tool for the dissemination of information on health systems and the exchange of experiences of reform strategies between policy-makers and analysts in the different countries of the European Region.

The HiT profiles are produced by country experts in collaboration with the research directors and staff of the European Observatory on Health Care Systems. In order to maximize comparability between countries, a standard template and questionnaire have been used. These provide detailed guidelines

and specific questions, definitions and examples to assist in the process of developing a HiT. Quantitative data on health services are based on a number of different sources in particular the WHO Regional Office for Europe health for all database, Organisation for Economic Cooperation and Development (OECD) health data and the World Bank.

Compiling the HiT profiles poses a number of methodological problems. In many countries, there is relatively little information available on the health care system and the impact of reforms. Most of the information in the HiTs is based on material submitted by individual experts in the respective countries, which is externally reviewed by experts in the field. Nonetheless, some statements and judgements may be coloured by personal interpretation. In addition, the absence of a single agreed terminology to cover the wide diversity of systems in the European Region means that variations in understanding and interpretation may occur. A set of common definitions has been developed in an attempt to overcome this, but some discrepancies may persist. These problems are inherent in any attempt to study health care systems on a comparative basis.

The HiT profiles provide a source of descriptive, up-to-date and comparative information on health care systems, which it is hoped will enable policy-makers to learn from key experiences relevant to their own national situation. They also constitute a comprehensive information source on which to base more in-depth comparative analysis of reforms. This series is an ongoing initiative. It is being extended to cover all the countries of Europe and material will be updated at regular intervals, allowing reforms to be monitored in the longer term. HiTs are also available on the Observatory's website at http://www.observatory.dk.

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The current series of Health Care Systems in Transition profiles has been prepared by the research directors and staff of the European Observatory on Health Care Systems.

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The Observatory team working on the HiT profiles is led by Josep Figueras, Head of the Secretariat and the research directors Martin McKee, Elias Mossialos and Richard Saltman. Technical coordination is by Suszy Lessof. The series editors are Reinhard Busse, Anna Dixon, Judith Healy, Elizabeth Kerr, Suszy Lessof and Ana Rico.

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Introduction and historical background

Introductory overview

Spain covers 505 955 km^2 and has the third largest surface area of any country in western Europe. With an average altitude of 660 metres above sea level, it is a country with a highly varied geography and climate. The population, mostly Roman Catholic, tends to concentrate in the capital and along the coastline, while the central areas of the country are becoming increasingly under-populated, with average population densities that are lower than 20 inhabitants per km^2. This distribution of the population is partly due to climatic and water conditions, and partly due to the historical pattern of industrialization of the Spanish state.

The difficult climatic conditions of most areas of central Spain, the scarcity of water and the early destruction of the forest have progressively brought about a desert-like landscape in many areas of the two Castillas, Aragon, Extremadura and Andalucia (see Fig.1), traditionally dedicated to agriculture and fishing. Within these regions, apart from some exportable agricultural products (most notably, a variety of high-quality wines and olive oils), the rest of agricultural production is characterized by old-fashioned techniques and low productivity levels. A similar situation applies in some of the regions along the northern coastline (Galicia, Asturias and Cantabria), with a predominantly, backward primary sector that has been subject to limited modernization, and remarkably weak secondary and tertiary sectors based on relatively new alimentary and tourist industries.

In contrast, historically, most of the country's industrial production has concentrated in the northeastern quarter, including the three vertices of Madrid, Barcelona (Catalonia) and Bilbao (Basque Country), where the most affluent service sectors also tend to concentrate. The heavy industry inherited from the nineteenth century mostly concentrates in the Basque Country, with some additional presence in the Catalan and Valencian regions. Catalonia has

Fig. 1. Map of Spain. Autonomous Communities[1]

Source: Ministry of Health and Consumer Affairs, 1999.

traditionally been specialized in the textile and chemical industries (most notably, pharmaceuticals), and recently also houses an affluent automobile sector. The Mediterranean coastline, together with the northern regions of Navarra and La Rioja, and some areas of Aragon, Catalonia and Andalucia, consist of prosperous settlements for the most productive, export-oriented agricultural sectors, and for a modern, rapidly developing food industry. Tourism is a highly productive sector in the Mediterranean regions (including Andalucia, Valencia, the Balearic Islands and Catalonia) as well as in the Canary Islands. Finally, Madrid has progressively been evolving from a merely bureaucratic capital into a modern centre of financial and commercial services and, during the last few decades, has also absorbed an increasing share of new industrial investment ventures.

[1] The maps presented in this document do not imply the expression of any opinion whatsoever on the part of the Secretariat of the European Observatory on Health Care Systems or its partners concerning the legal status of any country, territory, city or area or of its authorities or concerning the delimitations of its frontiers or boundaries.

Marked differences in culture, language and political-administrative traditions coexist within these varying climatic and economic settings. First, there are four official languages in the country, linked to different cultural traditions: Castillian (the first official language, spoken by the whole of the population), Catalan (spoken, under different dialects, in Catalonia as well as in Valencia and the Balearic Islands), Galician (closely related to Portuguese) and Basque (the only non-romance language). Second, historically the political organization of the Spanish state comprised a number of kingdoms, each with its separate government and administrative, legal and judicial systems. Of special relevance were the autonomous political institutions of Catalonia and the Basque Country, which persisted almost untouched until the eighteenth (Catalonia) and nineteenth (Basque Country) centuries and were later re-established during some of the few subsequent democratic periods.

Spain has nearly 40 million inhabitants (see Table 1). More than 50% of the population have completed at least secondary education (and nearly 15% obtain a university degree), making Spain well placed internationally regarding education. The population distribution by age is slightly younger than in other countries in the European Union (EU), but there are trends towards an ageing population and a significant reduction in the birth rate. In 1997, the fertility rate was 1.18 children per woman aged 15–49, the lowest in western Europe, and very far from the replacement rate. Available official estimations for the last two years indicate that the fertility rate kept on decreasing to reach 1.15 in 1998 and 1.08 in 1999. At regional level, in 1998, the birth rate oscillated between a maximum of 1.44 children in Murcia and a minimum of 0.81 in Asturias.

As a result of these low fertility rates, Spain (together with Italy, Hong Kong and Portugal) is presently one of the countries in the world in which the population is decreasing most rapidly. In fact, it is calculated that at the current rate, the country will lose about 25% of its population in 50 years' time. In addition, population forecasts show that, unless either fertility or immigration increase substantially in the next few decades, the proportion of the population over 65 years of age will more than double in the next 50 years, reaching 37% of the population, the highest figure in the world.

Health status

Life expectancy in the late 1990s is well above the European average (the third highest in the EU in 1996, after Sweden and France), and it has been constantly rising since the 1970s. For women, life expectancy is particularly high, with Spain ranking second within the EU in 1996 (after France). Male life

Table 1. Demographic and health indicators, 1990–1997

Indicators	1990	1991	1992	1993	1994	1995	1996	1997	1998
Population (million)	38.851	38.920	39.008	39.086	39.150	39.210	39.270	39.323	39.852
% over 65 years	13.4	13.6	13.9	14.2	14.6	15.1	15.5	15.7	16.1
% with secondary education or higher	39.3	40.6	42.3	44.4	46.2	47.9	50.3	51.7	–
Crude birth rate (per 1000 population)	10.3	10.1	10.0	9.9	9.3	9.2	9.0	9.2	9.2
Crude death rate (per 1000 population)	8.6	8.7	8.7	8.7	8.6	–	–	8.9	9.1
Total fertility rate	1.36	1.33	1.32	1.27	1.21	1.18	1.15	1.16	1.15
Female life expectancy at birth	80.4	80.6	80.7	80.9	81.0	81.2	81.8	82.0	–
Male life expectancy at birth	73.4	73.4	73.4	73.3	73.3	73.2	74.5	74.6	–
Infant mortality (per 1000 live births)	7.6	7.2	7.1	6.7	6.1	5.5	5.5	5.5	–

Sources: UN HFA Database 2000, OCDE Health Data Base 1999, INE Data Base 2000

expectancy figures are however lower in comparative terms, placing Spain (together with the Netherlands) fourth highest in the EU (after Sweden, Greece and Italy). With an average national figure of 77.9 years in 1995, regional variations were within the range 79.3–76.9 (corresponding to Castilla-Leon and Andalucia, respectively). The nationwide increase registered between 1975 and 1995 is slightly higher than the average EU growth level. These relatively high figures are mainly due to the fact that Spain has considerable under-average mortality rates for the most frequent causes of death (such as those due to ischaemic heart and cerebrovascular diseases, cancer, and accidents and external causes of death). However, during the 1990s, the rate of growth in life expectancy has not been as pronounced as in previous decades, especially for males.

The slowed growth in life expectancy has been attributed to the increasing incidence of lung cancer, cardiovascular diseases and AIDS. In fact, in the late 1990s, Spain had by far the highest standarized mortality rate caused by AIDS within the European Union (followed by Italy, France and Portugal), and also over-average rates of mortality caused by infectious diseases as well as by traffic- and work-related accidents. During the 1990s, with the exception of AIDS, the prevalence of these causes of death has been decreasing, partly due to improved health prevention and promotion practices. The same is true with regard to most chronic illnesses. In contrast, aggregate adjusted mortality rates for cancer increased by 8% between 1985 and 1995. This is in contrast with the generalized decrease experienced in the EU, as exemplified by a 3% to 4% decrease in mortality due to lung and breast cancer respectively between the mid-1980s and the mid-1990s. Of particular concern is the 11% increase in mortality due to lung cancer in Spain during this same period.

This trend is consistent with the fact that, in 1997, Spain had one of the highest rates of tobacco consumption per capita in the EU, along with Greece, Germany and Luxembourg. While the overall trend in Europe is one of slight but continuous decrease, in Spain this rate almost doubled between 1976 and 1997. Between 1987 and 1997, however, the percentage of smokers among men decreased from 55% to 45%. On the contrary, the rate of smokers among women increased from 23% to 27% during the same period. In terms of alcohol consumption, Spain was also over average in the late 1990s. In fact, with a consumption rate of 10.2 litres per capita, it occupied the fifth highest position in the world in 1995. Nevertheless, unlike tobacco, this indicator shows an over-average decreasing trend since the mid-1970s. Finally, the percentage of the population with weight and obesity problems was higher than the EU average in 1997, and the same was true for the relative number of people who did not exercise regularly.

HIV and AIDS require a specific mention, as Spain has a high prevalence of both, particularly among intravenous drug users. From 1981 to December 1999, 56 491 cases of AIDS had been reported. Some 55% of those, or 31 070, had died from AIDS by 1999. The total number of people infected with HIV, excluding AIDS cases, has been estimated to range between 100 000 and 120 000.Recent data suggests that the rate of HIV infection is beginning to fall; there is a drop in sero-prevalence of the infection in intravenous (injection) drug addicts, the number infected by homosexual practices has stabilized, and there is a substantial decrease (amounting to 80% between 1995 and 1999) in mother–child transmission of HIV. According to the latest available data, the annual incidence of AIDS declined by 60% between 1995 and 1999, with between 5000 and 3000 new cases diagnosed each year over the last five years. There has also been a decrease in other sexually transmitted diseases. Nevertheless, in spite of this decreasing annual trend in incidence rates, the global prevalence of AIDS continues to rise.

Other especially relevant public health problems in Spain, as mentioned above, are traffic- and work-related accidents. Mortality rates due to road accidents were 17% higher than the EU average in 1995. Since 1975, the trend has been as follows. While in the European Union there is a continual decline in mortality between 1975 and 1995, in Spain the indicator suffers several important increases and decreases. Of special concern was the 50% rise registered during the 1980s. Between 1990 and 1995, however, the trend was reversed and mortality rates dropped by almost 40%, resuming the levels achieved at the start of the 80s. As for occupational injuries, in the mid-1990s, Spain presented the highest incidence rate of the EU. In addition, between 1994 and 1997, the incidence of this type of accident has constantly been increasing, as reflected in an accumulated growth rate of more than 20%.

Infant mortality has been rapidly decreasing since the mid-1970s, at a rate very similar to average EU levels. In 1975, the rate (18.9 deaths per 1000 live births) was slightly above the EU average of 18.1 per 1000. However, between 1975 and 1985, it decreased at an average rate of 5% per year, dropping to 9 per 1000 in 1985. From the mid-1980s to the mid-1990s, infant mortality decreased by 3.5% on average each year, with a more pronounced decline during the 1990s. In 1997, the infant mortality rate was 5.5 per 1000 live births, slightly under average levels in the European Union. At the regional level, there are considerable variations in this indicator, which are within the range 7.5–4.0 per 1000 live births (corresponding to La Rioja and Cantabria, respectively).

Evidence available on health inequalities in Spain, as reported by Benach and Urbanos, points to the following situation and trends. In the early 1980s, standardized mortality rates for manual workers were 30% higher than those of professionals and managers, while this difference had increased to 70% in the early 1990s. As for self-assessed health status, in 1995 40% of the lowest social class declared that their health was very bad, while only 27% of the higher social classes assessed their own health status as being very bad. The time trend here also shows an increase in inequalities from 1987 to 1995, with both the level and the growth rate of inequalities being more marked in the poorer regions. As for self-assessed morbidity, the prevalence of chronic illnesses and disabilities is also greater among the poorer, with differences among social classes increasing over time. For instance, in 1993 the age-adjusted prevalence of diabetes among women was 2.5 times higher among the lowest social class than among the highest, while in 1986 the percentage of physically disabled persons among the illiterate was six times higher than among those with university education. As for lifestyles, similarly, there is a significant pattern of social inequalities, which tend to increase with time, suggesting that the richer benefit more from health promotion policies than the poor.

Economy

In 1998, the Spanish GDP per capita in US $PPP was 16 400, ranking thirteenth in the European Union. Between 1986 and 1991, GDP growth was higher than the EU average. This trend was reversed in 1992 and 1993, after an especially severe economic downturn. After economic recovery in mid-1990, by the end of the decade the GDP growth rate had resumed its 1990 level. Following a similar trend, the unemployment rate peaked in 1994, remaining at levels higher than 20% during the period 1993–1997. However, since the mid-1990s, they have been dropping and, in 1998, had fallen to 18.8% of the active population. The annual registered inflation rate has been constantly decreasing during the

1990s. Available estimates for 1999 point to a slight slowdown in the GDP growth rate, a further drop in unemployment, and an increase in inflation, which amounted to almost 3% in 1999 (see Table 2).

Political environment

Spain is a parliamentary monarchy. The 1978 Constitution followed a long period of dictatorship. Since then, the country has undergone a deep transformation of the state, its political structure and its legal framework. One of the main elements of this metamorphosis has been the profound political decentralization of state structures incrementally implemented since the start of the transition to democracy. Spain joined the EU in 1986.

At central level, legislative power is placed in a two-chamber parliament (Congress and Senate). In practice, however, the Senate has been rather weak for a prolonged period of time, although several reforms to reinforce the Senate's role within the system have been discussed recently. Territorially, the political organization of the Spanish state is made up of the central state, 17 regions (termed *Comunidades Autónomas*, Autonomous Communities) with their respective governments and parliaments, 50 provinces, and almost 8000 municipalities. In addition, Spanish territory also includes two cities in the north of Africa, which have a statute of autonomy (Ceuta and Melilla). The size of these political units differs considerably, with Autonomous Communities ranging between 7.2 million (Andalucia) and 264 000 inhabitants (La Rioja). Municipal populations range from the almost 3 million inhabitants in Madrid to less than 10 inhabitants in the isolated municipalities of central and northwestern Spain. There are close to 6000 municipalities with less than 2000 people, and nearly 2700 with less than 500 inhabitants. The small average size of municipalities in Spain has traditionally been an important obstacle for decentralization of responsibility over major policy sectors to this level. For this and other reasons, during most of the twentieth century, provinces were usually preferred as the target level for administrative decentralization. From 1978 on, however, political decentralization focused on the regional tier of government, represented by the autonomous communities, which are by far the most politically relevant subcentral level of government in contemporary Spain.

Since the approval of the 1978 Constitution, three political parties have held office at the central government level. First, the centre-right Union of the Democratic Centre (*Unión de Centro Democrático, UCD*), which led the transition process in the period 1976–1978, governed between 1979 and 1982. Then, the social democratic *Partido Socialista Obrero Español, PSOE* was in office under the same Prime Minister from 1982 to 1996. During this time, the

Table 2. Macroeconomic indicators, 1990–1998

Indicators	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
GDP growth rate (% change)	3.6	2.1	0.5	-1.4	2.1	2.6	2.3	3.4	4.0	3.7
GDP per capita US $PPP	11 856	12 873	13 287	13 440	13 743	14 318	15 162	15 800	16 400	–
Annual average rate of inflation	67	6.4	6.4	5.6	4.8	4.7	3.6	2.0	1.8	2.9
Total employment, % annual change	2.6	0.2	-1.9	-4.3	-0.9	2.7	2.9	3.0	3.4	5.2
Unemployment rates	16.2	16.4	18.4	22.7	24.1	22.9	22.2	20.8	18.8	15.4

Sources: UN HFA Database 2000, OCDE Health Data Base 1999, INE Tempus Data Base 2000

social democrats also held office in almost two thirds of the regions. Since 1993, under a minority government, the social democrats had to rely on the support of regional parties in order to pass legislation. Over these years, the Ministry of Health was directed by five different ministers, each of whom formed their own high-level team.

In March 1996, after almost 14 years of social democratic rule, the centre-right Popular Party won the general elections with a slight majority of the votes. Accordingly, between March 1996 and March 2000 it held office at the central level with the parliamentary support of two regional parties, the Catalan and Basque centre-right parties, the same groups previously supporting the PSOE between 1993 and 1996. These two parties, in turn, run minority governments in their respective Autonomous Communities (Catalonia and Basque Country). In addition, there is another community, the Canary Islands, with a minority government led by a regional nationalistic party (*Coalición Canaria*, CC). The rest of the regional cabinets are governed by the two main central parties (PP and PSOE) either alone, in coalition with regional parties, or along with the third, small nationwide party, United Left (*Izquierda Unida*, IU). In particular, since 1999, the Popular Party holds office in seven Autonomous Communities, while the social democratic party PSOE is present in the seven remaining regions (Andalucia, Aragon, Asturias, Castilla-La Mancha, Extremadura, and Baleares). In March 2000, the Popular Party won again the general elections, this time with a majority of the votes, and more than 50% of the seats in the two chambers of the central parliament.

Each of the 17 Autonomous Communities has one basic law (Statute of Autonomy). Together with the 1978 Constitution, these 17 *Estatutos de Autonomía* comprise the constitutional framework of democratic Spain. The constitution lays out the spheres of responsibility which are the exclusive responsibility of the central state; those which may be assumed completely by the Autonomous Communities, and those which are shared between the two.

In all matters which are not the exclusive responsibility of the state, regional laws have the same legal status as those of the state, and conflicts between the two must be settled in Constitutional Court.

Health care and social security are shared areas of responsibility, although to very different degrees. In addition, an important specific feature of the territorial structure in Spain is that the powers devolved to the regional tier of government vary across Autonomous Communities. This makes for a rather complicated division of powers among levels of government, which is described in more detail on the section on *Organizational structure and management.* There are seven special Autonomous Communities (see Fig. 3 in the next section) which enjoy considerable legislative freedom and autonomy with regard to health care policy. In addition, they have restricted implementation powers in the field of social security. The ten remaining regions, ordinary Autonomous Communities, do not have devolved responsibilities in social security; at the same time, they only have a limited degree of autonomy in the health care field. On the other hand, all 17 Autonomous Communities have important legislative and implementation powers in the fields of public health, community care and some social services. Provinces and large city councils own most psychiatric hospitals, mental health care centres and nursing homes, although their role in the management and regulation of these centres has been fairly limited during the present century. Municipalities hold some managerial responsibilities in the fields of sanitation, environmentally-related health activities, and public health. Generally speaking, therefore, major health planning and legislative initiatives are based on the need for fundamental consensus among the different political powers.

Historical background

Health care and public health networks before 1975

The development of the Spanish health care system is closely related to the history and development of the social security system. The first measures of social protection began to be studied and discussed during the last quarter of the nineteenth century, within the framework of the newly-created Commission on Social Reforms. During the early 1900s, the National Institute of Social Insurance (*Instituto Nacional de Previsión, INP*) was created to coordinate the design and implementation of the first social insurance policies. This was a highly autonomous, flexible agency, which employed many prominent Spanish

social reformers from all ideological fronts, and had a democratic decision-making structure comprised of independent experts and representatives from civil associations. The first attempt to develop public health care insurance for low-salaried workers was launched by the INP under the initiative of the socialist party during the Second Republic (1931–1936), within an integrated package of social insurance schemes. At the time, all political parties supported the proposed introduction of a comprehensive social insurance scheme, although under different ideological and political motives. The draft was in the process of being discussed in the parliament at the moment of the coup by General Franco who, after three years of civil war (1936–1939), established an authoritarian regime which lasted until his death in 1975. After the war, many of the previous policy proposals were recovered by the Francoist government. This was the case with the republican health insurance package, which was approved almost unchanged in 1942. During the 1940s and 1950s, the means-tested public health care system remained largely marginal in terms of population coverage and extent of benefits. To illustrate, in 1942, the public insurance system covered 20% of the population, in 1950 30% and in 1960 45%.

The Basic Social Security Act of 1967 initiated the expansion of coverage to self-employed professionals and qualified civil servants. As a result, the percentage of the population covered rose from 53.1% in 1966 to 81.7% in 1978. During the 1960s, in addition, the social security system developed an extensive publicly-owned network of centres and services for general medical care, and specialized outpatient and inpatient care. Activity reached its highest point with the development of the modern public hospital network during the 1970s. Since the mid-1960s, the public sector has owned 70% of the available hospital beds, and has employed 70–80% of the hospital doctors, while public providers spent 75–85% of the public health care budget during the period 1975–1995. The predominance of public provision within a social security system, in fact, can be considered the main distinctive feature of the Spanish health care sector as it emerged from the Francoist period. Consistent with this, the vast majority of primary health care provision is public, with general practitioners having the status of civil servants.

Social security health care was run by the Ministry of Labour and Social Security until 1977, between 1977 and 1981 by the Ministry of Health and Social Security, and from then on by the Ministry of Health. Its networks of health care centres and services were managed since 1942 by the INP, and from 1978 onwards by the National Institute of Health (*Instituto Nacional de la Salud*, *INSALUD*), the highest health care management authority in the country, although hierarchically subordinated to the corresponding ministry. Social security hospitals, in addition to providing health care to the bulk of the

population, were also the driving force behind the training of specialists through a system of resident physicians.

General medicine emerged from the Francoist period as a secondary priority in terms of budget, infrastructure and human resources, especially in contrast with the extensive, modern public hospital network developed during the 1960s and 1970s. It was provided either in small clinics (*consultorios*) made up of individual family doctors, or in ambulatory polyclinics (*ambulatorios*) along with a few outpatient specialties. The official working hours of the general practitioners (and specialists) working in public clinics consisted of only two and a half hours a day. Doctors worked on their own, without direct contact with other colleagues. Administrative and diagnostic support were almost completely absent. At the organizational level, primary care governance was a highly fragmented task, divided among largely uncoordinated state authorities. Rural primary health care was provided by solo practitioners working as part-time employees of local councils, while the network of rural practice itself was formally in the hands of the centralized social security administration since the 1970s. In urban settings, ambulatory care was part of a separate, distinctive subsystem, with general practitioners (as well as outpatient specialists) holding the status of part-time social security employees.

Unsurprisingly, the institutional weaknesses of the primary care network were reflected in widespread social dissatisfaction with the services. In 1979, a series of surveys conducted by the central state authorities highlighted these results. Among the sample of 3000 medical professionals included in the study, 85% declared that the quality of primary care was clearly unsatisfactory, an opinion shared by two thirds of the general population. In contrast, only 15% of doctors, together with 40% of the general population, were dissatisfied with public hospital care.

The management structure of health care provision in the period prior to the transition was regulated by a ministerial ordinance approved in 1972 (*Ordenanza General sobre Régimen, Gobierno, y Servicio en las Instituciones Sanitarias de la Seguridad Social*). The ordinance established a territorial configuration of power based at the provincial level. Provincial delegations were the highest government authority at the local level, headed by a provincial director appointed by the corresponding ministry. Within provinces, both ambulatory clinics and hospitals had a similar organizational structure. The highest authority was the medical director and the government council, mainly comprising Social Security civil servants, together with some representatives from health care personnel, the Francoist trade union, and the Corporative Medical Organization (*Organización Médica Colegial*, OMC), the political body of the provincial colleges of physicians. The medical director of each ambulatory

clinic or hospital was advised by the medical council of the centre, consisting of the medical directors of each clinical service. Under the authority of the medical director, there was the nursing council and one administrator (who, alone, performed the few managerial functions attributed to health care centres). Most of the top managerial posts in the system were chosen among the members of a special civil servants' corporation, the *Corporation of Social Security Inspectors*, which had a similar prominent role as a recruitment body during the democratic period.

Responsibility for public health services was historically attributed to the central government and, in particular, to the Ministry of Governance (namely *Governación*, equivalent to Interior), the origin of which goes back to 1855. From then on, several waves of decentralization and re-centralization have occurred. During the nineteenth and early twentieth centuries, periods of decentralization were targeted at local governments. After the first quarter of this century, institutional delegation to territorial agencies of the central state was preferred over devolution to local governments. In any case, the public health infrastructure and facilities varied only slightly up until 1977, when they were integrated, together with the rest of health-related programmes, departments and centres, under the responsibility of a single Ministry. The role of the government was to attend to health problems which could affect the overall population, leaving individual health problems to the other health care networks.

In addition, local government (municipalities and provinces) had responsibility for charity health care and treatment of infectious diseases. It owned a network of general hospitals that was progressively reduced as the social security centres took over the central role in the provision of health care. Mental health care in psychiatric hospitals, however, continued to be provided by local governments.

Other health care networks, whose responsibilities were distributed over a number of different government departments, included: health care for the military (Ministry of Defence); university hospitals (Ministry of Education); and prison health services (Ministry of the Interior).

The democratic period

Overall, therefore, the main problems of the Spanish health care system at the start of the transition to democracy (1975) might be summarized as follows. First, the variety of health care networks and the number of different departments to whom the networks were responsible led to poor coordination and inadequate organization. Second, primary health care and preventive care were

considerably underdeveloped. Third, there was not universal coverage and, as a result, important inequalities developed among the needy (with restricted access to the charity-based network), the bulk of salaried workers (covered by the social security network), and the upper classes (mostly resorting to the private health care system, especially for primary and preventive care).

Some unsuccessful attempts were made during the democratic transition (1976–1982) to launch a comprehensive reform of the system, mainly as a result of political pressure exerted by the leftist parliamentary opposition on the government. These attempts were not successful because the centre-right governing party, UCD (*Unión de Centro Democrático*), in office during the transition period, did not have a clear consensual reform model in mind, and was overridden by serious political and economic problems that diverted attention from the health sector. During these years, nevertheless, a few crucial changes were introduced.

First, the 1978 Constitution highlighted the need to tackle health care reform by establishing the right to protection of health for all Spaniards. Second, it defined the new region-based organization of the state, establishing the range of responsibilities for each level of government. Thereafter, the central government launched five policy initiatives: 1) in 1977, most health-related programmes and centres were integrated under the responsibility of the newly created Ministry of Health and Social Security; 2) health care administration was lately given a separate organizational status within the social security system, following the creation of the National Health Institute (INSALUD) in 1978 and the Ministry of Health in 1981; 3) user co-payments for pharmaceuticals were introduced in 1978 for social security users under 65 years of age, initially covering 20% of the actual retail price of prescription drugs, and subsequently raised to 30% in 1979 and to 40% in 1980; 4) the training process of general practitioners was modified, following the introduction of family medicine as a separate specialty; and 5) the first stages of the process of devolution to regions (Autonomous Communities) were implemented.

In 1982, the Socialist party PSOE won the general elections with an overwhelming majority of the votes, and therefore obtained 58% of the seats in central parliament. A few months later, the Ministry of Health publicly presented the first programmatic version of a comprehensive package of reforms, articulated around the transition from the Francoist social security system to the National Health Service model (universal access, tax-based financing, predominant public provision). Some of these measures were launched rapidly through decrees and ordinances within the next two years, while others were modified or discarded during the process of parliamentary discussion which followed.

As a result of this process, the General Health Care Act was approved in 1986. Generally speaking, the main effect of the act was to consolidate, push forward and integrate most of the piecemeal reforms introduced since 1977 under a unified legislative framework. In particular, the act laid out the National Health System scheme, bringing all publicly-administered health services under one roof. This dovetailed with the new decentralized organization of the Spanish state. In this respect, the 1986 Act further refined the provisions of the 1978 Constitution, incorporating the latest decisions of the Constitutional Court and developing those institutional and financial details which the constitutional framework left intentionally undefined.

During the late 1980s and 1990s, most of the reforms prescribed by the General Health Care Act were progressively implemented, including the transfer of central and local health care centres and powers to the Autonomous Communities. Rural primary care, as well as those hospitals which depended on local governments and universities, were gradually integrated along with the social security centres into a single public network within each Autonomous Community.

Simultaneously, from the start of the 1990s, a new set of reform policies entered the scene, with the basic aim of containing costs, rationalizing organization and management, and increasing the effectiveness and efficiency of health care provision. In fact, some steps in this direction had already been made as early as the mid-1980s, such as the progressive introduction of professional management teams in most public hospitals, or the repeated attempts to keep down health care professionals' salaries. More details on these and other issues can be found in the last section of the report, dedicated to *Health care reforms*. Table 3 below provides an overview of the reforms pursued until 1999.

Table 3. The health care system: historical background and recent reform trends

1855	The Basic Health Act was passed which created, for the first time, an organizational framework for health care which depended on the Ministry of the Interior. The charity service, which depended on provincial councils, was also developed.
1900	The Accidents at Work Act was approved, which marked the start of the social insurance system.
1908	The National Institute for Social Insurance (*Instituto Nacional de Previsión, INP*) was set up. It protected the population against a variety of risks.
1929	Statutory maternity insurance was established, guaranteeing health care during pregnancy and delivery. After the approval of the Old Age Pensions Act in 1919, this was the second kind of social insurance in which the statutory nature of the worker's contribution was made effective.
1931	A process of consultation with political parties, associations and international experts was initiated for the elaboration of an integrated package of unified social insurance schemes.

1934 The Act of Health Coordination was passed, which reorganized responsibilities and infrastructures in the field of public health and infectious diseases prevention.

1936 The formulation of the Draft on Unified Social Insurance was concluded, and the last phase of parliamentary discussion and public consultation was started. The text of the law included a complete draft of the Statutory Sickness Insurance scheme implemented beginning in 1942.

1942 The Act which implemented the Statutory Sickness Insurance was approved by the newly-established (1939) Francoist government.

1944 The Basic Health Act was approved, which incorporated most of the content of the republican Act on Health Care Coordination.

1963 The Basic Social Security Act was approved, which implied the transition from a previous means-tested set of social insurance schemes to a system of social security coverage for the bulk of the working population and dependants.

1967 Basic Social Security Act began to be implemented. The social security health care system was formally introduced for workers and their dependants

1977 The Ministry of Health and Social Security was created by the first provisional democratic government, led by the centre-right party UCD (unión de Centro Democrático), which was re-elected in 1979 and remained in power until 1982.

1978 The Spanish Constitution was approved by the Constitutional Assembly and popular referendum.

The National Institute of Health (INSALUD) was created as a semi-independent public agency in charge of centralized management of the health care system.

The transfer of powers to Autonomous Communities in the field of public health was started, targeting Catalonia and the Basque Country

1981 An independent Ministry of Health was created for the first time in Spain.

The process of transferring the management of health care over to the Autonomous Communities was initiated, with the devolution of central government power to the Autonomous Community of Catalonia.

1984 Primary health care reform was started, after the electoral triumph of the socialist party PSOE (in office between 1982 and 1996).

Central health care powers were transferred to the Autonomous Community of Andalucia.

1986 The General Health Care Act was approved.

The process of devolving central public health powers to the regions was completed.

1987 Health care powers were devolved to the Autonomous Communities of the Basque Country and Valencia.

1989 There was a switch from social insurance to general taxation as the main source of funding of the health care system. Coverage was extended to those without economic resources.

1990 Health care powers were transferred to the Autonomous Communities of Galicia and Navarra.

1991 The Review of the National Health System was reported by the parliamentary commission charged with this task (Informe Abril), and several organizational and cost-containment measures were proposed.

1992 Explicit contracts with hospitals and prospective funding systems began to be piloted.

1993 A selective list of pharmaceuticals was excluded from public funding for the first time. Free choice of GPs and paediatricians was generally introduced (piloted since 1984).

