Introduction

Government and recent political history

Spain is a parliamentary monarchy. The 1978 Constitution followed a long period of dictatorship, after which the country underwent a major transformation of the State and its political structure. Territorially, the political organization of the Spanish State is made up of a central state and 17 highly decentralized regions (Comunidades Autónomas, autonomous communities) with their respective governments and parliaments. Every four years each autonomous community elects a regional parliament, which in turn elects the president by majority. There are 50 provinces and almost 8000 municipalities in Spain. Spanish territory includes Ceuta and Melilla, two cities in the north of Africa with autonomous status.

Population

Spain, with a population of 44,108,530 people (1 January 2005), covers 505,955 km² and has the third largest surface area in western Europe. The fertility rate is one of the lowest in the European Union (EU) (1.23 children per woman in 2003), which suggests that there will be an ageing population in future.

Average life expectancy

The life expectancy in Spain is one of the highest in Europe: 83.15 years for women and 76.42 years for men in 2003. Life expectancy for women was the highest in the EU in 2003. In Spain, disability-adjusted life expectancy in 2002 was 69.9 years for women and 75.3 years for men (European Health for All database, January 2005).

Leading causes of death

Diseases of the circulatory system accounted for almost one third of all deaths in 2003. The second largest and increasing cause of death during the last three decades has been malignant neoplasms. Mortality from cancer of the trachea/bronchus/
lung has doubled since 1970, and mortality owing to mental disorders and disorders of the nervous system has also been increasing since the 1970s. In 2003, 5399 people died and more than 26 000 were seriously injured as a result of traffic accidents. AIDS and HIV are considered important health issues: the incidence of AIDS per 100 000 people in Spain in 2003 was 3.32, while the EU average was 1.42 (European Health for All database, 2006).

Recent history of the health care system
The basis for the current organizational structure of the Spanish health system was formed during the transition to democracy. Central government has the responsibility for promoting coordination and cooperation in the health sector. Until 2001, the central government had only devolved responsibility for the health care network to seven regions. The National Institute of Health (INSALUD) managed most health care services in the other 10 regions.

Reform trends
The focus of policy-making in the late 1970s and early 1980s was on improvement of primary health care (PHC) and specialized ambulatory care. From 1986, the transition to a national health system (NHS) involved a reform of financing, which has transformed the former insurance-oriented system into a system financed by taxes, with almost universal coverage for all citizens. The decentralization reform was completed in 2002 and resulted in governance of the system being decentralized to all 17 autonomous communities.

Health expenditure and gross domestic product
In 2003, Spanish health care expenditure was 7.4% of gross domestic product (GDP), a figure lower than in France and Germany, and higher than in Italy and Portugal (Fig. 1). The same year health care expenditure in US$ purchasing power parity (PPP) per capita was US$ 1771. During the last two decades health care expenditure has increased (5.4% of GDP in 1980), while public expenditure decreased from almost 80% of total expenditure in 1980 to 72% in 2004.

Overview
Organizational structure of the health care system
The 1986 General Health Care Act outlines the main principles of the Spanish NHS. This system, created from the social security health services, provides universal coverage with free access to health care, is publicly funded – mainly through taxation – and has a regional organizational structure.

At central level the Spanish Ministry of Health and Consumer Affairs assumes responsibility for certain strategic areas, including general coordination and basic health legislation; definition of a benefits package guaranteed by the NHS; international health; pharmaceutical policy; and undergraduate and postgraduate education. The 17 autonomous communities hold health planning powers as well as the capacity to organize their own health services in their regions. The Interterritorial Council of the NHS, composed of representatives of the autonomous communities and the State, promotes the cohesion of the system.

Planning, regulation and management
Health policy-making power in Spain lies at regional level, with health authorities and regional health governments playing a central key role. The Ministry of Health and Consumer Affairs maintains responsibility for several health policy issues, including coordination and education. Ten of the seventeen regional health ministries have planning offices. “Health Plans” developed by the Ministry of Health and Consumer Affairs and the autonomous communities are the principal instruments for achieving health goals.
Decentralization

Different health care powers have been transferred to regions at different stages of decentralization. The health care networks that existed before the social security system was put in place were decentralized to all regions during the period 1978–1986. During the period 1981–1994 the social security network of health care centres was transferred to seven regions. In January 2002, decentralization of powers to the other 10 regions took place, which ended the process of asymmetric decentralization in Spain. Power sharing remains the pivotal issue in Spain, partly owing to unresolved political disagreements over the territorial structure of the State.

The autonomous communities usually have their health competencies separated between a health authority and a health service management body. All autonomous communities have drawn up a health map stipulating territorial subdivisions (health areas and zones). Health areas and basic health zones are structural elements of the Spanish health care system. Each health area, responsible for the management of facilities, benefits and health service programmes within its geographical limits, should cover a population of no fewer than 200 000 and no more than 250 000 inhabitants. Health areas provide primary and specialist health care services. Basic health zones are the smallest units of the organizational structure of health care. They are usually organized around a single 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.

