The Spanish health care system: lessons for newly industrialized countries

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This article summarizes the organization, financing, and delivery of health care services in Spain, and discusses the elements that made it possible to maintain high levels of health among the population, while spending comparatively fewer resources on the health care system than most industrialized countries.

The case of Spain is of particular interest for newly industrialized countries, because of the fast evolution that it has undergone in recent years. Considered, by United Nations' economic standards, a developing country until 1964, Spain became in a few years the fastest growing economy in the world after Japan. By the early 1970s the infant mortality rate was already lower than in Britain or the United States.

Introduction

Six hundred years before Jesus Christ, Charodes decreed that all citizens of Athens had the right to receive free medical care provided by physicians employed by the State and paid with the money collected by a specific tax: the 'iatricon' (Attali 1979). Since then, social organizations around the world have taken different approaches to dealing with illness and disability, but whenever a society decides to assure the care of all or the majority of its members, usually to secure its own stability and continuation, it has to resolve who, how, and by which means such care will be facilitated or become available.

Most Western societies have come to consider health care a human right and a moral obligation of the community as a result of their own historical development, and the same applies to the determination of the specific structures of health care provision and their financing. It is, therefore, very difficult to understand the present health care system of any country without putting it in an historical perspective.

We have seen an increasing interest in the discussion of health care reform in Europe in recent years (Elola 1996; Vienonen 1996). The case of Spain is of particular interest for less developed countries, because of its recent and rapid political, economic, and cultural evolution. Considered until 1964 by United Nations' economic standards, Spain became in a few years the fastest growing economy in the world after Japan.

As one of the largest countries in Europe, at the end of the 1990s Spain has a population of over 39 million people, one of the lowest birth rates in Europe (with a fertility rate of 1.18) and the highest unemployment rate of the European Union (OECD 1997). Table 1 describes basic demographic and economic indicators for Spain and other countries, including the United States.

The country spends 7.6% of GDP on health care, and it performs remarkably well in morbidity and mortality indicators. As described in Table 2, the infant mortality rate (percentage of live births) was 0.60 in 1994, and life expectancy at birth was 81 years for women and 73 years for men. Around 75% of the Spanish health care system is publicly funded, largely through taxes, and has a fairly dependent private sector. Almost 90% of private funding is from direct payments. Private insurance premia only account for 2.5% of the total expenditure. Above 70% of the available beds are publicly owned, although there are great differences across regions. The organizational structure is decentralized to 17 Autonomous Communities or regions but only seven of them are invested with almost full competencies in the administration and delivery of health care. The resulting management scenario is that of a group of ten regions directly controlled by Madrid-INSALUD (National Health Institute) and seven highly autonomous Regional Health Services. The whole of the INSALUD and the Regional Health Services shape the Spanish National Health Service (NHS).

Brief historical development of the Spanish health care system

The basis of the modern Spanish health care system can be traced back to the development of the first social insurance legislations, which appeared much later than their counterparts in most Western European countries.

Originally designed to cover the health needs of industrial workers, compulsory sickness insurance was extended to the entire active population by the early 1970s.

The public health sector within the Social Security (SS) system was financed by workers and their employers, and managed through a centralized structure. In the late 1970s it served about 81% of the population, financed 70% of all
health care provided and maintained 26% of the country’s best and most efficient hospital beds (De Miguel 1986). The SS system was restructured during the first years of the newly achieved democracy and divided into four branches. The health care branch of the SS was named INSALUD in 1978. (For a detailed historical account see Rodriguez and de Miguel 1990a, and Kelley 1984.)

After Franco’s death in 1975, the democratic period raised new political expectations. Since its installation in 1982 the socialist government (PSOE) tried to improve INSALUD. Its three basic objectives were: a) to increase the health level of the population, b) to reduce socio-sanitary inequalities, and c) to increase the efficiency of available resources through better organization and management, with the purpose of attaining the first two objectives while keeping health care costs under control (Rodriguez and De Miguel 1990b). Along with political reforms, the Seguridad Social experienced rather incrementalist albeit necessary changes until 1986 when the National Health Act (NHA) established the foundation of a decentralized National Health System. As de Miguel points out, the ‘Ley General de Sanidad’ (LGS) – National Health Act – of 1986 follows a model more in

