17

From Assistencialism to Universal Care: The Spanish National Health System

Rafael Muñoz De Bustillo and José-Ignacio Antón

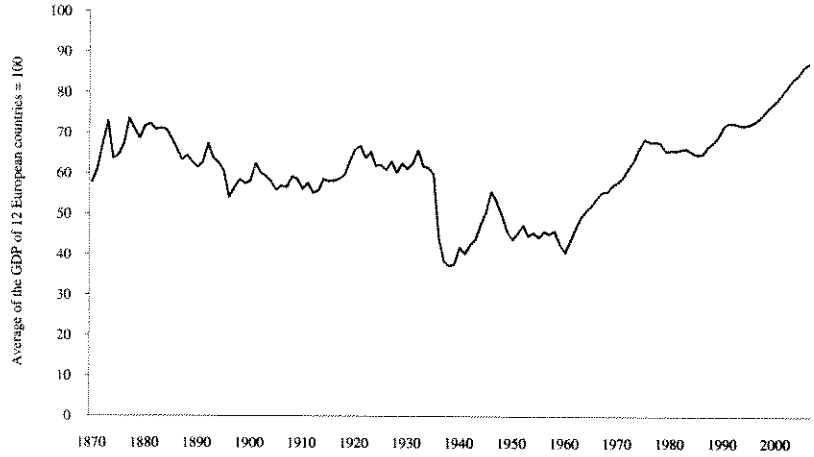
1. Introduction

It is widely accepted that the National Health System (NHS) is the jewel in the crown of the Spanish Welfare State. This statement arises from the large comprehensiveness and coverage of public health care insurance compared to other ties of the welfare system, like, for instance, social assistance or child care. Whereas the Spanish Welfare State as a whole looks underdeveloped when compared to their counterparts in other OECD countries, the NHS, as it is argued in this chapter, stands comparison with other European health systems. In order to understand the peculiarities of the Spanish NHS, it is important to keep in mind that Spain has always been a relatively less developed country, in terms of per capita GDP, with respect to most European countries. As shown in Figure 17.1, the already lower degree of economic development of Spain in the 19th Century–60 percent of the average of twelve European countries–suffered from an important drawback originated by the Spanish Civil War (1936-1939) and the subsequent dark decade of 1940, known as the *famine years*. The triumph of the rebels, leaded by General Franco, follower of a local variant of fascism, the so-called *falangismo*, drives the country to the pursuit of what proved to be a self-defeating strategy of self-sufficiency and to the subsequent sinking of the national economy. The beginning of the Cold War in the 1950 produced a change in the international status of Spain, which suddenly turned from a pariah to a loyal ally thanks to the fierce anticommunist position of Franco's regime, culminating in the slow insertion of Spain in the world economy and the main international organisations (the United Nations or the GATT, for example).

For Spain, as for most of the world, the 1960s were a time of fast economic growth. It is in that decade that Spain witnessed some timid steps in the direction of creating a national health service. In 1967 the government passed a law granting workers, pensioners and their families (under certain requisites) the right of access to public health services. However, as shown in Figure 17.2, the resources devote to public health, barely 2 percent of GDP, were clearly insufficient to meet the needs of the population. [1] With the death of the dictator in 1975, and the promulgation of a new democratic constitution three years later recognising citizens' right to health care irrespective of their economics circumstances, the process of building and funding the NHS stepped up, leading to a universal national health service covering all major health risks. In some areas, the NHS

has gained a deserved world reputation; for example, that is the case of the very well internationally considered integrated transplant program, which is partly the responsible of the world-leading position of Spain in this area. [2]

Figure 17.1: Per capita GDP of Spain Compared to the Average of other 12 European Countries, 1870-2006



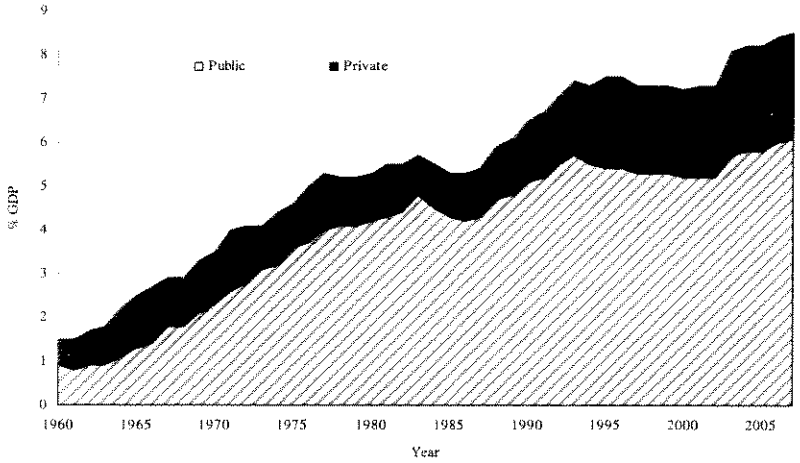
Note: European countries include the UK, Austria, Norway, Sweden, Italy, France, the Netherlands, Belgium, Switzerland, Denmark and Finland.
Source: Authors' analysis from Angus Maddison's *Historical Statistics of the World Economy* (available at http://www.ggdc.net/Maddison).

