HiT summary

Spain

Introduction

Government and recent political history

After a long period of dictatorship Spain approved a new Constitution in 1978, which set up a Parliamentary Monarchy and a new territorial organization of the State.

Population

Estimated 39 852 000 (1998). Future trends point to an ageing population and significant reduction of birth rates. The fertility rate was the lowest in the European Union (EU) in 1997 (1.18 children per woman aged 15–49).

Average life expectancy

It is well above the European average (the third highest in 1996) . Since the 1970s it has been constantly rising. In 1997 it was 82 years for women and 74.6 years for men.

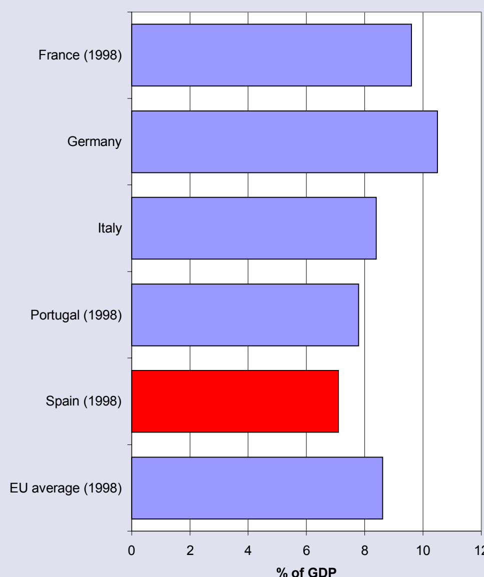
Leading causes of death

Highest standardized mortality rate caused by AIDS within the EU. Increasing incidence of lung cancer, cardiovascular diseases and work-related accidents but deaths from infectious diseases and traffic-related accidents are down.

Recent history of the health care system

Under dictatorship there was a means-tested and centralized health care system, rooted in a social security scheme. The Constitution established the right of all Spaniards to health protection and set out a new regionally based organizational framework. The creation of the National Health Institute in 1978 and the Ministry of Health in 1981 gave rise to a separate organization for health care within the social security system.

Fig. 1 Total health care expenditure as % of GDP, comparing Spain, selected countries and EU average



Source: WHO Regional Office for Europe health for all database

Reform trends

Decentralization of the health care system is based on the model of devolution so that responsibility is being transferred from central administration to the 17 regional governments. From 1986, the transition to a National Health System involved a reform of financing, which has transformed the former insurance-oriented system into a system financed by taxes with an almost universal coverage for all citizens.

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Health expenditure and GDP

Total expenditure on health accounted for 7.4% of the GDP in 1997, while in the same year health care expenditure in US $PPP per capita was 1183, which represented 75% of the EU average. Public expenditure consists of nearly 77% of the total.

Overview

The Spanish health care system has undergone major changes since the approval of the Constitution. The most important ones are the transition from a system of social security to a National Health System and the process of devolution to the regions. While there are still important problems to be addressed in these two fields, citizen satisfaction has increased throughout the 1990s.

Organizational structure of the health care system

The National Health Service is *de facto* still considered a part of the social security system for many administrative purposes. It is publicly financed through taxes and provision is mostly publicly owned and managed. The governance of the system has been decentralized to the regions, although only 7 out of 17 have obtained full powers (the INSALUD – National Health Institute – manages most health services in the remaining regions).