### Table 1. Demographic and economic characteristics of selected countries: 1995

<table>
<thead>
<tr>
<th>Country</th>
<th>Population (000s)</th>
<th>GDP per capita using current PPPs¹</th>
<th>Unemployment rates²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>18 054</td>
<td>19 314</td>
<td>8.5</td>
</tr>
<tr>
<td>Canada</td>
<td>29 606</td>
<td>18 915</td>
<td>10.3**</td>
</tr>
<tr>
<td>Czech Republic</td>
<td>10 331</td>
<td>4 420*</td>
<td>3.9**</td>
</tr>
<tr>
<td>France</td>
<td>58 141</td>
<td>19 939</td>
<td>11.6</td>
</tr>
<tr>
<td>Germany</td>
<td>81 662</td>
<td>20 497</td>
<td>8.4**</td>
</tr>
<tr>
<td>Hungary</td>
<td>10 579</td>
<td>4 273</td>
<td>10.2</td>
</tr>
<tr>
<td>Italy</td>
<td>57 283</td>
<td>19 464</td>
<td>11.9**</td>
</tr>
<tr>
<td>Japan</td>
<td>125 250</td>
<td>21 795</td>
<td>2.9**</td>
</tr>
<tr>
<td>Mexico</td>
<td>91 120</td>
<td>7 383</td>
<td>3.5**</td>
</tr>
<tr>
<td>Netherlands</td>
<td>15 457</td>
<td>19 782</td>
<td>6.8**</td>
</tr>
<tr>
<td>Spain</td>
<td>39 210</td>
<td>14 226</td>
<td>23.8**</td>
</tr>
<tr>
<td>Sweden</td>
<td>8 827</td>
<td>18 673</td>
<td>8.0**</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>58 613</td>
<td>17 756</td>
<td>9.6**</td>
</tr>
<tr>
<td>United States</td>
<td>263 057</td>
<td>26 438</td>
<td>6.0**</td>
</tr>
</tbody>
</table>


¹ Purchasing Power Parities (PPPs) are the rate of currency conversion which eliminates the differences in price levels between countries. This means that a given sum of money, when converted into different currencies at these rates, will buy the same basket of goods and services in all countries. PPPs are given in national currency units per US dollar.

² National definitions.

* Using current exchange rates, not PPP.

** 1994.

### Table 2. Health indicators of selected countries: 1995

<table>
<thead>
<tr>
<th>Country</th>
<th>Total fertility rate</th>
<th>Infant mortality</th>
<th>Years of life expectancy at birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>% of live births</td>
<td>Women</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Men</td>
</tr>
<tr>
<td>Australia</td>
<td>1.82</td>
<td>0.57</td>
<td>80.9</td>
</tr>
<tr>
<td>Canada</td>
<td>1.66</td>
<td>0.63*</td>
<td>81.3</td>
</tr>
<tr>
<td>Czech Republic</td>
<td>1.30</td>
<td>0.77</td>
<td>76.9</td>
</tr>
<tr>
<td>France</td>
<td>1.68</td>
<td>0.58*</td>
<td>81.9</td>
</tr>
<tr>
<td>Germany</td>
<td>1.24</td>
<td>0.53</td>
<td>79.5</td>
</tr>
<tr>
<td>Hungary</td>
<td>1.64</td>
<td>1.10</td>
<td>74.5</td>
</tr>
<tr>
<td>Italy</td>
<td>1.17</td>
<td>0.66*</td>
<td>81.0</td>
</tr>
<tr>
<td>Japan</td>
<td>1.42</td>
<td>0.43</td>
<td>82.8</td>
</tr>
<tr>
<td>Mexico</td>
<td>2.90</td>
<td>1.70*</td>
<td>76.0</td>
</tr>
<tr>
<td>Netherlands</td>
<td>1.53</td>
<td>0.55</td>
<td>80.4</td>
</tr>
<tr>
<td>Spain</td>
<td>1.18</td>
<td><strong>0.60</strong></td>
<td><strong>81.5</strong></td>
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<tr>
<td>Sweden</td>
<td>1.74</td>
<td>0.40</td>
<td>81.5</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>1.71</td>
<td>0.62*</td>
<td>79.7</td>
</tr>
<tr>
<td>United States</td>
<td>2.03</td>
<td>0.80*</td>
<td>79.2</td>
</tr>
</tbody>
</table>


health care and maintained 26% of the country’s best and most efficient hospital beds (De Miguel 1986).
Table 3. Provision of care: percentage of population covered by public or private insurance

<table>
<thead>
<tr>
<th></th>
<th>1987</th>
<th>1993</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public coverage</td>
<td>97.1%</td>
<td>98.5%</td>
</tr>
<tr>
<td>Private insurance</td>
<td>5.6%</td>
<td>6.4%</td>
</tr>
<tr>
<td>Private insurance contracted by firms</td>
<td>1.8%</td>
<td>0.1%</td>
</tr>
<tr>
<td>Other arrangements</td>
<td>2.2%</td>
<td>0.6%</td>
</tr>
</tbody>
</table>


accordance with the PSOE’s definition of the Welfare State. ‘The new model defines health and medical care as a right, and so directs the expansion of SS assistance to the totality of the population’ (Rodriguez and De Miguel 1990a). In short, the main purpose of the 1986 National Health Act was to make improvements in two areas derived from two principles outlined in the 1978 Constitution Act: achieving universal coverage (art. #43 and 49), and fostering decentralization (Title VIII). Table 3 shows the increase in universal coverage up to 1993.