1994 An agreement was reached among the central government and the special Autonomous Communities on the regional resource allocation system, which involved the rationalization

	of a set of previous piecemeal, bilateral agreements, and the commitment to renegotiate the terms of the agreement once every four years.
	Central powers were transferred to the Autonomous Community of Canary Islands.
1995	A benefits package to be provided by the National Health System was established.
	The first National Health Plan was approved.
1996	Free choice of specialist doctors within 12 specialties was introduced by the socialist government within the territory managed by INSALUD (comprising the 10 ordinary regions).
	The Decree on the self-governing status of health care centres was approved by the newly elected Popular Party.
	Occupational health care insurance (occupational accidents and work-related illnesses) was contracted-out to the private sector, along with significant responsibilities as regards sickness leave.
	The Decree on liberalization of pharmaceutical services was introduced, allowing for flexible operating hours and the establishment of new community pharmacies.
1997	A broad process of parliamentary discussion and public consultation on health care reform took place, which ended up with the approval of the Law on the self-governing status of health care centres (which mirrored the previous 1996 Decree)
1998	An updated negative list of pharmaceuticals was approved, and the first agreement with the main employers' association in the field of pharmaceuticals (Farmaindustria) on a set of cost-containment measures is signed. A new agreement on the regional resource allocation system was reached.
1999	Employer-purchased insurance plans were subjected to tax subsidies, by a provision included within the Annual Budgetary Act. As a result of this, the previous tax break on private health care expenditure was suppressed.
	Through the same act, the way was opened for the transformation of all public hospitals into independent agencies, under the legal status of public fundations.
	A debate began on the rights of access of illegal immigrants to the public system. As a result, the rights of access of non-Spanish children to all public benefits, approved in 1990, was generally made effective. In addition, the 1999 Immigrants Law, approved by all opposition parties in Parliament, included also full rights of access for adult immigrants. The future of this latter provision is nevertheless unclear, as it might soon be modified, according to the public declarations of the current government.

Organizational structure and management

Organizational structure of the health care system

The Spanish health care system has been set up as an integrated National Health Service which is publicly financed and provides nearly universal health care free of charge at the point of use. Provision is mostly publicly owned and managed: this applies to all general practitioners and primary health care centres, to outpatient specialized clinics and physicians, and to 80% of hospital care. Governance of the system is decentralized, with local organization in each of the 17 Autonomous Communities, or regions, which comprise the Spanish state. The general principles of the National Health System as defined by the 1978 Constitution and the 1986 General Health Care Act are:

- universal coverage with free access to health care for almost all citizens;
- public financing, mainly through general taxation;
- integration of different health service networks under the National Health System structure;
- political devolution to the Autonomous Communities and region-based organization of health services into health areas and basic health zones;
- development of a new model of primary health care, emphasizing integration of promotion, prevention and rehabilitation activities at this level.

These principles have resulted in far-reaching change, a process which is not yet complete. The Spanish National Health System presents a complex panorama as it evolves away from its origins as a centralized system rooted in a social security scheme towards one of universal coverage delivered through 17 Autonomous Communities. Difficulties remain in guaranteeing equal access to deprived social groups, consolidating a stable system of financing, controlling the increase in health expenditure, decentralizing services to all Autonomous Communities and coordinating and integrating the various services within the National Health System.

The role of central government

The central state assumes responsibility for certain strategic areas, including:

- general coordination and basic health legislation
- financing of the system, and regulating the financial aspects of social security
- definition of a benefits package guaranteed by the National Health System
- international health
- pharmaceutical policy
- undergraduate and postgraduate training
- civil servant human resource policies.

Many departments/ministries share these areas of responsibility. Although the Ministry of Health and Consumer Affairs plays the most significant role in determining the parameters of health policy, it increasingly shares its policy formulation authority with regional governments. In addition, many financial matters, as well as the definition of benefits, still require the approval of the social security system and/or the Ministry of Economy and Finance, while most of the issues related to personnel are dealt with by the Ministry of Public Administration. A more detailed view of the power-sharing scheme follows.

The role of the Ministry of Health

The Ministry of Health and Consumer Affairs guarantees the effective right of all citizens to health protection. This is the key authority charged with the general coordination of public health and health care services, and is responsible for the drafting of health policy and any basic enabling legislation required. It must liaise with the Ministry of Labour and Social Affairs to ensure the effective coordination of health and social services where there is joint responsibility. It is also the highest authority of the country in the sphere of consumer affairs.

Under the direct authority of the Ministry of Health are the following:

- The National Institute of Health (INSALUD), the body which manages the social security health care services in the 10 Autonomous Communities (of 17) which have not yet assumed full political responsibility for health services (covering 38% of the population).
- The Institute of Health Carlos III, which is in charge of the following tasks: promoting and coordinating biomedical research; training of personnel in public health and health services management; services on public health; health information; technology assessment; scientific and technical accreditation; and technical advisory functions. The Institute performs these functions through the Agency for Assessment of Health Technologies, the

National School of Public Health, the Health Research Fund, and a set of National Centres, which cover a series of research and service areas (Epidemiology, Clinical Research and Preventive Medicine, Nutrition, Environmental Health, Health Information, Microbiology and Fundamental Biology).

- The National Organization for Transplants, which is in charge of coordinating the extraction and transportation of organs and the selection of recipient patients.
- The National Institute of Consumer Affairs, in charge of inspection, arbitration, research, training and other tasks related to the field of consumer affairs
- The National Plan on AIDS, the body in charge of coordinating research, information, prevention and treatment of AIDS
- The Spanish Pharmaceuticals Agency, in charge of ensuring that pharmaceuticals products registered in Spain meet the criteria of quality, safety and clinical efficacy

The Ministry of Health also regulates postgraduate training for medical professionals (jointly with the Ministry of Education), pharmaceutical policy, and the standardization of medical and health products in general. An agency for the assessment of health technologies was founded in 1994 to replace the technology assessment unit of the Ministry of Health Planning Department. This agency is responsible for setting technical criteria for the election, incorporation and dissemination of health care technology. Health care technology assessment, however, is shared with the special regions, and accordingly, some of these Autonomous Communities have developed their own agencies (see the section on *Health care delivery*). In addition, the Spanish Agency for Pharmaceuticals was created in April 1999 as a semi-independent body supervised by the Ministry of Health, and is in charge of the scientific evaluation and registry of new pharmaceutical products. Given that these changes are so recent, it is not possible to evaluate whether these measures will succeed in making the system more rational and efficient.

The role of other ministries

The health system draws on the input of a number of other ministries which, until April 2000, were the following:

- *The Ministry of Labour and Social Affairs* defines the financial structure of the social security system, its package of benefits and its affiliation plans. In spite of the process of detachment from the social security framework initiated in the mid 1980s, public health care is de facto still considered a

part of the social security system for many administrative purposes. Of special relevance is the role of the National Institute of Social Security (*Instituto Nacional de la Seguridad Social*), the top managerial authority of the social security system, which is under the authority of this Ministry. Among its most prominent functions are the final approval of any changes related to the package of public health care benefits, and the authorization of all payments made within the National Health System. As for the latter function, it acts as the liaison between public health care authorities and the Treasury of the Social Security System (*Tesorería General de la Seguridad Social*). In addition, it deals with economic and social problems which occur in cases of sickness or ill health. Moreover, the Ministry of Labour and Social Affairs is responsible for social and community care (including nursing and elderly homes), although these have been progressively transferred to the regions.

- *The Ministry of Economy and Finance* is in charge of drawing up the draft bill for the state budgets including that of health care, the regulation of private insurance and the prices of pharmaceuticals. It also exerts tight control over the health care budget, and plays a prominent role in the regional health care resource allocation system.
- *The Ministry of Public Administration* is in charge of regulating most aspects of recruitment and employment of health personnel and, more generally, of civil servants.
- *The Ministry of Education and Culture* is responsible for undergraduate training and, in association with the Ministry of Health, for postgraduate training and human resources planning.
- *The Ministry of the Environment* deals with environmental health problems.
- *The Ministry of Defence*, *the Ministry of Justice* and *the Ministry of Public Administration* all sponsor an insurance scheme offering protection to their own civil servants. These funds are the mutual companies for the Social Institute for the Armed Forces (ISFAS), the General Legal Mutual Company (MUGEJU), and the Mutual Fund for State Civil Servants (MUFACE). In addition, the Ministry of Defence is still in charge of the network of military hospitals, health care centres and pharmacies, although most of these providers have been progressively contracted out to the National Health Service.

This government structure was reorganized in April 2000, with the Ministry of Economy and Finance being split into the Ministry of Economy and the Ministry of Finance, and the Ministry of Education and Culture changing its name to the Ministry of Education, Culture and Sports. In addition, the previous responsibilities of this latter in the fields of scientific research and technological

development were transferred to the newly created Ministry of Science and Technology.

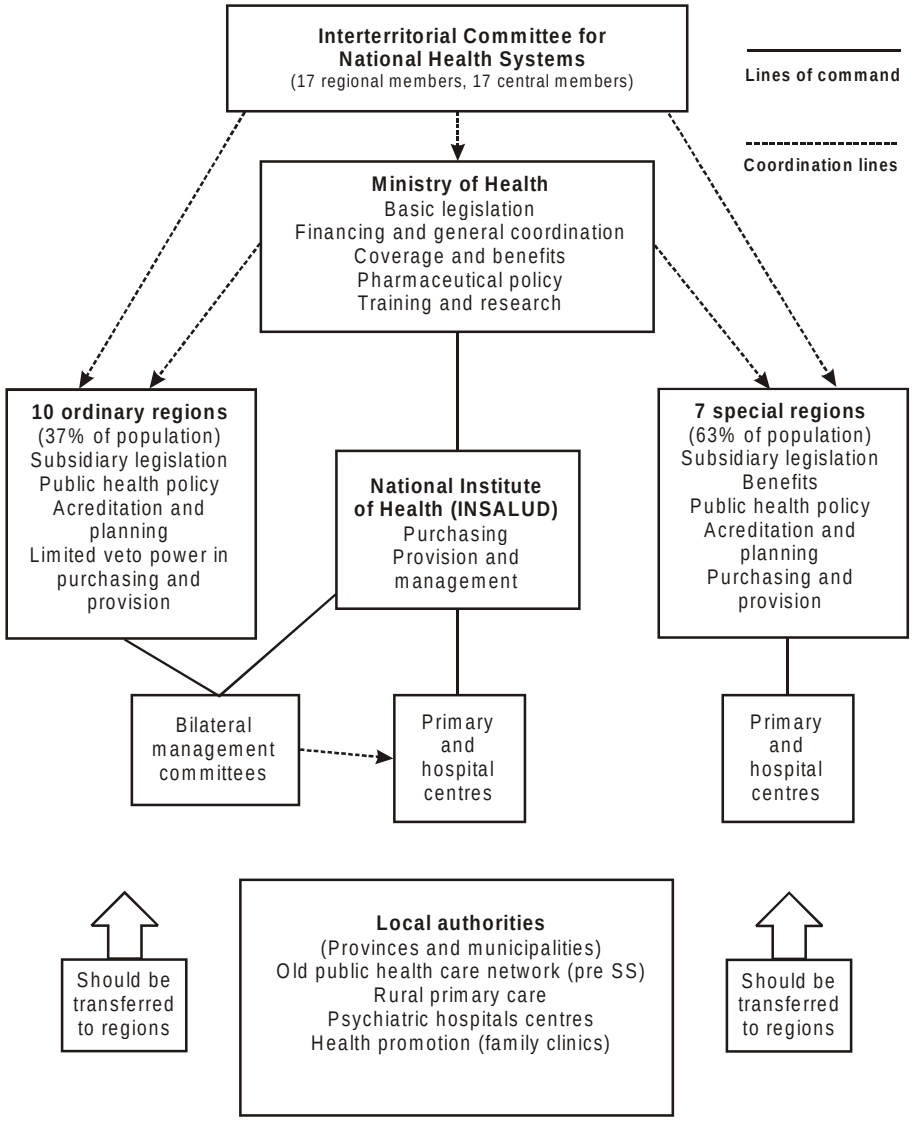
The role of regional governments

Decentralization of the state in Spain is mainly based on the model of devolution, so that responsibility for health care is transferred from the central administration to the regions, in line with the basic constitutional structure of the country. According to this model, each Autonomous Community holds health planning powers as well as the capacity to organize its own health services to the level of decentralization that it considers most appropriate to its needs. This is believed to allow for more effective resource allocation in response to the socio-demographic and cultural characteristics of each Autonomous Community and to achieve a more balanced development of the country's health services.

In spite of these organizational and planning powers given to all regions, the government and management of a significant part of the health care system in 10 out of 17 regions remains in the hands of central government. In fact, the pattern of power-sharing among government tiers is rather unusual in Spain, partly as a result of unresolved political disagreements with regard to the preferred territorial structure of the state. The distinction between symmetric and asymmetric federalism should be recalled here. Symmetric federalism consists of a territorial division of powers which gives all regions the same constitutional powers. Asymmetric federalism, on the contrary, refers to a territorial structure of the state allowing for maximum political self-government by some Autonomous Communities alongside only administrative decentralization by the rest of the regions. The prevailing power-sharing scheme in the health care sector directly results from the partial agreement reached between the defenders of both institutional alternatives during the democratic transition and the drafting of the constitution. As is well known, in several of the Autonomous Communities with distinctive cultural traditions and language (and most notably in Catalonia and the Basque Country), there are strong peripheral nationalistic groups and political parties with self-governing interests, which stand for asymmetric federalism. In the rest of the Spain, on the other hand, there tends to be support for symmetric federalism.

Constitutional regulations resolve these political tensions by introducing a non-uniform power-sharing scheme across policy sectors, and by allowing considerable room for manoeuvre to national politicians to modify the territorial structure of the state. Generally speaking, there are three types of policy sectors, each with a different territorial division of powers: 1) Those policies considered of the highest strategic importance (e.g. most economic and tax policies, as

Fig. 2. Organizational chart of health care system



well as the social security system) are retained under the authority of the central government, while only limited (if any) implementation powers are given to regions; 2) Within some (perceived as less strategic) policy sectors (e.g. public health, social services for the poor) the 1978 Constitution gives all autonomous communities the same (large) powers, which usually consist of policy

formulation and implementation within the framework of the basic legislation approved by the state; 3) As for many core policy sectors (e.g. health care, education), asymmetric federalism prevails instead. Thus, regarding health care, this presently implies that only seven regions qualify to obtain maximum powers, while the rest are only entitled to limited (if any) implementation powers. Finally, the Constitution usually leaves the issue of power-sharing considerably open to further devolution through simple legislation and subsequent modification of the autonomous communities' basic laws (Statutes of Autonomy). In fact, from the start of the 1990s, many of the policies originally included within the third category (asymmetric federalism) have recently been transferred to the ten ordinary Autonomous Communities even though they do not have constitutional powers in these fields. The most prominent example of these latest transfers is education, while the constitutional status of health care itself is currently being debated along the same lines.

Both of these power-sharing schemes (asymmetric and symmetric) are present in the field of health, which is especially chaotic in terms of territorial power-sharing. On the one hand, all Autonomous Communities have been given constitutional responsibility over the multiple public health care networks which coexisted prior to the inception of the social health insurance (SHI) system (including public health, the old networks for infectious diseases monitoring and treatment, the charity-based system, most health promotion and prevention activities, the old network of rural primary care, psychiatric care and some community care programmes). For the sake of simplicity, from now on, we term these *pre-SHI networks*. The operation of such networks represents approximately 15% of total public health care expenditure. On the other hand, the remaining 85% corresponds to health care centres and personnel formerly included within the social health insurance system. The Constitution only has devolved responsibility of the social security health care network for the seven special regions.

We will term these services *the SHI network*. It should be made clear, however, that the term may be misleading, as it barely corresponds to the current legal status of the National Health System. As it is explained in other sections of the report, from 1986 on, Spain formally initiated the transition from the Social Security scheme to a National Health Service model, which involved the progressive detachment of health care from the social security system.

The main conclusion from the above description, in any case, is that such a constitutional power-sharing scheme imposed considerable constraints upon health care policy-makers interested in guaranteeing the coordinated operation of the health care system. In fact, one of the main problems in this respect is that, within each of the ten ordinary Autonomous Communities, the two different

networks (the pre-SHI one and the SHI one) could not easily be integrated under the same roof as, under the constitutional framework (which comprises both the Constitution and the regional Statutes of Autonomy), each should be managed by different political authorities. To make matters worse, until 1978, many of the pre-SHI networks were in the hands of local governments, which historically owned, financed and managed them in cooperation with the central state. In this respect, the 1986 General Health Care Act prescribed that most local health care powers should be transferred to the Autonomous Communities. Not surprisingly, therefore, implementation of the constitutional power-sharing scheme soon turned into a huge, problematic exercise of redistribution of power and institution-building.

The 1986 General Health Care Act tried to partly solve such problems through the following organizational structure. First, it maintained the transfers to all autonomous governments of health planning and self-organizational authority made during the democratic transition. Second, it also respected the earlier decision of transferring the central pre-SHI network, which was devolved to regions between 1978 and 1986. Third, it prescribed the transfer of local pre-SHI networks to all Autonomous Communities, in order to allow for their unified governance under the authority of regional governments. Fourth, it included the effective transfer of the SHI network to the special communities.

As a result, within the former seven communities, both the pre-SHI and the SHI networks could become integrated under one roof, while the opposite applies to the ten remaining regions. In an attempt to avoid this latter problem, the act introduced a coordinated governance structure of the health care system in the ten ordinary regions, operated through bilateral committees that formally concede equal representation to the Autonomous Communities and the central state. In practice, however, the balance of power clearly favours central state authorities at the expense of these ten regional governments, and so INSALUD (the central National Institute of Health) effectively manages most health care services in these ten regions, with the bulk of health care regulation remaining in the hands of central government authorities. In short, and for present purposes, it can be said that regarding former social security services, regional governments basically retain the right to veto the limited range of policies over which they have partial responsibility (such as primary care, psychiatric care, etc.).

Regional governance of the devolved policy sectors is by the health department of the regional government (*Consejerías* or *Departamentos de Sanidad*), which is responsible for the formulation and implementation of those health policies over which the Autonomous Community holds constitutional powers. Management is by the associated regional health service, which plays a hands-on role in the delivery of health care. In fact, a peculiarity of Spanish legal

Fig. 3. Map of special Autonomous Communities and of the territory managed by the INSALUD (comprising the remaining 10 Autonomous Communities)

Source: INSALUD, 1999.

terminology is that the highest management agency at the regional level has the same name as the global regional health care system itself: both are termed *Servicio Regional de Salud* (or regional health service). Some autonomous governments have chosen to combine health and social services within one single department, while the rest usually combine health care with consumer affairs, as in the case of central government.

The National Health System's Interterritorial Council acts as the coordinating body for the state and the regions in the area of health. It is made up of the councillor for health in each of the 17 Autonomous Communities and an equal number of representatives from the central administration, and is presided over by the Minister of Health. It has merely advisory functions but, in spite of that, it has fulfilled an important role in guaranteeing policy diffusion and learning across government tiers, as well as consensual policy options. In addition, another multilateral intergovernmental body with important implications for health care policy is the Financial and Fiscal Policy Council, within which changes in the regional health care resource allocation system are discussed and agreed upon by representatives of central and regional finance departments.

In fact, the system has been continually reformed since 1986. Until 1994, this was done through bilateral agreements between the central government and each of the regional governments. From then on, these negotiations took place every four years within the multilateral body mentioned above, while cost-containment agreements and commitments among levels of government have also been introduced in these negotiation rounds.

The role of local governments

As previously stated, the Spanish Constitution attributes most of the former local health responsibilities to the Autonomous Communities, with the significant exception of basic sanitation policies and environmental health activities. In addition, the 1986 General Health Care Act prescribes that local governments should continue owning and financing the health care networks inherited from the past, although both management and personnel have to be transferred to Autonomous Communities. This peculiar power configuration has created considerable problems, with some local governments either blocking the transfers or refusing to finance the regionally operated health care services. In an attempt to resolve this issue, legislation concedes some rights to local governments to participate in the governance of the system, with mostly advisory functions, through their presence in community health councils. In addition, the Catalan regional governments resolved its long-standing conflict with the Barcelona City Council in 1989 through the creation of a consortium that allows joint management and operation of the city health care network. In 1999, this was transformed into a public corporation mainly subjected to private law. In sum, therefore, local governments continue to play a role in ensuring a healthy environment, and sometimes also in collaborating in the management of health services although, overall, their role in the system has been considerably decreased.

Organizational structure of the national health system at regional level

Most of the Autonomous Communities (14 out of 17) have legally created their health services, laying down organization by function and geographical area and the system's legal, economic and financial status. As explained above, there are significant differences in the degree to which the regional health service links all regional public health services and centres under a single strategic, managing body. Each regional health service depends, in turn, on the corresponding health department (*Consejerías o Departamentos de Sanidad*) of the autonomous government, which is the highest government authority in

the seven special Autonomous Communities, but which holds largely limited powers in the ten ordinary Autonomous Communities. In these ten communities, the ministry and INSALUD have traditionally run the services through their territorially-based provincial delegations, which are also present in the special communities, but with a small role. From the start of the 1990s, the territorial offices of the central health care administration passed to the regions instead of the provinces, and several unsuccessful attempts were made to decentralize management of the system to the health care areas in which each region is administratively divided.

Furthermore, each Autonomous Community has drawn up a health map stipulating a series of health areas and basic health zones, which often do not correspond with local governments or other political–administrative landmarks. Each area comprises several health zones. Administration is in the hands of managerial teams appointed by the regional government or the central state (depending on the constitutional status of the region), which according to the 1986 General Health Care Act, should operate at the level of the health areas, led by an area manager. Such an integrated management scheme has not, however, been implemented so far, and therefore there are still two separate managerial tiers – one for primary care and the other for hospital care. Whilst in the case of primary care there is a single area manager, the administration of secondary and tertiary care is still based on hospitals, each with its own managerial team. This implies that in those areas in which there is more than one public hospital, several hospital management authorities operate within one single health area, which often leads to uncoordinated delivery of specialist care as well as problems of coordination with other levels of care operating within the same health area.

Health areas

Formally, health areas are the basic structures of the health system according to current central legislation. They were defined according to geography, socio-economic standards, demography, employment, epidemiological factors, cultural concerns, transportation and the health facilities existing in the area. Each health area is responsible for the management of facilities, benefits and health service programmes within its geographical limits. As a general rule, each health area should cover, according to the 1986 Health Care Act, a population of no less than 200 000 inhabitants and no more than 250 000. In practice, however, many Autonomous Communities do not comply with the rule.

The following services are provided in the health areas:

- *Primary health care (PHC):* defined as care of individuals, families and the community at large through a number of programmes, including health promotion, prevention, curative care, and rehabilitation, using the area's basic resources and those of the units which support the public network of primary care centres;
- *Specialized ambulatory care:* provided through an integrated public network of specialized ambulatory centres which are dependent on hospitals, and in some cases staffed with the same teams which comprise the clinical services of general hospitals (with members who rotate to cover ambulatory visits);
- *Hospital (outpatient and inpatient) care:* each health area is linked to, or has, at least one general hospital.

Basic health zones

Basic health zones are a subdivision of health areas and are the smallest unit of the health care organization. Each basic health zone is defined in accordance with the degree of concentration of the population, the epidemiological characteristics, and the facilities and health resources of the area. A maximum distance between communities and the location of services and a standard travelling time to these facilities (30 minutes) were also taken into account. This approach has given rise to basic health zones covering 5000–25 000 inhabitants. They constitute the territorial framework for PHC delivery in the sense that they are usually organized around a single primary care centre, termed Primary Care Team (*Equipo de Atención Primaria*, EAP), which is also the main management unit of the zone, coordinating prevention, promotion, treatment and community care activities. Two thousand four hundred and forty-eight (2448) basic health zones have been designated within which the resources of PHC are organized and the corresponding health centres deliver care oriented towards resolving the health needs and problems of the local population.

Both hospitals and primary care centres are governed by a general manager appointed either by INSALUD or by the special autonomous governments. In the case of primary health care centers, the leader of the team (termed *coordinador*) reports to the area manager while simultaneously holding a direct line of accountability to central or regional state authorities. This double dependency is mainly due to the markedly limited managerial autonomy given to health care areas. In addition, the governance structure in hospitals is made up of a medical division, a nursing division and an administrative division, all hierarchically subordinated to the general manager, who directly reports to the corresponding central or regional authorities. This management system was created through central legislation during the 1980s. Autonomous Communities,

however, are free to modify this organizational model, and to choose a higher or lower degree of decentralization of powers within their respective territories. So far, however, considerable imitation across government tiers has prevailed in institutional design, and thus most regions have managerial structures which differ little from the one described above.

The role of insurance companies

Insurance companies play a relatively minor, but increasingly relevant role within the health system. In addition to private voluntary schemes, which cover some 10% of the population, there are three publicly-funded mutual funds which cater exclusively to civil servants in government departments, and occupy a unique quasi-public position. Civil servants are free to choose between public provision within the social security network of centres, and fully private provision. For service delivery for those opting for private provision, the mutual funds rely on private companies which integrate insurance and provision. In addition, it is worth noting that there is some evidence pointing to the tendency among this group of users to resort to public hospital providers for high technology interventions, although state regulation explicitly rules out this possibility.

As for private voluntary insurance, since the mid-1990s several recent reforms were targeted at the expansion of its role within the health care sector. The two main moves in this direction are as follows. Until 1996, health care for accidents at the workplace and work-induced illnesses was managed through the social security mutual funds themselves, or directly through the National Health System. Beginning in 1996, these services have progressively been contracted out to private insurance companies, which were simultaneously given a mandate regarding sick leave. This measure was adopted after a sudden increase in the (already high) rates of work-related illnesses and accidents at work registered beginning in 1993. The second political initiative in this sector can be potentially even more consequential. In December 1998, the Annual Budgetary Law for 1999 included a series of tax deductions for employer-purchased private insurance aimed at promoting this economic sector. The generic 15% tax break previously applied to all private health care payments was, however, simultaneously suppressed. More details on this policy measure are given within the sections on *Health care finance and expenditure* and *Health Care Reforms*.

Other providers

There are other public health care resources, such as military health services, under the Ministry of Defence, and the health care networks which depend on

the Ministry of Justice and the Interior (largely prison services). However, these networks are bound to undergo a process of integration into the National Health System.

Additionally, although the public system provides health care mainly through its own resources, it has traditionally contracted out some 15–20% of hospital provision with private non-profit providers. The only important exception to this rule is the Catalan public health care sector, in which two thirds of public hospital services are provided by private not-for-profit hospitals, which have deep historical roots, linked to the strong Catalan tradition of civil society mutualism. The 1986 General Health Care Act opens up the possibility for these hospitals to enter into long-term agreements with the public health care system under special (and intentionally undefined) circumstances. Usually, however, contracts with private hospitals are renewed annually.

The role of user groups

Citizens' participation was incorporated into the General Health Care Act and participatory committees were introduced at all levels of the managerial structure of the health care sector. However, they are mostly made up of representatives of local governments and professional groups, with only a markedly small percentage of membership reserved to local civic associations. This policy approach partly reflects an attempt to overcome the problems of coordination introduced by the pattern of power-sharing among government tiers, and partly is due to the limited development of user associations and voluntary organizations in Spain. The main participatory bodies act at the following levels:

- Health councils exist at the level of health zone, to advise on the management of primary and community care;
- Hospital participation committees have been set up to allow representatives of the municipalities and local consumers associations to provide input into hospital management; in 1990, these committees were transferred to the managerial structure of the health areas, in order to improve their role in the coordination of primary and specialized services at the territorial level;
- A consultative committee has recently been created at state level, which informs on the work of the Interterritorial Council and allows for representation from trade unions, employers, consumers and experts.

In practice, this participation has not been wholly effective because these committees lack direct responsibility for health care expenditure, and because Spanish consumer associations are weak and not entirely representative of the wider community.

Professional representation

The weakness of civic networks in Spain, which largely results from their prohibition and the expropriation of their assets during Francoism, also affects professional associations of health care professionals. The only institutions that survived during Francoism were the provincial medical colleges, integrated into a vertical corporative structure, the General Council of Medical Colleges. This council was represented within health management structures by the Organization of Medical Colleges (OMC), a separate political body created to protect its vested interests and represent the profession within the state.

At the start of the transition, the high level of authoritarianism of these official organizations led to the emergence of multiple, fragmented professional associations (with a political or ideological focus) which nonetheless achieved low membership levels among the bulk of the medical profession. In fact, according to survey data, barely 20% of doctors were affiliated to professional associations. The main trade unions in the sector are the medical union CESM and the nursing association SATSE, as well as the class-based socialist (UGT) and communist (CCOO) trade unions.

In the political field, it can be stated that professional associations have only had a significant impact upon the policy-making process under exceptional circumstances. Keeping that in mind, the associations with a higher impact have been, on the conservative side, the OMC itself; the left-wing Federation of Associations for the Defence of the Public Health Care System or FADSP (formerly linked to the socialist party and, beginning in the mid-1980s, playing the role of "opposition from within", accusing the Socialists in office of being too eager to abandon their initial programmatic goals of enlarging the public system in favour of cost-containment strategies); a professional association, the Spanish Society of Family and Community Medicine or SEMFYC, which has played a major, leading role in the design, formulation and implementation of primary health care reforms; and, more recently, a scientific association, the Spanish Society of Public Health and Health Management (*Sociedad Española de Salud Publica y Administracion Sanitaria, SESPAS*), which through its annual conferences and biannual reports on the health care system has been increasingly influential in political, managerial and professional fields. In addition, the class-based unions, UGT and CCOO, have also been important political actors since the start of the transition to democracy, often supporting the FDASP and the SEMFYC in their attempts to promote the development and improvement of the public health care system. Recently, the professional trade unions CESM and SATSE have also been highly influential regarding the professional strikes and wage agreements taking place within the sector.

Finally, there is one professional society per medical specialty that plays a very important role in the self-regulation of the profession, in recruitment and in professional training. They are all represented within the National Council of Medical Specialties, which exerts some regulatory powers as well as holding an advisory role. In the field of primary care, the SEMFYC, which represents those general practitioners who received specialist training in family medicine, coexists with two other associations (SEMG and SEMERGEN) representing other sectors of the profession.

As a result of the predominance of public providers, the existing nation-wide association of private providers (*Federación Española de Clínicas Privadas*) is very weak both in organizational and political terms. Catalonia constitutes a significant exception here, in accordance with the predominance of private providers within the Catalan public health care sector. Two powerful, resourceful providers associations rival for representation of the private contracted-out sector in this Autonomous Community, the Union of Catalan Hospitals (UCH) and the Catalan Hospital Consortium (CHC). Their degree of influence upon Catalan health care policy, both as vested interest groups and as independent consultants, has been considerable, especially during the 1990s.

Planning, regulation and management

Although the provider-purchaser split is increasingly present in Spanish health care legislation since the start of the 1990s, it has not been implemented so far. Accordingly, the organization and management of the National Health System generally continues to integrate the functions of financing, purchasing and provision. Planning and regulation of the health system are areas of shared responsibility. The General Health Care Act prescribes that health care areas, as well as the regional governments and the central state, should produce their own health plan, through a process of broad social participation. These area plans are to be progressively aggregated and summarized into regional plans from below, and the same process is expected to take place at the central level with regional plans. Both the regional and central plans have to be approved by the corresponding parliaments. While autonomy implies significant independence here, the central state and the different Autonomous Communities seek to reach a consensus which reflects the interests of the different political powers and regional administrations, and to ensure that the various health plans are kept informed of the national as well as regional health priorities.

By 1999, all regional governments have produced and approved their own regional plans, following the increased emphasis given to priority-setting since

the beginning of the 1990s. Such emphasis has been the result of two separate political processes. On the one hand, the introduction of the WHO health for all objectives into the Spanish legislation in 1990, promoted by (mostly left-wing) politicians and health professionals linked to the fields of epidemiology and public health, and basically targeted at increasing the quality, equity and clinical effectiveness of the health care system. On the other hand, the increased discussion and utilization of cost-containment measures since the mid-1980s, which mainly conceived priority-setting as a strategy to control the increase in health care demand and expenditure. Up to the late 1990s, these two separate political processes have followed largely independent paths, and it is only in recent years that a common approach has started to emerge, emphasizing the need to link health status priorities with resource allocation and financial planning.

As is this case in many countries, the possibility of using regional plans as the basis for resource allocation and capacity planning has not yet been considered, and therefore they have mainly played the role of instruments for information development and needs assessment. An additional problem in Spain is that the majority of health care plans offer unrealistically large lists of objectives, which are often not sufficiently based on the available epidemiological and cost-effectiveness evidence, and the accomplishment of which has seldom being evaluated. However, the process of planning has had important outcomes, especially with regard to grassroots participation, coordination among different territorial units, and information systems development. In addition, in the Autonomous Community of Catalonia, the health plan has effectively been used from the mid-1990s to set targets in contracts with providers. The first evaluation of this experience, made in 1998, showed positive results.

The first Central Health Plan, approved in 1995, lays down the general framework of the system and the intersectoral programmes across different administrations. It sets 14 priority areas for action (the elderly, AIDS, diseases of the cardiovascular, respiratory, digestive and musculoskeletal systems, communicable diseases, cancer, tuberculosis, diabetes mellitus, prenatal and postnatal care and infant health, mental health, dental health and accidents), in accordance with the regional health plans. Through a legislative measure approved the same year, the central government also specified a package of benefits which the National Health System must offer in all regions, and sets out minimum requirements which must be met as regards public health, health care and health facilities.