- The Ministry of Health: coordinates public health and health care services, is responsible for the drafting of health policy and any basic enabling legislation, and ensures coordination of health and social services with the Ministry of Labour and Social Affairs. It is also the direct authority of INSALUD and regulates postgraduate training for medical professionals (together with the Ministry of Education), pharmaceutical policy, and the standardization of medical and health products in general.
- The Ministry of Labour and Social Affairs: defines the financial structure of the social security system, the guaranteed package of health care benefits and authorizes payments made within the National Health System.
- Regional governments: each holds health planning powers as well as the capacity to organize its own health services, although in 10 out of 17 regions these powers partly remain in the hands of central government (through INSALUD). The non-uniform power-sharing scheme hampers coordination, specially in regions with less powers. The basic structures of the health system are health areas, which provide primary care, specialized ambulatory care and hospital care. Health zones are the smallest units of health care organization and usually are organized around a single primary care centre.
- Local governments: their role in the system has decreased since the Constitution allocated most of the former local responsibilities to regional governments, with the exception of some sanitation policies and environmental health activities.
- Insurance companies have a minor but increasing role. Private voluntary schemes cover 10% of the population and there are also three publicly-funded mutual funds exclusively for civil servants, who are free to choose between public or private provision. There are also other providers such as military health services or prison services. Traditionally, the public system has contracted out approximately 15–20% of hospital provision with private non-profit providers.

Planning, regulation and management

Planning and regulation of the health system are areas of shared responsibility. Central and regional top management institutions generally continue to integrate the functions of financing, purchasing and provision. However, since 1990 legislation has been introduced aimed at gradually

separating provider and purchaser functions through the establishment of contracts with objectives attached to funding.

Decentralization of the health care system

From 1978 to 1986 most centrally managed pre-social security networks had been transferred to all regions. Between 1981 and 1994 the social health insurance network (which became National Health System from 1986 on) was devolved to the seven regions with fully devolved powers (62% of population). The highest government authority in these regions are regional health departments while in the remaining ten it is the ministry and INSALUD through their territorially based delegations. Prospects for the future point to the devolution of the health care network to the ten ordinary regions, although this still remains uncertain.

Health care financing and expenditure

The health care system is financed out of general taxation, which has replaced a more insurance-oriented system. Most taxes are centrally raised since regional and local governments have limited fiscal autonomy. Civil servants' mutual funds are funded approximately 70% by the state and 30% through contributions from civil servants to their own funds.

The non-uniform process of decentralization gave way to a somewhat fragmented system of health care financing and, consequently, to significant problems regarding control of health care expenditure.

The affluent self-employed and liberal professionals, who represent about 0.6% of population (1997), are not covered by the National Health System. For the remaining Spaniards covered by the statutory system, 94.6% are covered by the obligatory affiliation to the social security system and the remaining 4.6% are civil servants and their dependants, mostly covered by mutual funds. A special means-tested non-contributory scheme is in place for the disadvantaged. The extension of health care rights to the adult immigrant population was approved recently but its future remains unclear.

Health care benefits and rationing

Benefits covered by the NHS include: a) primary health care, which covers medical and paediatric health care, prevention of disease, health promotion and rehabilitation; b) specialized health care in the form of outpatient and inpatient care covers all medical and surgical specialties in acute care; c) pharmaceutical benefits and complementary benefits such as prostheses or orthopaedic products. The package does not include social and community care and the main benefit historically excluded is dental care.

Complementary sources of finance

Private health care financing is the sum of three complementary sources of finance: out-of-pocket payments to the public system, out-of-pocket payments to the private sector and voluntary insurance. The data on private expenditure suffer from a number of problems.

Total out-of-pocket payments represent 16.9% of total health care expenditure. They are distributed as follows: 40% co-payments for prescription pharmaceuticals to the population under 65 years of age who does not suffer from permanent disability or chronic illness; 57% direct payment for private outpatient (including nursing) care; 3% direct payment for inpatient care.

There are three categories of private insurance: purely voluntary, civil servants' mutual funds and employer-purchased insurance, which together cover between 13% and 19% of total population (depending on the source). A distinctive characteristic is that for most of the sector the provision of health care services is integrated with insurance. It accounts for between

14% and 34% of total private health care expenditure. In 1999, tax discounts to employer-purchased health care insurance 1999 were introduced.