Since its election in 1996, the new government of the conservative Partido Popular (PP) has not changed the basic objectives outlined in the NHA. These objectives are broad enough to accommodate different political agendas. Ultimately, they reflect a public consensus which no political party is willing to challenge, and which includes the public financing of the system through taxes.

The Spanish health system

Overall strategy

The Spanish health system has a strong public provision sector (about 70%) that dominates the health care market, and a smaller fairly dependent private sector (about 30%).

The National Health Act (NHA) of 1986 dictated that the public sector health care system be financed primarily by State general budget (BOE 1986). While a somewhat fragmented system remains (both in terms of funding and provision of services), the NHA of 1986 established the legal mechanism for unifying the public health services into a single body, controlling expenditures through a centralized economic fund, and mandating an overall health plan.

The NHA also promoted decentralization in the provision of health care services. (For a more detailed account of the decentralization see Bennett 1990, Cheema et al. 1983, Rondinelli 1981, Smith 1985.) The Spanish health system operates through regions called Autonomous Communities. These 17 Autonomous Communities are expected to be responsible for the delivery of their own health services.

In Spain, the health care system decentralization process took the form of devolution. Devolution has been defined (Mills 1990) as the creation or strengthening of sub-national levels of government that are substantially independent of the national level with respect to a defined set of functions. The theory asserts that these levels of government normally have clear legal status, recognized geographical boundaries, perform a number of functions, and have statutory authority to raise revenue and make expenditures. They are rarely completely autonomous but are largely independent in terms of their functional responsibilities.

The legal frame for Spain’s health decentralization has been shaped by three elements: the 1978 Constitution Act, the regions’ Estatutes, and the 1986 NHA. The NHA is part of a broader, more comprehensive and constitutional process of decentralization and State redefinition known as the ‘State of the Autonomies’. Through the Regional Health Services, regions have become the administration level in charge of health management and control. This level of decentralization was considered by the NHA to be the most convenient way to bring together two key elements: autonomy and efficiency.

However, the decentralization process in Spain remains fragmented and is yet to be completed. The transfer of authority in the health policy area from central government to the regions has been accomplished unevenly, resulting in diverse levels of autonomy. Only seven of the 17 Spanish regions benefit from full decentralization and a thorough body of competencies. Although they have some degree of autonomy, the remaining ten regions are still under the central management of INSALUD (National Health Institute) in Madrid.

A complex set of laws permits the regions to develop the NHA and use the competencies transferred to them according to their statutes of Autonomy (Political Statute for the region). The NHA’s first step was the gradual creation of the 17 Regional Health Services (RHS). There is, however, an implicit danger for the system to become centralized at the regional level once the decentralization process to the regions has started. In order to avoid this, the RHS are structured in lower level administrative units where an important role is played by the municipalities. The NHA specifies a series of competencies to be managed by municipal authorities, including control of environmental health, hygiene and food inspection. Participation of these local entities in the Health District governing bodies is also assured by the NHA. In addition, some municipalities keep control over the management of local hospitals.

Every RHS would produce a regional health plan according to the region’s health needs, and within a rational use of resources. The resulting 17 health plans would eventually be essential elements in shaping the Plan Integrado de Salud (National Integrated Plan). This latter plan would result from the combination of four sources: regional plans, specific plans of a national scope, specific common plans of the regions and the State, and other considerations related to financial resource allocations.

The central administration is responsible for the coordination of manpower; prevention, promotion and assistance; principles of coherence, egalitarianism and solidarity of the health
system; and basic and common criteria to an efficient distribution of resources. This coordination function was established to promote reciprocal information, common action, and integration of services, and could be pivotal in achieving the integration of the NHS. Regardless of the level of competencies the regions may achieve, the State holds competence on Alta Inspección (High Inspection). High Inspection is addressed by the NHA with reference to three main issues: adequacy of the regions’ plans and health programmes in accomplishing the general objectives set up by the State; evaluation of the achievement of common goals; and supervision of regions making use of the transferred competencies.

The body established to preserve the system’s integration and integrity is the Consejo Interterritorial de Salud (Interregional Health Council). This body provides reciprocal information within regions and with the State. The task of this institution is threefold: coordination of the basic lines of policy regarding acquisitions, contracts, pharmaceuticals, and personnel; some planning role; and a general coordination role.

However, a significant weakness of the NHA is its ambiguity. For example, it is not clear what the law refers to by ‘basic lines of policy’ (De Miguel 1986) in relation to the role of the Interregional Health Council (IHC). Furthermore the law does not provide the IHC with any monitoring or control mechanisms to properly address its tasks. This may have contributed to a diversity of regional policies in the health care area, threatening the unity of the SNS. It is debatable, however, whether the IHC should go beyond the coordination of regional objectives to achieve a National Health Plan, and to encourage the linkage of health policies and other social policies in a more homogenous way.