In the early 1990s public expenditure reached 6 percent of GDP. This percentage has remained roughly constant since them; therefore the increase in public health expenditure in the last decade has been largely associated with the growth of the size of the Spanish economy and not to a reallocation of production to favour the delivery of public health services.

Although not necessarily fully explained by the change in trend of public health expenditure as percentage of GDP, the observer will notice how in Figure 17.2 the increase in private health expenditure in relation to public health expenditure is related to the change in trend of the latter in 1983-1986 and later in 1993, as if citizens were compensating the lack of increase in relative public expenditure in health with their own increase in private expenditure. This could be dangerous for the future survival of the NHS as it might undermine the loyalty of the taxpayer to the public health service. Nevertheless, the rate of recourse to private health care has stabilised since 1995 around

28 percent (of total health expenditure). In any case, the available information points to the existence of a very high public support of the role of the public sector in the supply of health. According to data from the International Social Survey Programme, in 1996, 81 percent of Spaniards considered that giving medical assistance for those in need "definitely should be" responsibility of the government, compared to an average of 54.5 for 11 high income countries. [3]

Figure 17.2: The Historical Evolution of Health Care Expenditure in Spain (1960-2007)



Source: Authors' analysis from OECD Health Data, 2009.

In order to review the characteristics, strengths, shortcomings and challenges of the Spanish NHS the following section places Spanish public health expenditure and health outcomes in the context of the advance economies. The third section of the paper deals with the coverage, benefits and organisation of the NHS, while section four is devoted to the major future challenges faced by the health care in Spain. Some of them, such as the process of ageing of the population are shared by many countries; others, like the increase in demand of health services due to the high immigration flows experienced by Spain in the last decade or the possible consequences of the decentralization of the health system, are largely country specific issues. Finally, in section five, we summarise the main conclusions of the chapter.

2. The Spanish Health Care System from a Comparative Perspective: Resources and Outcomes

Though Spanish total and public health expenditure are more or less in line with the European Union (EU) simple average (Table 17.1), it is possible to highlight some differences in the composition of such social spending. Particularly, the participation of the public sector in health spending is lower on average than in the EU: while public health expenditure accounts for 6 percent of the GDP, a figure below the 6.7 percent in the EU, private expenditure exceeds the EU average 2.4 versus 2.1 percent in the EU. To the extend that, as we will see, public health is a universal service in Spain, the existence of a higher than average expenditure in private health could be interpreted in terms of the exercise of the option of partial "exit" of citizens, that resort to the private system to avoid some of the shortcomings of the public health system. In fact, when Spain is compared to the "old EU members" -that is, countries like France, Germany or Belgium-, both total and public Spanish health spending look remarkably lower than in those states.

As it is well-known, the efforts of both the EU countries and Spain in terms of health expenditure dwarfs when they are confronted with the USA (with a total health spending of 15.8 percent of the GDP). Interestingly, Spain and the USA are roughly in line when we look at public health expenditure, but whereas such resources allows a virtually universal coverage (in terms of both people and medical treatments) in Spain, in the American case they only allow for the provision of health care to people in welfare (Medicaid) and 65 and over (Medicare).

It is well known that social expenditure in general and health expenditure in particular, grows more than proportionally with the level of income (Muñoz de Bustillo, 2007). In this respect, it is interesting to find out whether the lower than average public health expenditure of the Spanish NHS can be explained by its lower GDP per capita. Figure 17.3 responds to such query showing the relation between GDP per capita (independent variable) and public health expenditure for a sample of 30 OECD countries. According to the figure, the lower public health care expenditure is not fully explained by the lower economic development of the country, although the difference with the statistically expected expenditure (mark by the fitted line) is small.

A different and complementary perspective for evaluating a health care system is to focus on health outcomes. After all, health expenditure is not an aim in itself, but an answer to medical conditions. In other words, if successful, health expenditure should show in the improvement of the health status of citizens. In Table 17.2 we present a collection of different indicators of mortality and morbidity for Spain, the EU 15 (excluding Spain), the European Union plus Norway and Switzerland and the United States. With the exception of a few indicators (such as incidence of tuberculosis) all the figures show a comparatively very good output in terms of health in Spain, similar, if not better, than in their wealthier European neighbours-EU 15-and much better than in the USA. Obviously, it is very difficult to disentangle the influence of the health care system on health outcomes, since-as it is well-known- health status depends on many variables