Health care expenditure

The level of total health care expenditure is below the EU average for the period 1990–1997. Per capita expenditure represents 75% of the EU average, and the same is true for public health care expenditure. In 1997, public expenditure represented 76.1% of the total and from 1986 to 1996 it nearly tripled in nominal terms. Private health expenditure rose at a similar rate as public expenditure during the 1990s. With regard to total expenditure there has been an over-average increase in pharmaceutical expenditure. Public expenditure channelled through the regional resource allocation system accounts for 80.6% of the total (1996) and on a per capita basis it has been increasing at a faster rate in the seven special regions, because of the small degree of central government control over the latter. Scarce fiscal autonomy in most regions also creates incentives to increase expenditures.

Health delivery system

After the General Health Care Act (1986), primary health care was given an independent, reinforced status. Implementation was slow, problematic and it was not accompanied by a parallel change in the structure of financing.

Primary health care (PHC)

Its functions are health promotion and prevention, curative care and rehabilitation follow-up. The traditional system of delivery consisted of a solo practitioner working part-time, while the reformed model is based on the primary care team, working full-time on a salaried basis (since primary health care is 100% publicly owned and staffed). The first contact the population has with the health system is the general practitioner, who has a gatekeeper role.

In spite of the reform, Spain has, in general, given low political priority to primary health care. A negative indicator of the impact of reforms is an increase in the percentage of patients in accidents and emergencies departments of hospitals (around 50% of admissions result from problems with accessibility to PHC). There is still a lack of basic infrastructure, such as that required to conduct minor surgery, and a national information system does not exist, a serious obstacle to monitor the quality of day-to-day clinical management of patients. On the other hand, coverage of the reformed network was 85% in 2000 and user satisfaction is increasing, with important differences among regions (for example in accessibility rates) that reflect differences in provision.

Public health services

This is one of the areas of responsibility that has been largely decentralized to the regions. However, core areas have remained under the exclusive power of the state and the process of devolution is not totally implemented because local government transfers are not fully completed. Problems of coordination have arisen due to fragmentation of responsibilities. The newly created specialty of Preventive Medicine and Public Health is not very well established yet, which has undermined attempts at raising professional qualifications in the area.

Core national programs are epidemiological surveillance and AIDS. The National Epidemiological Surveillance Network was created in 1996 and the Ministry of Health is the key sponsor of the National Plan against AIDS. There is also a National Anti-Drug programme, run through the Ministry of the Interior, since drug addiction is a major problem in Spain.

Secondary and tertiary care

The health care system is still centred around hospitals rather than around PHC. Organization and planning is regionally based. 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. In the reformed model of provision, members of specialist teams in clinical departments of general hospitals rotate to cover outpatient care in ambulatory centres (in the old model specialist doctors were fully dedicated to outpatient care, which made coordination between outpatient and hospital care difficult).

The main problems of the sector are coordination with primary health care centres, waiting times, number of persons sharing each hospital room and administrative procedures needed to obtain access to services. In 1995, Spain had one of the lowest figures regarding the number of beds per 1000 population. The sector has coped with increasing demand by using its resources more intensively (shorter average stays, quicker turnover and higher occupancy rates). However, unnecessary hospital utilization rates range from 15% to 20% of hospital admissions. To decrease waiting times, a scheme was initiated in 1996, whose effects were a reduction of 70% in average waiting times in the ten centrally managed regions.