Following both the decentralization process and the use by the regions of the transferred competencies, difficulties have emerged. On one hand, the imperfect definition of responsibilities in the legal framework (1978 Constitution Act, Regions’ Statutes, and the NHA), has resulted in different (sometimes opposing) interpretations of the law from both the State and the regions. The constitutional appeals and the competence conflicts have forced the intervention of Spain’s Constitutional Court. On the other hand, administrative problems have presented a second set of difficulties. Regions with a lack of administrative tradition face management problems in order to carry out the competencies they have assumed. Both groups of difficulties support the idea that health care decentralization in Spain is a long-term process requiring political consensus and repeated calls for continuous development and adjustment. Any further reform in the health care area should bear in mind this protracted decentralization process, the principles in the Constitution, the Statutes, and the NHA. The need for political consensus, development, coordination, and adjustment goes beyond the process itself and affects any future reform proposal at regional or national levels.

**Financing**

Today, the Spanish health care system remains a mixed financed system. In order of importance, the four main sources of funding are taxes, social security contributions, out-of-pocket payments and private insurance premiums. Historically, public and private financing have followed different paths. Today, the balance between these two funding sources is not the same as in the 1960s and 1970s. Private finance is down to approximately 25% of the total expenditure in health. Of this 25%, more than 90% of expenditures are out-of-pocket payments in pharmaceuticals and private medicine (i.e. those services that are not entirely covered by the public health system such as dentists, gynaecology, and opticians). Public finance is now above 75% of health expenditure. From 1960 to 1987 public expenditure in health grew at an annual rate of 9%, well above the other OECD countries. Until 1974 public finance accounted for just over half of the total expenditure in health, but the 1974 Financial Law committed authorities to increase public expenditure up to present levels.

How is public financing raised? Previously the Seguridad Social (SS) and the NHA relied on social contributions as their main source of public financing. The State’s contributions (through taxes) to the health system in the 1960s and 1970s were less than 5% of the total public expenditure in health. By 1980 they represented 10%. By 1988 there was a rapid increase in tax contributions to reach 30%. Since 1989, finance through taxes has continued to increase and is now above 90% of the total public finance. Social security contributions are now below 10%.

The change towards a more direct General Budget financial contribution has resulted from an increasing public awareness that high social contributions were a burden to most businesses and employers, and secondly, from an effort to promote equity in the public finance of health services.

A cross-national study by Van Doorslaer et al. (1993) demonstrated the inequity of the Spanish health financing system in 1980. This study indicated that social contributions are slightly regressive, since they could be perceived as taxes on wages and these are proportionally a lower part of the final income in high income groups. While taxes are certainly more progressive, we should question whether the index for taxes has changed after indirect taxes for goods and services like VAT (Value Added Tax) were recently introduced. Finally, out-of-pocket payments are perceived to be progressive. This is due to the fact that they are mainly payments for pharmaceuticals and lower income groups, such as pensioners, receive a waiver from such payments. Direct payments represent 90% of private finance. Although there has not been any equity study after the 1989 changes towards a more tax-based public finance, an extrapolation of those indexes would show that the system today is somewhat more progressive than in the 1980s.

**Expenditures/delivery**

In Spain, as in most industrialized countries, there was a significant growth in health expenditure between 1960 and 1990. By the mid-1980s the country had experienced a doubling of its health expenditure as a proportion of its GDP (OECD 1987; Scheiber and Poullier 1990). As indicated in Table 4, by
1995 the total Spanish health care expenditure was 7.6% of its gross domestic product, similar to Japan (7.2%) or the Czech Republic (7.9%), but higher than the United Kingdom (6.9%), and much lower than Germany (10.4%), France and Canada (9.8% and 9.6% respectively), and the United States (14.2%). In Spain, 6.0% of the total expenditure corresponds to the public sector (OECD 1997).

It has been noted that countries with National Health Services seem to be more successful in controlling costs than those having social insurance schemes, because of their capacity to exercise a direct control over expenditures (Somoza et al. 1991). In the case of Spain the centralization of funds has facilitated control over expenditure. Although a mixed market exists, the greater weight of the public sector has allowed better regulation of prices, including those negotiated by INSALUD and its regional counterparts with the private sector for the contracting of complementary services.

The biggest share of health care expenditure corresponds to hospital services, which account for about 45.5% of the total, close to the European Union average. About 16% is spent on ambulatory services. Regarding drugs, Spain expends proportionally more than the EU average. When we consider the actual per capita expenditures in health care services, however, Spain’s are significantly lower, representing less than 70% of the European average (Schneider et al. 1992).

### Hospital services

The public sector holds about two-thirds of the total hospital beds in the country. INSALUD and regional equivalents own and administer about half of all public hospital beds and one-third of the total beds. The rest of the public health care sector includes health facilities administered by charitable institutions of local administration, and hospitals run by the Ministry of Defense. The private sector includes hospitals owned by the church, the Spanish Red Cross, private charities, as well as for-profit organizations.