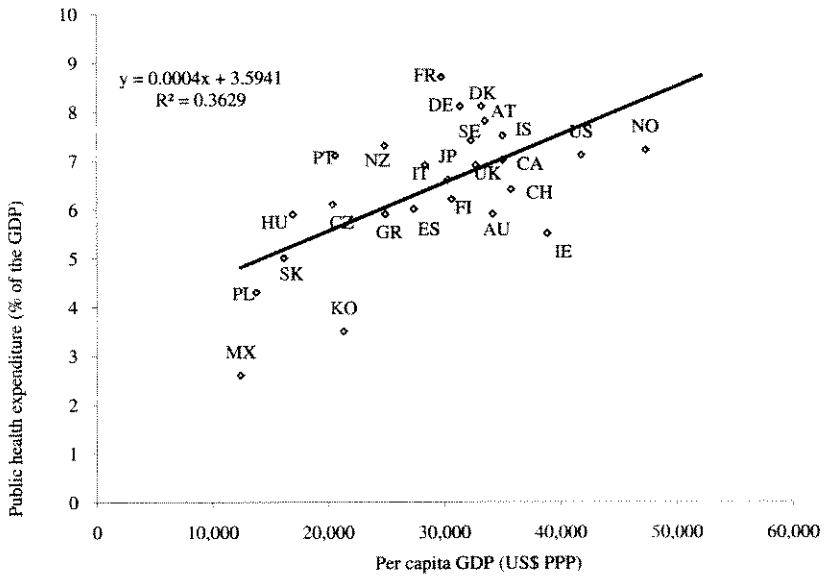
outside the health system (Crepaz and Crepaz, 2004; Shaw, Horrace and Vogel, 2005; Cutler, Deaton and Lleras-Muney, 2006; OECD, 2009). Nevertheless, even though the Spanish NHS cannot be credited by itself for this positive outcome, the figures presented in Table 17.2 suggest a positive contribution of the Spanish Health System to the achievement of reasonably good health outcomes. This is particularly remarkable considering the lower resources, from both a comparative and absolute point of view, allocated to health care in Spain.

Table 17.1: Patterns of Health Expenditure in Spain Compared to other OECD Countries

	Total expenditure on health in 2006 (percent GDP)	Public expenditure on health in 2006 (percent GDP)	Private expenditure on health in 2006 (percent GDP)	Public health expenditure as percent of total social expenditure in 2005	Public health expenditure as percent of total public expenditure in 2005
Austria	10.2	7.8	2.5	21.1	13.6
Belgium	10.0	---	---	22.7	14.0
Czech Republic	6.9	6.1	0.8	26.8	14.0
Denmark	9.6	8.1	1.5	17.2	11.0
Finland	8.3	6.2	2.1	19.4	12.3
France	11.0	8.7	2.3	22.5	14.6
Germany	10.5	8.1	2.4	24.6	16.2
Greece	9.5	5.9	3.6	22.9	12.9
Hungary	8.1	5.9	2.2	21.7	12.0
Iceland	9.1	7.5	1.6	26.1	14.9
Ireland	7.1	5.5	1.6	30.5	19.0
Italy	9.0	6.9	2.1	23.3	14.1
Netherlands	9.7	---	---	23.2	13.2
Poland	6.2	4.3	1.9	16.3	9.9
Portugal	9.9	7.1	2.8	25.4	15.1
Slovak Republic	7.3	5.0	2.3	25.6	13.6
Spain	8.4	6.0	2.4	22.9	15.1
Sweden	9.1	7.4	1.7	18.8	12.1
United Kingdom	8.5	6.9	1.5	26.7	15.9
European Union	8.9	6.7	2.1	23.0	13.9
Norway	8.6	7.2	1.4	20.9	13.5
Switzerland	10.8	6.4	4.4	23.2	17.0
Canada	10.0	7.0	3.0	32.3	17.3
United States	15.8	7.1	8.7	33.3	18.9
Australia	8.7	5.9	2.8	27.1	16.8
New Zealand	9.4	7.3	2.1	29.1	17.9
Korea	6.5	3.5	2.9	27.9	10.7
Japan	8.1	6.6	1.5	28.8	16.4

Source: Authors' Analysis from OECD Health Data, 2009.

Figure 17.3: Public Health Expenditure as Percent of the GDP Per Capita and Per Capita GDP (2005)



Source: Authors' Analysis from OECD Health Data, 2009.