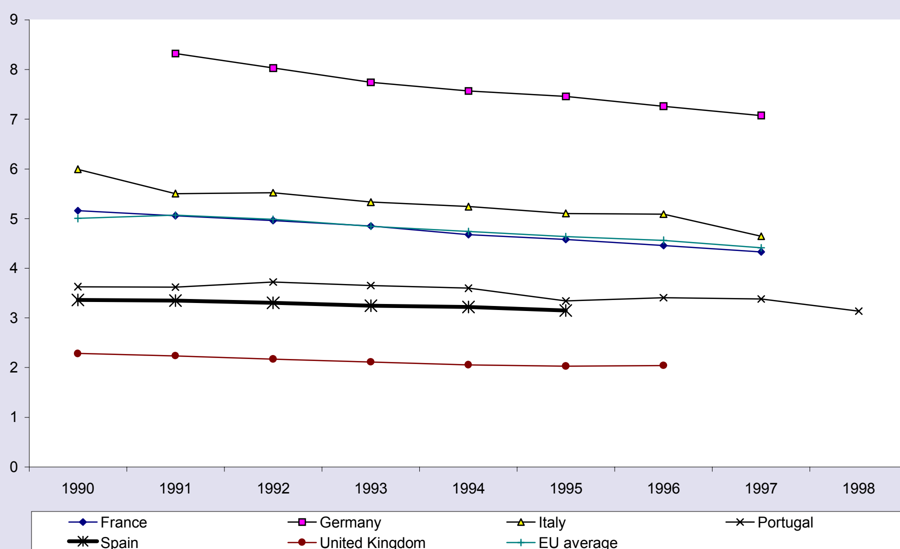
The most important reform in specialist care is the separation of financing and purchasing of health care from actual provision of services through the so-called "contract-programmes", which are based on target activity but financed through global budgets.

Social and community care

These services are partly managed by the Ministry of Labour and Social Affairs, and partly by the regions. Local governments are also involved, especially in the planning and management of services. There are high co-payments for most social services.

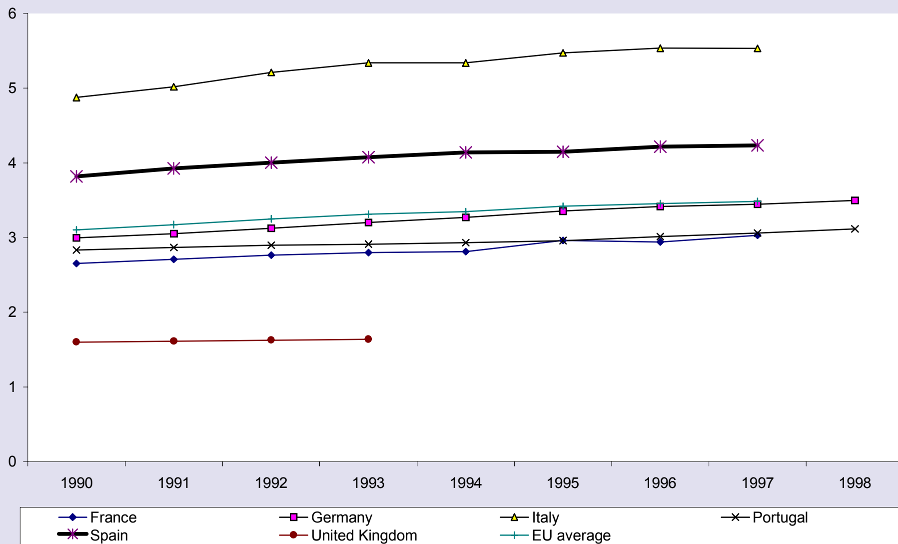
The key area of overlap between health and social services is the provision of care for the elderly, whose main problem is that only 30% of existing beds are public (1998) and the number of places falls short of demand. The most favoured model in the public sector is the use of

Fig. 2 Hospital beds in acute hospitals per 1000 population, Spain, selected countries and EU average



Source: WHO Regional Office for Europe health for all database

Fig. 3. Physicians per 100 population, Spain, selected countries and EU average



Source: WHO Regional Office for Europe health for all database

nursing homes with medical support, when needed, by the public sector. Although home care is expanding, in general accessibility is severely restricted and there is a lack of coordination with medical care in many aspects.

Mental health care was integrated within the general health care system in 1986, and submitted to structural reform. From 1991 to 1996 psychiatric beds within general hospitals increased while the number of beds in psychiatric hospitals decreased. Psychiatric reform has had an uneven development among regions and there are difficulties coordinating health and social services in this area.