The size and staffing of hospitals varies immensely depending on the ownership of the institution. In general, INSALUD-owned hospitals have better staffing ratios per bed and the most sophisticated high technology equipment.

Patients receive free care at any public institution or private hospital whose contracting status has been previously approved. In 1982, 64% of patients were hospitalized in public facilities, and 36% in the private sector (INE 1986). By 1993, of the 799 hospitals in the country, 445 were private, but given that private hospitals are smaller than public, they accounted for only 30% of the total hospital beds available (Anuario 1995).

The reimbursement of hospital services is prospectively provided by budgeting. The payment to private hospitals contracting with INSALUD is based on a mixed formula that takes into account the type of institution, the type of patients sent to that particular centre, and the type of service provided.

The number of hospital beds is considerably lower than the average of OECD countries, and their numbers continued a decreasing trend during the decade of the 1980s. As displayed in Table 4, it is now very similar to the United States. Although Spain lags behind most industrialized countries in the number of available hospital beds per capita, at the same time the inpatient occupancy rate (about 75%) is lower than that of most OECD countries. This does not indicate, however, a lack of need for more hospital beds, but a series of structural problems. As a result of an absence of clearly defined health planning over most of this century, the NHS not only has to deal with an unbalanced distribution of resources in terms of geographical location, but also in terms of the types of facilities available. For instance, there is a scarcity of psychiatric and long-term hospital beds.

<table>
<thead>
<tr>
<th>Country</th>
<th>Health expenditures as % of GDP</th>
<th>Hospital beds per 10 000 of population</th>
<th>Doctors per 10 000 of population</th>
<th>Average length of hospital stay (days)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Total</td>
</tr>
<tr>
<td>Australia</td>
<td>8.6</td>
<td>5.8</td>
<td>22.4c</td>
<td>8.9b</td>
</tr>
<tr>
<td>Canada</td>
<td>9.6</td>
<td>6.9</td>
<td>21.5</td>
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</tr>
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<td>Czech Republic</td>
<td>7.9</td>
<td>...</td>
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</tr>
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<td>France</td>
<td>9.8</td>
<td>7.7</td>
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<td>8.9</td>
</tr>
<tr>
<td>Germany</td>
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<td>8.2</td>
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<td>9.7</td>
</tr>
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</tr>
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<td>7.7</td>
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<td>16.5d</td>
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</tr>
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<td>7.2</td>
<td>5.7</td>
<td>17.1a</td>
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<td>Mexico</td>
<td>4.9</td>
<td>2.1</td>
<td>15.9</td>
<td>1.2</td>
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<td>Netherlands</td>
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<td>6.8</td>
<td>...</td>
<td>11.3</td>
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<td><strong>6.0</strong></td>
<td><strong>40.8b</strong></td>
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<td>6.9</td>
<td>5.9</td>
<td>15.6a</td>
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</tr>
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<td>14.2</td>
<td>6.6</td>
<td>26.3a</td>
<td>4.1</td>
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</table>


1995 the total Spanish health care expenditure was 7.6% of its gross domestic product, similar to Japan (7.2%) or the Czech Republic (7.9%), but higher than the United Kingdom (6.9%), and much lower than Germany (10.4%), France and Canada (9.8% and 9.6% respectively), and the United States (14.2%). In Spain, 6.0% of the total expenditure corresponds to the public sector (OECD 1997).
As a consequence of these structural problems, waiting periods in cases of elective or non-emergency surgery may vary greatly between geographical locations. There seems to be an agreement between both the public and the health planners that the resources available could be used more efficiently. The NHS is taking into consideration such deficiencies and 80% of INSALUD hospitals are currently undergoing partial (50%) or total (30%) renovations, in order to be more responsive to socio-demographic changes, spontaneous increases in demand for certain services, and technological changes. However, one of the greatest challenges is the lack of accurate documentation and reliable information systems, which makes it necessary to rely on anecdotal information most of the time.

At the beginning of the decade, the percentage of people admitted to hospitals in a year period was about 9% of the total population, in comparison with 15% in the US or Canada, and over 20% in France or Germany (Riosgo 1990). This could probably be explained by the more traditional structure of Spanish society, and the still strong role of the family as a care-taker of its sick members. Between 1972 and 1986 the hospital admission rates increased and the average length of stay decreased; however, in both cases the average was below that of the OECD countries.

Primary care services
The third-party payment system also applies to primary care services (PCS) provided in ambulatory settings. Unlike hospital care, however, these primary care services provided under the national health system are almost exclusively supplied in public facilities.

A unique characteristic of the way in which PCS have been organized since 1984 is that they have been increasingly based on full-time primary health care teams, including general practitioners, paediatricians, and nurses serving a defined geographical area. In these health care teams, the full-time physicians are paid a salary with a small capitation supplement. Other general practitioners work only a few hours per week and are paid on a capitation basis (Abel-Smith and Mossialos 1994).