The planning and regulation of regional health services at primary and specialized levels, the integration of the two levels and the introduction of approved high technology, however, fall within the domain of the Autonomous Communities. Nevertheless, in those communities which have yet to

assume the legal authority to manage their own social security health care services, the National Institute for Health (INSALUD), which falls under the Ministry of Health, takes on many of the planning and regulatory functions. In these communities, INSALUD operates alongside the relevant regional health service and is not integrated into it.

Since 1990, some Autonomous Communities, such as Catalonia, Andalucia or the Basque Country, as well as INSALUD, have introduced legislation aimed at launching a progressive process of separation between the provider and purchaser functions. According to this model, the purchasers (regional health services or INSALUD) will contract services from public and private hospitals, and in some cases, health centres covering specified populations. A "contract-programme" is negotiated between the payer and the provider of services. This contract sets out the package of health care services to be provided in accordance with a series of objectives, such as level of activity, performance or population coverage, and establishes the financial allocation in the form of a global budget. This model has not yet been fully implemented. In particular, the purchaser-provider split has not been introduced, although the practice of contracting has, however, become common across health care administrations. An important landmark here is the introduction of a refined prospective payment system in Catalonia in 1998 (see the section on *Health care reform*).

Decentralization of the health care system

The process of decentralization of the pre-SS networks to all Autonomous Communities started in 1978, shortly before the approval of the Constitution, and ended in 1986. In addition, between 1981 and 1994, the SHI network was devolved to the seven special Autonomous Communities, which cover 62% of the Spanish population, according to the following timetable: Catalonia (1981), Andalucia (1984), the Basque Country and Valencia (1988), Navarra and Galicia (1991), and the Canary Islands (1994). The ten ordinary communities, which account for the remaining 38% of the population, still have health care systems under the direct control of the state's general administration. The successful accomplishment of the process of devolution took considerable time and effort and was far from problem-free, mainly due to disagreements between the central state and regional governments on financing issues related to the regional resource allocation system. Partly due to this piecemeal process, the transfer of services was carried out under different conditions to the seven Autonomous Communities, giving way to a somewhat fragmented system of health care financing and, ultimately, to significant problems regarding control of

global health care expenditure (see the section on *Health care finance and expenditure*).

The gradual move towards decentralization described above has created a degree of confusion. The coexistence of relatively autonomous regions and those where central government continues to manage health care delivery directly has blurred the distinction between the functions which correspond to the ministry as a health authority at national level and those which relate to the direct supervision and management of health care in a given part of the country. This has become especially problematic since it tends to undermine the legitimacy of the central authorities in the eyes of the Autonomous Communities as an impartial coordinating and planning body for the National Health System, and particularly as the regulatory body for financing.

Other problems derived from the decentralization process are as follows. First, coordination and integration of all health care activities within the territory of the ten ordinary Autonomous Communities have proved to be considerable costly tasks due to the prevalent power-sharing schemes. Instances of policy blockage through regional vetoing of central initiatives have not been uncommon, as happened, for instance, with the implementation of primary health care reforms in Galicia from the mid-1980s to the mid-1990s. Second, the process of transferring local government functions to the Autonomous Communities has also been subjected to considerable political tension, generating additional coordination problems. Third, as it has been observed in other international episodes of political decentralization, centralized steering has become increasingly more difficult as the process of devolution developed, due to instances of pre-emption of the central policy space by the regional governments, and to political resistance by the autonomous governments to comply with centrally-issued regulation.

In this context, it is generally acknowledged that the eventual devolution of the health care network to the ten ordinary Autonomous Communities and the abolition of INSALUD will improve mechanisms for coordinating and planning the system, and will enable the Ministry of Health to better meet its obligations as a national health authority and as the body responsible for guaranteeing the system's equity and quality. In fact, the electoral programme of the Popular Party for the periods 1996–2000 and 2000–2004 included this move high on the political agenda, although it is unknown whether this will be put into practice. The significant political difficulties encountered by both the Socialist party and the PP since the early 1990s during the course of their unsuccessful attempts to launch these same reform proposals contributed to slow down and eventually block implementation of these proposed reforms. Therefore, the prospects for the future still remain uncertain.

Health care finance and expenditure

Main system of finance and coverage

Broadly speaking, the Spanish health service is financed out of general taxation which has replaced a more insurance-oriented system. Funding is collected centrally and is allocated on a per capita basis to autonomous communities, which manage these resources with varying degrees of independence.

Coverage of the population

Coverage is almost universal for Spanish citizens and guarantees a fairly comprehensive package of benefits to all citizens regardless of personal wealth. If individuals are not covered by the national scheme, this is usually on the grounds of membership in an alternative, employment-linked insurance programme and not on the basis of inability to contribute. The option of purchasing additional private insurance is also open to all citizens.

In fact, there is only a small group of the Spanish population formally not covered by the National Health System: those who are not obliged to join the social security system and, simultaneously, do not qualify for access through the non-contributory scheme (reserved for the population with scarce economic resources). This excluded group is basically made up of self-employed liberal professionals and employers. It is estimated that they represented about 0.6% of the Spanish population in 1997 although this figure, taken from the latest available National Health Survey, might well underestimate the size of this group, as explained below. As for the remaining 99.4% of Spaniards who are covered by the statutory system, the 1997 National Health Survey yielded the following results:

- 94.8% of the Spanish population was covered under the obligatory affiliation to the social security system;
- 4.6% of the Spanish population – civil servants and their dependants – was covered through a special system (mutual funds), whose most salient characteristic is the option given to these civil servants to choose between health care within the National Health System or coverage through private insurance. Approximately 50% of the members of the mutual funds choose each option, according to the same survey. However, as explained below, registered data shows considerably different figures.

Therefore, public health care coverage, while it may be characterized as "universal", does not in fact cover 100% of the population. This is because it is still linked to social security on an employment-related basis and not to citizenship and residence. This explains the exclusion of the affluent self-employed population mentioned above, and also the fact that a special non-contributory scheme is in place for the economically disadvantaged (the old users of the charity-based network). In particular, the latter are still subjected to separate administrative regulations (e.g. they have to pay the full price of medicines, except in the Basque Country where this amount is paid by local councils). Although from 1989 they have gradually been acquiring the right of getting access to the same facilities and centres as the rest of the population, there is no information on whether the integration has already been completed. An additional problem here is that they need to submit to a process of means-testing (in order to prove that they do not earn more than the minimum salary) and obtain a special access card to make effective their new rights. In addition, adult residents who did not attain citizenship do not generally have the right of access, except in the case of urgent life-threatening conditions or pregnancy. Legal non-Spanish residents, however, attained the right of access in 1988 in the Basque Country, which was also the first Autonomous Community to put into practice the actual integration of the users of the charity-based system starting this same year.

The exact size of each of these groups of beneficiaries is however uncertain. In fact, as there is not a population-based registration system of beneficiaries in the country, estimations have to rely on survey data. This leads to a number of technical problems that might be particularly misleading given the small size of some of these social groups. In fact, the registered data for civil servants (the only group of beneficiaries for which such data is also available) shows that survey data has serious estimation problems here. Whilst the 1997 National Health Survey estimates that 4.6% of the population is covered by the special civil servants mutual funds, the officially registered data from the National Institute of Social Security (*INSS*) gives a figure of 9%. In addition, while

survey results point to 50% of members opting for public provision, according to the *INSS*, barely 12% of them choose public providers.

The political agenda as regards coverage has been as follows. Extension of coverage to the entire population on the grounds of citizenship has not yet been considered, in spite of the formal adoption of the National Health Service model in 1986. At the start of the 1990s, two Autonomous Communities, Catalonia and Navarra, passed legislation contemplating the integration of the affluent self-employed within the public system, through an insurance premium equivalent to average per capita public health care expenditure. The measure, however, thus far has not been put into practice.

During the second half of the 1990s, a debate opened up about the status of civil servants who are members of mutual funds. On the one hand, it was argued that civil servants should be included in the mainstream system under the same conditions as the rest of the population. On the other hand, it was proposed that the system of choice of insurer, now only available to civil servants, should be extended to other population groups. In fact, the latter proposal was included in the electoral programmes of both the nationwide Popular Party and the Catalan governing party CiU starting in 1993. Seven years later, however, the issue has not ever been the subject of any public debate or concrete policy proposal.

In 1998, another political debate began on the rights of immigrants. In 1990, the Children's Rights Act gave all immigrant children under the age of 18 years full rights of coverage and access to the public health care system. However, this provision of the Act was never implemented. As a result, in February 1998, the Ombudsman of the Autonomous Community of Madrid issued a formal complaint against INSALUD and central state authorities based on some cases of immigrant children who had been asked to pay for public health care centre services. The conflict received wide media attention, with newspapers conveying that the immigrant population was only getting informal, ad hoc access to the system basically as a result of altruistic doctors' individual decisions to treat them in spite of their lack of real coverage rights. The final outcome of the public debate was as follows. First, during 1999, immigrant children's rights were made effective through development of the necessary implementation measures. Second, the extension of full health care rights to the adult immigrant population was included within the first draft of the Immigrants Act, which was approved by all the main opposition parties in parliament in 1999, but rejected by the party in office, PP. Accordingly, government declarations during parliamentary discussions posed doubts as to the likelihood of effective implementation, suggesting that the Act might be revised after the elections in March 2000, in which the Popular Party obtained an

absolute majority of the votes. The main government argument against the extension of coverage was financial: the expected annual cost of the measure has been calculated at about 5000 million pesetas.

Financing of the National Health System

In theory, the financing of the National Health System is formally characterized by the principle of solidarity: the population should contribute to the financing of health according to its own level of wealth and should have access to health care according to its own particular needs. In practice, however, recent research has shown that the reality of this system is different, which has mainly occurred through the 1986 reform of the indirect tax system to introduce VAT, after accession to the EU. The progressive, re-distributive income tax-system, after being complemented with indirect and other taxes, gives nearly proportional results in Spain: each citizen contributes to general taxation by a fixed, similar proportion of their income, independent of their total level of wealth.

In fact, the conclusions of a well-known cross-national comparative study on equity in health care financing show that Spain was intermediate in western Europe both in the early 1980s and in the early 1990s. In particular, the situation at the start of the 1990s was as follows. Overall health care financing was almost proportional, with public financing being slightly progressive and private health care financing clearly regressive. The growth from 1980 to 1990, in turn, shows a significant, but small, increase in equity, as total health care financing was slightly regressive in the early 1980s. General patterns reversed by sub-sector, as public financing was regressive in 1980, while private payments were slightly progressive. By detailed sources of finance, the evolution has been as follows. In spite of the income tax system doubling its progression during the period, the overall progression of general taxes halved. This is mainly explained by the introduction of the VAT system following membership of the EU in 1986, which involved a parallel shift from near proportionality to regression in the indirect tax system (which prior to 1986 was targeted at luxury goods). In addition, the estimated share of indirect taxes over total health care finance increased from 6% to 25% due to the combined effects of two changes: the shift to tax financing initiated in 1989 and the increase in overall indirect taxes resulting from the adoption of VAT. Social security contributions changed from being regressive in 1980 to being progressive in 1990, but their effect upon financing was increasingly less important over the years as the reliance on taxes increased. Time trends also differ for the different types of private health care financing: while private insurance became less regressive, the effects of out-of-pocket payments shifted from near proportionality to clear regression.

Historically, the system was funded mainly by insurance contributions, which were supplemented with funds from the state budget. The transition to a National Health System initiated in 1986 led to a major shift of health care financing from social security payroll contributions to direct state funding. Presently, the system is principally financed by taxes. The transition process has been as follows. Since the mid-1970s, the social security system covered about two thirds of total health care expenditure, while the remaining third was covered through the state budget. In 1989, this pattern was reversed for the first time, with state funding increasing to 70%, and social security contributions dropping to about 30% of the total. Throughout the 1990s, the role of social security contributions in health care financing has been steadily decreasing (especially from 1994 on) and by 1999, had completely disappeared.

Currently, therefore, 98% of total public health care expenditure (excluding civil servants' mutual funds) is funded through general taxation, while the remaining 2% is generated by care provided for patients with other types of coverage. Most taxes are centrally raised, due to the limited fiscal autonomy of Spanish regional and local governments. For example, in 1996, taxes generated by Autonomous Communities represented less than 9% of total public health care financing, while the equivalent figure for local governments was 0.3%. These figures do not take into account user co-payments to the National Health System, which only apply for pharmaceuticals and some orthopaedic-prosthetic products.

Regarding the financing of civil servants' mutual funds, it is estimated that they are 70% funded by the state (through taxation) and 30% through contributions from the civil servants to their own mutual fund. The funds protect their member from other social risks, and so the concrete financing scheme for health care services is not known. When members opt to be covered by the National Health System, the mutual funds pay a per capita sum directly to the national system. If, on the other hand, members choose to join the private health care system for civil servants, a sum is paid to private insurance companies in line with the pre-agreed stipulations of the mutual fund. Health care expenditure by these funds represented about 4% of total public health care expenditure in 1996.

Finally, the allocation of resources to the various Autonomous Communities is laid out in the State Budget Act of the Spanish Parliament on an annual basis. The General Health Care Act envisages the progressive transition from a regional allocation system based on historical expenditure to a capitation system for those communities which have taken on full responsibility for regional health care. The regulation and steering of regional resource allocation during the transition process is made from within the Financial and Fiscal

Policy Committee, which includes representatives from the finance departments of the Autonomous Communities and the central state. However, central state authorities retain the constitutional right to make final decisions in this area. (A more detailed description of this system can be found in the section on *Financial resource allocation.*)

Health care benefits and rationing

Until recently, there was no clearly defined package of benefits guaranteed under the social security health care system. The extension of treatments available was a gradual process often in response to advances in technology and medical science and without any prior attempt to assess either effectiveness or efficiency. This failure to evaluate new interventions threatened both the quality of health care and efforts to control rising costs. In addition to these problems of effectiveness and cost control, the absence of a systematic response to technological developments in a decentralized environment increasingly gave rise to inequalities in the benefits offered by the different regional health services.

For all of these reasons, the Royal Decree 63/1995 was passed to define services covered by the National Health System. The two main objectives of this regulation were:

- to complement the charter of citizens' rights included in the General Health Care Act with a explicit list of benefits guaranteed by the public health system all over the country, maintaining the benefits which were already available within the system, and making universal those which were not yet available to everyone;
- to regulate the introduction of new services and technologies, applying the criteria of effectiveness, safety, quality and efficiency.

Nonetheless, it should be noted that the definitions laid down are not always precise, and they do not necessarily specify the financing needed or how benefits will be financed. Some advances have recently been made in this field, as detailed regulation on the extent of, and limits for coverage for four different treatments were approved during the period 1996–1999. In addition, pharmaceutical benefits were also extensively regulated during the 1990s.

Benefits covered by the National Health System

The Royal Decree 63/1995 defined benefits as follows:

Primary health care (PHC) covers general medical and paediatric health care at the doctor's office and the patient's home, as well as programmes for prevention of disease, health promotion, and rehabilitation.
Specialized health care in the form of outpatient and inpatient care covers all medical and surgical specialties in acute care.
Pharmaceutical benefits: The user pays 40% of the price of prescription drugs, with the exception of inpatients and specific groups (the retired, the handicapped, invalids, and people who have suffered occupational accidents), for which there are no out-of-pocket payments. There is a range of drugs for chronic diseases for which only 10% of the cost is paid, with a ceiling of about 500 pesetas, updated annually. From December 1995, this reduced contribution was also extended to AIDS patients. All users of civil servants' mutual funds pay 30% of pharmaceutical costs.
Complementary benefits include prostheses, orthopaedic products, wheelchairs, health care transportation, complex diets and home-based oxygen therapy. Recently, children's hearing aids were also included in this package. In general, there is no payment by the user for these complementary benefits, except for certain orthopaedic products or prostheses.

It should be noted that, historically, the package of health care benefits in Spain does not include social and community care, which is partly in the hands of the Ministry of Labour and Social Affairs, and partly decentralized to Autonomous Communities. The latter usually preserve this same division of labour, including social care within a government department which is separate from the one in charge of health care. In addition to the coordination difficulties created by such an organizational structure, a relevant problem here is that expenditure in social care only amounts to 1% of the GDP, which is a considerably small figure for western European standards. This is an indicator of the fact that the social and community care package offered by the public system is significantly underdeveloped. Accordingly, the electoral programmes of the two main political parties for the year 2000 general elections included proposals to reform and expand this area.

As regards the health care field, a number of benefits have explicitly been excluded from financing:

- psychoanalysis and hypnosis;
- sex-change surgery (the inclusion of which is currently under consideration, following political pressure by homosexual associations in 1999);
- spa treatments or rest cures;
- plastic surgery not related to accidents, disease or congenital malformation;

- dental care: only extractions and health education are effectively included, together with pregnancy diagnosis services

As for dental care, it constitutes the main benefit historically excluded from the public system and, accordingly, it accounts for an important part of private health care expenditure. The Basque Country and Navarra, however, are exceptions to this rule, as regional authorities have made effective full public coverage of children's dental care starting in 1988 and 1990 respectively. In addition, the 1995 royal decree on benefits also included dental health care for children, but this measure has not been effectively implemented so far. In fact, during the electoral campaign for the general elections of year 2000, the proposal to implement public coverage to dental care for children was included for the first time in the electoral programmes of the main political parties. As for the other benefits not covered by the public system, exclusion criteria include:

- lack of scientific evidence on safety or clinical effectiveness, or evidence that the intervention has been made redundant by other available procedures;
- failure to clearly establish that the intervention is effective in the prevention, treatment or cure of the disease or that it contributes significantly to the conservation or improvement in life expectancy, to self-help, or to the elimination or relief of pain and suffering;
- classification of the intervention as a leisure activity, relating primarily to rest and comfort, e.g. sports, aesthetic or cosmetic improvement, water therapy, residential centres or spas.

New medical technologies are also scrutinized for efficiency and effectiveness by the Agency for the Assessment of Health Technologies. In October 1999, the coordinated introduction of six new technologies within public benefits was piloted, including, among others, surgical treatment of epilepsy and non-pharmaceutical treatment for Parkinson's. In addition, a negative list of pharmaceuticals was introduced for the first time in 1993 and updated in 1998 which excluded all products of unproven clinical effectiveness from public funding. The Pharmaceuticals Department of the Ministry of Health is in charge of determining which pharmaceuticals should be co-financed by the state budget. A separate, quasi-independent Pharmaceuticals Agency is in charge of evaluating the clinical effectiveness of new brands and authorizing their commercial registry since 1999. Given the recent nature of this regulation of benefits and technologies, it is difficult to evaluate its significance. In any case, it is a starting point from which to develop more specific techniques and procedures for evaluation, and helps encourage the establishment and strengthening of mechanisms to vet the introduction of new benefits and review existing ones.

Complementary sources of finance

Complementary sources of finance mainly include the following: out-of-pocket payments to the public system (e.g. user co-payments for pharmaceuticals), out-of-pocket payments to the private sector (either in the form of user co-payments or fee-for-service), and voluntary insurance. The sum of these amounts is usually termed private health care expenditure. Available data on private expenditure, in Spain as elsewhere, suffer from a number of problems.

Notwithstanding these data problems, available estimations on complementary sources of finance are as follows. Although the bulk of health service funding is public, in 1997 it was estimated that approximately 24.9% of the country's total health expenditure was financed privately. Estimates from the annual update of the Household Budget Survey of 1998 point to a decrease in this figure to 19.7% in 1998. In 1996, the latest year for which comparative data is readily available, Spain spent US $268 PPP per capita on private health care, a figure slightly below the EU average (US $305 PPP). However, there is considerable variation in this respect among EU countries, with Germany displaying the highest figures in 1996 (US $483 PPP) and Greece the lowest (US $128 PPP). As a percentage of GDP, private health care expenditure stood exactly at the average EU level, which was 1.8% in 1996. Private health expenditure received a tax break (15%) until 1999, when it was replaced by a series of fiscal measures and discounts on employer-purchased health care insurance.

Out-of-pocket payments

There is no cost-sharing for public primary, outpatient or inpatient care in Spain. As explained above, 40% co-payments for prescription pharmaceuticals only apply to the population under 65 years of age who does not suffer from permanent disability or chronic illness. In 1998, according to the official registration system for pharmaceutical expenditure, total out-of-pocket payments to the public system were estimated to be at around 79 266 million Ptas. This represents 7.7% of the total public pharmaceutical bill, or 1.5% of total public health care expenditure.

In addition, according to the General Household Budget Survey of 1998, total out-of-pocket payments (to the public and private systems), amounted to 868 628 million Ptas, or 16.9% of total health care expenditure. In 1998, this figure broke down as follows:

- 40%: co-payment by patients for pharmaceutical and orthopaedic-prosthetic products;

- 57%: direct payment for private outpatient (including nursing) care;
- 3%: direct payment for inpatient care.

Voluntary health insurance

According to the 1997 National Health Survey, up to 8.9% (that is, some 3.5 million) of the Spanish population had private health coverage through voluntary insurance in 1997, although, as explained above, survey data probably tends to underestimate the size of this group of the population. The privately insured is unevenly concentrated in big cities: 20–25% of the population of Madrid and Barcelona is covered through voluntary insurance. The majority of policies are taken out directly with private insurance companies, which are generally profit-making. In addition, Spanish private insurance has an important special characteristic when compared with other European countries, since for most of the sector, the provision of health care services is integrated with insurance services, either through shared ownership or long-term contracts. Private coverage is directed towards supplementing services offered by the National Health System (e.g. dental services which are not covered, and preventive gynaecological services which are subject to significant problems of effective access), or providing an alternative modality of care. An additional percentage of the population (civil servants and their dependants) is insured through mutual funds which simultaneously offer other social benefits. As explained above, the estimated size of this group varies according to the data source used, but should range between 4.6% and 9% of the population. An uncertain percentage of those (between 50% and 88%, according to different data sources, opt for private insurance (with the state, however, acting as a third payer). Employer-purchased health care insurance schemes, according to survey data, covered 1.9% of the Spanish population in 1997.

When these three categories of private insurance (purely voluntary, civil servants' mutual funds and employer-purchased insurance) are jointly considered, the percentage of the Spanish population covered by private insurance ranges between 13.1% and 18.7% (i.e. between 5.2 and 6.8 million population). If we exclude the civil servants mutual funds, based on their quasi public status, the estimated figure drops to 10.8%. As regards the financial size of the private insurance sector, estimates also differ depending on the data source used. The General Household Budget Survey (GHBS) of 1998 reports that 143 179 million Ptas were spent by families in private insurance premiums. Under reporting bias affecting all income and expenditure surveys, together with the exclusion of employers' contributions from this source should be kept in mind here. The official accounting system of the Ministry of Finance's Department of Private Insurance (DPI), in contrast, estimates that expenditure

on private insurance premiums (excluding civil servants' mutual funds and all accident insurance not included within the more general sickness insurance) amounted to 373 443 million Ptas in 1998. Finally, recent data from the OECD of total expenditure on private health and accidents insurance give the figure of 465 512 million Ptas for 1997. Depending on the data source used, therefore, expenditure on private insurance consists of between 3% and 9% of total health care expenditure.

It should be noted here that the estimate of private expenditure itself (and therefore that of total health care expenditure) depends on the particular estimate of expenditure on private *insurance* used in the calculation. Accordingly, current estimations of private health care expenditure in Spain are between 20.6% and 25.4% depending on the data source used. The same applies to the estimations of the share of insurance over total private expenditure, which range between 14.2% and 34.4%.

Other details of the insurance market are equally difficult to ascertain given the significant problems with information systems in this field. Despite these data problems, however, and according to official government data, in 1998 the structure of the insurance market by **type of insurance** provided was as follows:

- The *health care insurance* sub-sector, based on direct provision of services by the insurance companies, was clearly dominant, with a market share of 89.6%.
- *Sickness insurance*, based on reimbursement, and with services delivered by independent providers, represents the remaining 10.4% of the market. The latter, however, has been increasing its share since 1988, when they held 7.1% of total premiums.

As regards general evolution trends, and according to data presented by Lopez Casasnovas (taken from the information produced by the national association of private insurance employers) for the period 1990–1997, the total number of insured within the sector increased by only 20% between 1990 and 1997, while, by contrast, the average premiums more than doubled (a 106% increase in 1990–1997).

Several reforms were introduced in this field in the late 1990s. First, responsibility for the provision of health care and for the management of sickness leave in the case of accidents at work and work-induced illnesses was contracted out to private sickness insurance companies (and more concretely, to employers' mutual funds) in 1998. Second, the 1999 Annual Budgetary Act introduced a series of significant tax discounts to employer-purchased health care insurance and, as a result, growth rates within the sector will probably boost. More details on these policy measures are given within the section on *Health care reforms*.

Health care expenditure

The main indicators on the evolution of health care expenditure during the last decade are presented in Table 4. Total health care expenditure as a share of GDP increased from 6.9% in 1990 to 7.5% in 1993, to remain relatively constant thereafter, probably as a result of the agreement reached in 1994 among levels of government to adjust the rate of growth in public health care expenditure to GDP. This trend is consistent with the broader European experience. In addition, during the second part of the 1990s, there seems to be a certain degree of convergence between Spanish expenditure levels and those of other nearby countries, like Italy and Portugal (Fig. 4).

Table 4. Trends in health care expenditure, 1990–1997

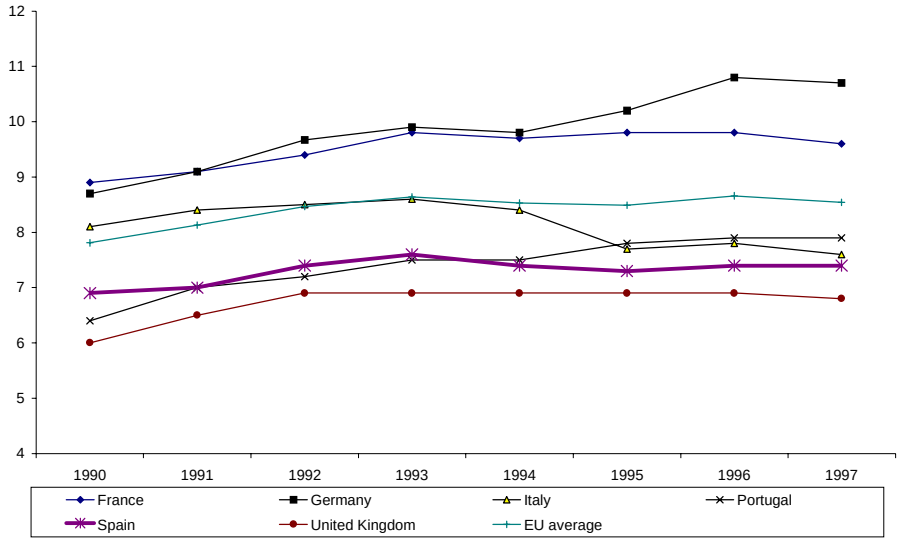
Total expenditure on health care	1990	1991	1992	1993	1994	1995	1996	1997
Value in current prices, billions of Ptas	3 468	3 865	4 366	4 616	4 819	5 110	5 448	5 762
Value in current prices, Million US $ PPP	31 670	35 012	38 045	39 466	39 721	41 694	44 049	46 509
Value in current prices, per capita (US $PPP)	815	900	974	1 010	1 015	1 042	1 115	1 168
Share of GDP (%)	6.9	7.0	7.3	7.5	7.4	7.3	7.4	7.4
Value in constant Ptas 1995, per capita	106 398	112 070	120 297	122 548	124 979	127 320	–	–
Public as a % of total expenditure on health	78.7	78.9	78.9	79.7	78.8	78.3	78.5	76.1

Source: OECD health data (1999)
Note: Billion = thousand millions.

The percentage of Spanish GDP devoted to health in 1997 is seen in a wider European context in Fig. 5, and its level is below the EU average. The level of health care expenditure in US $PPP per capita is shown in Fig. 6 and amounts to US $PPP 1183, also below European average levels. In fact, per capita health expenditure in Spain represents 75% of the EU average, and the same is true for public health care (PHC) expenditure.

Public expenditure consists of practically 77% of the total, according to the WHO health for all database (Fig. 7), although the official figure (76.1%) is slightly lower (Table 4). This places Spain in a intermediate position within western Europe, although well above the rest of southern European countries. Table 5 presents the evolution of total public health care expenditure between

Fig. 4. Trends in health care expenditure as a share of GDP (%) in Spain and selected western European countries, 1990–1997



Source: WHO Regional Office for Europe health for all database.

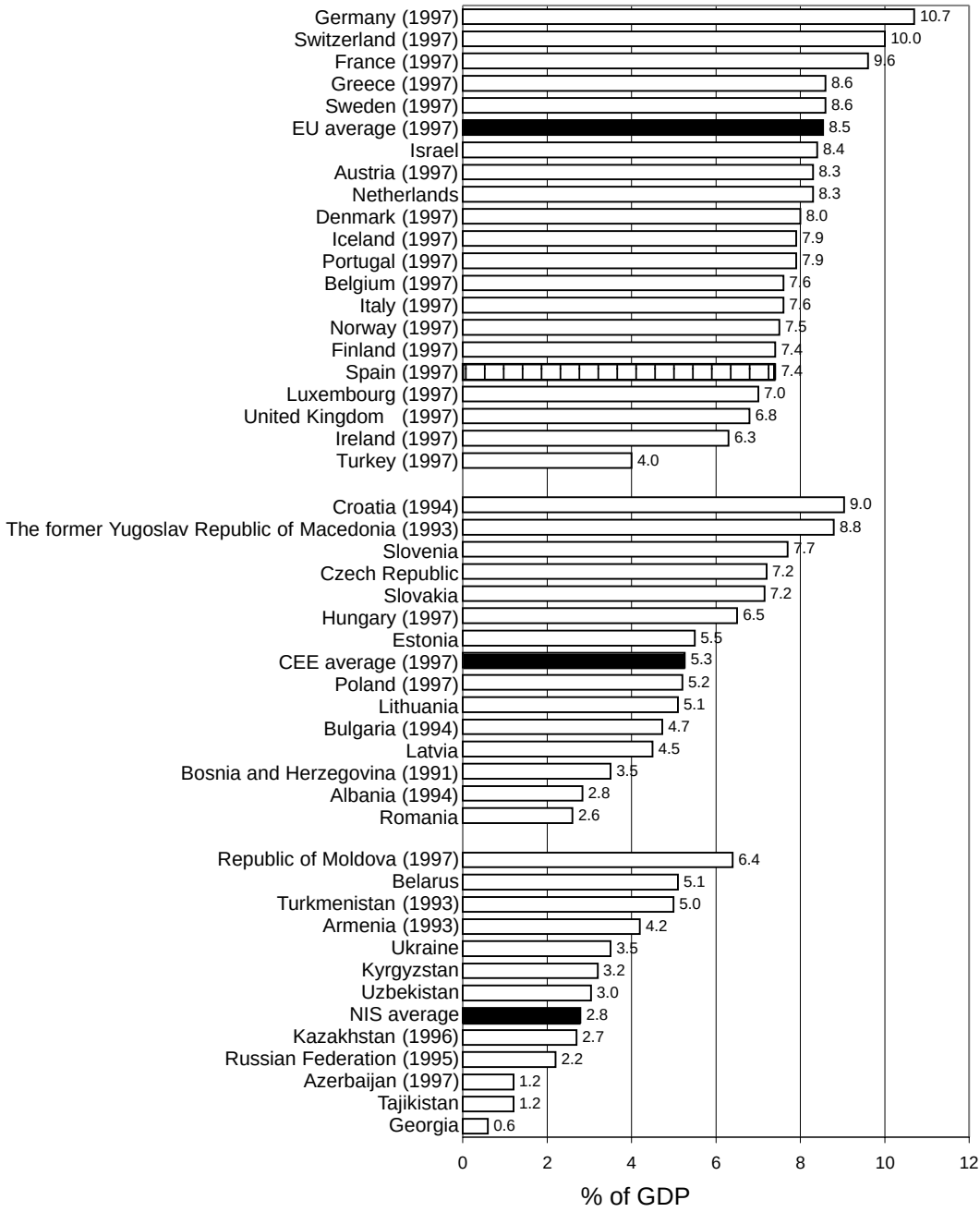
1986 and 1996, according to an official report recently published by the Ministry of Health. An important problem of official statistics as regards this indicator is that there are significant delays in the incorporation of the fractions of total health care expenditure financed through local and regional taxes as well as other sources of finance (e.g. central taxes dedicated to public health), so the latest figure available corresponds to 1996. Such delays, however, do not affect the bulk of public health care expenditure, based on central taxes and dedicated to financing the Social Security health care network, which is channelled through the regional resource allocation system (see Table 7). The data displayed in Table 5 indicates that between 1986 and 1996 public health care expenditure in nominal terms nearly tripled.