Health care financing and expenditure

Main sources of financing

Currently almost all public health care expenditure (excluding civil servants’ mutual funds) is funded through general taxation, which replaced the social health insurance model. The new model of financing was adopted in 2001 and is intended to guarantee financial sustainability. The two main resources of the autonomous communities are taxes and assignments from central government. Civil servants’ mutual funds are financed approximately 70% by the State and 30% through contributions from civil servants to their own funds.

Complementary sources of financing

Private health care financing consists of three complementary sources of finance: out-of-pocket payments to the public system, out-of-pocket payments to the private sector and voluntary health insurance (VHI). Private household out-of-pocket expenditure became significant (23.7%) in 2003. Officially, in the Spanish public health care system there is no cost sharing, except for pharmaceuticals and in most prosthesis cases. The method of cost sharing that is applied is direct co-payments with mechanisms to protect vulnerable groups of people. VHI is, in essence, supplementary, and is not widespread in Spain. In 2001, 5.48 million inhabitants had private health insurance.

Health care benefits and rationing

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

Health care expenditure

Public health expenditure in Spain in 2004 was approximately 71%, which was lower than the average for the countries belonging to the EU before May 2004. Pharmaceutical expenditure has been the main cost increase factor in Spain in recent years. In 2004 the growth of pharmaceutical expenditure was 6.26% and made up 20.56% of total public health expenditure. In 2003 the growth of pharmaceutical expenditure was 12.84% and made up 22.4% of public health expenditure.

Health care delivery system

Primary health care
Since 1984, the PHC sector has experienced an extensive process of institutional reform and capacity building. Primary health care is an integrated system composed of PHC centres and multidisciplinary teams and provides personal and public health services (single-handed practices are restricted to small towns and to the private sector). PHC in Spain is predominantly publicly funded and run. General practitioners (GPs) have a gatekeeper role and are the first point of contact between the population and the health system. In 2001, there were 50 GPs per 100 000 people in Spain, one of the lowest figures in the EU. In comparative terms, GPs in Spain tend to bear a higher workload than those in neighbouring countries. There has been no comprehensive evaluation of the impact of PHC reform in Spain.

PHC reform has not been a political priority despite the objectives outlined in the 1986 General Health Care Act and the rhetoric of primary care-led reform. One of the indicators that PHC is not functioning well is the constantly increasing number of patients who enter the system directly through the emergency departments of hospitals. In 2004 only 21.5% of emergency hospital
admissions were as a result of professional referral. Reasons given for avoiding PHC include amongst others: patients’ perceptions that they will receive better care at a hospital due to better treatment and diagnostic services in terms of technology; referral systems, from specialists to PHC doctors, that do not always function well; and traditional attitudes.

Public health services
The Ministry of Health is in charge of guaranteeing unified information and infrastructure development, as well as consensual policy design and evaluation in the field of public health. Public health responsibilities, however, have been passed over to a large extent both from the State and from local governments to the autonomous communities. Overall, substantial improvements in public health have been achieved, even if there is sometimes a lack of integration due to organizational fragmentation.

The approach to public health services is their link to primary health care. The integration of all public health responsibilities into a single level of government has led to the coordination and management of epidemiological surveillance at regional level. The bulk of preventive medicine and health promotion is integrated with PHC and carried out by GPs and practice nurses as part of their normal workload.

The National Epidemiological Surveillance Network was created in 1996. Responsibility for AIDS is shared between the central government and the autonomous communities. Drug addiction is a significant social problem in Spain, which is intended to be tackled by the anti-drug plan under the responsibility of the Ministry of Health and Consumer Affairs.

Secondary and tertiary care
Specialized care is the central element of the Spanish health care system. The model of provision of specialized care varies across the autonomous communities. Most hospitals are publicly owned and the majority of staff are salaried employees.

The main problems of the sector are coordination with PHC centres, duplication of clinical records and diagnoses, delays in treatment, and waiting times. In addition, there are a high number of emergency hospital admissions. Nevertheless, hospital care in Spain is assessed as being satisfactory by users.

Long-term and social care
Social care services are the responsibility of the regions, while home care services are managed at local municipal level. Long-term care services in Spain are underdeveloped. One of the major challenges in this area is the lack of coordination. Efforts to improve integration of health and social services in long-term care provision at central level include agreements between the Ministry of Health and the Ministry of Labour and a

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<th>Beds per 1000 inhabitants</th>
<th>Admissions per 100 inhabitants</th>
<th>Average length of stay in days</th>
<th>Occupancy rate (%)</th>
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<tbody>
<tr>
<td>France</td>
<td>3.8*</td>
<td>16.6*</td>
<td>6.1*</td>
<td>84.0*</td>
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<td>Germany</td>
<td>6.4</td>
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<td>8.7</td>
<td>75.5</td>
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<td>8.2*</td>
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<tr>
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<td>11.7*</td>
<td>7.0*</td>
<td>78.2*</td>
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<tr>
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<td>EU average</td>
<td>4.2</td>
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Source: European Health for All database, June 2006.
Notes: * 2003; † 2002; ‡ 2001; † 2000; † 1999; ‡ 1998; † 1997; ‡ 1996.
commission set up by the Interterritorial Council of the NHS. In December 2000, a National Plan, establishing the principles and strategies for palliative care, was approved. Mental health in Spain had not received adequate attention for a long time, despite the increasing demand, until during the last decade when a legal base for mental health care provision was established. The autonomous communities present diverse pictures in terms of resources, services and policies for mental health care.