Human resources and training

The majority of medical staff has a status similar to that of civil servants. Negotiation of working conditions is done centrally, while health centre managers have limited capacity to negotiate salary incentives.

The relative number of doctors is the second highest in Europe (1998), although data is only relatively trustworthy since it does not differentiate between active and non-active doctors. In contrast, Spain has the fourth lowest figure with respect to the number of nurses per 1000 population.

Spanish human resources policies have been characterized by overproduction of doctors, which has caused unemployment among physicians who have been unable to specialize. The number of primary health care doctors is markedly lower than the number of physicians concentrated in hospital and outpatient specialties (specialized care absorbed 76.2% of the total in 1997, 20% above the EU average). There is also an over-average supply of pharmacists.

Pharmaceuticals and health care technology assessment

Out of the total public consumption of pharmaceutics, in 1998 the National Health System paid 92.3% of the total, while the remainder was covered by co-payments (a percentage that had decreased since 1986 due to an increase of

population over the age of 65 years, for whom pharmaceuticals are free).

The increase in public pharmaceutical expenditure during the 1990s seems to be due to raised prices rather than to an increase in the number of prescriptions. This led to the adoption of cost-containment measures from 1993 onwards. The most important of these was the introduction of negative lists (with some pharmaceuticals excluded from public funding), which had limited effects on expenditure. Other measures were the introduction (in 1996 and 1997) of generic drugs and global reference prices. There was also a reduction (in 1999) of wholesaler profit margins, from 11% to 9.6% and a 2% reduction over the maximum allowed profit margins. Cost-containment measures aimed at doctors have consisted of the assignment of separate drug "budgets" (to foster consciousness of the expenditure made) and the production of comparative information on individual prescription patterns.

The Basque Country and Catalonia have been pioneers in the introduction of technology assessment and evaluation bodies. The central administration shortly followed and in 1994 the Spanish National Office of Technology Assessment was created. Several agencies were created at the regional level, as well. There has been a significant improvement in the available evidence on cost-effective practices but there is still considerable work to do in this area.

Financial resource allocation

The regional resource allocation system accounts for more than 80% of total public expenditure. The parliament approves the state budget and the resulting resources are then allocated to the regions with devolved powers and to INSALUD (for those regions whose health services are centrally managed). The percentage of total public health care expenditure financed by taxes is below 10% (except in the Basque Country and Navarra, which enjoy full fiscal autonomy). From the early 1990s, however, some management responsibility over 30% of income taxes was devolved to all regions.

Prior to 1994, the regional resource allocation system was based on historical criteria. In practice, each region's share was decided through bilateral negotiations subject to political discretion. This approach perpetuated inequalities, eroded credibility of central government regarding cost-containment commitments and decreased incentives for regions to reduce their debt.

In 1994, a multilateral agreement was reached for the first time for introducing unweighted capitation targets as well as for tightening cost containment policies. In 1997, however, the financial agreement for the period 1998–2001 introduced ad hoc compensations for regions losing population (Catalonia and Galicia). The resource allocation system, thus, is far from being based on a stable formula.

Payment of hospitals

Catalonia pioneered changes in the design of hospital budgets. Traditionally, hospital expenditures were retrospectively reimbursed, with no prior negotiation and no formal evaluation. In contrast, in contract-programmes, introduced since the late 1980s, there is a prospective financing of targeted activities (they set objectives and financing attached to them). Since the mid 1990s the use of contract-programmes with private hospitals has increased due to the emphasis given to reducing waiting times.

Payment of physicians

The basic salary for all public sector physicians is regulated by the central government, although the regions can modify some of the components which make up the salary.

The payment system for hospital professionals largely fails to reward efficiency. The use of financial incentives has not been very effective. In general, mechanisms for evaluating health care

delivery are still very rudimentary and measures aimed at assessing efficiency have proved difficult to apply.