Table 5. Total public health care expenditure, 1986–1996

	1986	1990	1991	1992	1993	1994	1995	1996
Billion current Ptas	1 450	2 730	3 048	3 444	3 679	3 799	3 999	4 279
% Increase over 1986	100	188	210	237	254	262	276	295
% Increase over 1991	–	–	100	113	121	125	131	140

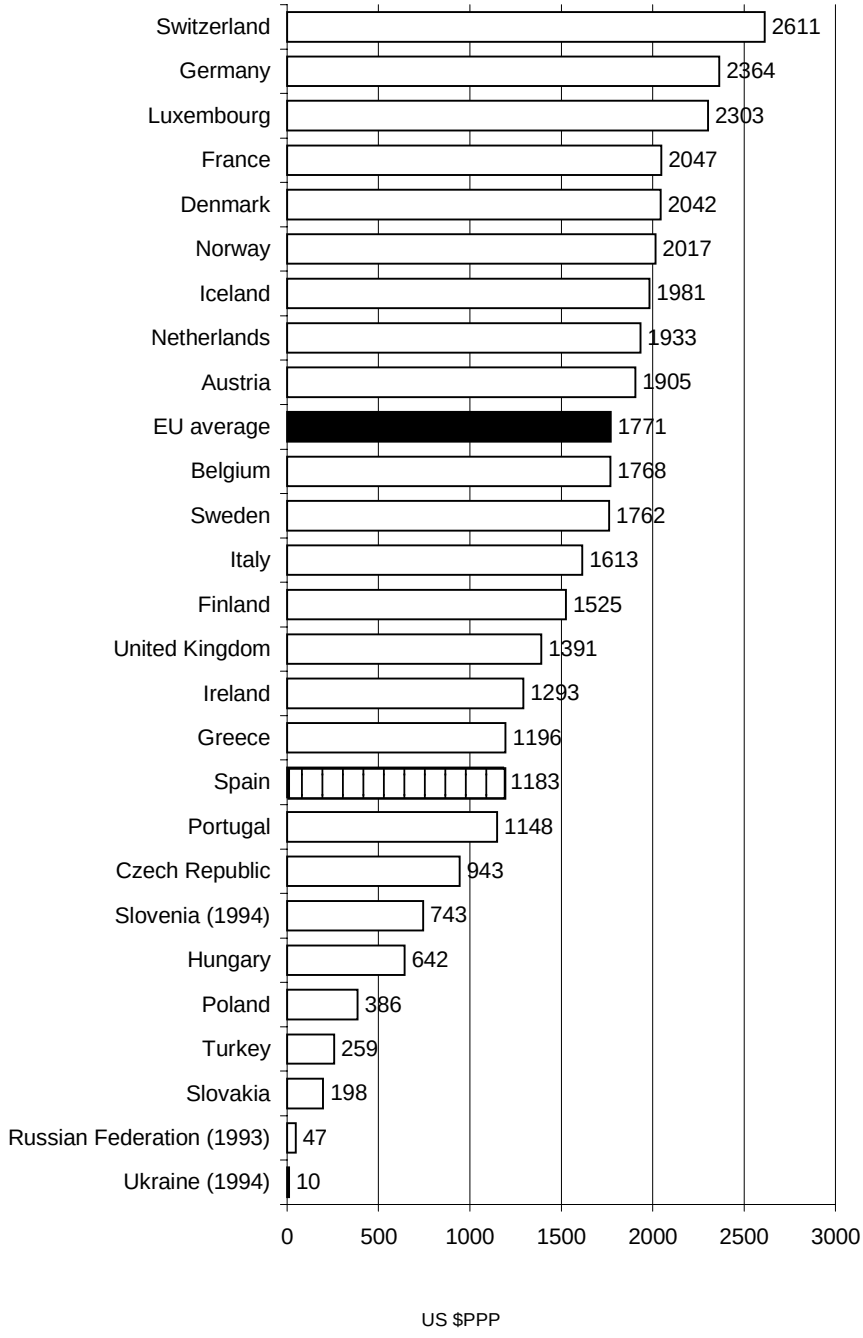
Source: Ministry of Health and Consumer Affairs (1999).
Note: Billion = thousand millions.

Fig. 5. Total expenditure on health as a % of GDP in the WHO European Region, 1998 (or latest available year)



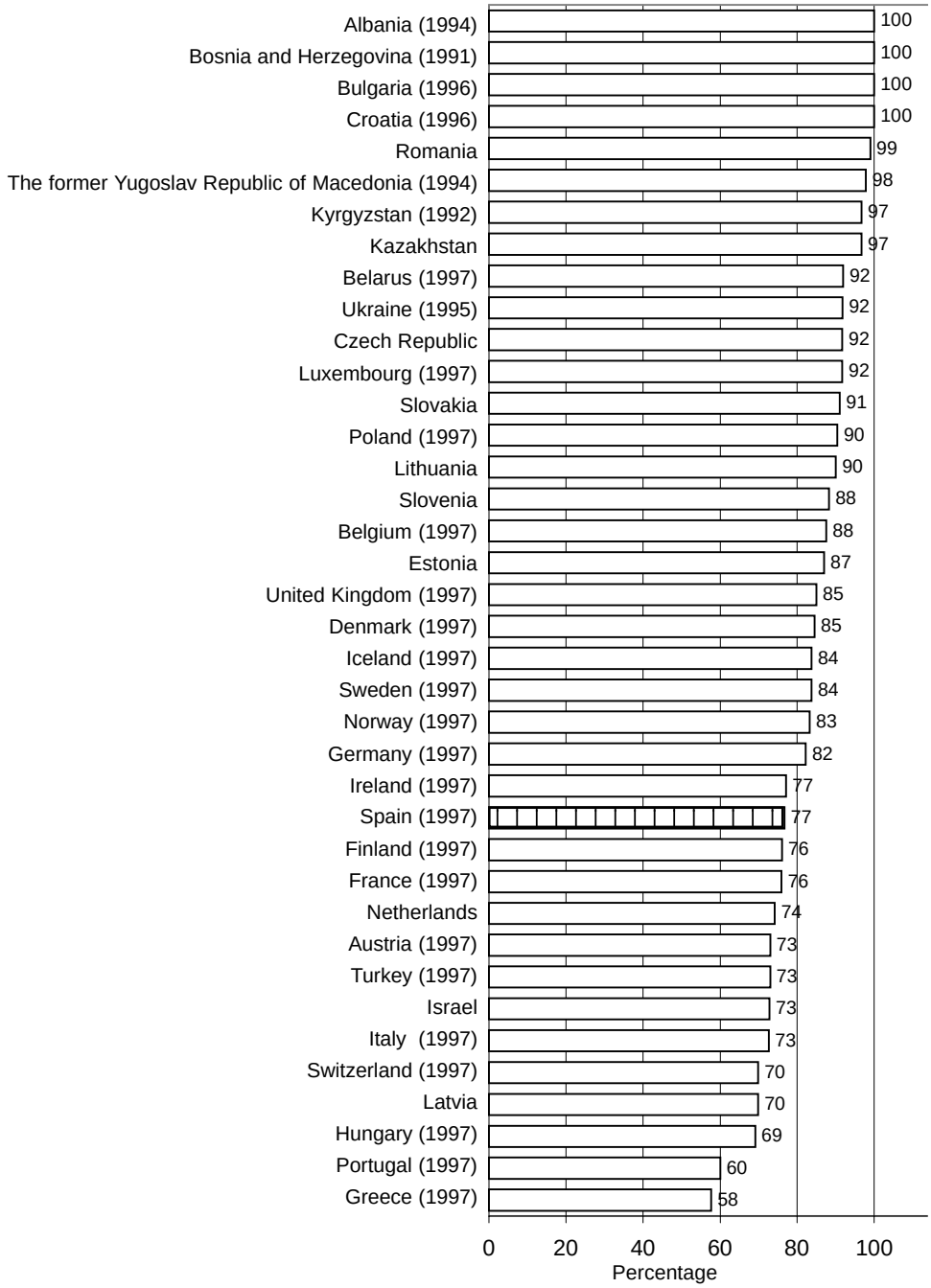
Source: WHO Regional Office for Europe health for all database.

Fig. 6. Health care expenditure in US $PPP per capita in the WHO European Region, 1997 (or latest available year)



Source: WHO Regional Office for Europe health for all database.

Fig. 7. Health expenditure from public sources as % of total health expenditure in the WHO European Region, 1998 (or latest available year)



Source: WHO Regional Office for Europe health for all database.

By sub-periods, between 1991 and 1996 total public expenditure increased by 40%. This moderate increase is in contrast with its evolution between 1986 and 1991, which shows an accumulated increase in nominal terms of 110%. One of the reasons for this high growth rate is because of the important effort made to contain costs during the first part of the 1980s, resulting in a series of general and sectoral strikes which exerted considerable political pressure on the government to raise public health care expenditure from 1987 onwards. The period also saw the start of the implementation of the health care reforms approved in 1986, which mainly involved the primary health care sector, apart from an increase in coverage of about 5%.

The structure of health care expenditure has changed only slightly since 1991 (Table 6). During this period, reform of the primary health care sector advanced rapidly which did not, however, put a greater demand on resources, as reflected in its decreasing share over the total. The most important changes affected capital investment, which decreased its share of the total by almost 2 percentual points. In addition, figures in the late 1990s reflect an over average increase in pharmaceutical expenditure at the expense of other categories of care.

Table 6. Health care expenditure by category (as % of total expenditure on health care) (TEHC), 1991–1996

Total expenditure as share of TEHC (%)	1991	1992	1993	1994	1995	1996
Primary care	16.9	16.7	16.2	16.2	16.5	16.2
Specialized care	54.6	55.1	55.8	55.7	54.1	54.0
Pharmaceuticals	16.8	17.2	16.9	17.7	18.8	19.5
Investment	4.5	3.5	3.6	2.6	2.9	2.7
Public health, management costs, training and research	5.2	5.4	5.3	5.2	5.2	5.2
Other	2.0	2.1	2.3	2.6	2.4	2.5

Source: Ministry of Health and Consumer Affairs, 1999.

Private health expenditure, as recorded through the General Household Budgets Survey (GHBS), also rose during the 1990s at a similar rate as public expenditure. For an average Spanish family, total private health care expenditure per year was 20 648 Ptas in 1980, 65 086 Ptas in 1990, 83 934 Ptas in 1995, and 83 542 Ptas in 1998. By category, the percentage spent on pharmaceuticals decreased from 30% in both 1985 and 1990 to 23% in 1995. In contrast, the percentage spent on dental care increased between 1985 and 1990 from 17% to 30%, to remain constant from 1990 to 1995. The share of inpatient and

outpatient care remained relatively constant between 1980 (27%) and 1995 (25%), with a slight decrease in 1990 (19%); while small increases applied to voluntary insurance (from 11% in 1985 to 14% in 1995) and protheses (from 9% in 1985 to 11% in 1995) throughout the period.

Finally, it is important to include the course of public expenditure by some selected Autonomous Communities, for which data has been estimated through a recent study on regional health care services edited by Lopez Casasnovas. The figures presented in Table 7 are not based on total public health care expenditure, but on the fraction of it channelled through the regional resource allocation system (comprised of central taxes earmarked for the social security health care network), which in 1996 accounted for some 80.5% of the total. In particular, neither regional nor local taxes are included in these figures, nor is expenditure on the pre-Social Security network (public health, health planning, etc.). The main fact to highlight here, however, is that per capita social security public health care expenditure has been increasing at a faster rate in the special Autonomous Communities than within the territory managed by the National Institute of Health-INSALUD.

Table 7. Public per capita expenditure (Ptas) channelled through the regional resource allocation system by selected Autonomous Communities, 1991–1999

Territories	1991	1992	1993	1994	1995	1996	1997	1998	1999
Andalucia	55 462	62 020	73 623	73 163	80 982	83 429	87 823	96 628	100 515
Catalonia	58 532	65 236	74 287	76 301	86 043	89 871	94 874	104 184	108 217
Basque Country	58 095	64 955	70 893	76 446	85 870	91 503	96 708	101 474	107 260
INSALUD	59 457	67 040	71 265	73 453	80 642	86 249	89 887	97 087	100 654
coef. of var.	0.026	0.028	0.020	0.021	0.031	0.036	0.039	0.031	0.034

Source: Pellisé, Truyol, Blanco y Sánchez-Prieto, 2000.

In fact, one of the main sources of the problem of overall cost containment in Spain is the relatively small degree of central government political control over the 7 special Autonomous Communities which hold full health care powers. In addition, given the scarce fiscal autonomy of most Autonomous Communities in Spain, there are considerable incentives for regions to try and increase their expenditure levels, as they will receive the political credit for it without bearing the financial cost. This trend has been more significant in powerful, affluent regions such as Catalonia and the Basque Country (in spite of almost full fiscal autonomy of the latter), than it has been in the territory managed by INSALUD or in the less developed, southern Andalucian region. However, there is also qualitative evidence that the regions with higher expenditure levels have also

been obtaining better health care outputs, specially in terms of modernization and rationalization of the public system as well as in the fields of coverage and access. This has recently been complemented with a quantitative estimation of the factors accounting for the increase in expenditure in different territories, conducted by Pellise and her research team. The authors show that, once the effects of prices, demography, and compulsory extension of coverage (following adoption of the NHS model) are discounted, the remaining increase in expenditure, which is attributed to an expansion in the quantity and/or quality of benefits, is lower within the territory managed by the INSALUD than in the three special regions studied (Andalucia, Basque Country and Catalonia). The different growth rate of public expenditure accross territories, in any case, has tended to expand regional differences, as reflected in the 30% increase registered in the coefficient of variation. It should be noted in this respect that regional differences decreased between 1991 and 1994, to rebound thereafter.

Health care delivery system

Before the General Health Act of 1986 came into force, the delivery of public health sector services was structured into three health care levels:

- *primary health care* (PHC) with general practitioners working on an individual, part-time basis and paid a capitation fee;
- *outpatient specialties* with medical specialists working on an individual basis in ambulatory polyclinics (together with a general practitioner within urban areas), also paid on a capitation basis;
- *hospitals* with inpatient and outpatient care, provided by salaried physicians directly employed by the public sector.

After implementation of the General Health Care Act, primary health care was given an independent, reinforced status, which partly built on previous features (e.g. gatekeeping), and partly incorporated new ones, such as extending the role of the primary care team to be (a) the provider of an integrated package of care covering primary, preventive, health promotion and rehabilitation services; (b) and the main actor in the process of needs assessment and health planning within the health area. Outpatient specialties formerly delivered at the ambulatory care level were put under the responsibility of hospital services in order to guarantee improved coordination between secondary and tertiary care. The process of implementation of these reforms was considerably slow and plagued with problems, due to several factors, such as the simultaneous development of an ambitious reform of the territorial structure of the state, the opposition to the reforms from some sectors of the medical profession, and the fact that the formal attempt to tip the balance towards primary care was not accompanied by a parallel change in the structure of health care financing.

Primary health care and public health services

The primary health care sector

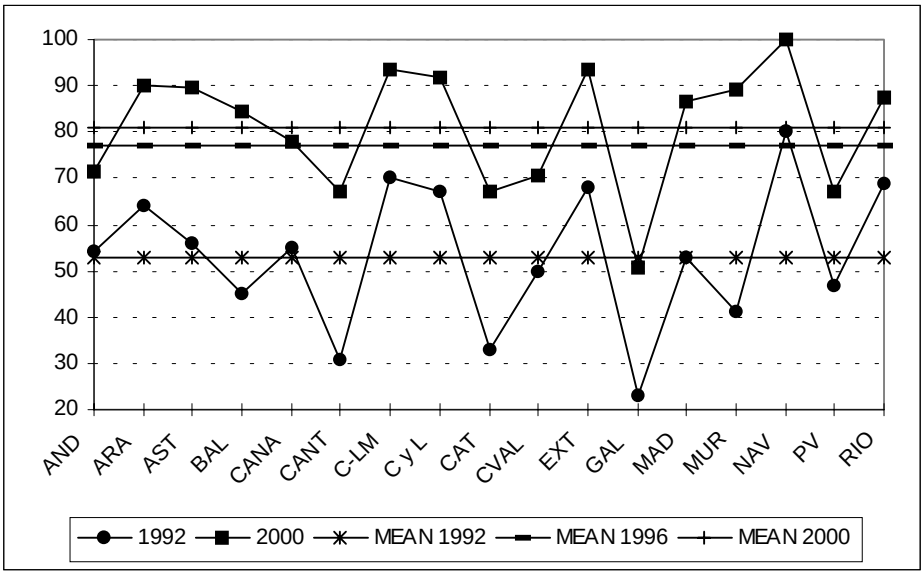
Primary health care (PHC) in Spain is an integrated public system with its own centres and staff. Management is primarily through specific PHC management bodies at the level of the health area, and organization is based on the basic health zone, the smallest geographical unit of the health system. Starting in the early 1980s, the creation of family medicine as a medical specialty has contributed to higher professional standards and a distinctive professional identity for family doctors. In addition, since 1984, the primary health care sector has experienced an extensive process of institutional reform and capacity building.

Health professionals are employed within the system only after passing an entrance examination, through which they acquire a special status similar to that of civil servants. General practitioners (GPs) are the first contact the population has with the health system. They should screen patients and provide both diagnosis and treatment if appropriate. They may also refer patients on to specialized services if necessary. Despite the gatekeeper role of the general practitioner, a referral is not needed by patients wishing to see either an obstetrician or dentist or, in certain cases an ophthalmologist, e.g. for an eyesight examination, in case of emergency, etc. Patients having received specialist care are expected to return to the primary care physician who then assumes responsibility for follow-up treatment, repeat prescriptions, etc.

Since 1986, patients have had the right to choose their physician within the health area. In addition, in 1993, this choice was extended to physicians working in other health areas, under the sole requisite that the general practitioner chosen actually accepts the new patient on his or her list. However, there are important practical difficulties in making this right effective. Some of them derive from the fact that general practitioners also conduct home visits. In addition, although general practitioners receive a capitation fee, its size is rather small. For these reasons, they tend to reject patients from other health areas.

Primary health care is delivered through two distinct networks – the traditional model and the reformed model – which offer a slightly different range of services and have their own funding formula. The former is the oldest, and increasingly less common, network of care. The latter represents a team-based, multidisciplinary approach to primary health care problems, and is the result of an extension of the 1984 primary care reforms, a process which, at the beginning of the year 2000, is about to be completed. However, both types of models have coexisted during almost two decades, and still coexist today (Fig. 8).

Fig. 8. Percentage of the population covered by the new primary care network, 1992–2000



The traditional system depended on a solo practitioner working individually and on part-time basis (2.5 hours daily, plus time to cover home care). Payment was purely on a capitation basis for a specified list of patients and functions were exclusively curative. Administrative and diagnostic support were rather weak, and doctors and nurses did not have specific training in primary care. Clinical records were not kept, and follow-up care was rare.

The newly reformed network of care is essentially a team-based, group practice, working full-time on a salaried basis which, since the mid-1990s, was complemented with a small capitation fee (amounting to approximately 15% of the total salary). In each health zone, there is a Primary Care Centre (*Centro de Salud*), within which a Primary Care Team (*Equipo de Atención Primaria, EAP*) delivers services. Doctors have to complete three years of specialized training in family medicine, in addition to the six years required to become a general doctor. Functions formally asigned to primary care teams are more comprehensive and cover health promotion and prevention, curative care and rehabilitation. Administrative and diagnostic support have been improved. A new improved list system tries to ensure that patients are able to maintain a personal relationship with their physician as well as adequate follow-up since they will should be seen by the specific doctor on whose list they are registered. Each EAP is directed by a coordinator or director, a physician from within the group who undertakes both clinical and management tasks.

Primary health care after 1984

The 1984 reforms did, in fact, follow the principles of the Conference of Primary Care at Alma Ata, namely: teamwork, increased accessibility, comprehensiveness and follow-up care, and community participation. While this is shared by many European (and other) countries, a specific feature of Spanish primary care provision is that it is one hundred percent publicly-owned and staffed, with public general practitioners paid on a salaried basis. Only three additional countries in Europe have a similar model of provision (Finland, Portugal and Sweden). In 1997, a comparative study (Table 8) of these four countries found the following. Accessibility is highest in Spain, with 92% of patients having to wait only 0–1 days for a consultation with the general practitioner. In fact, patients only need to wait one day if they opt for setting the appointment by telephone. At the same time, the number of patients treated by each doctor per week was also the highest and, accordingly, the time dedicated to each visit

Table 8. Primary care in the European countries with publicly owned and staffed systems, 1997

N = 6495	Spain	Finland	Portugal	Sweden	Average
Days waiting for consultation (%)					
0–1 day	92	39	50	37	57
2–4 days	8	22	10	9	13
5–8 days	0	33	15	27	18
> 8 days	0	6	25	27	13
Patients/week by doctor (average)	154	94	89	90	103
Duration of consultation (%)					
<5 minutes	52	29	30	36	37
5–9 minutes	35	27	25	27	29
10–14 minutes	10	29	29	17	22
>15 minutes	3	15	16	20	13
Type of problem (%)					
Acute	34	38	17	35	31
Sub-acute	18	21	13	23	18
Chronic	43	29	55	39	42
Preventive	5	11	13	2	8
Other	0	1	2	1	1
Previous consultation (%)					
Same problem	64	49	78	62	63
Another problem	79	69	90	78	79
For a member of family	70	54	82	54	66
Follow-up (%)					
No	48	40	24	30	36
Same doctor	41	44	64	57	51
Another general practitioner	1	9	1	3	4
Specialist	10	7	11	10	9

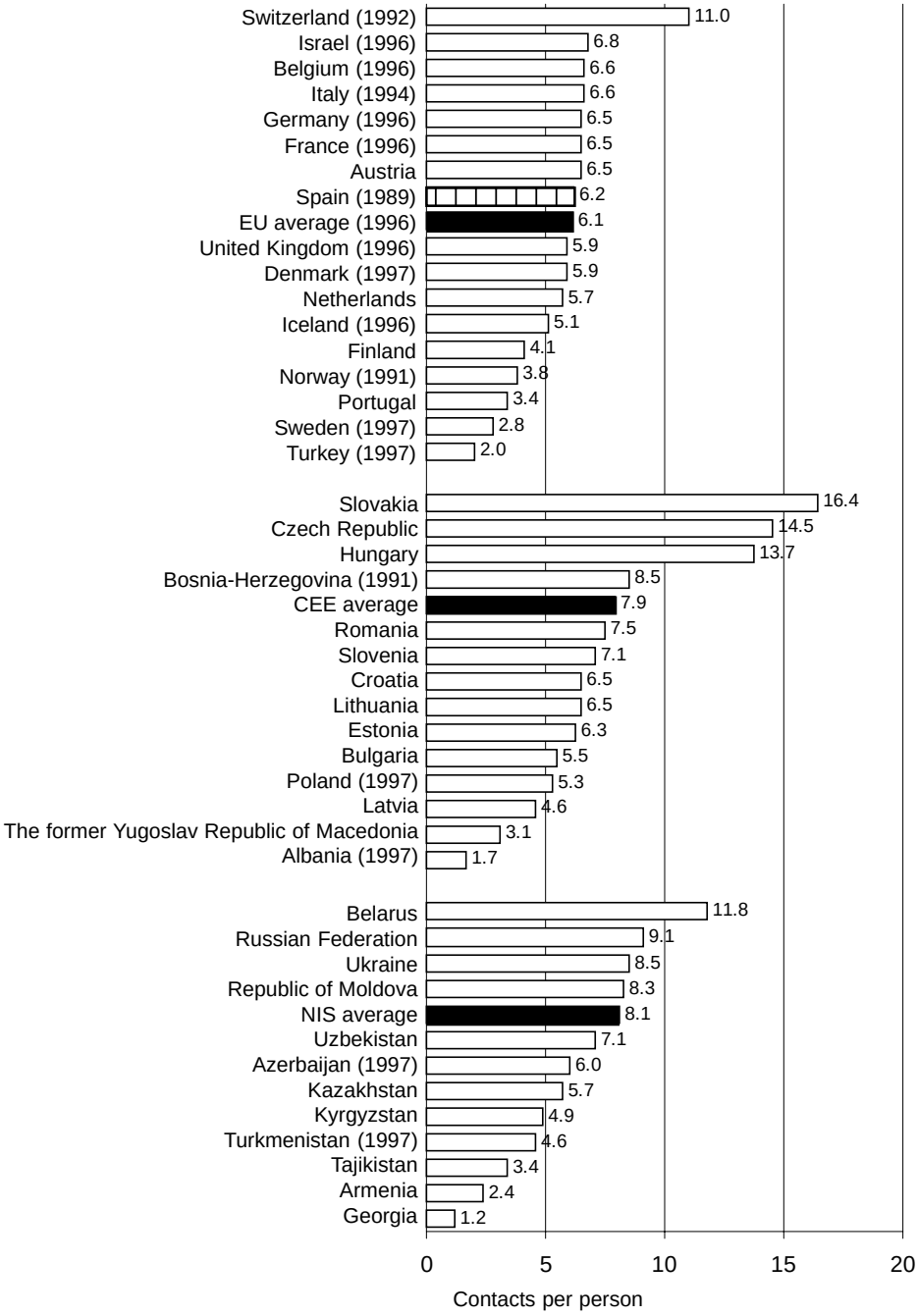
Source: Ortún and López-Casasnovas (1999).

was considerably lower than in the other three countries. Finally, follow-up and continuity of care were consistently higher in Spain and Portugal than in Sweden and Finland.

In fact, and as compared with the old network of care, the new EAPs are generally perceived in Spain as being more progressive, with a greater emphasis on the use of clinical histories and protocols, reduced prescriptions and referrals, and more time per patient, therefore ensuring a higher quality of service. Many of these improvements have been illustrated through independent research based on case studies. However, more than 15 years after the start of the reform process, there are no official, comprehensive evaluations of the impact of reforms. This is in line with the low political priority generally given to primary care, which is also reflected by the marked bottom-up policy-making, with family doctors taking the lead all throughout the reform process. There is some evidence that these political problems have, however, partially impaired the potential of the reforms to reap the full benefits initially expected. A particularly worrying indicator is the recent increase in the percentage of patients who enter the system directly through the accidents and emergencies (A&E) department of hospitals. Emergency hospital admissions rates almost doubled from the mid-1980s and the mid-1990s and they currently account for two thirds of total hospital discharges. In particular, recent research demonstrated that more than a third of admissions in A&E departments occur during the working time of primary care centers, and that some 50% of admissions are related to patients' perceptions of problems with accessibility to primary care.

The evolution of primary care during the 1990s has been as follows. Official data only exists for the years 1992 and 1994 for the coverage of the reformed primary health care model, but since then, the medical journal *Jano* has been generating periodic data on the progress of reforms. In March 2000, according to this source, 81% of the total population was receiving services through an EAP (as compared with nearly 50% in 1992, 67% in 1994, 77% in 1996 and 81% in 1998), although there were still wide variations among regions (between 51% and 100%). By sub-periods, between 1992 and 1996 the coverage of the new network of care increased by 25 percentage points, while the equivalent figure for 1996-2000 is only 4%, showing a clear slow-down in the progress of reform. As for health care personnel, official data for 1998 points to 73% of primary health care doctors working within the reformed network (with regional variations ranging between 42% and 89%). As regards health care facilities, in the mid-1990s the primary health care network consisted of 1702 health centres (approximately 2500 in 1998), 3128 small rural *consultorios* (health posts with only one or two general practitioners and a nurse), many of which depended on the health centre (basic health zone), and 206 town *consultorios* (structured

Fig. 9. Outpatient contacts per person in the WHO European Region, 1998 (or latest available year)



Source: WHO Regional Office for Europe health for all database.

Spain

around the traditional quota system). Primary health care was provided by general practitioners (first contact physician for population of over 15 years of age), paediatricians (idem for those under 15 years of age) and associated nursing staff who in 1995 carried out a total of 213 million consultations (including office and home visits). In addition primary health care personnel attended to approximately 15 million emergencies, or 0.4 per inhabitant per year.

According to the WHO Regional Office for Europe health for all database, there were 6.2 outpatients contacts per inhabitant per year in 1989 (Fig. 9), a figure which is close to the 1996 European Union average. Official national data point to 5.4 and 5.3 contacts in 1992 and 1994 respectively, which rose to 6.1 in 1996. In addition, Table 8 shows that each Spanish general practitioner sees 154 patients weekly, a figure 70% higher than the average shown by the other three countries with a similar model of PHC, which stands at about 90 patients per week. Moreover, the European Survey of the Task Profiles of General Practitioners shows that in 1991 Spanish GPs had one of the highest rates of patient contacts per day within Western Europe (ranking third after Germany and Austria), at 39 daily visits per GP, a figure 40% higher than the unweighted EU average.

It can be safely concluded, therefore, that in comparative terms, general practitioners in Spain have to bear higher workload than in other nearby countries, in spite of efforts to increase the infrastructure and personnel in this field. Additional evidence in this direction can be derived from the database of the British Royal College of General Practitioners, which shows that in Spain in 1992 there were only 50 general practitioners per 100 000 population, representing 15% of total physicians. As for the primary health care sector, these are the lowest figures in the EU, and they are considerably far from the standards prevalent in other nearby countries like France (147 general practitioners per 100 000, 54% of total physicians), Italy (102 per 100 000, 26% of the total), Portugal (61 general practitioners, 23% of the total), or the United Kingdom (54 per 100 000, 42% of the total). It is true, however, that the lower number of general practitioners is counterbalanced by higher corresponding numbers of specialized physicians, but this situation is inconsistent with the attempt to tip the balance of the health care system towards the primary level explicitly embodied in the 1986 General Health Care Act.

As regards the average number of inhabitants per general practitioner, between 1992 and 1996, this increased by 30% (from 1460 to 1867), and stabilized between 1996 and 1998. During the same period, annual physician contacts per person rose by 15%. In rural areas with a widely dispersed population, there are usually less than 1250 inhabitants per physician, while in urban areas there are more than 2000 inhabitants per physician. No member of the population lives more than 30 minutes travelling distance from the nearest health centre,

while the average was 16 minutes in 1997 (against 15, 17 and 18 minutes respectively in 1987, 1993 and 1995). Access, in terms of the availability of appointments, is generally good, although in some urban settings, EAPs restrict afternoon and evening appointments which causes delays in obtaining routine/non-emergency care. In fact, although the timetable of GPs working for the public sector has increased from 2.5 to 7 hours per day, this has not always resulted in a parallel expansion of the actual time dedicated to consultations, as this particular aspect is not subjected to state regulation. In fact, recent research suggests that some 20% of admissions to A&E departments in hospitals are due to users' perceptions of accessibility problems derived from constraints on the time schedule of consultations in primary care centres. As for the time required to obtain access to care once in the health care centre, in 1997 patients had to wait some 30.2 minutes on average, while the equivalent figure for 1987 was 19 minutes.

The differences among Autonomous Communities are considerable, both in terms of patients per doctor (Fig.10) and for utilization (Fig.11). The evolution during the 1990s is towards increasing territorial inequalities in these respects.

The services offered are all within the definition of National Health System benefits for this level of care and include compulsory services. The details of primary health care activity have been specified by both health areas and health centres since the beginning of the 1990s. Increasingly, the contract programme is used to define the population to be covered and the services to be provided, ensuring central and area agreement on activity levels. "Contracts" set out the extent of the EAP system, the target immunization level for children and adults, numbers of home visits, protocols for monitoring prevalent chronic diseases, early identification of pregnant mothers, etc. They also specify the prospective global budget available.

Primary health care is instrumental in the integration of preventive and curative functions. Preventive medicine has grown in importance over recent years and is now included in the legally defined package of benefits. By 1995 more than 400 EAPs had joined the Programme for Preventive Action and Health Promotion which involves voluntary drafting of protocols for health promotion and disease prevention according to specific risk groups (age, sex, individual risk). The programme was launched through the sole initiative of the Spanish Society for Family and Community Medicine, which has been the most relevant political actor in the process of progressive improvement of primary care since the early 1980s. In addition to that, there are two other associations representing general practitioners (SEMG and SEMERGEN). Within the terms of the programme, opportunistic strategies are developed to appeal to the relevant population and these are audited annually by external assessors who review both coverage and outcomes.