There is no user charge for medical services, physiotherapy, transportation for medical emergencies, or basic dental care (i.e. only extractions are covered by INSALUD; there is no provision for payment of dentures or other dental treatment). Eye glasses or prostheses are reimbursed only in very special cases.

The number of consultations and visits per capita is lower than the OECD average, but recent survey data indicates that the reported average number of physician visits was 5.9 in 1991. Interestingly, the lowest rates of utilization correspond to the highest income group (3.7 visits a year on average), and the highest utilization rates to the lowest income group (9.1 visits), which is also the group that reports a higher number of health problems. As Blendon et al. note (1991), this distribution indicates that the Spanish NHS provides reasonable access to care for its low-income citizens.

Pharmaceuticals
Within the EU, Spain has the highest co-payment by users for drugs. Drugs administered while receiving inpatient care are included in the total expenses of the treatment and are free of charge to the patient. However, for most outpatient prescribed drugs the user pays 40% of the cost, and the remaining 60% is directly refunded to the pharmacist by INSALUD. Pensioners and the unemployed are exempted from co-payment.

The price of drugs is regulated by the Ministry of Health. Following the Ley del Medicamento a list of over 1600 pharmaceutical products were excluded from public co-payment and are only available on an out-of-pocket payment basis.

The consumption of pharmaceutical products increased considerably during the 1970s, surpassing by far the average of the OECD countries. One of the major sources of expenditures is drug consumption which is increasing under public financing.

Manpower
As previously described, the payment of physicians providing ambulatory services is made partly on a capitation basis and partly on a salary basis. Hospital doctors are almost exclusively paid in the form of salaries, with an incentive scheme that takes into account years of experience, and full-time dedication. Private medical treatment is payable by fee for service under private insurance schemes.

An important consideration in understanding the delivery of health services in any country is the make-up of its professional class, especially the composition of physicians. In addition to their role as providers of services, physicians have traditionally maintained a powerful position in determining health related legislation.

In the 1970s, Spain doubled its number of practising physicians. As displayed in Table 4, by 1993 the number of physicians per 10 000 inhabitants (40.8) was considerably above the average of OECD countries and represented more than twice the concentration in the United Kingdom (15.6).

While half of these professionals have at least two jobs, the number of unemployed physicians has remained very high over the last decade; 10% in 1983 and 20% in 1987 (Rodriguez and De Miguel 1990a). About 95% of active physicians work as full- or part-time employees of public or private health care organizations, and about 40% also have a private practice (CIS 1990). For 76% of these physicians their main job is a salaried one, and it is hospital based in 44% of the cases.

In 1985, the PSOE government passed a bill to prevent physicians from holding two full-time jobs (in the public and private sectors combined), or more than one job in the public sector. The implementation of the so called bill of ‘incompatibilities’ took place amidst a bitter battle between the government and the medical organizations, which considered it a
direct attack on their professional freedom. In addition, the government has tried to control the growing number of physicians by introducing barriers of entry into the admission requirements for medical schools.

The most important event that has affected medical manpower, however, is probably the Residency training system introduced in the mid-1960s. The Ministries of Health and Education have control over posts for postgraduate training all over the country, and graduates are required to fulfill between three and five years of Residency training (depending on the specialty chosen) in the assigned posts. Those who have the best qualifications in the country (based on an annual postgraduate examination and other merits) have priority in choosing the centre and the area of specialization for their Residency training.

The number of nurses has also doubled in the last two decades. Their training has been formalized at a university level, and the areas of specialization increased. However, nurses, and nurse aids, are still in demand. Although there is a high demand for nursing studies, there is a relatively high turnover among these professionals.

**Public health services**

Health education and prevention are also the responsibility of the public health care sector. However, the management and implementation of such activities has been already transferred to each Autonomous Community.

Public education campaigns are now planned by Autonomous Communities, and some of the most aggressive ones in recent years have included cessation of smoking, hypertension control, AIDS prevention, nutrition, and physical activity. It is difficult to evaluate the impact of these activities, but extensive coverage in the media has contributed to increase awareness. On the other hand, summary data indicate that trends in smoking rates tend to be maintained.

The number of required vaccines and the coverage provided to children has expanded within the last 15 years. Periodic physical exams are performed at schools, as a complement to the care received at the primary care centres, for children six years old and older. Other programmes, like family planning and attention to pregnant women, have also been established in recent years.

Health Technology Assessment agencies and institutions have been set up across the country to aid government and hospital decision-making on the introduction, adoption, and diffusion of new and established technologies.