Health care reforms

Before 1986, the main problem of the health care system was that it had different health care networks which were dependent on different funding and regulatory bodies. The General Health Act (1986) meant the formal transition from a system of Social Security to a National Health System.

The 1990 reforms openly addressed the need to control rising costs and to improve levels of public satisfaction. As dissatisfaction was mainly concentrated on management and organizational issues, the reform package launched focused on the introduction of organizational and managerial improvements within the extended public sector emerging from the 1980s reforms.

Reforms have progressed to different degrees. The health care system is currently 100% financed by taxes. The percentage of the population covered by public insurance was 81.7% in 1978 and today it is 99.4% and includes the low-income non-statutory population and immigrant children. The benefits package still excludes dental care, and social and community care are not fully covered either. At the start of the year 2000, transfers of the social security network of health care centres to the ten regions which still are under central rule had not yet materialized. In these regions, legislation on health care is of little meaning, since they are centrally managed.

Separation between financing, purchasing and provision has been introduced in both central and regional legislation during 1990s but not implemented so far. In 1999, new legislation allowed the future generalization of flexible, autonomous organizational forms to all Spanish hospitals. The role of private providers within some areas of the health system has expanded since the provision of care in the case of accidents at work, work-induced illnesses and some authority over the management of sick leave were transferred to employers' mutual funds in 1996. While primary health care still lacks political priority, in specialized care, problems of accessibility remain and waiting lists were still a major policy problem in the late 1990s. Considerable public opposition to market-oriented policies exists in Spain, which has contributed to preventing the adoption of some of the reforms proposed in this direction.

Citizen satisfaction figures show an overall positive trend throughout the 1990s, especially in primary health care, which shows higher increases than satisfaction with hospital care. Spain is moving closer to the European Union average on citizen satisfaction with the public health care system.

Table 1. Inpatient utilization and performance in acute hospitals in the WHO European Region, 1999 or latest available year

Country	Hospital beds per 1000 population	Admissions per 100 population	Average length of stay in days	Occupancy rate (%)
France	4.3[a]	20.3[d]	5.6[a]	75.7[a]
Germany	7.0[a]	19.6[b]	11.0[a]	76.6[b]
Italy	4.5[a]	17.2[a]	7.1[a]	74.1[a]
Portugal	3.1[a]	11.9[a]	7.3[a]	75.5[a]
Spain	3.2[c]	11.2[c]	8.0[c]	77.3[c]
United Kingdom	2.4[a]	21.4[c]	5.0[c]	80.8[a]
EU average	4.6[a]	18.8	8.3[a]	77.1[b]

Source: WHO Regional Office for Europe health for all database.
Note: [a] 1998, [b] 1997, [c] 1996, [d] 1995, [e] 1994, [f] 1993, [g] 1992.

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 and rationalizing both financing and management structures. In these areas, the extension of the public network and the transition from a social security system to the National Health Service model has reaped particularly successful results.

However, the formal goal of primary care reform, namely to tip the balance of care towards this level, has not been accomplished. Levels of citizen satisfaction with waiting times, number of persons per hospital room and administrative procedures required to obtain access to hospital care still remain low, and have been decreasing through the 1990s, which suggests that the main problems of specialized care still require further attention. Some of the most urgent future challenges require special mention: namely the completion of the decentralization process in the ten regions which have not as yet assumed full powers, the agreement on a definitive model to finance the system, information development, managerial autonomy and the expansion of social and community care within the framework of the National Health System.

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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 Greece, Norway and Spain, the European Investment Bank, the Open Society Institute, the World Bank, the London School of Economics and Political Science, and the London School of Hygiene & Tropical Medicine. This partnership supports and promotes evidence-based health policy-making through comprehensive and rigorous analysis of the dynamics of health care systems in Europe.