Fig. 10. Inhabitants per general practitioner in Autonomous Communities, 1992–1998

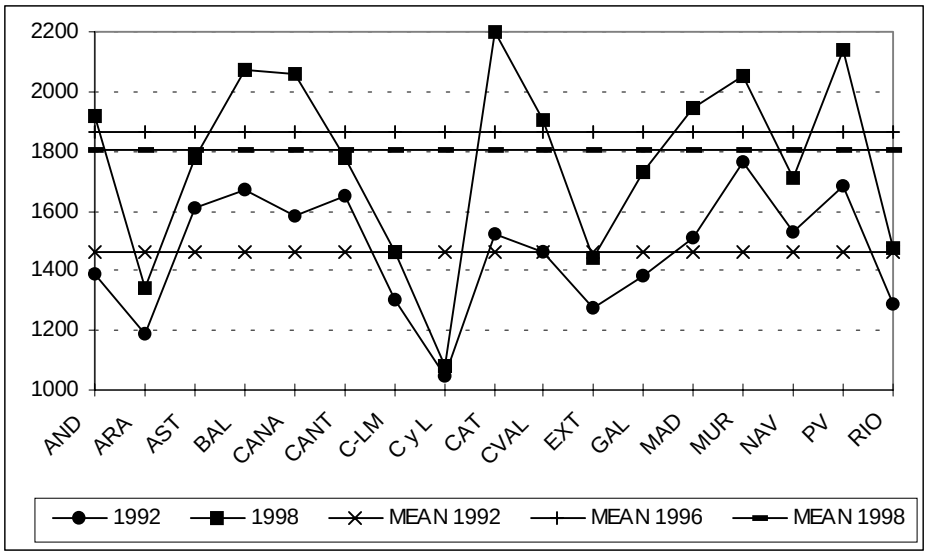
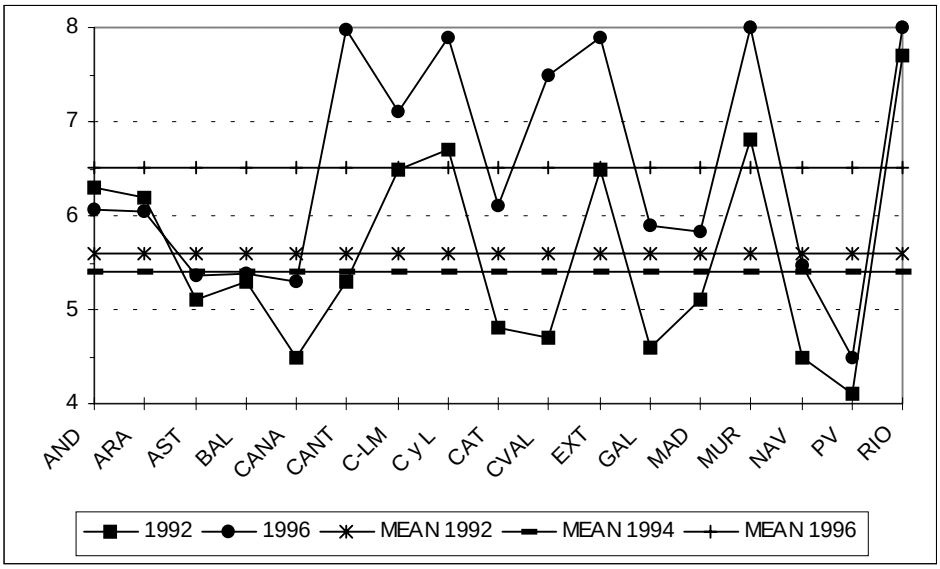


Fig. 11. Physician contacts per year in Autonomous Communities, 1992–1996



In addition to the PHC offered by general practitioners and community-based paediatricians, specific services have been developed to target particular population groups, such as women, the mentally ill, etc. These services function

in conjunction with the more specialized levels of care. Primary health care teams also collaborate with social workers whose main task is to act as a bridge between the social and health services networks.

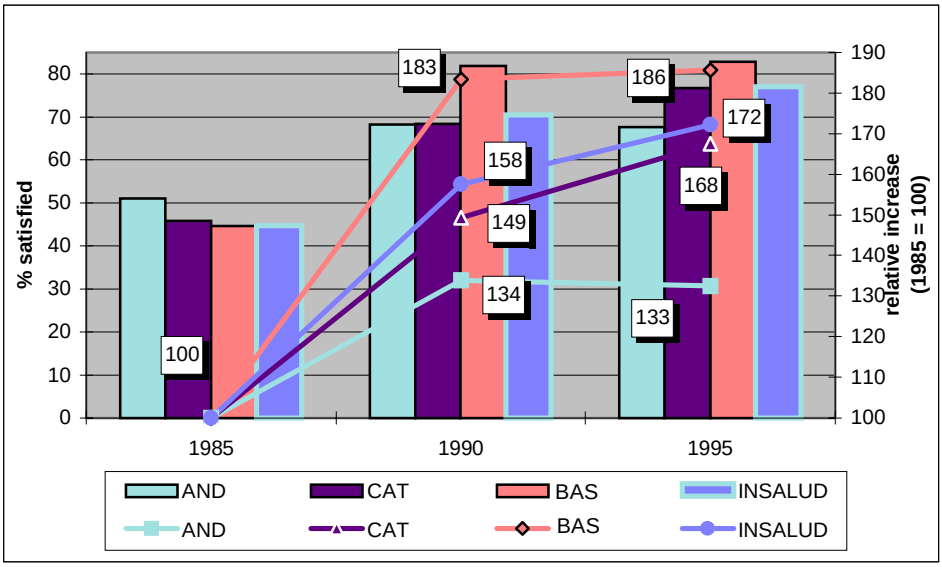
Primary health care is also responsible for the provision of around-the-clock emergency coverage either at the health care centre or in the patient's home. This may be provided by a dedicated emergency services team or, as is increasingly likely, by a rotation of EAP personnel. In urban areas, there are special emergency services (covering road accidents and home emergencies) run by city councils or autonomous communities, which often operate largely separately from the continuous care services provided by primary health care teams.

Some dental health care is also provided by the primary care network, specifically: information and education on hygiene; preventive and health measures for children (topical fluoride, sealing of fissures, etc.); and treatment of acute problems, including dental extraction and dental care for pregnant women. In the Basque Country, full dental care for children is included within the public package of benefits. In addition, in the year 2000 Spanish general elections, the main two political parties contemplated the implementation of full coverage of children's dental care in their electoral programmes.

Health centres usually have dry chemical strips for testing urine and glycaemia in emergency cases, and an electrocardiograph. There are almost no clinical analysis laboratories in health centres, and samples collected at the primary level are sent to the nearest hospital laboratory. In general, radiological, ultrasound and lung function tests are carried out by the specialized services at polyclinics or hospitals. Since the mid-1990s, elective minor surgery has been progressively introduced in primary care. In 1997, 5217 of these procedures were carried out within the INSALUD territory, and this number increased to 47 580 in 1999.

User satisfaction with PHC has been gradually increasing as the new system has been introduced (Fig. 12). In 1985, average satisfaction levels were below 50%, a figure that had increased to 70% in 1990 and came close to 80% in 1995. Although figures are not totally comparable across years, health care levels or Autonomous Communities, they seem to suggest that average satisfaction levels almost doubled during the period, in contrast with the hospital sector, in which levels of satisfaction have remained relatively constant between 1985 and 1995. The evolution of satisfaction, however, has followed varied trends in different Autonomous Communities. Of special concern is the smaller increase apparently registered in Andalucia, one of the Spanish poorest regions, which has also been below average in terms of health care resources.

Fig. 12. Evolution of citizens' satisfaction with primary care by selected Autonomous Communities, 1992–1996



Source: Rico and Pérez-Nievas, 2000.

At national level, satisfaction seems to have remained rather constant from the mid to the late 1990s, according to comparable satisfaction surveys carried by the state central survey bureau (CIS). With satisfaction being measured on a 1 to 7 scale, the average numbers corresponding to both the general performance of primary care and the different dimensions of service (access, information, trust in the doctor, equipment, home care, etc.) remained relatively stable between 1994 and 1998. In particular, general satisfaction with the services received a 5.23 score in 1994, which evolved to 5.29, 5.24 and 5.26 in 1995, 1997 and 1998, respectively. It should be remembered here that by 1994, two thirds of the population were already covered by the new primary health care network, a percentage that had increased to nearly 80% in 1998. Three aspects of the delivery of care have experienced net increases in their average satisfaction scores during the period: namely the average consultation time per visit; the information received from the doctor; and technological equipment and installations.

The equity of acessibiltiy and rate of utilization of the primary health care sector markedly differs across different programmes and services. While general consultations with GPs are more frequent among the lowest social classes, the opposite applies to rates of utilization of preventive and dental services. With

regard to preventive services, the example of gynaecology displays particularly marked differences, with richer women showing attendance rates which are 2.5 times higher than those of the poorer. This is probably due to the lack of public services in this field, with most women having to resort to the private sector in order to access preventive care. The same applies to dental care, which is not generally covered by the public health care system. Accordingly, among the higher social class, the percentage of population having declared a visit to the dentist in 1993 was almost twice as high as the corresponding figure among the lower social class. As expected, the difference in access to the private sector is also supported by available evidence: among those declaring a consultation with a physician in 1995, only 10% of the less advantaged had done so through the private sector, while the percentage for the upper social class is 40%.

Although there have been significant improvements made during the period, there are still important problems that will require future reform. For example, in spite of the explicit legislative commitment made in this respect, the health care system is still centred around hospitals rather than around primary care. The capitation supplement for general practitioners is too small to constitute an effective incentive to attract and retain new patients through improved quality of care. Despite progress in diagnostic support, primary health care centres still lack other basic infrastructure, such as that required to conduct minor, elective surgery. There is no standard model for clinical records or clinical protocols across Autonomous Communities, and they are only rarely computerized. Economic incentives to reduce the amount and cost of pharmaceutical prescriptions, introduced in the mid-1990s, do not incorporate a quality component for prescriptions. The cost-effectiveness of preventive and curative practices has not been evaluated. Most seriously, a national information system does not exist which covers basic indicators like personnel working for the public system, variations in the payment system at the regional level, physician contacts per person, utilization patterns by age, gender and social class, or morbidity/mortality profiles at the health area level. In addition, the effective size of each general practitioner list is only updated erratically, and under considerable delays (which may be as long as five years), and so the capitation supplements cannot be adequately updated. The problem is especially serious in the outskirts of medium to large cities, which keep on growing relatively rapidly, therefore experiencing drastic increases in workload which are not adequately compensated through the capitation supplement. Finally, all the above information problems not only make it difficult to evaluate or manage the system from above, but also constitute a serious obstacle to improving the quality of day-to-day clinical management of patients.

Public health services

Public health is one of the areas of responsibility which has been passed over, in a large part, to the Autonomous Communities. Conclusions from a careful four-year study of progress made at the regional level since the late 1970s, published in 1999 by a group of experts sponsored by the Catalan Institute of Public Health, are as follows. The process of the transfer of powers to the Autonomous Communities (and both from local governments and the central administration), started in 1979, had not been totally implemented twenty years later (in particular, although central powers were fully transferred in 1986, transfers from local governments were not fully completed at the end of the 1990s). The improvements following the near completion of the process have been considerable, especially due to the parallel development of an extensive, reformed primary care network and to the progressive integration of all public health responsibilities in the hands of a single level of government. Also, professional standards have been significantly enhanced, following the introduction of specialized training. The process, however, has been considerably slow. In 1990, there were 131 specialists enrolled for training in the newly-created specialty of Preventive Medicine and Public Health (out of a total of approximately 5000 specialist training positions being offered annually) while, in 1997, this figure rose to only 281 registered specialists. Probably for this reason, specific professional qualifications were rarely considered by public sector recruitment policies up to the late 1990s. At the same time, sometimes effective organizational integration has not occurred due to the fragmentation of public health responsibilities among different departments of the regional administrations. In addition, special problems of coordination derived from the newly-decentralized government structure.

The Ministry of Health is in charge of guaranteeing unified information and infrastructure development, and consensual policy design and evaluation. Its role in this respect has been considerably improved, particularly over the last few years. It also retains a coordinating role over Autonomous Community functions in public health, which it exercises through the Interterritorial Council of the National Health System, conditional on the voluntary agreement of the Autonomous Communities. In addition, there are core areas of public health which have remained the exclusive role of the state, including external relations, the management of the Nutrition Alert Network, and the Environmental Surveillance Network.

Core programmes

Epidemiological surveillance

At present, all physicians are required to notify health authorities of all diagnosed cases of communicable diseases (international and national). Notification is made through the Autonomous Community authorities who are committed to communicating this to the Ministry of Health where a central record of notifiable diseases is kept.

From 1 July 1996, new regulations came into force with the creation of a National Epidemiological Surveillance Network. Implementation of these regulations involved, among other measures, the development of guidelines for the prevention, diagnosis and treatment of infectious diseases, the creation of a network of national epidemiological laboratories linked to similar institutions at the international level, or the promotion and development of the telematic network *PISTA* to facilitate the transmission of epidemiological information across health care authorities. As part of this, field epidemiology was created as a new medical specialty. This should enable epidemiological information to be coordinated and exchanged and will facilitate collection, analysis and assessment. This, in turn, aims to promote a more effective use of epidemiological information in the detection and control of health problems.

AIDS

Responsibility for AIDS is shared between the central government and the Autonomous Communities, although the Ministry of Health is the key sponsor of the National Plan Against AIDS. Action in this area is directed towards better knowledge and analysis of the reality of the epidemic; the development of prevention programmes (information campaigns, needle exchange, prevention of sexual transmission, methadone substitution programmes); training and support programmes for health care staff; recommendations on treatment; screening, etc. Recently, AIDS patients were included in the group which pays a reduced charge for medicines.

Drug addiction is a major problem in Spain, with high numbers affected. There is a National Anti-Drug Plan which is run through the Ministry of the Interior and which coordinates action to be taken in the fight against drugs. Drug substitution programmes are held in health centres with explicit authorization and are closely regulated by law. In the late 1990s, the Autonomous Community of Andalucia first launched a policy proposal of administering heroin to drug addicts who have tried and failed several rehabilitation programmes. This policy measure, however, was vetoed by the central state, on grounds of a lack of legal coverage.

Preventive devices and health promotion

The bulk of preventive medicine and health promotion is integrated with primary health care and carried out by practice nurses as part of their normal workload.

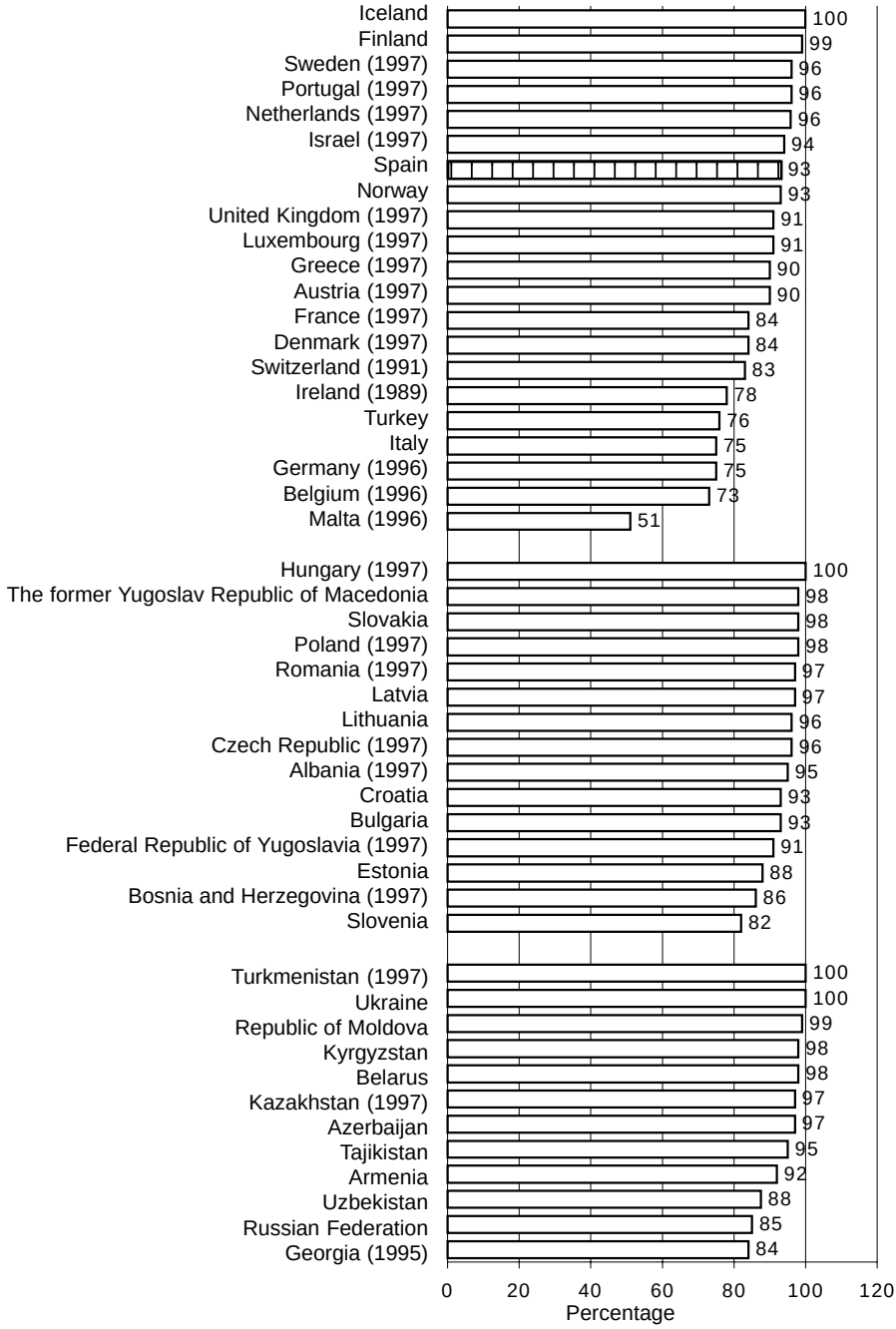
Immunization
While primary care nurses administer vaccinations, the planning and management of immunization programmes is one of the areas handled by the Autonomous Communities. Each community agrees on an immunization calendar and ensures that it is implemented. It may also choose to offer additional immunization beyond the package agreed on nationally. From 1999, a unified calendar came into use, as agreed by the Interterritorial Council. Programmes appear to be successful and a drop in preventable illnesses has been observed. There have been no cases of diphtheria since 1987, and only 4 cases of poliomyelitis during the period 1989–1999. The latter reflects the significant efforts made through the Plan for the Eradication of Poliomyelitis, which started in 1996, following the recommendations of WHO. In 1998, the level of immunization against measles stood at 93%, well above the western European average (Fig. 13). However, significant problems remain also in this field. For example, although the cases of tetanus decreased in the last decade, current prevalence (36 cases in 1999) is ten times higher than in the United Kingdom. In addition, the incidence of cattle-borne diseases is still high for western European standards, and it was only slowly decreasing during the first half of the 1990s, followed by a sudden increase from 1995 to 1996. Between 1996 and 1999, incidence rates stabilized, but at rather high levels (e.g. more than 1500 cases of brucellosis in 1998 and 1999, the equivalent of annual incidence rates of 4 per 100 000 population).

Health education
Autonomous Communities undertake education programmes within their own geographical regions. The Ministry of Health has launched national information campaigns for specific problems, such as alcohol, drugs, AIDS or work-related illnesses at state level. In addition, there is an agreement with the Ministry of Education through which health education has been introduced into the school curriculum. There is also legislation on tobacco and alcohol which regulates its sale, consumption and advertising.

Secondary and tertiary care

Both secondary and tertiary care are included under a single category of the Spanish National Health System, that of specialized care. Its structure and

Fig. 13. Levels of immunization for measles in the WHO European Region, 1998 (or latest available year)



Source: WHO Regional Office for Europe health for all database.

organization include a number of features which distinguish the Spanish system from that of other European countries.

The system is predominantly integrated, as most hospitals are publicly-owned, and the majority of staff are salaried employees. Alongside the hospital system there is an extensive network of outpatient ambulatory centres. While they depend on hospitals to a significant extent, they are responsible for the provision of outpatient care. This derives from a long tradition of independent specialized ambulatory care which included not only physician consultation, but also minor surgical and diagnostic procedures (e.g. endoscopies).

The concrete mode of provision varies across Autonomous Communities and hospitals. In some cases, there are specialist doctors who are fully dedicated to outpatient care in ambulatory clinics (model 1). In fact, this is the traditional provision model, still in place in many health areas. In other cases, the members of specialist teams at the clinical departments of general hospitals rotate to cover outpatient care in the ambulatory clinics included within the same health area (model 2). This is the reformed model, progressively introduced by the central government within the territory managed by the INSALUD from the late 1980s onwards, and then followed by some special Autonomous Communities. In both cases, hospitals also maintain their outpatients visits, which are targeted to the patients referred to the hospital from the ambulatory clinic and, accordingly, usually correspond to a highly specialized modality of care.

Across most of the country, both outpatient and inpatient care are formally regarded as functioning at a single level, although health system structures do not always facilitate this approach. Significant coordination problems remain, which differ depending on the model of provision which is prevalent in a particular area. Under model 1, as described above, it is sometimes difficult to guarantee adequate coordination between the ambulatory clinic and the hospital, while ambulatory specialists often find difficult to maintain their professional training standards at the same level as hospital specialists. Under model 2, in contrast, the higher degree of integration ensures that specialized outpatient care is provided by professionals who are effectively linked to the corresponding hospital service, and consequently favours high quality care. The fact that the members of the hospital clinical team rotate to cover ambulatory services, however, often generates problems regarding adequate continuity of care to each patient.

Organization and planning of specialized care is regionally based and all health areas must either have, or be linked to, a general hospital for acute cases. Hospitals within the system largely confine themselves to acute care and provide at least the minimum basic services of: internal medicine; general surgery; core surgical specialties (ophthalmology, ear, nose and throat);

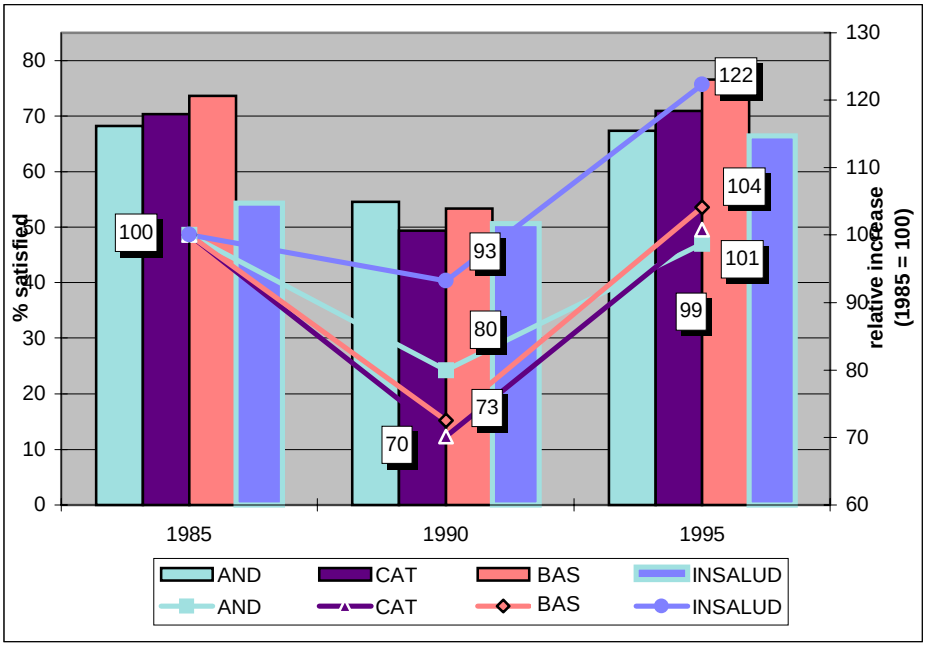
orthopaedics; obstetrics and gynaecology; paediatrics; physiotherapy; radiology and laboratories. All these hospitals have 24-hour emergency services.

Larger hospitals, mainly those which are located in the provincial capitals, offer highly-specialized services (cardiovascular surgery, neurosurgery, organ transplants, etc.) which are not cost-effective in smaller areas. In general, all Autonomous Communities have at least one general hospital for acute cases with the full range of specialties available and a benefits package that reflects all the most recent medical advances. Access to these services, although referral-based, is only through referral by other specialized health care services and not general practitioners. This implies that the patients in need of hospital care have to go through three levels of care (general practitioner, ambulatory specialists and hospital physicians) which are not always well coordinated. Duplication of clinical histories and diagnoses is actually not rare, generating considerable economic inefficiencies, delays in treatments and discomfort for patients. Another important problem here is the high number of emergency hospital admissions: 60% of total hospital discharges correspond to patients who entered the hospital through the accidents and emergency department. There are large regional differences in terms of emergency hospital admission rates per 1000 population, with 1995 figures ranging from 381 in the Basque Country to 549 in Catalonia, with a national average of 426.

In general terms, coordination across levels of care is one of the areas of greater attention and experimentation by front-line managers and professionals during the last few years, and several new experiences were piloted during the 1990s. In spite of this, serious problems still remain, which mainly affect the information and communication systems used to ensure continuity of care across levels, and the lack of respect for family medicine by many hospital doctors.

As regards patient satisfaction, available figures suggest that about 70% of the population is satisfied with outpatient and hospital services, a level already achieved in 1985, with 1995 average figures being only slightly higher than ten years before. In the case of hospitals, the evolution during the decade and by Autonomous Communities was as follows (Fig. 14). In 1985, about 70% of the population was satisfied with hospital services in the three selected Autonomous Communities (Andalucia, Catalonia and the Basque Country), while the equivalent figure in INSALUD territory was only 55%. From 1985 to 1990, overall satisfaction dropped to 50%. This might have resulted from the significant cost-containment efforts carried out during the period (following an especially severe economic downturn), with health care expenditure decreasing in real terms between 1985 and 1987 which, in turn, led to a period of prolonged strikes among public health care professionals. Finally, between 1990 and 1995, a period of significant increase in public health care expenditure, citizens' satisfaction with hospital care recovered the 1985 70% level

Fig. 14. Evolution of citizens' satisfaction with hospital care by selected Autonomous Communities, 1985–1995



Source: Rico and Pérez-Nievas, 2000.

again in the three special regions and, this time, this was also within the territory managed by INSALUD.

As for the period 1994–1998, the series generated by the state central survey bureau (*CIS)* point to the following trends. As is the case of primary care, satisfaction apparently remains fairly stable (the average scores on the 1 to 7 scale were 5.2 for 1994, and 5.3 in 1995, 1997 and 1998). An additional similarity among the two fields is that technological equipment and installations, which already was the highest valued dimensions of care in 1994, also experienced net increases during the period. In sharp contrast with primary care, however, there were three dimensions of hospital care (out of the nine being evaluated) for which satisfaction scores suffered a net drop: this is the case of waiting times, of the number of persons sharing each hospital room, and of the administrative procedures needed to obtain access to services. Also in contrast with primary care (where increased satisfaction relates to aspects which had low satisfaction scores in 1994), these three dimensions of hospital services were already the ones receiving the lowest scores in 1994. Thus, this seems to suggest that the main problems of the sector still require further attention by policy-makers.

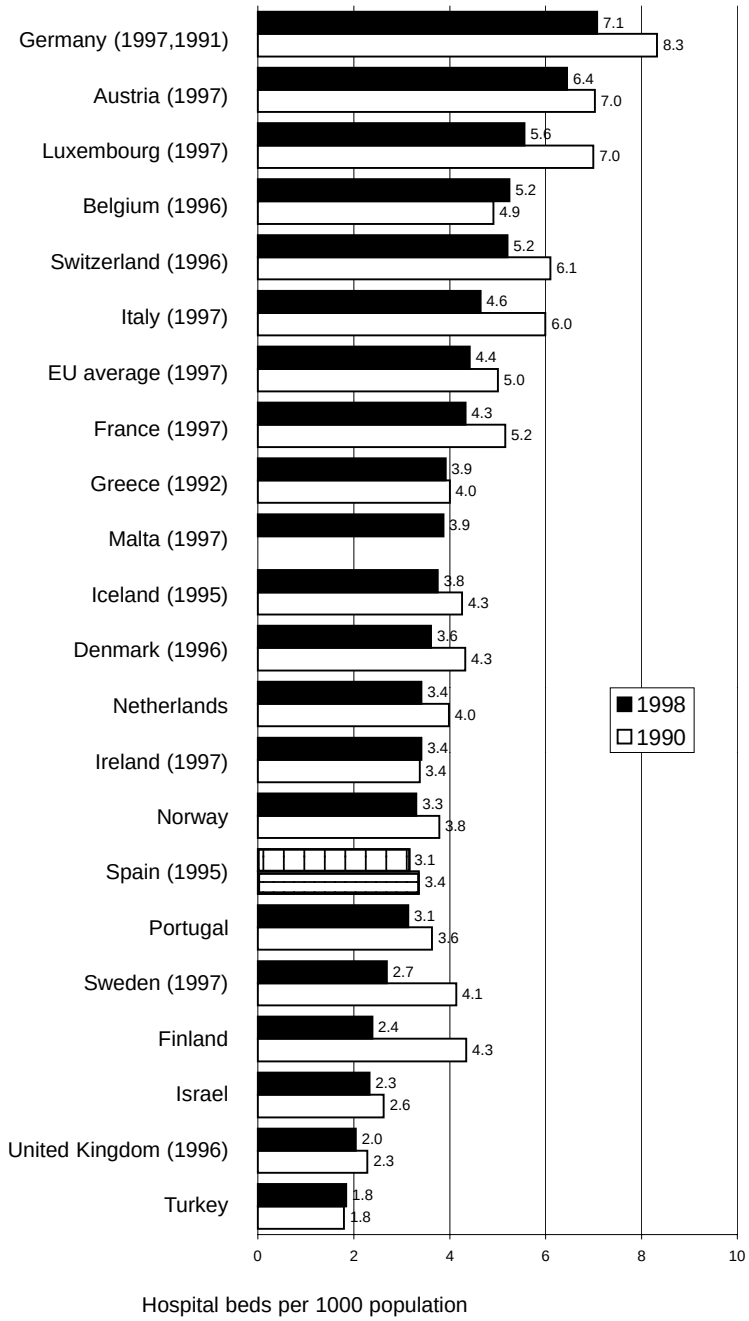
Hospital and bed numbers

The number of hospitals (public and non-public) in Spain on 31 December 1997 was 799, with a total of 166 276 beds or 4.2 beds per 1000 inhabitants. As for the details on different types of beds, the latest available comparative cross-national data are for 1995, when there was a total of 3.9 beds per 1000 population. Of these, 3.1 were acute care beds, 0.3 were long-term care beds, and 0.5 were psychiatric care beds. As it can be seen in Fig. 15 and Fig. 16, the 1995 figure for hospital beds in acute hospitals is one of the lowest within the European Union, with only three member countries showing smaller rates (Sweden, Finland and the United Kingdom).

Between 1979 and 1996, the evolution in the number of beds has been as follows. The absolute number of beds dropped by 25%, with important differences among regions. The comparison is restricted to the three Autonomous Communities for which data has been produced recently through a study directed by Lopez Casasnovas, and conducted by González López-Valcarcel and her team. For example, in the Basque Country and Andalucia, the reduction was of 30%, while in Catalonia, the number of beds only decreased by 10%. The drop especially affected obstetric and paediatric beds (partly as a consequence of the low fertility rate), as well as psychiatric ones (as a result of a reform in mental health care which emphasizes community care). There are also important differences at the regional level in this respect. As regards obstetrics, the reduction in capacity amounted to almost 60% in the Basque Country and Catalonia, while the equivalent figure for Andalucia (40%) was considerably lower; and the national average was 55%. In paediatric care, the average national decline (40%) was also experienced by Andalucia and Catalonia, but in the Basque Country, the reduction was even higher (60%). Psychiatric beds decreased by 75% in Andalucia (the region pioneering the Spanish psychiatric reform), by 30% in Catalonia, and by 20% in the Basque Country, against a national average of 40%. In sharp contrast, beds dedicated to long-term (non-psychiatric) care multiplied by four in Catalonia between 1984 and 1996, and almost doubled in the Basque Country. The national average, however, remained constant during the same period, while in Andalucia, long-term beds dropped by 70%.

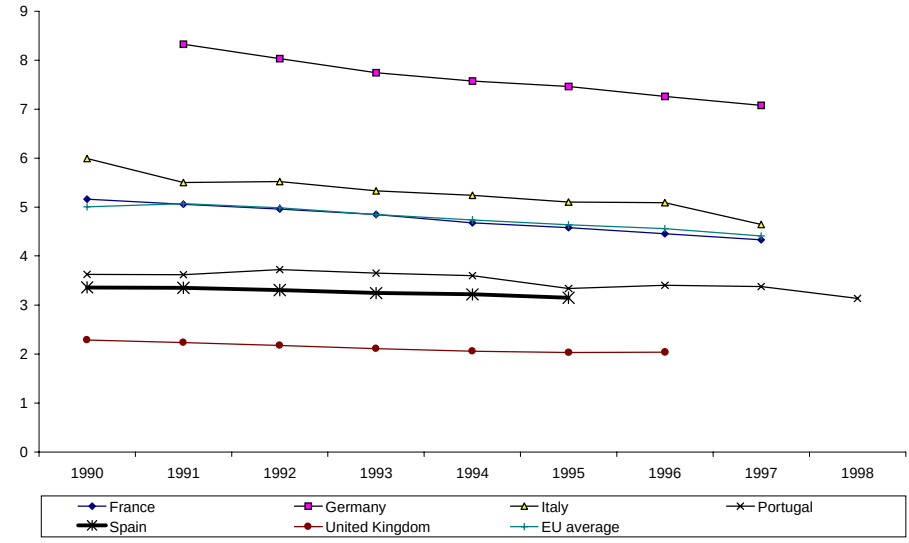
These figures point to the following reform trends, prevalent in most advanced countries: an overall closure of acute and psychiatric beds, accompanied by new investment in capacity building in the field of long-term non-psychiatric care. The increase in the latter was, however, smaller than the drop in the former, resulting in a general downsizing trend within the hospital sector between 1979 and 1996. This general tendency, clearly followed in the whole of Spain as well as in the Basque country, is not equally found in Catalonia and

Fig. 15. Hospital beds in acute hospitals per 1000 population in western Europe, 1990 and 1998 (or latest available year)



Source: WHO Regional Office for Europe health for all database.