**Human resources and training**

In 2002, there were 4.6 qualified doctors per 1000 inhabitants in Spain. Of these, 40% were women, an increase of 8% since 2001. In comparison with other countries, the number of physicians is the second highest after Italy. In contrast, Spain displays the fourth lowest number of nurses per 1000 people, after Greece, Italy and Portugal. The national average of the distribution of the workforce between PHC and specialized care is 21% to 79%, respectively.

Most medical staff working in the NHS have a status similar to that of civil servants. Planning of human resources in health care has some deficiencies owing to human resource policies being oriented towards short-term issues.

**Pharmaceuticals**

Pharmaceutical expenditure seems to be the main cost increase factor in Spain in recent years. Publicly funded drugs expenditure in 2003 showed an annual increase of almost 13% compared with 2002. The growth rate of pharmaceutical expenditure outside hospitals in the period 1992–2002 surpassed the GDP and health care expenditure growth rates.

The pharmaceuticals department of the Ministry of Health is in charge of determining which pharmaceuticals should be co-financed by the state budget. Since 1999 the Pharmaceuticals Agency has been in charge of evaluating the clinical effectiveness of new brands and authorizing their commercial registry.

**Financial resource allocation**

**Payment of health care facilities**

Traditionally, hospital expenditure was retrospectively reimbursed with no prior negotiations with the third-party payer (INSALUD or regional health services). Prospective financing of targeted activities (contract programmes) was introduced in the early 1990s.

Hospitals in the NHS are funded through a global budget, set against individual spending headings. From 1991, aggregate measures of activity were defined which enabled comparisons between hospitals, differentiated among four hospital production levels.

**Payment of health care professionals**

GPs receive a salary plus a capitation component, which amounts to approximately 15% of the total. GPs working under the single practice model are paid by capitation. Private physicians are paid on a fee-for-service basis. All specialists working at hospitals and in ambulatory settings are salaried. The basic salary for public sector physicians is regulated by the national government, although regions have the capacity to vary some components, which leads to considerable variations in salaries among the autonomous communities.

**Health care reforms**

Since 1986, the public health system has undergone considerable development. The focus of reforms in the 1980s was on rationalization of the system and cost-containment, while in the 1990s efforts were put on managerial issues, the internal market and competition. During 2001–2003, the importance of governance and clinical management, was highlighted, among other issues.
Health system coverage in Spain has expanded from 81.7% of the population in 1978 to 99.5% in 2005 and includes those with a low income, and immigrant adults and children. The basic benefits package of services for the whole health system is set out in the Cohesion and Quality Act adopted in 2003, following previous legislative instruments in this field. In 1989 the financing of health shifted to general taxation, supplemented by insurance contributions through the allotted social security budget, and health care is currently financed predominantly by taxes. The new financing system, which was adopted in 2001, aims to guarantee the financial sustainability of the system.

Decentralization of the Spanish NHS was accomplished in 2002 after almost 20 years of reforms and this resulted in the 17 autonomous communities being responsible for provision and financing of health care in their territories. All regions have established a regional organization of the health care system through the integration of all public health services and centres.

Primary health care reform was initiated in 1984 and important achievements have been made, including the set-up of a network of PHC centres throughout the country. Nevertheless, this sector has not received adequate political attention, which has resulted in the relatively weak role of PHC in Spain.

Spain illustrates an interesting experience of innovative hospital management (foundations) since 1997, when relevant legislation was adopted. Public hospitals with foundation status are self-governing units with less external bureaucratic control and emphasis on outcomes. Purchasing reform was formally introduced in both central and regional legislation during the 1990s. However, complete separation between these functions has not been achieved. Waiting lists and waiting times remain significant policy concerns and are major causes of user dissatisfaction, despite some efforts to tackle these issues.

A number of important health reforms have taken place in Spain. However, systematic evaluation of their impact upon health outcomes is lacking. For future evidence-based policy-making it is therefore important to carry out a systematic evaluation of health reforms in Spain.

Conclusions

The Spanish NHS has been undergoing constant reform since 1986, including reforms focusing on universal coverage, primary health care, financing and management, public health and research. Health indicators of the population show continuous improvement during the last three decades, which is attributable not only to improvements in the health system but also to general changes in Spanish society.

Despite significant achievements, a number of challenges in the Spanish NHS need to be addressed in the near future, such as cost-containment, further strengthening of PHC and reform of long-term and social care services. Challenges in the context of the decentralized health system include reform of the regional financing system, completing the establishment of a national information system, reducing regional inequalities in health and improving coordination mechanisms between central and regional levels.
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