**Accomplishments**

**Health status of the population**

During the last decades, Spain has been able to keep health care expenses at a moderate level in comparison with most Western countries, while the health level of the population has increased. The infant mortality was reduced by half between 1976 and 1986, and by 1994 was among the lowest of Western European countries, and lower than that of the United States. As shown in Table 2, in Spain, life expectancy at birth is also among the longest (81 years for women and 73 for men).

There is an increasing amount of evidence that relates health improvement to factors other than the provision of health care itself. For instance, per capita income and literacy shows a strong inverse correlation with infant mortality and other health indicators (Tresserras et al. 1992; Mcisaac and Wilkinson 1997; Pritchett and Summers 1996), and in Spain, both per capita income and education levels have increased considerably during the last two decades. It is also possible that the proliferation of public health programmes focusing on prenatal care had an impact on raising health education levels, which could contribute to low infant mortality.

A description of social factors and public health activities that could account for the increasing health levels of the population is outside the scope of this paper. Here we will, therefore, emphasize those accomplishments directly related to the health care system.

**Reduction of health inequalities**

The greatest accomplishment of the Spanish health care system has been its ‘universalization’ of coverage. Expanding health benefits to almost the entire population has helped to reduce health inequalities. Available data indicate that the groups at a higher risk of becoming ill (i.e. the lowest income groups) are in fact receiving medical care more often than higher income groups. These data, however, have been collected from individuals selected from the census, and we do not have information on the most marginal groups of the population, mainly illegal or recent immigrants.

Spain has been successful in providing its population with access to adequate levels of health care, while at the same time being able to control expenditures by containing the supply side, through a central regulation of funds. The mixed system of provision allows for a two-tier scheme where those who can afford to purchase additional private insurance coverage or pay for private physicians have the possibility of using the system more effectively, enjoying more amenities and shorter waiting periods for elective surgery when they use the private sector, and still using the public sector when necessary.

Not only has Spain been able to control expenditures while providing universal coverage, but it has been able to do so without imposing a co-payment for the use of services. Free access to care is not sufficient to assure access to those who need it most (e.g. low income and marginal groups, and people in rural areas with scarcity of services available), however, it is a necessary condition to lessening the gap between different socioeconomic groups in regard to access to care and health improvement. Analyzing the potential use of co-payment as a measure to control cost at the demand side while maintaining access to needed care, Mechanic has noted that the RAND Health Insurance Experiment in the US found that cost sharing did not result in appropriate decisions.
about when to seek care. The probability of missing at least one episode of highly effective care for poor children was 56% of the free care level, while the comparable figure for non-poor children was 85% (Mechanic 1986).

These variations may reflect differences in willingness to make health investments in children (Grossman 1972), levels of knowledge and understanding, and differences in the capacity to cope with crisis. Cost sharing by the patients may reduce utilization of services, and increase socio-sanitary inequalities. In addition, if conditions amenable to medical care are not treated at an early stage, the ultimate cost of future disability may be higher than the savings.

**Organization and management to increase efficiency**

Spain has tried different approaches to increase the efficiency of available resources through better organization and management. Over the last two decades the government has confronted great difficulties in transforming the over-bureaucratic structure upon which the health system was built, but has succeeded in making limited reforms.

Although it is still too early to assess its impact, the decentralization of services looks very promising for those Autonomous Communities with capable leaders and a desire to prove that they can do a better job in organizing health care than the central administration. It is questionable, however, whether regions without an infrastructure of well-trained personnel and a strong commitment to the plan will benefit from decentralization, and a delay of its implementation in those regions not ready to play an active role may be appropriate. In addition, to avoid duplication of bureaucratic entities, the central administration should be willing to eliminate the administrative services that became redundant once the transfer of administration to the regional local entities is accomplished.

A significant change included in the new health systems is the introduction of freedom of choice in the selection of health care providers on the part of patients. The patient’s privilege to choose physicians and hospitals has been limited so far, but as social mobility and standards of living increase, there is a greater demand for choice.

**Unintended functions of the health care system**

During the last two decades, although the overall economic standards of the country have increased, a large portion of the population has been adversely affected by periods of economic instability and high unemployment. Unemployment was the highest recorded in the OECD countries through the 1980s, and it was 22.7% of the active population in 1996 (34). Job losses and economic instability have been extensively reported as causing symptoms of psychological disorders and physiological distress (Catalano 1991; Rodriguez et al. 1997) and recent studies confirm these findings for the Spanish population (Rodriguez 1994; Del Llano 1990).

There are reasons to believe that the Spanish health care system plays an important psychotherapeutic role. It has been noted that this is more obvious in outpatient clinics or ambulatories where physicians complain that 75% of those who seek care are not ill (De Miguel 1986). It seems that people distressed by personal and/or socioeconomic circumstances are using primary care centres for relief of symptoms that, while not related to medically defined illnesses, are equally disabling to the optimal functioning of the individual.