Fig. 16. Hospital beds in acute hospitals per 1000 population in Spain and selected European countries, 1980–1997



Source: WHO Regional Office for Europe health for all database.

Andalucia. While the former successfully transformed acute beds into long-term ones during the period (which explains the insignificant fall in total number of beds during the period), the latter reduced capacity in all fields, including long-term care.

An additional fact to take into account is that the trends differ considerably when the analysis is divided by sub-periods. The efforts to reduce capacity, especially visible during the early 1980s, were substantially moderated between 1985 to 1990 (with the exception of psychiatric care). During the early 1990s, in contrast, the number of beds increased slightly, and from then on, they started to decrease again, but at a considerably lower rate than during the early 1980s. The final result, in the case of total public acute care beds, was a slight increase between 1986 and 1996 (from 84 153 beds to 87 589), partly as a result of the construction of about 60 new general hospitals between 1983 and 1996. The combined effects of the closures in large hospitals and the building of new smaller centres explains that the average size of hospital establishments decreased during the 1990s. The increased emphasis placed on a more even distribution of hospital infrastructures has tended to improve access and, by the mid-1990s, practically the entire population lives within 60 minutes of a general hospital. In fact, although the rates of beds per 1000 population

decreased sharply in surgical and psychiatric hospitals between 1981 and 1996, the equivalent figure for general hospitals remained constant during the same period, in spite of the 5% population growth registered between these two dates.

While autonomous health services and INSALUD provide health care through their own hospital networks, they also contract out services where necessary to private hospitals (profit or non-profit) so that both private and public beds support the delivery of public inpatient care. The percentage of public expenditure channelled through private, contracted-out hospitals oscillated from 15% to 25% between 1979 and 1996. From a point of departure of nearly 25% in 1979, it went down to about 15% by the mid-1990s.

In the mid 1990s, of the total number of beds: 68.8% were public (325 hospitals), 18.4% were private for-profit (332 hospitals) and 12.4% were private not-for-profit (135 hospitals). The reduction in the number of private beds during the 1990s has been especially notable, with the closure of 185 hospitals and more than 6000 beds. As in the public sector, small hospital clinics are replacing large establishments in the private hospital sector. As for the period 1985-1994, the reduction in the size of the private sector amounted to 20%, while the number of public beds remained relatively constant. As a result, private beds decreased their share of the total during the period: while in 1985 there were 1.1 private acute beds out of a total of 3.5 acute beds per 1000 (or 31.4% of the total), in 1994 this figure dropped to 0.8 out of a total of 3.2 per 1000 (or 25% of the total).

Between 1986 and 1996, the demand for specialized services, as reflected in population-adjusted utilization rates, has grown in all categories, including outpatient consultations (which multiplied almost by four, but this includes the impact of the integration of secondary care into hospital services), emergency services (which rose by more than 60%), and inpatient care (with discharges increasing by about 20%, and surgical operations by nearly 60%). The only exception to this general increase in demand was for care during childbirth, which has gone down in line with expectations.

According to a recent study directed by Esteban de Manuel, the admissions rate for acute hospitals (admissions per 100 inhabitants) rose from 9.3 in 1985 to 10.0 in 1996 over the whole country. Of the latter figure, 8.4 were publicly financed admissions. By selected Autonomous Communities, in Andalucia, the increase was smaller than the national average, probably as a result of steeper reductions in hospital capacity; on the other hand, Catalonia and the Basque Country, with higher points of departure in the mid-1980s (10.0 and 10.1 respectively), experienced different trends during the decade: by 1996,

Table 9. Inpatient utilization and performance, 1985–1996

Inpatient	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996
Admissions per 100, total	9.32	9.18	9.38	9.68	9.68	9.73	9.95	10.23	10.47	10.68	10.88	–
Admissions per 100, acute public hospitals	6.21	6.22	6.41	6.64	6.62	6.72	6.91	7.22	7.39	7.57	–	–
Average length of stay in days, total	13.42	13.09	13.10	12.74	12.58	12.17	11.86	11.35	11.00	10.54	10.46	–
Average length of stay in days, acute hospitals (public + private)	10.05	9.87	9.98	9.78	9.68	9.42	9.25	8.84	8.58	8.24	–	–
Average length of stay in days, public hospitals	10.4	10.2	10.5	10.2	10.1	9.9	9.7	9.2	9.0	8.9	8.8	8.5
Occupancy rate, acute hospitals (public + private)	72.23	70.47	73.37	74.51	74.26	73.60	74.27	73.97	74.82	73.93	–	–
Occupancy rate, public hospitals	76.9	74.5	78.7	78.6	77.8	77.4	77.8	77.6	78.6	80.1	80.4	81.2

Source: INE Database 2000; Fernández-Cuenca, 1999 and Repullo and Fernández-Cuenca, 2000.

admissions in Catalonia rose to 12.3, while they remained relatively stable in the Basque Country. Overall, hospitals have coped with this increase in demand by using their resources more intensively (shorter average stays, quicker turnover and higher occupancy rates). However, it has not proved possible to absorb all of the very significant increase in demand for surgical operations, with waiting lists and times increasing substantially until 1996, when a specific scheme to reduce waiting times was initiated.

The evolution by sub-sectors, according to a different source (Table 9), has been as follows. Increased productivity is reflected in an increase from nine admissions per 100 population to almost eleven, or a 17% accumulated increase for the total hospital sector between 1985 and 1994. This trend is more marked for acute public hospitals, which experienced a 22% increase in admissions during the same period. In addition, average lengths of stay were generally reduced from 13.4 to 10.4 days (22%) between 1985 and 1995 for the whole hospital sector. For acute hospital care, and for public acute hospitals, the reduction was somewhat smaller. Occupancy rates, in turn, increased from 76.9 to 81.2 between 1985 and 1996 in the acute public hospital sector, while for total acute hospital care the evolution was from 72.23 in 1985 to 73.93 in 1994. Improved accessibility and productivity are reflected, however, in higher current hospital expenditure, which almost doubled during the decade, a figure which may also reflect the significant increase in the case-mix attended by (increasingly technology-intensive) hospitals.

Table 10. Inpatient utilization and performance in acute hospitals in the WHO European Region, 1998 or latest available year

Country	Hospital beds per 1000 population	Admissions per 100 population	Average length of stay in days	Occupancy rate (%)
Western Europe				
Austria	6.4[a]	24.7[a]	7.1[a]	74.0[a]
Belgium	5.2[b]	18.0[b]	7.5[b]	80.6[c]
Denmark	3.6[b]	18.8[b]	5.6[b]	81.0[b]
Finland	2.4	20.5	4.7	74.0[c]
France	4.3[a]	20.3[c]	6.0[b]	75.7[a]
Germany	7.1[a]	19.6[a]	11.0[a]	76.6[a]
Greece	3.9[f]	–	–	–
Iceland	3.8[c]	18.1[c]	6.8[c]	–
Ireland	3.4[a]	14.9[b]	6.7[b]	82.3[b]
Israel	2.3	18.4	4.2	94.0
Italy	4.6[a]	16.5[a]	7.0[a]	76.0[a]
Luxembourg	5.6[a]	18.4[d]	9.8[b]	74.3[d]
Malta	3.9[a]	–	4.5	72.2[a]
Netherlands	3.4	9.2	8.3	61.3
Norway	3.3	14.7[b]	6.5[b]	81.1[b]
Portugal	3.1	11.9	7.3	75.5
Spain	3.1[c]	10.7[c]	8.5[b]	76.4[c]
Sweden	2.7[a]	16.0[b]	5.1[b]	77.5[b]
Switzerland	5.2[b]	14.2[e]	11.0[a]	84.0[a]
Turkey	1.8	7.1	5.5	57.3
United Kingdom	2.0[b]	21.4[b]	4.8[b]	–
CCEE				
Albania	2.8[a]	–	–	–
Bosnia and Herzegovina	3.4[g]	7.4[g]	9.7[g]	70.9[g]
Bulgaria	7.6[b]	14.8[b]	10.7[b]	64.1[b]
Croatia	4.0	13.4	9.6	88.2
Czech Republic	6.5	18.4	8.8	70.8
Estonia	6.0	17.9	8.8	74.6
Hungary	5.8	21.7	8.5	75.8
Latvia	–	–	–	–
Lithuania	–	–	–	–
Poland	–	–	–	–
Romania	–	–	–	–
Slovakia	7.1	19.3	10.3	77.9
Slovenia	4.6	15.9	7.9	75.4
The former Yugoslav Republic of Macedonia	3.5[a]	8.1	8.9	66.5
NIS				
Armenia	6.0	6.0	10.7	30.2
Azerbaijan	8.0	5.6	–	–
Belarus	–	–	–	88.7[d]
Georgia	4.6[b]	4.8[b]	8.3[b]	26.8[d]
Kazakhstan	6.6	14.9	13.0	91.2
Kyrgyzstan	6.7	15.8	12.9	81.7
Republic of Moldova	9.1	16.9	15.4	77.6
Russian Federation	9.0	19.9	14.0	82.5
Tajikistan	6.2	9.7	13.0	59.9[b]
Turkmenistan	6.0[a]	12.4[a]	11.1[a]	72.1[a]
Ukraine	7.4	17.9	13.4	88.1
Uzbekistan	–	–	–	–

Source: WHO Regional Office for Europe health for all database.
Note: [a] 1997, [b] 1996, [c] 1995, [d] 1994, [e] 1993, [f] 1992, [g] 1991, [h] 1990.

Finally, when the acute hospital sector is considered globally, and in an international context (Table 10), the conclusions are as follows. Admission rates per 100 population in Spain were the lowest in western Europe after the Netherlands. Average length of stay in days, in turn, was one of the highest, with only three western European countries (Germany, Switzerland and Luxembourg) showing higher rates. Occupancy rates, in contrast, stand at the average western European levels.

Although official waiting list time has not been routinely published by the government until the mid-1990s, there is evidence of significant increases since the mid-1980s. Specific funding to reduce waiting lists was introduced in 1996 by central government, following the agreement between the previous socialist government and hospital doctors in 1996, which was reached after a long strike of hospital personnel centred around higher salaries and improved personnel stability. The strategy consisted of paying hospital doctors an additional amount for after-hours work dedicated to shortening waiting lists. In 1996, official estimates pointed to 53 828 patients waiting more than 6 months within the INSALUD territory, with average waits of 207 days. According to the figures recently published by the Ministry of Health, the main result of this strategy has been a significant reduction in average waiting times which, within the territory managed by the INSALUD, is estimated to amount to a 70% decrease (from 210 days in June 1996 to 60 in June 1999). This meant a parallel decrease in the number of patients waiting more than six months, which dropped from 53 828 to 510 in 1999. In addition, from January 2000, patients waiting for more than six months are given the right to choose another public or private contracted out hospital.

Finally, a recent statistical study measuring the difference in access to, and the utilization of, specialized care across social classes points to the following results: Rates of utilization of specialized care (standardized by gender, age, and health status) in 1987 showed a clear imbalance in favour of the rich, which was particularly marked for hospital admissions. During the early 1990s, however, such differences seemed to become insignificant. A clearly varied pattern remained though with regard to the accessibility of services: waiting times were considerably longer for the less educated, particularly so in hospital services, with the less educated waiting 84 days on average and the more educated only 19 days.

Issues for specialized care

The organization of specialized care in the mid-1980s suffered from a number of problems, which have not always been adequately addressed during the 1990s:

- a limited capacity to manage centres due to over centralization of decision-making;
- the quasi-civil service status of health professionals linked to the health system;
- difficulties in encouraging health professionals to identify with the objectives of the system, e.g. conflicts over the introduction and use of health care technology when professional preferences do not necessarily coincide with the system's strategic needs;
- overly formal control with little assessment of effectiveness of outcomes or quality;
- lack of managerial skills;
- lack of coordination between primary health care and specialized care;
- long waiting times for some medical and surgical specialties.

All of these factors have led to changes in specialized care. Among these are initiatives intended to separate financing and purchasing of health care from the actual provision of services. These have been brought about through the introduction of the contract-programme (contracts that are based on target activity but financed through global budgets). The contract-programme is an instrument which relates the third-party payer to public and private integrated hospitals and links the activity carried out with the relevant budget allocation. The introduction of this type of contract has encouraged the improvement of information systems, the definition of the benefits package, the development of management tools, etc. and has increased cost consciousness, thus changing the culture of health system organizations.

Other issues debated are those which relate to the active participation of health professionals in the management of resources. Consideration was given to creating professional managers with greater autonomy, encouraging an entrepreneurial approach to hospital management, introducing clinical management and evidence-based medicine, and shifting to prospective financing systems. A detailed description of these changes is included within the sections dedicated to *Financial resource allocation* and *Health care reforms.*

In spite of the effort made, accomplishments in the field of cost-effective management practices are still lacking compared to European figures. The percentage of total suitable interventions effectively conducted through ambulatory care, for instance, is only 30%, below the European average and well below the levels of other countries, like the Netherlands, which have figures up to 60%. However, from 1995 to 1999 the number of major ambulatory surgical procedures almost tripled within the INSALUD territory, increasing from 36 676 cases to 101 408. There are important weaknesses in the management of central

hospital services (diagnostic support, overhead, surgical room management, etc.), which take up 40% of the total hospital budget. In addition, estimates of unnecessary hospital utilization rates range from 30–40% of hospital bed-days to 15–20% of hospital admissions.

Social and community care

Social services

Social services are neither universal nor comprehensive. These services are managed partly by the Ministry of Labour and Social Affairs, and partly by the Autonomous Communities. The 1995 Royal Decree which defines the benefits package for the health care system established the need for coordination among the departments in charge of health care and social services in dealing with the social problems associated with ill health, but the advances made in this field are not yet visible.

Most of the responsibilities within the field of social affairs have now been transferred to the Autonomous Communities, which gradually enacted legislation in the 1980s to govern social services provision within their area of responsibility. At a national level, the Sectoral Conference on Social Affairs ensures coordination between the state and the Autonomous Communities. In general terms, this body is the social affairs equivalent of the Interterritorial Council of the National Health System. Within this latter body, an agreement was reached in the late 1990s to elaborate a framework for legislation to be passed on the coordination of social and community care.

The Autonomous Communities plan and regulate local services, coordinate resources and oversee assessment and control. Local governments are also involved in social care, especially in the planning and management of services. In contrast to practice in the health sector, there are co-payments for some social services with users contributing part of the cost although, in general, care at social service centres and day hospitals is free of charge. The social services system also covers part of the cost of spectacles, dentures, technical aids, etc., which are not covered by the National Health System for those users in particular need.

The key area of overlap between health and social services is in the provision of care for the elderly. There is a national plan for the elderly aimed at improving older people's standard of living. This plan includes a component on health care which focuses on health promotion, the prevention of illness and accidents, and healthy lifestyles.

Social services are responsible for elderly residential care. The number of places currently falls short of demand: in 1998, there were 2.83 places for every 100 people over 65. Only 30% of existing beds were public sector owned this same year, but this figure had rapidly increased from 1994, when the equivalent number was only 20%. Total supply in 1998 amounted to 188 913 places (58 493 public and 130 200 private), increasing from 163 338 in 1994, and about 100 000 in 1988. In 1998, there were 3689 elderly homes, which gives an average of 48 places per centre. Additional places are purchased through contracts with private institutions. Room in public institutions is normally determined in line with priority needs and criteria include social status, family situation, the applicant's economic position, physical state of health, age, etc.

The issue of the elderly requiring continuing medical care has not been resolved satisfactorily and there is no uniform, national/cross-sectoral approach. In 1998, it was estimated that some 10% of the total places, for instance, are located within residences that did not receive official accreditation. Criteria for accreditation, in turn, are not adequately nor uniformly regulated within the territory. No assessment of the degree of dependency is made, nor is treatment tailored according to the specific needs of the end user. In the public sector, the most favoured model is the use of nursing homes with medical support provided, when needed, by the public health system. Rehabilitation of the elderly with physical or mental disabilities has still to reach the desired level of development.

Home care is being expanded and within most municipalities, an infrastructure exists to deliver basic support to those being cared for or caring for others at home. However, generally speaking, accessibility to these services is severely restricted, and coordination with medical care is still lacking in many aspects.

Mental health care

Mental health care in Spain was traditionally one of the most neglected aspects of the Spanish system largely due to the division of responsibility for services among various public administration bodies and the lack of coordination among the parallel networks providing care. There was a pronounced marked over-reliance on the hospitalization for chronic psychiatric cases, inadequate provision of outpatient care and a notable lack of social resources. In response to these very real problems, the Ministerial Commission for Psychiatric Reform was set up in 1983, which drafted a document laying down the framework and broad criteria for reform of psychiatric services. The General Health Act (1986) went on to confirm that mental patients were to be treated as users of equal worth and made provision for the integration of mental health within the general health care system.

The psychiatric system was thus required to integrate its resources: to create mental health centres; to extend the number of psychiatric day care units; and allow for the hospitalization of acute cases in general hospitals, while reducing beds in psychiatric hospitals. A recent study conducted by the Ministry of Health reported the following figures and trends within the sector for the period 1991–1996. In 1996 there were 555 mental health care outpatient centres (477 in 1991), with an average coverage rate of 70 757 inhabitants per centre (79 061 in 1991), and a utilization rate of 92 annual visits per 1000 population (53 in 1991). Regional differences were especially marked, with coverage rates ranging from 139 333 inhabitants per centre in Madrid to 35 676 inhabitants per centre in the Basque Country, and utilization rates ranging from 238 annual visits per 1000 population (Basque Country) to 13 per 1000 in Castilla-La Mancha. In addition, there were 145 (inpatient and outpatient) psychiatric day care units in 1996, which offered 3916 places (or 11 places per 100 000 population). As for ordinary inpatient care, the transition from psychiatric to general hospitals has been as follows: psychiatric beds within general hospitals increased from 2107 to 2407 during the period, while the number of beds in psychiatric hospitals decreased from 1694 to 1564. The productivity of general hospitals, as reflected in utilization rates, is considerably higher (1.4 per 1000 population versus 0.5 in psychiatric hospitals), partly due to shorter length of stay (16 versus 25 days). These figures correspond to the main hospital psychiatric network. In addition to that, there is a special network of care for these patients requiring very long hospital stays due to particularly severe conditions. The number of beds located within these special hospital units decreased from 20 040 in 1991 to 13 226 in 1996.

In 1995, when the wider health system's benefits were fully regulated, the content of mental health care and psychiatric care was defined, including: diagnosis and clinical follow-up; treatment; drug therapy; individual, group or family psychotherapy; and where applicable, hospitalization of acute cases.

The main challenges now facing the system are the lack of alternatives to institutionalization and the shortage of community care resources. There are also major concerns about the uneven development of psychiatric reform in the Autonomous Communities and the ongoing difficulty of coordinating health and social services in this area.

Interventions often require coordinated action among the different levels of the health system and the various public networks. Specific priority measures therefore include:

- training of PHC professionals in handling and evaluating mental disorders, thus guaranteeing the care of psycho-emotional disorders at this level;
- encouraging general hospitals to admit cases of acute mental disorders;

- establishing coordination systems and integrating these with health and social services;
- facilitating community care and rehabilitation of psychiatric patients in their normal environment;
- increasing the coordination of different public networks which care for the mentally ill, in order to make their work more effective.

Human resources and training

Health sector staff fall into one of three categories:

- *university-qualified health care personnel*: including physicians, dentists, pharmacists, biologists, chemists and clinical psychologists;
- *intermediate graduate health care personnel*: including social workers, qualified nursing staff, midwives, physiotherapists, occupational therapists, specialist technicians, hygienists, dental nurses, and auxiliary nursing staff;
- *other personnel*: including technical, special service, maintenance and other staff in health institutions.

The majority of medical staff working in the National Health Service have a status similar to that of civil servants. Professional recruitment into the health system is contingent on passing an entry examination which in turn confers a permanent employment status on successful candidates. In addition to that, four years' specialist training (three years for primary health care doctors) is required to enter the public sector. This requirement was introduced in the early 1980s for both public and private specialized care, and in 1995 it was extended to public primary health care, following a 1991 EU directive. All negotiation of working conditions is done centrally, while health centre managers have a markedly limited capacity to negotiate salary incentives. This makes a flexible staffing policy difficult and hampers managers' attempts to harness professionals to the objectives of the particular institution.

While a sizeable proportion of health professionals still work in both the public and private sectors, there have been attempts in recent years to encourage full-time commitment to the public sector using limited economic incentives.

Training

The Ministry of Education is responsible for undergraduate education and training of health personnel. Basic medical studies are for six years, with many National Health System hospitals taking part in teaching. Most other

undergraduate health care studies last five years. Nurses and physiotherapists are trained at specialist university schools, and their studies last 2–3 years.

Specialist training of doctors

The postgraduate training of medical specialists and general practitioners is through the postgraduate training system (MIR), and is based on a period of paid practical work of between three and five years – depending on the particular specialization – in centres and services which are specifically accredited for training delivery at this level.

Each specialization is governed by a national commission, made up of representatives of the scientific societies, university teachers, health professionals, residents, and medical colleges, and they define the training programmes for each specialization and the duration of training.

Since 1978, the number of places available are fixed annually and candidates selected through a competitive entry examination. The total number of places (including family medicine) available for specialized training varies from year to year but was generally between 4500 and 5000 per annum in the mid-1990s. In general, during the early 1980s, some 2000 places were offered annually, with an average of 8000 new doctors graduating per year. During the second half of the 1980s the number of places doubled, while the number of new graduates halved. The same trends continued during the 1990s, although increments were much more moderated. It is worth noting that in 1996, the number of specialist training places was already slightly higher than the number of new graduates. As for specialist training places in family medicine, the number of places has grown from 500 places per year in 1981 to 2000 in 1996, while this represented between 10% and 30% of the total number of specialist training places being offered throughout the same period.

Any centre, public or private, may request accreditation for training delivery, conditional on their compliance with rigorous standards, which are audited by a team of medical inspectors. The centres which pass the accreditation process are authorized to provide training for a specific number of graduate students for a maximum period of three years, after which time they must be re-accredited. The accreditation process is run jointly by the Ministry of Health and the Ministry of Education in collaboration with the National Council for Specialties.

Specialist training of nursing staff

Specialties in nursing are still in the development phase. Thus, at the present time, there are only specialties in mental health and midwifery, which both started in 1996. Access to training is the same as it is for other medical

specialists. The global number of nursing places was also limited in the late 1990s to about 7000 per annum, in spite of the acute shortage of trained professionals in Spain.

Specialist training of managers

There are no official programmes for training health sector managers, although the National and Regional Schools of Public Health and other public and private teaching bodies do offer management training courses. The health care system does not demand specific management qualifications of those contracted to carry out management functions, although in general health managers must have a university degree and management training is valued. Systems of recruitment in this field, however, have been changing from the mid-1990s, following the contracting out of managers to independent recruitment companies and the creation of an specialized unit within the Ministry of Health to coordinate the process.

Staffing levels

In 1997, according to international databases, there were 4.2 physicians and 4.6 nurses per 1000 population in Spain (Table 11). In comparison with western European standards (see Fig. 17 and Fig. 18), the relative number of doctors is the second highest after Italy. In stark contrast, Spain displays the fourth lowest number of nurses per 1000 population, after Greece, Italy and Portugal. These figures, however, should be considered carefully, as routinely-collected data in Spain is restricted to health care professionals registered as members of the medical colleges, who may or may not be actively working, which might make comparisons with European data on active physicians difficult. This is specially factible due to the high number of unemployed doctors in Spain (24 512 in 1999, or 15% of male registered doctors and 30% of female). According to one of the main professional associations within the sector (*CESM*), the total number of active doctors in 1999 was 83 534, or 2.2 per 1000 population, a figure which considerably differ from that presented in Table 11. In addition, it should be taken into account here that the data on nurses displayed in Fig. 18 does not include these who work in the social care sector.

In fact, according to data recently collected by the Ministry of Health, the numbers of active health professionals working in the public sector in 1998 were as follows (Table 12). There were a total of 1.6 doctors and 2.4 qualified nurses per 1000 population, as well as 1.4 auxiliary nurses, 0.1 physiotherapists and 0.1 midwives. This gives a ratio of 1.5 nurses per doctor, which rises to 2.4 when auxiliary nurses and midwifes are included in the calculation. By

Table 11. Health care personnel, 1970–1997

Per 1000 population	1970	1975	1980	1985	1990	1991	1992	1993	1994	1995	1996	1997
Active physicians	1.34	1.56	2.30	3.30	3.82	3.93	4.00	4.08	4.14	4.15	4.22	4.2
Active dentists	0.10	0.10	0.11	0.13	0.27	0.29	0.30	0.31	0.34	0.36	0.38	–
Nurses	–	0.84	3.16	3.73	4.09	4.13	4.23	4.30	4.29	4.40	4.51	4.6
Midwifes	–	–	0.11	0.16	–	–	–	–	–	–	–	–
Active pharmacists	0.47	0.53	0.62	0.80	0.94	0.97	0.99	1.01	1.03	1.06	1.10	–
Physicians graduating	–	–	0.21	0.20	0.13	0.13	0.13	0.11	–	–	–	–
Nurses graduating	–	–	0.14	0.13	0.14	0.14	0.14	0.16	–	–	–	–

Source: WHO Regional Office for Europe health for all database.

Table 12. Active physicians and nurses per 1000 population in the public sector, 1998

	Primary care		Specialized care		Total	
	GPs	Nurses	Physicians	Nurses	Physicians	Nurses
Spain	0.6	0.6	1.1	1.9	1.6	2.4
INSALUD	0.5	0.6	1.2	1.9	1.6	2.5
Andalucia	0.6	0.5	1.2	2.2	1.8	2.6
Basque Country	0.5	0.6	1.1	1.6	1.5	2.2
Canary Islands	0.5	0.5	1.0	1.6	1.5	2.1
Catalonia	0.6	0.6	0.6	0.9	1.3	1.5
Galicia	0.6	0.5	1.2	1.9	1.8	2.5
Navarra	0.7	0.8	1.6	2.4	2.3	3.1
Valencia	0.6	0.6	1.0	2.0	1.7	2.6

Source: Ministry of Health and Consumer Affairs, 1999.

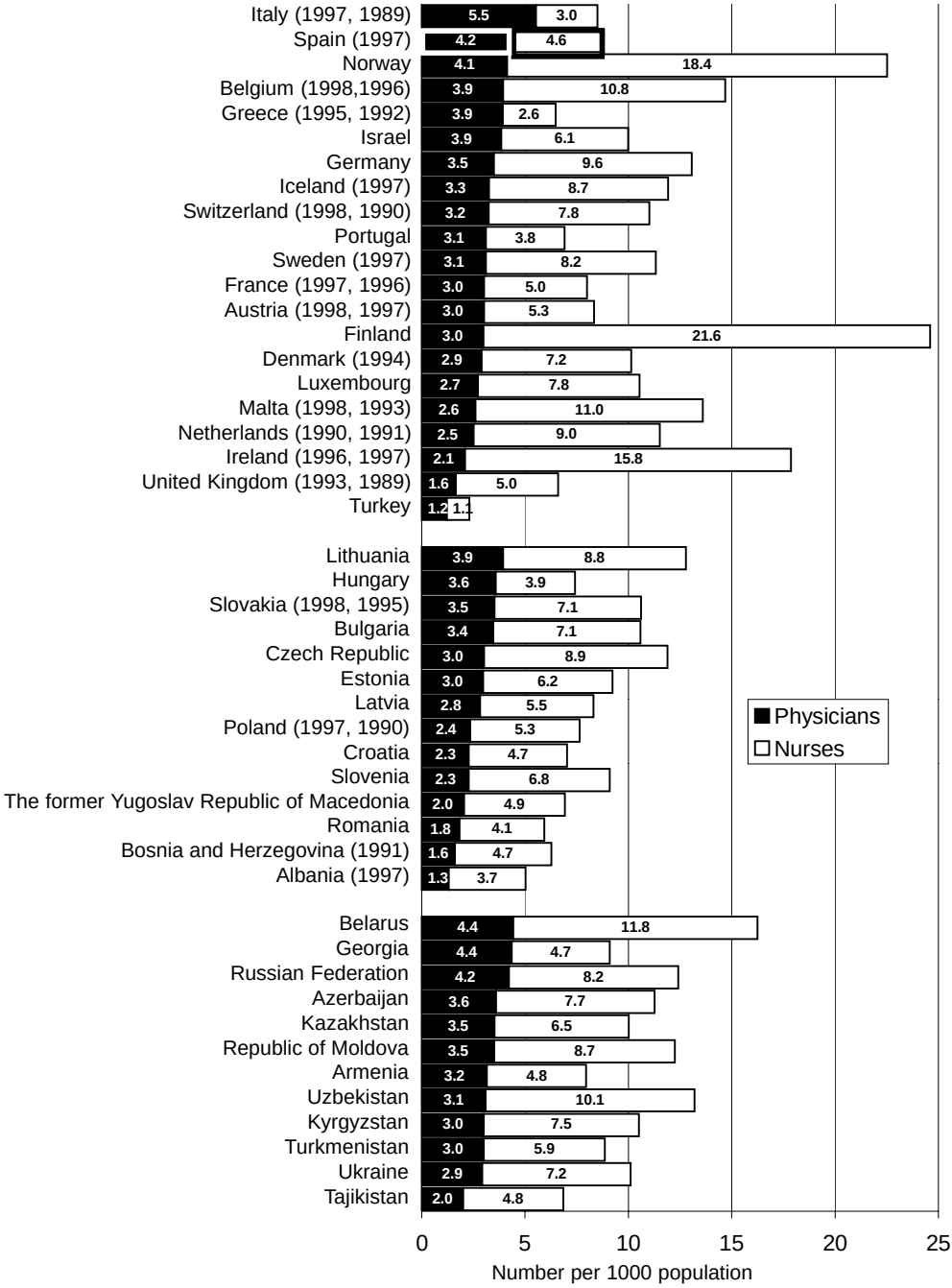
sub-sector, there were 0.6 general practitioners and 0.6 practice nurses per 1000 population. As for specialized care, there were 1.1 doctors, 1.8 qualified nurses, and 1.3 auxiliary nurses working either in hospitals or in outpatient specialized care. In addition, administrative personnel constituted almost one third of the total public health care system workforce, while the equivalent figure for high level managers and directors was 1%. Regional data show that Catalonia deviates the most from national averages in the field of specialized care, due to the important role that private, non-profit, hospitals that are contracted out play in this region. Otherwise, the rates of health care personnel hardly vary across regions, with the exception of Navarra, which shows higher ratios in all categories of health care personnel.

Spanish human resources policies have been characterized by overproduction of doctors, especially during the 1970s and early 1980s. In fact, during the mid-1970s, the average number of students enrolled in the first year undergraduate course was very high: around 20 000. Since then, there have been significant reductions in the number of entrants to medical schools following the introduction of restrictions in the number of places in 1978, and especially after the 1987 agreement of the University Council to further limit admission. In the late 1980s, accordingly, the number of students decreased to less than 10 000. The production of excessive numbers of doctors in the past has left a legacy of difficulties, in particular by medical specialties. The examination entry system for residents could not absorb the high numbers of graduates coming out of the universities and this has caused unemployment among physicians who have been unable to specialize.

As regards the growth of active doctors by sub-sector and the relative position of Spain internationally, a recent study conducted by González López-Valcárcel and her team points to the trends outlined in the following. As no official data was published on public health care personnel at the time, the study had to rely on figures of health care personnel registered with their respective professional colleges, which do however offer a useful picture of the sector. The most visible figures refer to the low number of primary health care doctors in spite of the explicit priority given to this level of care starting in 1984. In 1985, 82.6% of physicians were concentrated in hospital and outpatient specialties, a figure which was almost 20% higher than the western European average. In 1997, specialized care kept on absorbing 76.2% of the total, which was still 20% above the EU average. By selected Autonomous Communities, the three Autonomous Communities for which there are available comparative data (Andalucia, Catalonia and the Basque Country), show very similar levels and tendencies, with slightly less than 50 general practitioners per 100 000 inhabitants in 1991, a figure which almost remained constant up to 1996. The three of these communities were relatively understaffed in this field, however, as compared with the territory managed by INSALUD, which had a rate of 63.9 general practitioners per 100 000 population in 1996.

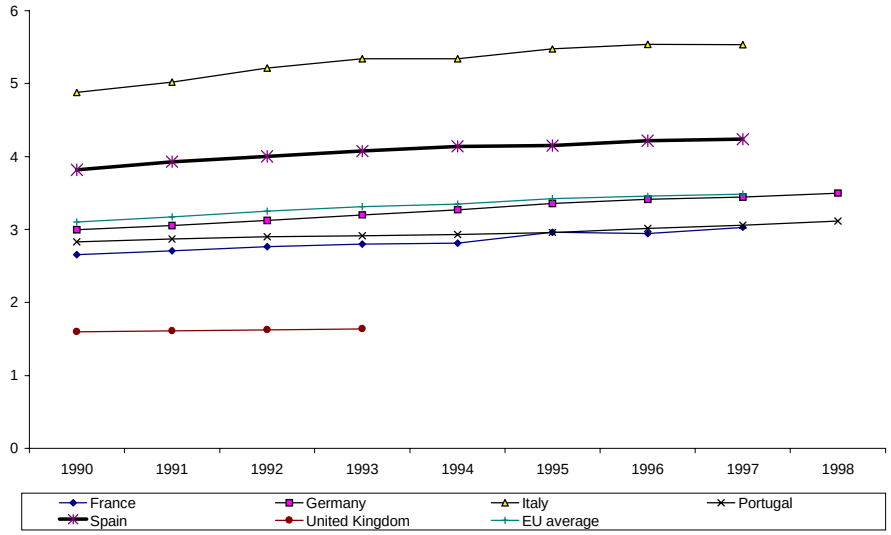
According to the same study, there is also an over average supply of pharmacists compared with average European levels during the period 1985–1997. In contrast, there is undersupply of nurses, with a ratio of 1.8 nurses per physician in 1997, almost half the EU average, which stood at 3.2 this same year. A cause for concern here is the little progress made in this field since the mid-1980s, with the rate of nurses increasing only by 20%, slightly below the increase of physicians, and very far from progress registered in other health care professions, like dentistry (with a 186% increase) or veterinary science (126%). In

Fig. 17. Number of physicians and nurses per 1000 population in the WHO European Region, 1998 or (latest available year)



Source: WHO Regional Office for Europe health for all database.

Fig. 18. Physicians per 1000 population in Spain and selected western European countries, 1970–1998



Source: WHO Regional Office for Europe health for all database.

any case, acute shortages still characterize dentistry in Spain, which was at 22% of the European average in 1985, and which rose to 64% of the average EU level after significant efforts made during the 1980s and 1990s.

With regard to health care professionals working for the public hospital sector, the evolution has been as follows. In 1996, the total hospital personnel expenditure amounted to 1938 billion pesetas, or 69% of total current expenditure. Between 1985 and 1996, personnel expenditure almost doubled in real terms, following the general pattern of total current expenditure. By profession, between 1989 and 1995, managerial staff multiplied by two both in directive and support positions. In contrast, the increases in the other categories of hospital personnel were much more moderate, ranging between 10% and 30%. The share of physicians per medical specialty remained almost constant between the early 1980s and the mid-1990s.

Pharmaceuticals and health care technology assessment

The pharmaceutical sector

The Medicines Act of 1990 forms the basis of pharmaceutical policy in Spain, and most legislation regulating the pharmaceutical market has been updated since then in line with the Act's requirements. The main actors involved in the pharmaceutical sector are:

- *Pharmaceutical industry*: in 1998 there were 305 private companies (manufacturing laboratories) in Spain supplying medicines to the National Health System (including specialist drugs and anti-allergy immunizations);
- *Wholesalers*: this same year, there were 194 wholesalers supplying drugs to pharmacies;
- *Privately-owned pharmacies,* all of which have agreements with the public Health System; pharmacies are in charge of preparing and dispensing prescriptions as issued by the System's physicians. In 1998, there were 19 222 pharmacies in Spain. The number of pharmacies is determined by central planning, and pharmacies must be owned by a qualified pharmacist;
- *National Health System prescribing physicians, of both primary and specialized health care*, who prescribe publicly-financed pharmaceutical products by official prescription;
- *Patients,* who pay a co-payment ammounting to 40% of the retail price of pharmaceuticals, with the exception of the population over 65 years of age and those suffering from a permanent disability;
- *Regional health services or INSALUD,* which pays the balance of drug costs by reimbursing pharmacies through their professional colleges on a monthly basis (professional colleges are also in charge of computerizing prescriptions);
- *Health authorities at a national and Autonomous Community level,* who take on a range of regulatory responsibilities.

Governmental authority over pharmaceuticals can be divided into three levels (state; Autonomous Community; and regional health services/INSALUD) with the relevant health authority taking charge at the appropriate level. The state regulates and authorizes clinical trials; issues marketing authorizations for pharmaceuticals; controls the advertising of drugs and health care products directed towards the general population; licenses pharmaceutical laboratories; regulates

the quality and manufacture of pharmaceutical products; fixes the price of drugs; sets co-payments and decides on the inclusion or exclusion of pharmaceuticals on the list of publicly-financed medicines.

The Autonomous Communities undertake the planning of pharmacies, fixing the criteria for the opening or relocation of outlets, while health services or INSALUD are in charge of the day-to-day administration of pharmaceutical benefits, setting the conditions of the agreements with pharmacies, and implementing cost-containment programmes. By law, they hold wider powers over the implementation of centrally-issued legislation in the pharmaceutical field.

Table 13. Public pharmaceutical consumption: main indicators, 1986–1998

	1986	1990	1993	1994	1995	1996	1997	1998
Public consumption in billion Ptas	249	472	673	714	799	888	932	1024
% increase over previous year	–	15.23	7.33	6.06	11.88	11.18	4.98	9.77
Public expenditure in billion Ptas	214	420	609	649	728	813	856	945
% increase over previous year	–	16.24	7.76	6.53	12.27	11.60	5.31	10.36
User co-payments as a % of total public consumption	14.15	11.01	9.56	9.16	8.85	8.51	8.21	7.71
Total prescriptions (in millions)	–	–	505	494	525	552	526	561
Per capita prescriptions	–	–	13.91	13.44	14.2	14.7	15.0	14.9
% increase over previous year	–	–	-2.9	-3.4	5.7	3.5	2.0	0.7
Average price per prescription in current Ptas	542	847	1 271	1 380	1 455	1 539	1 589	1 755
% increase over previous year	5.7	10.0	10.2	8.6	5.4	5.8	3.2	10.4
Average price per prescription in constant 1986 Ptas	542	672	865	900	910	933	944	1 028
% increase over previous year	–	3.3	5.0	4.1	1.1	2.5	1.2	8.9

Source: Dirección General de Farmacia y Productos Sanitarios, Ministry of Health and Consumption Affairs.

Note: Billion = million millions.

Transferrals of responsibility in this field were part of the global health care package adopted by the special regions from 1981, although for various reasons this earlier devolution did not always allow for the effective exercise of powers transferred. Since the mid-1990s, a further wave of transfers has been accomplished in this field, partly directed to address the aforementioned problems, and partly to extend devolution to other, non-special regions. These later transferrals of responsibility were made in 1996 to the Canary Islands; in 1997, to Catalonia, Navarra and Galicia; in 1998, to Castilla-Leon; and in 1999, to the Balearic Islands and Aragon.

Table 13 presents the evolution of the main indicators of public pharmaceutical consumption and expenditure. Private consumption is not included in these figures, nor is pharmaceutical expenditure by the civil servants' mutual funds. Medicines prescribed in hospitals are not included either, as they are acquired directly from the manufacturing laboratories, in line with the therapeutic guidelines approved by each hospital. There are no co-payments for inpatients.

In 1998, the total public pharmaceutical bill amounted to 1 023 491 million Ptas (some 7% of which corresponds to medical supplies other than drugs). This figure includes user co-payments and is known as 'public consumption' to differentiate it from 'public expenditure', which is equivalent to public consumption minus user co-payments. Current public consumption multiplied by four during the period. The highest increases tend to concentrate in the late 1980s and early 1990s, while growth rates slow down thereafter, reflecting the increased emphasis on cost-containment within pharmaceutical policy. Out of this total, the National Health System paid 944 534 millions, while user co-payments absorbed the remaining 78 956 millions (7.7% of the total in 1998). The percentage of user co-payments over total public consumption has been decreasing since 1986, experimenting an accumulated reduction of almost 50%. This explains the fact that public expenditure has been increasing at a higher rate than total public consumption. The main reason for the overall drop in user co-payments from total pharmaceutical consumption is the increase in the percentage of population over 65 years, as well as the increase in life expectancy in this group.

During the same period, the average price per prescription in current Ptas more than tripled. In constant Ptas, average prices almost doubled. During the period 1991–1998, in addition, the number of per capita prescriptions experimented a 5% accumulated increase.. The number of total prescriptions, in turn, grew at double the rate than the equivalent per capita figures. These trends suggest that the global growth in public pharmaceutical expenditure during the 1990s is mainly due to raised prices, not to an increase in the number of prescriptions.

The significant year-by-year growth in pharmaceutical expenditure during the 1980s and early 1990s led to the adoption of a number of cost-containment measures from 1993 onwards, targeted at different areas of the pharmaceutical sector.

The most important policy change has been the introduction of a negative list of pharmaceuticals excluded from public funding by the 83/1993 Royal Decree on selective pharmaceutical financing, which was enlarged and updated through the 1663/1998 Royal Decree. The 1993 list led to the exclusion of

specific groups of drugs for minor symptoms, in particular: hygienic products; dermatological products; nutritional supplements; anabolic drugs; and anti-obesity products. In total, 892 pharmaceutical specialties were excluded from public funding. The 1998 list, in turn, excluded 831 additional pharmaceutical specialties considered of low therapeutic value and for minor symptoms. The combined effect of both decrees led to the exclusion from public funding of 29% of the total pharmaceutical brands registered on the market.

The negative lists aimed to reduce costs while simultaneously increasing the quality of public prescription patterns. Recent research on the economic impact of these measures underlines their limited cost-containment effects in the medium term. As regards the 1993 Decree, there was only a small decrease in the growth rates of drug expenditures in 1993–1994, followed by a significant rise in 1995–1996. Shifts in prescription patterns towards substitute and more expensive drugs constitute one of the most likely explanations for this, as well as an increase in the number of prescriptions. As for the 1998 decree, it has recently been estimated that it generated savings equivalent to 8385 million Ptas between September 1998 (when it was made effective) and December 1998.

Other cost-containment policies applied within the pharmaceutical sector have been as follows. In 1993, a reduction in the value added tax (VAT) rate from 6% to 3% was applied to medicines, while in 1995 the rate was fixed at 4%. In addition, an agreement with the pharmaceutical industry to reduce the commercial prices of drugs by 3% on average annually was reached this same year, which remained in force until November 1999. This reduction was scaled differently for drugs in different price intervals in a way that did not allow pharmaceutical companies to choose which type of drugs should be subject to sharper reductions. In addition to that, in July 1995, a further agreement was reached with the pharmaceutical industry. This set down a system of profit reduction in the sales to the public sector with an annual growth ceiling (7% for the next three years) and committed *Farmaindustria* (the national employers' association in the sector) to encourage the use of generic products. The agreement was revised in 1996 and 1998. In addition, pharmacies have been encouraged to include discounts (approximately 2% of global profits) in their agreements with regional health services and the INSALUD. These agreements were out of force from 1997 on, when the 165/1997 Royal Decree made generally compulsory a reduction of 2% over the maximum allowed profit margins, which dropped to 27.9%. In November 1999, a new cost-containment regulation was approved, which prescribed a 6% average decrease in the maximum allowed prices of all brands commercialized in the market. This measure replaced all previous agreements with the pharmaceutical industry mentioned above.

Finally, the 1990 Medicines Act was modified through the 13/1996 and 66/1997 Acts, which opened the way for the introduction of generic drugs and global reference prices within the Spanish health care market. In particular, the first generic brands were registered for commercial distribution in July 1997, while reference prices were effectively introduced through the 1035/1999 Royal Decree. Between July 1997 and November 1999, 343 generic brands were authorized, which yielded sales of 260 million Ptas in 1998, a figure which rose to 1585 million in total sales by October 1999. A recent evaluation of the impact of the introduction of generics estimates that global savings achieved until December 1998 amount to 836 million Ptas, in spite of the fact that this type of drug only absorbed 0.2% of total public pharmaceutical expenditure in 1998. An additional cost-containment initiative introduced in the late 1990s was the reduction of wholesalers' profit margins (over wholesale prices) from 12% to 11% in March 1997, and down to 9.6% in June 1999.

As a result of these regulatory strategies, the rate of growth in the prices effectively paid by the public sector has been decreasing since the early 1990s. As reflected in Table 14, increases over the previous year in constant Ptas dropped to the range of 1.1–2.5 between 1995 and 1997, although a rebound is perceptible thereafter. In fact, as mentioned above, the main driving force behind the important increase in public pharmaceutical expenditure until the mid-1990s has been the rising average cost per prescription, mainly due to the increase in the market share of new, more expensive drugs. For example, in 1996, the percentage of the total which was spent on drugs registered within the five previous years was 40%, while those recently introduced brands accounted for only 20% of the total quantity purchased. In addition, in 1998, the average price per prescription was 1755 current Ptas, while the average price for prescription of drugs registered between 1996 and 1998 amounted to approximately 5300 Ptas. Recent official data estimates that these latter type of drugs accounted for almost 14% of the 1998 public pharmaceutical bill (or 133 735 million Ptas). The corresponding increase in expenditure completely overrode the reductions of 836 and 8385 million Ptas achieved respectively through the introduction of generics and of the 1998 negative lists; we should keep in mind here, however, that the full economic impact of these policy measures is not yet realized. In addition, it has been estimated that only 50% of the expenditure on these most recent brands corresponds to drugs of high or medium clinical effectiveness, and which therefore implies a quality improvement on already existing brands.

The thrust of the cost-containment measures aimed at doctors has been to produce comparative information on individual prescription patterns. Accordingly, separate drug 'budgets' have been assigned to individual

physicians in order to foster professional consciousness of the expenditure made. There has also been some discussion on the potential decentralization of budget management to primary health care centres, with any savings made reverting back to the centres, thus creating incentives to reduce costs. However, these policy proposals are still in initial pilot stages. In addition, programmes on the rational use of medicines have been introduced, including drug therapy guides, treatment protocols and prescription profile analyses. The creation of the National Medicines Agency in 1997, and its effective implementation in 1999, might promote the diffusion and implementation of guidelines and protocols in the future.

Health technology assessment

Developments in this field took place in Spain in two separate phases, with a first wave of institutional design in the mid-1980s and a second, more significant one in the mid-1990s. The Autonomous Community of the Basque Country pioneered the first wave in 1982, with the creation of the first technology assessment body, included within public administration. In addition, Catalonia created a Commission of Health Care Evaluation in 1984, made up of experts and administrative officials. In 1988, a specific administrative department was created in this region. The central administration shortly followed in the mid-1980s, with ad hoc structures created both within the Ministry and the INSALUD.

During the 1990s, evolution was as follows. The Spanish National Office of Technology Assessment was created in 1994, and its functions and organization were enlarged and reformed in 1999. In addition, several agencies were created at the regional level. In 1994, Catalonia pioneered the introduction of new organizational forms within the sector, with the creation of a publicly-owned independent company. In the Basque Country, shortly after that, the former Service for the Evaluation of Medical Technology, created in the early 1990s, was given the status of a quasi-independent public agency in 1994. Similar developments occurred later in Andalucia (1996), Galicia (1999) and Valencia (2000). In the few years that these agencies have been in place, there has been a significant improvement in the available evidence on cost-effective practices. However, there is still considerable work to do in this area.

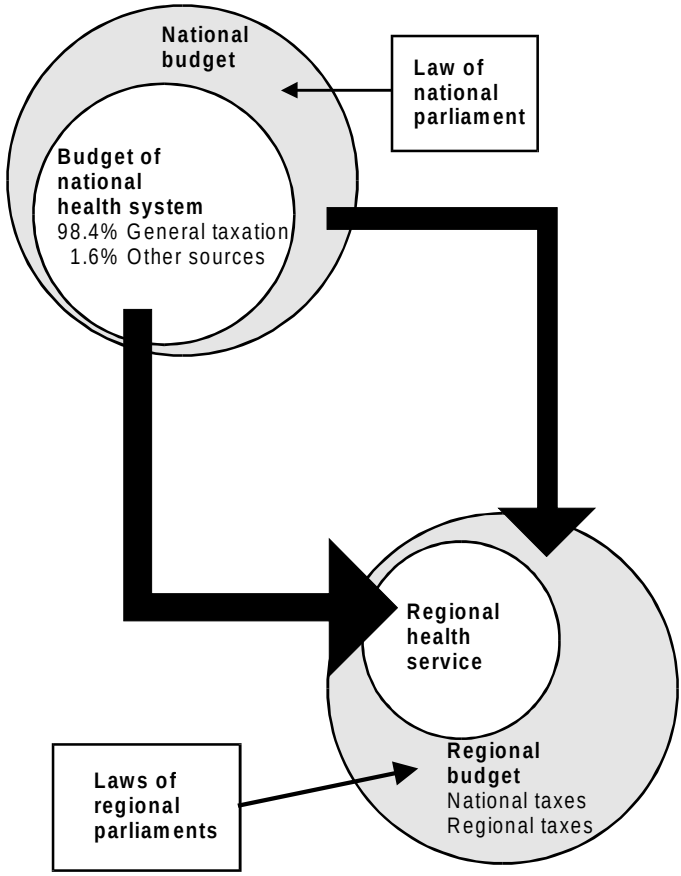
Financial resource allocation

There are three main resource allocation flows in Spain: the transfers made by the central state to the regions; the subsequent allocation of funds from the regions and INSALUD to hospitals; and the system of paying health care personnel. As fiscal autonomy is very reduced in Spain, the regional resource allocation system constitutes one of the main elements of health care financing, accounting for more than 80% of total public expenditure. As for hospital financing, the seven special regions together with the central management body INSALUD enjoy significant freedom in determining the particular method of payment that should be in place. Generally speaking, during the 1990s, there has been a general transition from retrospective to prospective funding, pioneered by Catalonia since the late 1980s. The bulk of regulation concerning the payment of health care professionals, finally, is in the hands of the central state, while the special regions can only modify some salary complements. Both specialists and general practitioners are public employees in Spain, and most of their wages come from fixed salaries. The details of the financial resource allocation system are summarized in Fig. 19 and Fig. 20 below.

Third-party budget setting and resource allocation

The Spanish Parliament approves the state budget and the social security budget on an annual basis. Until 1999, these comprised the national budget, at which time health care financing became totally reliant on taxes. The resulting resources are then allocated to the special Autonomous Communities with devolved health services and to the INSALUD for those Autonomous Communities whose health services are centrally managed. The INSALUD budget is earmarked under the various expenditure headings (investment, current expenditure, personnel costs, etc.) and for programmes (primary health care,

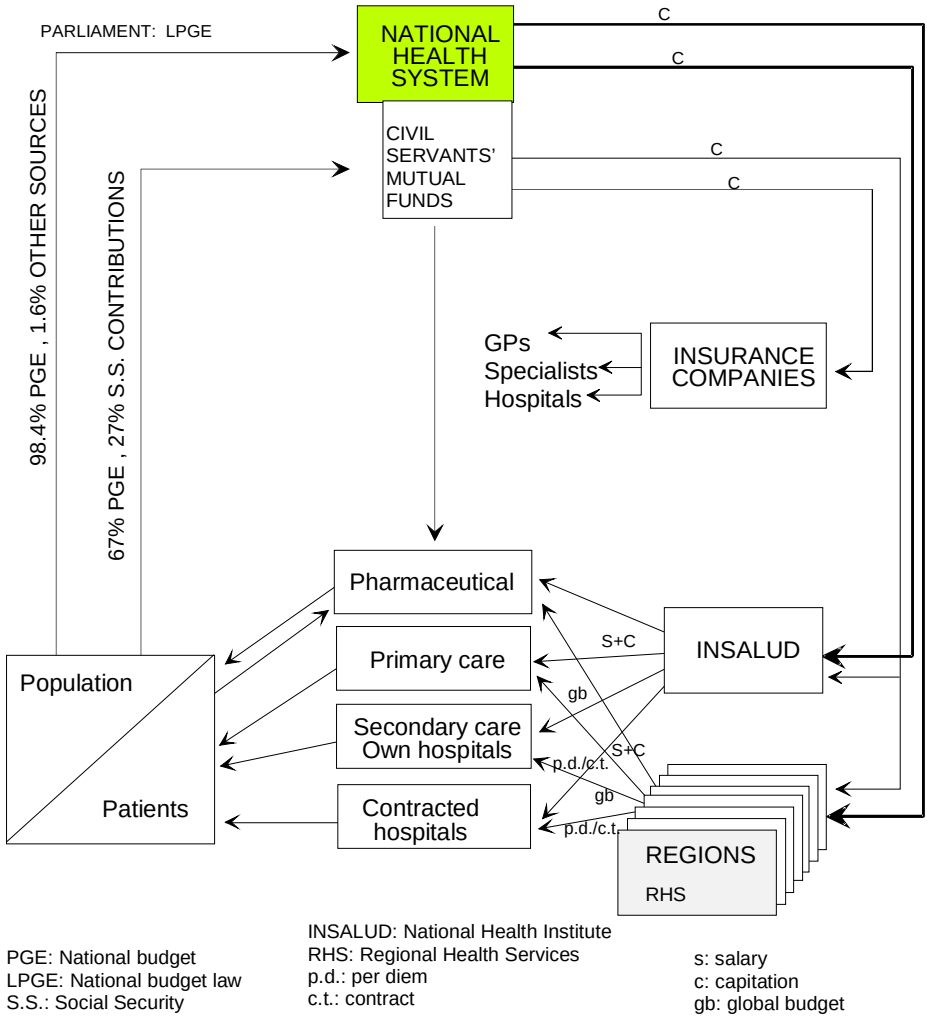
Fig. 19. Financing flow chart



specialized care, pharmaceuticals, etc.). The allocation of funds to the different regional health service programmes and expenditure headings in communities which control their own health systems is determined by the Autonomous Communities' parliaments in their respective budget acts.

The Autonomous Communities may add their own financial resources to the state financing, and the same is true for local governments. However, the room for manoeuvre left by central fiscal pressure is considerable reduced and, as a result, the share of total health care expenditure financed through taxes raised by sub-national governments is below 10%. From the early 1990s, however, some management responsibility over 30% of their income taxes was devolved to Autonomous Communities. In addition, two out of the seven

Fig. 20. Details of financial flows



special Autonomous Communities (the Basque Country and Navarra) enjoy full fiscal autonomy, and raise all public taxes in their own territories.

The General Health Care Law prescribes that the resource allocation system for special Autonomous Communities should take as the point of departure the effective cost of service delivery (and more concretely, the percentage of national expenditure channelled to each community the year prior to the transfer of services). From then on, it should progressively be adjusted to simple, unweighted capitation targets. In spite of this formally homogeneous system, in practice, the bases, percentages and other details of the regional resource

allocation system considerably differ across Autonomous Communities. This results from the separate bilateral financial agreements between the state and each Autonomous Community made prior to the transfers, which were subjected to different contextual and political pressures.

In practice, therefore, up to 1993, the initial annual budget for the Autonomous Communities was determined using diverse cost criteria which were essentially historical (but however were subject to considerable political discretion). The exceptions were Catalonia and Galicia, with resource allocations which converge towards capitation targets up to 1997 (see Table 14 and Table 15). In addition, further deviations from prescribed allocations resulted from the regular adjustments made to the system in order to incorporate the current (and significant) deviations from the planned budget made by INSALUD (which were, on average, approximately 10% per year between the mid-1980s and the mid-1990s), so that retrospectively, each special region received an extra share of funds equal to INSALUD's percentage deviations from the budget. This approach perpetuated inequality, reduced the credibility of central attempts at cost-containment, and produced a great deal of dissatisfaction. It also helped to undermine any sense of direct responsibility for (the sizeable) debts generated by those in charge of health care in the Autonomous Communities.

Table 14. Percentages of total expenditure allocated to regions, 1984–1990

	1984	1985	1986	1987	1988	1989	1990
Catalonia	16.30	16.25	16.20	16.15	16.10	16.05	16.00
Andalucia	17.47	17.47	17.51	17.55	17.59	17.63	17.67
Valencia					9.62	10.20	10.20
Basque Country					5.72	5.72	5.72

Table 14 (contd). Percentages of total expenditure allocated to regions, 1991–1998

	1991	1992	1993	1994	1995	1996	1997	1998	1999
Catalonia	15.95	15.90	15.85	15.99	15.99	15.99	15.99	16.27	16.27
Andalucia	17.71	17.72	17.72	17.72	17.72	17.72	17.72	18.07	18.07
Valencia	10.2	10.2	10.2	10.2	10.1	10.1	10.1	10.1	10.1
Basque Country	5.72	5.72	5.72	5.648	5.648	5.612	5.576	–	–
Galicia	6.044	6.158	6.272	6.462	6.651	7.03	7.03	6.93	6.93
Navarra	1.185	1.185	1.185	1.222	1.259	1.296	1.333	–	–
Canary Islands				3.917	3.910	3.904	3.898	4.02	4.02

Source: Truyol-Wintrich, 1999.

Table 15. Percentage of the Spanish populations by region, 1991 and 1996

	1991	1996	% increase
Catalonia	15.99	15.75	-1.50
Andalucia	17.72	18.07	+1.98
Valencia	10.03	10.23	+1.99
Basque Country	5.54	5.45	-1.62
Galicia	7.03	6.91	-1.71
Navarra	1.37	1.34	-2.19
Canary Islands	3.89	4.07	+4.63

Source: Truyol-Wintrich, 1999.

These problems are at the base of the decision made in 1994 by the Spanish Government and the governments of the Autonomous Communities to sign a new financing agreement covering the period 1994–1997, with the objective of achieving greater financial stability for the whole system, and promoting a more rational, homogeneous system of resource allocation to regions. The year-by-year increase in financing was fixed at the rate of growth in GDP, capitation targets were to be homogeneously based on the 1991 Census, and the regional share of financing was to be generally adjusted to the size of the population covered by each regional health service. Thirty-eight point seven per cent (38.7%) of National Health System funds went to INSALUD in line with the population covered.

The agreement also made explicit that the common practice of annual deviations from the planned budget would only be acceptable in extraordinary cases and would require parliamentary approval. In addition, the risks of debt generation were transferred to the administration of the particular health service responsible. At the same time, it was also envisaged that each Autonomous Community would supplement health sector financing from the community's own income and, if applicable, additional contributions would be made by local governments geared towards the health services they manage. Additional fundraising was expected to come from a series of proposed agreements with the pharmaceutical industry, as well as from improved tracking of financial compensation for services provided to non-entitled users. The reform also foresaw the future introduction of a compensation system for cross-boundary flows between Autonomous Communities, but information problems in this area prevented this element from having a more extended role within the resource allocation system.

In addition, in 1998, a new agreement was negotiated among central state authorities and regional governments for the period 1998–2001. For the first time in Spain, the base internal document produced by the Ministry included an estimation of adjusted capitation targets, which, following the British RAWP

system, weighted crude capitation figures by age, need (mortality, morbidity and socioeconomic factors), cross-boundary flows, research and teaching costs, and relative prices of the inputs in each territory. However, the representatives of central and regional governments did not reach an agreement on that global scheme, and so the final system only incorporated cross-boundary flows, as well as research and teaching supplements, into the system of regional financing. In addition, ad hoc financial compensation was included for regions losing population, in spite of the formal capitation system in place. The effects of the new system on the share of the total budget allocated to the five special autonomies which do not enjoy full fiscal autonomy are shown in Table 16. To be noted is the injection of more than 200 000 million Ptas to the global 1999 health care budget, in addition to the regular increase equivalent to the GDP growth which is applied each year starting in 1994.

Table 16. Percentage allocations in five special regions as agreed for the period, 1998–2001

	Share of finance under new system 1997–2000	Regional population as a share of the total, 1996	% deviation from single capitation target	Financial increase over previous year 1996–1997
Andalucia	18.07%	18.07%	0.0	+ 10.3%
Catalonia	16.27%	15.75%	+3.3	+9.2%
Galicia	6.93%	6.91%	+0.3	+7.0%
Valencia	10.13%	10.23%	-1.0	+9.0%
Canary Islands	4.02%	4.07%	-1.2	+12.4%

Source: Lopez Casasnovas (1999).

Finally, Table 17 presents the increases registered in actual health care expenditure effectively incurred by Autonomous Communities (note that the expenditure base corresponds to the fraction of total central public health care funding channelled through the resource allocation system; see section on *Health care finance and expenditure* for details on this issue). The differences among Autonomous Communities displayed in the last column of the table for the most part reflect the effects of the new financing agreement reached for the period 1998–2001.

Payment of hospitals

Hospitals in the National Health System are financed through a global budget, set against individual spending headings. Traditionally, hospital expenditure was retrospectively reimbursed on a routine basis, with no prior negotiation

Table 17. Increases in public per capita expenditure channelled through the regional resource allocation system (%), by selected Autonomous Communities, 1992–1999

Community	Accummulated annual average increase 1992–1999	Annual average increase 1992–1995	Annual average increase 1996–1999
Spain	40.8	15.9	14.3
Andalucia	46.6	20.1	17.7
Catalonia	50.0	21.1	17.8
Basque Country	46.8	19.5	14.8
INSALUD	34.6	9.8	14.2

Source: Own elaboration based on data from Pellisé, Truyol, Blanco and Sánchez-Prieto, 2000.

between the third-party payer (INSALUD or regional health services) and providers, and no formal evaluation.

Since the early 1990s, some regional health services and INSALUD (mainly through pilot tests) have changed the way in which hospital budgets are fixed. The Catalan government was pioneering these reforms (and the same is true for many of the managerial and organizational innovations introduced during the decade), partly due to the prevalence of a hospital sector dominated by private not-for-profit providers, which gave higher priority to sound contracting practices. This is now generally done through negotiation of a contract-programme between the third-party payer and the hospital which sets out the objectives to be achieved by the hospital and the financing attached to these objectives.

The shift towards contract-programmes and the negotiation of activity levels and financing has created the need for an agreed set of performance measures to be defined and to allow comparisons between hospitals. These needed to take into account the differences in the services offered by different centres, and the singular nature of each hospital (varying case-mix, rate of outpatient activity compared with inpatient care, etc.), which led to the generation of a new, significantly improved information system for hospitals (Minimum Basic Dataset, *Conjunto Minimo de Datos Basicos* or CMBD). The CMBD started to be developed in the early 1990s and, by 1999, it covered most Spanish hospitals. This should allow risk adjustment mechanisms in prospective financing to be refined and, therefore, a more equitable allocation of resources than would be possible if only the number of admissions or the overall length of stay were considered.

From 1991, crude, aggregate measures of activity were defined which enabled a comparison to be made among hospitals. The Catalonian experience of purchasing services from private sector hospitals provided the initial model,

using units of activity which differentiated among four hospital production levels. The first aggregate unit defined for use in financing public hospitals was the UPA (weighted health care unit, see Table 18 for details), adapted from the Catalan system by the Ministry of Health for application in INSALUD hospitals. The UPA was subsequently slightly modified by some Autonomous Communities for the financing of public hospitals in their health services. The UPA and the rest of aggregate units developed are based on converting all hospital activity into multiples or sub-multiples of an activity-based standard (the length of stay), after analysing average costs in each type of hospital service, which mainly depend on hospital technology and equipment.

Particular activities which are especially sophisticated (e.g. transplants), expensive (e.g. dialysis), or which are regarded as priority interventions because of the length of waiting lists (e.g. major outpatient surgery) remain outside the general UPA rate and have their financing calculated separately. The cost of treatments in these categories is added to the financing of overall activity by the UPA formula, to give the total prospective budget for each hospital. The UPA model is detailed below in Table 18.

Table 18. UPA: Weighted health care units

Activity	Weight
Medical stay	1.0
Surgical stay	1.5
Obstetrics stay	1.2
Paediatrics stay	1.3
Neonatologist stay	1.3
Intensive care stay	5.8
Emergencies	0.3
First outpatient contact	0.25
Outpatient revisions	0.15

Existing evaluations of the experience of introducing contracts which are increasingly based on prospective financing give the following conclusions. Up to 1997, most hospital contract-programmes had not been adequately linked to activity levels or to quality issues, they did not take into account coordination with primary care or existing health care plans, they were not monitored, and real risk decentralization to professionals and managers had not occurred, incorporating only weak economic incentives for the accomplishment of contractual objectives. During the late 1990s, however, important developments in this direction were made, with Catalonia first incorporating more adequate effectiveness and quality indicators and effectively linking contracts to the regional health plan. The Basque Country undertook the extension of contracts

to psychiatric and other long-term care hospitals, and also introduced significant changes along the same lines. In addition, the first Strategic Plan of INSALUD, approved in 1998, involved a significant turn, with the inclusion of a Plan of Quality Improvement within contracts, designed with the help of scientific societies, the introduction of a coordinator of the plan at the level of the hospital, and the development of economic incentives linked to the accomplishment of quality targets.

Since the mid-1990s, hospitals have also had another source of financing, albeit of minor importance. From this point on, they can now generate income from the provision of health care services or risk coverage to people not covered by the National Health System. During the second half of the 1990s, the autonomous communities of Andalucia, the Basque Country and Catalonia initiated pilot testing of more sophisticated prospective payment systems based on DRGs or Patient Management Categories. In 1998, a new system of hospital financing was introduced in Catalonia, which relied on yardstick competition schemes.