Even if it has not been done in the most adequate way, the health care sector has to be given credit for its function as a reintegrative mechanism in times of cultural, economic, and political transition, when the number of displaced, unsatisfied, lonely, threatened, and in summary, vulnerable people increases. Failing to provide humanitarian relief may make the transitions experienced by newly industrialized countries even more painful for people adversely affected by them. Better planning could, however, offer more appropriate care at a lower cost. Social workers, nurse practitioners, and psychologists could complement and substitute physicians work when appropriate.

**Challenges**

One of the biggest challenges of the present NHS is to address the structural distribution of resources caused by a lack of health care planning up until the 1980s. Spain lags behind most industrialized countries in the number of available per capita hospital beds, but at the same time the inpatient occupancy rate (76.4%) is lower than that of most OECD countries. This indicates that problems related to long waiting periods in cases of elective or non-emergency surgery could be ameliorated through a more efficient use of resources available including major ambulatory surgery. Of significant importance to address this issue is the need to collect adequate data to monitor the current state of affairs, as well as to monitor and evaluate future changes. Information and data collection systems are still behind European standards.

The importance of diverting resources from hospitals to primary care services has been acknowledged, but basic infrastructure or alternative provision of care is still needed in some regions of the country.

The demand for health care increases faster than the system’s capacity to respond. The cost of health care is increasing above the level of inflation, which has resulted in a higher deficit. The reasons for that increase include the universalization of health care, the adoption of new and expensive technologies by public hospitals, the investment in decentralization and in correcting structural inequalities, the demand for new and costly drugs, and the impact of an ageing population.

The main challenge is how to finance the increasing demand for health care. Proposed initiatives such as co-payments for health care services are not well received by the population, and therefore are difficult to implement. It is expected that the development of an information system, and better health care management of the system could help in reducing inefficiency, and thereby improve the distribution of resources.
Another area of concern is changing population patterns. With a decrease of birth rates, and an ageing population, the need for long-term care of chronic diseases will increase in the coming years. Spain lacks adequate facilities and coordination of home-care services for patients requiring long-term care. In addition, hospital data shows that a very low number of deaths occur in hospitals, which indicates a tendency to transfer terminal patients to their homes. Spanish society has relied on women fulfilling the role of care givers. The incorporation of women into the labour force, and the changes in the traditional family structure towards a nuclear family model, may aggravate the situation – common to most Western countries – caused by ageing. An emphasis on providing services, including institutional and home care, to deal with disabling chronic and degenerative diseases has become a priority as the turn of the century approaches.

Primary care was traditionally based on ambulatory care without an integral approach to population care. In the last years primary health care reform has been replacing the traditional gatekeeper model with a more comprehensive model of population care, including better training of primary care doctors though a specific and competitive training programme. In addition, some of the acute care hospital beds have been replaced by long-term care beds, which cost less and are more suitable to attend the needs of an ageing population.

The surplus of physician manpower is another example of lack of planning. Although unemployment among physicians is high, some of the poorest regions of the country are under-served and have a very low concentration of doctors. It is clear that incentives could continue to improve to correct this structural anomaly.

In summary, Spain is confronted with the dilemma of maintaining health care coverage to the whole population, expanding primary care services, providing support systems for long-term care, and building adequate medical facilities in under-served regions of the country, while trying at the same time to control and limit the growth of health care costs. An additional challenge to the health system is to implement the desired decentralization of services without affecting the existing coverage, maintaining the current health levels of the population, and better targeting the needs of the population.

Summary of lessons
The means used by Spain to accomplish its objectives have been:

1. Overall centralized planning with progressive delegation of functions to local governments, and decentralized implementation. Each of the 17 Autononomous Communities into which the country is divided will ultimately be responsible for the delivery of its own health services.
2. Control of cost at the supply side through a centralized economic fund financed largely through taxes. Physicians and other hospital care providers are paid on a salary basis, and physicians providing ambulatory care are reimbursed by a combination of capitation and salary. The price of drugs is regulated by a cost-plus method by INSALUD, and patients contribute a co-payment only for outpatient drugs.
3. The country has maintained its traditional mixed system of provision (70% public and 30% private) while providing health coverage for the whole population. It has implemented gradual changes by reaching consensus among different interest groups.
4. In conclusion, in Spain there is a general consensus that health care is a right and not a privilege, and all political parties have come to agree. The process by which a national health care system has been implemented has not been free of social and political conflict. Such conflict, and its resolution by democratic means, may be a constructive and necessary element in planning a national health system. There is no such thing as a perfect health care system, and each country has to continuously adapt to the needs and economic constraints of its changing population. The Spanish case proves, however, that even with limited resources it is possible to provide universal access to adequate health care to improve the health of the population.

Endnotes
2. The Spanish Constitution of 1978 and the regions ‘statutes of Autonomy’ set the grounds of a new organization of the State in 17 Autonomous Communities (regions), and were the landmarks for the beginning of an agreed and slow process of decentralization of important areas of public management among which we find Health Care.

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