Hospitals outside the National Health System may rely on their own sources of financing (from private health care or from other public administration bodies) but they may also provide services to the National Health System, regulated through agreements or contracts. The economic conditions of these agreements are determined by the National Health System (regional health services and INSALUD), depending on the nature of the particular activity. This is normally measured in terms of bed-days although, from the mid-1990s, case payment has been introduced. The conditions of the agreements are revised annually and may take the form of a contract-programme with an overall budget.

Since the mid-1990s, the role of private contracted out hospitals has tended to increase due to the emphasis given to reducing waiting times. The new scheme has also included financial compensation for public hospital doctors choosing to work in the afternoons to shorten waiting lists, as well as the right of patients waiting for more than six months to choose another public or private contracted out hospital (see the section on *Health care delivery*).

Payment of physicians

In 1997, the average annual salary in Spain was 3.066 million pesetas, while the legal minimum salary was only slightly higher than 1 million pesetas per year. The salary of physicians ranged from 5 to 8 million pesetas. Doctors, with their permanent, civil-servant type status are generally salaried whether they are in primary health care or specialized care (both outpatient and inpatient).

In primary health care, the general practitioners still working under the traditional single-handed practice model (which, in May 2000, covered 19% of the population) are paid according to capitation. Those in the new EAP system receive a salary plus a capitation component (amounting to about 15% of the total) which takes into account the nature of the population they care for, its concentration and the percentage of the population over 65 years of age. In Catalonia, an additional adjustment for the socioeconomic conditions of the population attended is also used. All hospital doctors are salaried.

The basic salary for all public sector physicians is regulated by the state government, although the Autonomous Communities have the capacity to vary some of the components which make up the total salary. Between 1970 and 1986, hospital doctors' salaries were tightly controlled by state authorities. From 1986 to 1991, they experienced a moderate rise in real terms. Since the early 1990s, hospital doctors' salaries are decreasing in real terms. There is considerable variation among Autonomous Communities both in the type and amount of salary complements applied.

The payment system for hospital professionals is very controversial at present and fails to satisfy either the system's payers or the physicians themselves. It is widely believed that it largely fails to reward efficiency. In addition, experience on the use of financial incentives, linked to the meeting of objectives, shows that these have not been very effective. This might be due to the fact that the rewards available for meeting efficiency targets only constitute a very small percentage of the physician's overall salary. Mechanisms for evaluating health care delivery are still very rudimentary and the measures geared to assessing efficiency have proved difficult to apply.

Staff dissatisfaction reached peaks in 1987 and 1995 when there were widespread strikes among INSALUD hospital physicians and in several regional health services. The strikes were followed by salary increases of 20% and 10%, respectively. In addition, the 1995 strike ended after a basic agreement was reached that was aimed towards reforming both the management structure in hospitals and the incentive system. A further result of the strike, as mentioned above, was the plan to reduce waiting times developed during the period 1996–1999. Formulas for assessing and fixing supplementary payments are to be developed, although the final outcomes of this agreement remain to be seen.

Health care reforms

Aims, objectives and contents of reforms

The situation of the health care system at the start of the democratic period, in the late 1970s, was as follows. Multiple health care networks coexisted within the public system with poor coordination among them. The administrative structure was extraordinarily fragmented and chaotic, due to the lack of any rational restructuring of the many, overlapping networks inherited from the past. At central level, 53 ministerial departments held health care responsibilities. A significant proportion of health care (in particular, curative services) was provided by the social security system managed by the Ministry of Labour and Social Affairs, while public health services were the responsibility of the central state. Charitable health care and psychiatric care, which depended primarily on local government, supported individuals not covered by social security. In particular, city and provincial governments owned and managed 30% of hospital beds, and held (somewhat overlapping) responsibilities for health prevention and promotion as well as rural primary care. In addition, there was also a series of other networks, such as the military and prison health care systems and the university hospitals.

Reforms of the late 1970s and the 1980s

The 1978 Constitution established the right of all Spaniards to health protection and set out a new regionally based organizational framework. Ultimately this would allow universal coverage and significant decentralization of the health care system, although this process took time to implement. Accordingly, the basic constitutional objectives were defined as: to recognize the right of all Spaniards to a healthy environment and adequate public health, to define the territorial division of powers in the fields of public health and health care, and to achieve equity in the territorial distribution of health care resources as well as in access to health care.

The period 1978–1982 was one of limited change in the health care services due to a difficult political and economic environment (significant civil unrest derived from the process of transition to democracy, and a severe economic downturn). Attention in the late 1970s and early 1980s was focused around the dissatisfaction of both health care professionals and patients with primary health care and ambulatory care in general. The social security hospitals tended to monopolize budgets for the introduction of technological and scientific advances, training and research, while general practitioners and specialized ambulatory physicians were left aside. The public health role was also under-funded and disease prevention and health promotion activities were lacking, and generally not integrated into the main social security health care network. More generally, the health care system had a number of different health care networks which were dependent on different funding and regulatory bodies. The system suffered, as a consequence, from problems of organization, co-ordination and financing, and failed to provide coverage for the whole population.

The first socialist government (1982–1986) partly tried to tackle the same problems and partly considered new reform goals and strategies, such as the extension of the public health care system. The General Health Act (1986) meant the formal transition from a system of Social Security (Bismarck model) to a National Health System (Beveridge model). It confirmed and extended the recognition of the universal right to public health care (only vaguely) established by the 1978 Constitution, and it prescribed a progressive transition from payroll contributions to general taxation as the main source of financing. It also defined the regionally-based organizational framework, as outlined by the Constitution, and established the necessary provisions for the future integration of all public health care networks under the authority of regional governments. The act was the result of a consensus among the centre-left and left-wing parties, and the class-based trade unions, and the Catalan and Basque regional nationalistic parties, and created a global framework for the developing health care system. However, the law postponed some key decisions around financing, management, organization, decentralization and patterns of coverage.

Since 1986, the public sector health care network has undergone considerable development, although not always in line with the initial plans of expanding the public sector. The period 1987–1991, however, experienced rapid growth in public health care expenditure, partly due to expanded salaries of public physicians, and partly to extended coverage. By the start of the 1990s, those responsible for health care were increasingly conscious of the emergence of a new crisis associated with the rapid growth in expenditure, increasing waiting lists, mounting user dissatisfaction and the lack of systemic incentives to

implement reforms. The generalized economic crisis, the public budget deficit, and the demands imposed on the country by the Maastrich Treaty, together with the mentioned concerns about the health system, persuaded the government to introduce the *Programa de Convergencia* (Convergence Programme) for the health sector, which set out proposals for structural and management reforms.

The 1990s reforms

This shift towards reform of the organization and management of the health system took place against a background of user dissatisfaction. The 1991 Blendon survey demonstrated that levels of satisfaction with the health system were lower than in other European countries. In particular, some 55% of the population stated that the health care system needed either fundamental changes or total should be completely rebuilt (see Table 19 below for the evolution of this indicator up to 1998). The survey showed that management and organizational issues were of the basis of citizens' dissatisfaction, while more than two thirds considered clinical quality to be generally fine. In addition, general opinion surveys carried out by a number of different bodies showed that the Spanish population wanted to increase the opportunities for choice, while simultaneously maintaining the guarantee of public protection for any health need.

The formal objectives of the health care reforms, which during the 1980s were focused on extending and rationalizing the public system as well as improving coverage and access, progressively shifted towards two significant new targets in response to the revision of the system initiated in the early 1990s. From 1991, the reforms have openly addressed the need to control rising costs and to improve levels of public satisfaction. Cost-containment measures, however, were initiated in the early 1980s but were not always openly on the political agenda. In addition to that, the start of the 1990s also witnessed the official incorporation of the health for all policy targets of the WHO Regional Office for Europe into Spanish health policy. Since then, Spain periodically assesses these targets. Up until 1999, four assessments had been completed, published in a user friendly format, and subjected to wide distribution and diffusion, under the initiative of the Epidemiology Department of the Ministry of Health. In addition, in 1999, the Spanish Society of Public Health and Health Management (*SESPAS*) published an excellent evaluation of accomplishments made with regard to the original health for all targets, which was the product of a collaboration among Spain's most prestigious experts and researchers in the field.

Therefore, the reform package launched during the 1990s concentrated, for the most part, on the introduction of organizational and managerial improvements within the extended public sector emerging from the 1980s reforms. As explained in the *Introduction*, the process of reform started in 1990 with the appointment of a commission to evaluate the main problems of the system and formulate proposals. The committee reported in 1991, putting forth a number of essentially moderate cost-containment and organizational proposals. However, a sudden outburst of public opposition to the report arose, due to the generalized perception that it involved an attempt to privatize the health care service. Social pressure against market-oriented policies has been considerably high and active since then, contributing to block most of the proposals made in this direction during the decade. The first outcome resulting from the opposition was the official announcement by the Socialist government in 1992 that the conclusions of the report were never going to be implemented. Nevertheless, some of the most prominent proposals were effectively introduced in regional and central legislation during the 1990s, among which the following are worth mentioning: changes in the organization and management of hospitals; experimentation with contracts and prospective payment systems; the launching of several measures to contain pharmaceutical costs; and small steps towards increasing the role of private management and ownership within the public health care sector. More details on the implementation of these simultaneous reform processes are included within the next section.

The process of legislative innovation in this field can be briefly summarized as follows. The 1990 Catalan Health Care Law opened the way for the introduction of new flexible forms of organization and management of health care centres, explicitly including for the first time the possibility of contracting out the management of publicly-owned health centres to the private sector or to public providers opting out of the public system. Several Autonomous Communities followed the Catalan initiative, although often confining the private sector to a considerably more restricted role than in Catalonia. Central legislation formally incorporated these changes in the summer of 1996, through a Royal Decree which was later presented as a draft in the parliament, discussed by the main political parties and subjected to broader public consultation. The corresponding law, the 15/1997 Act on new forms of organization and management within the National Health System, received parliamentary approval in 1997.

In fact, an important landmark within the 1990s reform process was the creation of a parliamentary commission in 1996 charged with reviewing the health care system and formulating proposals. The initiative was launched by the newly-elected Popular Party, as a result of complaints issued by the leftist political opposition regarding the lack of parliamentary discussion of such a

prominent change as the one included in the 10/1996 Royal Decree on new forms of organization and management. The main outcome of the process was the approval of the 15/1997 Act (which reproduced the content of the 10/1996 Decree). In addition, the report finally agreed upon by the parliamentary committee was approved by the parliament in December 1997. It contained a vague statement of principles plagued with ambiguities, as a result of the different positions held by the political and social representatives included in the negotiations. In any case, two practical conclusions resulted from the process. On the one hand, the Popular Party made a firm commitment to respect the basic principles of universal access and equity of care, while keeping pro-competitive regulation to a minimum. On the other hand, it was made clear throughout the debates that a majority of political actors in Spain, as well as the general population, were against the most radical proposals of the Popular Party, like competition among private insurance funds, higher co-payments or a transfer of major public responsibilities to the private sector.

Some other relevant policy changes introduced during the 1990s, already described throughout the report, are the following. On the cost-containment front, several important measures were adopted in the pharmaceutical sector. The regional resource allocation system was reformed, particularly regarding tighter budget limits, the linking of growth to GDP rates, and making homogenous the prior chaotic, tailor-made arrangements. An explicit package of benefits to be provided by the public sector was specified and approved. As for the role of the private sector, several relevant measures were taken during the 1990s, which are still in pilot stages. In addition, the period 1999–2000 involved a return to some of the issues prominent during the 1980s reform. The first of these themes related to the extension of coverage to non-Spanish residents, which was not contemplated within the 1986 General Health Care Act. The second issue debated during these years was the implementation of public coverage of children's dental care, as well as the expansion of the role of social and community care within the health care service. In fact, both the socialist party and the PP included proposals along these lines within their electoral programmes in the March 2000 general elections.

Reform implementation

The various reforms have progressed to different degrees:

- *Universal coverage*: The percentage of the Spanish population covered by public insurance was 81.7% in 1978. Today it is 99.4% and includes the low income population and immigrant children. Adult immigrants were

also given full rights to public health care at the start of 2000, but the short-term future of this measure remains unclear. The affluent self-employed, moreover, are still excluded from the public system. The process of implementation of the extended coverage to immigrant children and the poor was as follows. The 1986 General Health Care Law recognized the right of access to the National Health System to deprived groups of the Spanish population which did not contribute to the Social Security system. In 1988, the government of the Basque Country made these rights effective and extended them to registered immigrants. The central government and some of the special Autonomous Communities followed the Basque initiative between 1989 and 1991, although in these cases immigrants were not covered. Although the 1990 Children Act had recognized full rights of access to the public system for immigrant children, the ordinances needed to make this right effective had not been developed. This led to a formal complaint by the Ombudsman of the Autonomous Community of Madrid, which opened up a widespread political debate on the issue. As a result, children's rights were made effective, and were recently extended to legal adult immigrants through the approval in 1999 of a new Immigrants Act. However, the future of this latter reform is still unclear, as declarations by the current government suggest that these provisions might be soon revised.

- *Benefits package*: On a different front, the benefits package covered by the National Health System was broadly defined in 1995 by royal decree and is available to almost the entire population. Dental care is still excluded from public funding, and social and community care are not fully covered either. There is no clear link between the services covered and their financing. In 1999, details on the specific extent of, and limits for coverage for four different treatments were approved through the corresponding ministerial ordinances. In addition to that, pharmaceutical benefits were extensively regulated during the 1990s.
- *Financing*: Until 1989, the health care system was viewed as part of the social security system, and financed mainly by social security funds. Since 1989, financing of health has shifted to general taxation supplemented by insurance contributions through the earmarked social security budget. The general tax component reached 80% in 1995, almost 83% in 1996, and 100% in 1999. The measure, initially intended to increase redistribution, had only limited effects in that direction, due to the introduction of the EU regressive VAT system in the late 1980s. In addition, many aspects of the system, like arrangements to guarantee coverage to different social groups, major reform of the benefits package, as well as financial accounting and expenditure authorizations, are still in the hands of the social security

administration, therefore making the system complicated to manage and reducing the room for manoeuvre by health care authorities.

- *Devolution*: Three different groups of health care powers were transferred during the democratic period. First, responsibility over the pre-Social Security health care networks (public health, mental health, charity health care, etc.) was devolved to all regions between 1978 and 1986. Second, the Social Security network of health care centres was transferred to the seven special regions with constitutional powers in this field. The process began in 1981 in Catalonia and by 1994 covered seven Autonomous Communities and 62% of the population. There was no fixed date for the extension of the process, but 1997 was likely to be a key year, given that it would see the end of the agreement between the conservative and socialist parties on the overall decentralization process. However, at the start of the year 2000, the transfers to the ten remaining regions had not yet materialized. Finally, the last group of powers to be devolved, corresponds to some responsibilities in the field of pharmaceuticals, which were transferred to the seven special and the three ordinary regions between 1996 and 1999.
- *Regional self-organization*: All Autonomous Communities have established a regional health service which integrates all public health services and centres. Most of them have also approved general framework health legislation through a major regional health act as well as a regional health plan. However, in the ten Autonomous Communities which are still centrally managed, such legislation is of little meaning. Similarly, each Autonomous Community has completed the process of defining health areas and basic health zones which are the building blocks for the organization of regionally-based health services.
- *Budget allocations to the various regional health services* were originally agreed upon in a series of bilateral agreements as the transfer of responsibilities took place. The level of funding was conditioned by historical precedents which gave rise to inequity among regions. In 1994, a political agreement was achieved to ensure cost-containment and equity in system financing and budget allocations. A ceiling for public expenditure was fixed (linked to 1993 spending) and annual increases were to be adjusted to GDP growth. There was also agreement on a firmer commitment to capitation targets. These reforms in the regional resource allocation system were subjected to revision in 1997, when special supplements for cross-boundary flows and research and teaching were introduced. The new system, in place for the period 1998–2001, also included an additional fund to compensate regions with decreasing population sizes, which tended to undermine the 1994 commitment to make effective the adjustment to capitation targets

prescribed in the General Health Care Law. Finally, the responsibility for (and risks of) any debts generated has passed to the administration in charge of the health service starting in 1994, while parliamentary approval of deviations from planned budgets was first introduced this same year. In spite of the advances made, important problems remain to be solved in this area. As regards commitment to capitation and regional redistribution embodied in the General Health Care Law, accomplishments are still lacking in many respects, mainly as a result of the difficulties encountered in adjusting the effective cost of the services to capitation targets in regions with over average levels of expenditure. In addition, the long proposed adjustment of capitation fees according to age structure and health needs has never been made effective. Finally, some of the debt accumulated by the special Autonomous Communities during the 1990s has still not been accounted for.

- *Separation between financing, purchasing and provision* has been introduced in both central and regional legislation during the 1990s. However, measures allowing for their actual implementation have not been put into practice. During the 1990s, several Autonomous Communities proposed changes in the organizational status of their highest management institutions, the regional health services, partly directed to promote the effective implementation of the purchaser-provider split. In particular, both Catalonia and the Basque Country instituted them as quasi-independent public agencies, subjected in many of their activities to private law, in order to facilitate the attribution of an independent purchasing function to them, as well as the subsequent decentralization of purchasing responsibilities to health areas. In practice, however, the separation between the two functions has not been achieved. Rather, there is evidence, at least for Catalonia, of advances in the opposite direction, e.g. direct intervention of the regional health service in the operational management of health care centers, the involvement of public and private providers in health planning, and a higher dependence of independent providers on the state as a third party. However, as regards public provision, various experimental new forms of management and organization have been piloted since the early 1990s in Catalonia, most notably the establishment of teams of public general practitioners as independent health professionals' associations.
- *Management and organizational issues* have been high on the political agenda since the mid-1990s, although initiatives in this field are still in an early development phase. Increasingly, discussion on the reform process is pointing towards the structuring of public hospitals as entrepreneurial organizations and self-governing units, with less external bureaucratic control and with more emphasis on outcomes. Since the late 1980s, the

special Autonomous Communities, led by Catalonia, introduced changes in the legal and organizational status of health care centres, submitting part of their operations to private law. By 1999, 46 health care centres were under these new organizational forms. As regards central health care authorities, two new hospitals were created in the mid-1990s under the legal status of independent public agencies. In this context, the first strategic plan of INSALUD, approved in 1998, included a wide range of pro-competitive regulation proposals, such as: the decentralization of independent purchasing functions to health areas; the contracting-out of ancillary services, health care management, and primary and hospital provision; the improvement of prospective payment systems, the inclusion of quality indicators and monitoring for the first time; the linkage of contracts to explicit economic incentives; and the possibility for public providers to opt out of the public service. In addition, in 1999, the annual Budgetary Law implemented the content of the previous 15/1997 Act, and therefore opened the way for the generalization of flexible, autonomous organizational forms to all Spanish hospitals. In the field of management, the different health services have been trying to develop new prospective systems to finance hospitals which attempt to balance budgetary control, activity, and incentives that encourage efficiency. There has been a rapid introduction of management tools including patient classification systems, such as diagnostic-related groups (DRGs) or patient management categories (PMCs), but their implementation has been uneven and has yet to prompt real organizational change. A significant move in this respect was made by the Catalan autonomous government, with the introduction of a carefully designed system of hospital funding based on yardstick competition.

- *The role of the private sector within the National Health System*: Some private sector services are contracted out with the public system, but there is no competition among providers (public or private). At the regional level, Catalonia experimented with the contracting out of the integrated management of services in several health areas to private companies since the early 1990s while, in 1995, the Autonomous Community of Valencia contracted out hospital services in two health areas to fully private for-profit, newly-built hospitals which were offered a long-term contract with the public sector. In addition, two measures adopted by the central government during the late 1990s have tended to expand and promote the role of private providers within some restricted areas of the health care system: provision of care in the case of accidents at work and work-induced illnesses, together with some authority over the management of sick leave, were transferred to employers mutual funds in 1996; and, more generally, employer-purchased health care insurance was entitled to considerable tax deductions starting in

1999. Competition and free choice among insurers have been considered, and proposals in this respect have been present in the electoral programmes of both the Popular Party and the Catalan governing party CiU since 1993. However, the considerable public opposition to market-oriented policies which exists in Spain will probably prevent policy reform in this direction.

- *Primary health care* is now territorially organized throughout the country with virtually the entire population living less than 30 minutes from the nearest health centre. PHC teams resulting from the extensive reform of the system initiated in 1984 were available to 81% of the population in 2000, with the remainder covered by the traditional system. Since 1993, INSALUD and some regional health services have offered some user choice, allowing patients to select their primary health care physicians. However, in practice, professionals often reject patients from distant locations due to the increased cost of compulsory home visits. The primary health care reform has been slower than expected, mainly due to its lack of political priority. In addition, during the second half of the 1990s little advances have been made in the implementation of the reformed network of care. In spite of the more than 15 years elapsed since the formulation of reforms, moreover, the major policy goal of orienting the health care system towards the primary level has not been accomplished, and important qualitative aspects still need improvement. The recent piloting of different, more flexible alternatives of organization and management might help introduce further reforms in the future. However, the issue has been absent from major political debates since the mid-1980s.
- *Access and delivery of specialized care*: More than 60 new public hospitals have been opened. Practically the whole population now lives less than one hour from a public general hospital offering a minimum package of basic surgical, medical, obstetric and diagnostic specialties and 24-hour emergency coverage. An important effort has been made since 1995 to decrease waiting times. However, important problems of accessibility remain, and waiting lists were still a major policy problem in the late 1990s. The development of alternatives to inpatient care – in particular, major ambulatory surgery – has only recently been initiated. Some consumer choice of specialists has been introduced in INSALUD outpatient centres, but it has not been accompanied by the required economic incentives for the scheme to work correctly. In addition, managerial and clinical inefficiencies are considerable, so room for increasing efficiency is still considerable.
- In the *pharmaceutical sector,* several cost containment measures were implemented since the early 1990s: two negative lists of pharmaceuticals were introduced in 1993 and 1998, which ended up not having the desired

impact on expenditure, according to available research. Significant regulation took place with regards to pharmaceutical pricing, supply and distribution (profit and commercial margins, reference prices, operating hours, etc.), which had positive overall effects. The National Medicines Agency, created in 1997, started to operate as a quasi-independent public body in 1999, absorbing some of the responsibilities previously held by the Ministry of Health, such as the authorization of new drugs and clinical trials.

- *Assessment of technology*: Since the mid-1980s and the early 1990s, significant advances have been made in the assessment of medical technologies. At the regional level, five regulatory agencies have been created (Andalucia, Basque Country, Catalonia, Galicia and Valencia). At the state level, the Ministry of Health has sponsored the assessment of more than 40 emerging technologies since 1991, originally through a unit within the Ministry and, since 1994, through the National Agency for the Assessment of Health Technologies.

Citizens' satisfaction with the National Health System

Table 19 presents the evolution of general citizens' satisfaction with the National Health System and, in particular, of the survey designed by Robert J. Blendon, for which there is international comparative data. The series is taken from three different data sources: the 1991 figures come from a survey conducted by an international research team led by Blendon himself; the 1996 data is from the Eurobarometer, and other years correspond to a routine survey question included in several Spanish official surveys conducted by the *CIS*. Overall, the table shows a considerable increase in satisfaction throughout the decade. Spanish official figures show a significant increase between 1993 and 1998: in 1993, more than 50% of the population thought that the system worked rather well or only needed minor changes while, in 1998, two thirds of the population held the same opinion. On the other hand, in 1993, almost 20% of the population was in favour of completely rebuilding the system, while only 7% thought this five years later.

As regards the two years for which international data is available, 1991 and 1996, the evolution has been as follows: while in 1991 only 20% of the population thought that the health system worked well or only needed a few changes, in 1996, the equivalent figure had more than doubled. In addition, while in 1991 about one third of the population was in favour of completely rebuilding the system, by 1996, the figure had dropped to 14%. This also implies that Spanish satisfaction figures were moving closer to the European Union average. In fact, according to the satisfaction index displayed in the last two

Table 19. Citizen satisfaction with the public health care system (in percentages), 1991–1998

	1991*	1993	1994	1995	1996**	1997	1998
1. On the whole, the health care system works pretty well	–	20	17	20	14**	20	**20**
2. A few changes are needed to make it work better	21*	33	37	41	30**	41	43
3. Fundamental changes are needed to make it better	49*	30	31	29	34**	30	28
4. It has so much wrong with it that it needs to be completely rebuilt	28*	18	14	10	14**	8	7
Satisfaction index, Spain (1+2)-(3+4)	-56*	5	9	22	-4**	23	28
Satisfaction index, EU average	-32*	–	–	–	13**	–	–

Source: Ministry of Health and Consumption Affairs and CIS, 2000. *Blendon et al., 1992. **Mossialos, 1997.

rows of Table 20, Spain was at 57% of the EU average in 1991 while, in 1996, it had moved to 85% of the EU average. As for the period 1996–1998, there is also a comparable question included in the two Eurobarometers conducted in these two years (data not shown). More concretely, the question reads "In general, would you say you are very satisfied, fairly satisfied, neither satisfied nor dissatisfied, fairly dissatisfied or very dissatisfied with the way health care runs in your country". In 1996, 35.6% of the population was satisfied (very + fairly satisfied), while 28.6% was dissatisfied (fairly + very dissatisfied). This implies that Spain stood at 40% below the EU average as regards levels of satisfaction, and some 20% above average for dissatisfaction. Figures for 1998 show an important increase of average satisfaction levels together with a rapid move towards the EU average: 43% of the Spanish population was satisfied with the system (22% below the EU average), while 26.3% was dissatisfied (0.5% below the EU average).

By levels of care, the evolution of satisfaction figures, as described in the section on *Health care delivery*, has been as follows. In the primary care field, the average satisfaction level almost doubled between 1985 and 1995, to remain constant thereafter. In fact, while in 1985 less than 50% of the population was satisfied with public primary care, by the mid-1990s, this figure had risen to almost 80% of the population. In addition, between 1995 and 1998, although general satisfaction scores remained relatively constant, net increases were registered in three dimensions of care which were previously under-evaluated, namely: consultation times, clinical information, and facilities and equipment. Available satisfaction data, therefore, seem to suggest that the implementation of primary care reforms had an overall positive effect. The small evolution

registered since 1995, however, might suggest that there is a need for further reorientation of reform policies in this field.

In the field of hospital care, general increases in satisfaction have been less marked. In contrast with the primary care sector, the point of departure was particularly high, with almost 70% of the population already satisfied with hospital services in 1985. From 1985 to 1990, overall satisfaction dropped to 50% (perhaps as a result of the significant cost-containment efforts carried out during the period), and then recovered the 70% level in 1995. Between 1995 and 1998, satisfaction stopped growing, as was the case for primary care. In contrast with the primary care field, however, the three dimensions of care less valued in 1995 (waiting times, number of people sharing hospital rooms and administrative procedures needed to get access to hospital care) experienced net drops during the period.

Table 20. Citizen satisfaction scores (1–7 scale) for different aspects of health information, 1991–1998

	1994	1995	1997	1998
1. Benefits and services offered by the public system	3.91	4.01	3.89	3.82
2. User rights	3.51	3.49	3.33	3.22
3. Health care legislation and regulation	3.29	3.27	3.24	3.25
4. Health promotion and prevention campaigns	4.23	4.20	4.11	4.06

Source: Ministry of Health and Consumption Affairs and CIS, 2000.

Finally, information is the aspect of the National Health System that caused the most dissatisfaction in 1995 (Table 20). To illustrate, the average value given to this aspect on a 1 to 7 scale varied between 3 and 4 across the autonomous communities, while the equivalent figures for primary and specialized care were well above 5. In addition, average satisfaction scores in this field decreased between 1995 and 1998. This seems to suggest that the significant advances made in information development during the second half of the 1990s either did not address citizens' needs or did not yet reach the general population.

Conclusions

During the 1980s and 1990s, the Spanish health system underwent major change, achieving a significant extension of coverage, developing a new reformed primary care network almost from scratch, and rationalizing both financing and management structures. Thus, all throughout this period, Spain made a significant effort at welfare state expansion, in spite of the international climate of cost-containment, as well as the significant domestic problems which had to be simultaneously addressed in the areas of economic development and political transition to democracy.

In contrast with other latecomers to welfare state development, like Portugal or Greece (and, to some extent, Italy), the extension of the public network and the transition from a social security system to the National Health Service model initiated in the mid-1980s has reaped particularly successful results, as reflected in the levels of private health expenditure, which are lower than those in other Southern European Countries. In terms of citizen satisfaction, the results are especially remarkable: the percentage of the population declaring that the system works adequately and only needs minor changes increased from 20% to more than 60% between 1991 and 1998, with a concurrent drop in the percentage of those defending the need for a complete restructuring of the health care system from almost 30% to 7%. By level of care, satisfaction with primary care increased substantially (from less than 50% in 1985 to almost 80% in 1995), while the evolution in the hospital sector only shows a small increase throughout the period (partly due to the fact that satisfaction stood at a considerably high level, around 70% by 1985). It should be noted, however, that the three dimensions of care rated the worst in the early 1990s (waiting times, number of persons per hospital room, and administrative procedures required to obtain access to hospital care) suffered net decreases by 1998, suggesting that the main problems of the sector still require further attention by the policymakers.

More generally, the reforms launched during the 1980s and 1990s still leave some critical, unfulfilled strategic tasks ahead. The main challenges facing the health sector in this respect are to continue implementation of the reforms and to consolidate progress made to date. Specifically, this will be to:

- extend universal coverage to 100% of the population;
- guarantee improved levels of accessibility, equity and quality of the public health care network;
- make effective the formal goal of tipping the balance of the health care system toward the primary care level;
- complete the decentralization process in the ten Autonomous Communities (covering 38% of the population) which have not as yet assumed full responsibilities for health care management;
- build on the regional resource allocation agreement covering 1998–2001 to agree on a definitive model to finance the system, adjusting simple capitation targets by age and needs, and ensuring that regional health service administrations continue to bear the risk of any debt generated;
- reinforce the key role of the Ministry of Health as an impartial coordinating and regulatory body for the National Health System, (particularly after completion of the decentralization process);
- enhance legitimacy by increasing both user satisfaction and the participation of the population by encouraging a people-centred approach with fewer bureaucratic barriers and better staff–patient relationships. This implies, as first steps, maintaining the initiatives to decrease waiting times for both inpatient and specialized outpatient care, and introducing greater choice of provider.

Among the most urgent future challenges, three of them require special mention, namely information development, managerial autonomy, and expansion of social and community care within the framework of the National Health System. First, in comparative international terms, probably the most important deficiency in the Spanish health care sector at the turn of the century is the weaknesses of information gathering, particularly across Autonomous Communities. There are increasing difficulties obtaining access to data which covers the whole of the State territory as a result of the disappearance of *special* Autonomous Communities from statistical data sources at the central level. In spite of the significant advances made by Autonomous Communities and the central state agencies in the field of information development, these data are of limited use due to the lack of a homogeneous codification and a common data bank pooling information. Critical information, such as staff and utilization levels in primary care, size of patient lists, patterns of utilization by age and

social class, coverage of the new primary care network, waiting times, or the cost profiles of each hospital, is not generally available in Spain on a nation-wide basis while, until December 1999, the same was true for total public expenditure, and for its disaggregation by levels of care. In addition, survey data reflect that institutional information is the dimension which generates the highest dissatisfaction among Spaniards, particularly regarding issues as crucial for accountability and efficiency as the benefits and services provided by the public sector, patients' rights, health care legislation and public health programmes. It should be clarified here, however, that the provision of clinical information by physicians, in contrast, is one of the dimensions of service better evaluated by citizens.

Second, as in other European countries, there is a pressing need to manage health services with greater efficiency through: transferring responsibilities (and risks) to local budget holders; increasing the autonomy of hospitals and health centres, especially in terms of day-to-day organization; and involving health care professionals (particularly physicians) in clinical management. In addition, there is a need to make the most appropriate use of available resources by adopting alternative treatment methods, like major ambulatory surgery, and by promoting the extension of evidence based medicine into cinical practice. Following the pioneering initiatives undertaken by special Autonomous Communities during the 1990s, the Ministry of Health has laid the groundwork for extending and coordinating some of these innovations, and progress now depends on the extension and consolidation of the reform process.

Third, the most important problem of the National Health System as regards the extent of the benefits provided refers to social and community care. Within this broad field of activity, only mental care has been integrated into the public health care system and subjected to major reform. In contrast, long-term care for the elderly and handicapped is still considerably underdeveloped and managed from a different organizational structure, that of the Ministry of Labour and Social Affairs and its equivalents at the regional level. In addition, long-term beds for palliative care of the chronically and terminally ill only absorb a marginal share of the total. In addition, long-term beds for palliative care of the chronically and terminally ill only absorb a marginal share of the total. Significant reorganization and extension of benefits are to be expected in this field in the medium to long term, in line with Spain's projected future population structure which points to one of the highest percentages of the elderly in the European Union within the next few decades.

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