3. Coverage, Benefits and Organization

The present configuration of the Spanish health care system is the outcome of a long series of transformations mainly concentrated in the last quarter of the twentieth century. The assistencialist vision dominating national public health care until the 1960s progressively made way to a more comprehensive system that started to incorporate middle classes and professionals during the 70s and decidedly walked towards universality after the end of the dictatorship. Since then, the Spanish public health care, based on social insurance principles, progressively moved towards a national and universal health care system, which *de facto* became in rule with the 1986 Health Care General Law. This law, which settled down the basic structure of the current scheme, instituted the National Health System (NHS), consisting in a unique scheme of health services financed by payroll taxes and general tax revenue. The NHS provided access to everybody with any link to Social Security (salaried workers, pensioners, etc.) and their dependants (partner and children) and to low-income individuals. Self-employed could choose whether to join or not the NHS. A few groups--the Armed Forces and Civil

Servants- had the possibility of choosing between using the NHS or a range of private insurances funded by the public sector, an advantage that continues until today. In 2006, coverage was practically universal (Figure 17.4): more than 8 out of 10 citizens received health treatment in the NHS (and 3 percent of population enjoyed publicly financed private health care) while an additional 13 percent have both public and private coverage. Only 1.5 percent of people relied exclusively on private insurance.

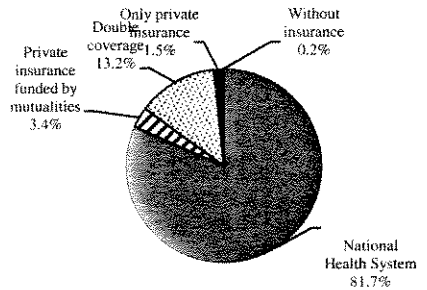
Table17.2: Mortality and Morbidity Indicators in Spain, the European Union and the United States

		Spain	European Union 15	European Union	USA
Adult mortality rate (people dying from 15 to 60 years per 1,000 inhabitants)	1990	103	110	132	132
	2000	86	93	116	114
	2006	75	80	104	109
	Female 2006	44	55	65	80
	Male 2006	105	105	143	137
Age-standardized mortality rate from the several causes (per 100,000, 2002)	Cancer	131	139	143	134
	cardiovascular diseases	137	188	259	188
	Injuries	31	37	50	47
	non-communicable diseases	395	431	503	460
	diarrhoeal diseases	0.1	0	1	0.1
	HIV/AIDS	0	0	0	0.1
Deaths among children under five years of age from the following causes (2000, percent)	diarrhoea diseases	0.1	0	0	0.1
	HIV/AIDS	0	0	0	0.1
	injuries	6.5	7	8	10.3
	neonatal causes	52.4	58	56	56.9
	other causes	39.6	34	33	31.3
	pneumonia	1.3	1	3	1.3
Healthy life expectancy at birth (years, 2003)	Total	73	71	69	69
	Female	75	73	72	71
	Male	70	69	67	67
Incidence of tuberculosis (per	1990	56	26	28	9

100,000 inhabitants)	2006	30	12	21	4
Infant mortality rate (per 1,000 live births)	1990	7	8	10	10
	2006	4	4	5	7
Life expectancy at birth	1990	77	75	74	75
	2006	81	80	78	78
	Female	84	82	81	80
	Male	78	77	75	75
Maternal mortality ratio (per 100 000 live births, 2005)		4	6	8	11
Neonatal mortality rate (per 1 000 live births, 2004)		2	3	3	4
Under-5 mortality rate x 1000 live births)	1990	9	10	12	11
	2000	6	6	8	9
	2006	4	4	6	8

Source: Authors' Analysis from the World Health Organization database.

Figure 17.4: Health Care Coverage in Spain (2006)



Source: Authors' Analysis from the Spanish National Health Survey, 2006.

Since 1986, the basic structure of public health care has remained largely unchanged, as can be easily assessed looking at Table 17.3, which presents the main characteristics of Spanish National Health System nowadays. The principle of universality has been enlarged and reinforced; currently, even illegal immigrants are entitled to public health care. Whereas, as a national health system, the Spanish NHS largely involves public production of health services, the last decade has witnessed a considerable increase in the importance of publicly financed but privately produced health care, through different forms of managed care. The relevance of these new forms of health care varies widely across regions. Regarding benefits, the NHS covers a wide set of health care treatments and only dental care is affected by important restrictions. In contrast to most OECD

countries, the Spanish NHS is free at the point of use, with copayments only limited to prosthesis, spectacles, hearing aids and drugs.

Table 17.3: Main Characteristics of the Spanish National Health System

Main Features	
Applicable statutory basis	Social Security General Act (Ley General de la Seguridad Social) approved by Legislative Royal Decree No. 1/94 of 20th June 1994. Law No. 14/86 of 25th April 1986, Health General Act (Ley General de Sanidad) amended. Decree No. 2766/67 of 16th November 1967. Royal Decree No. 1088/89 of 8th September 1989.
Basic principles	Tax-financed public health service (asistencia sanitaria).
Beneficiaries	Employees and persons assimilated thereto; pensioners and persons in receipt of regular cash benefits; all residents with insufficient means of existence. Only some high-income self-employed might opt-out. The following groups are eligible dependants: persons living with and economically dependent on the insured person: spouse, children (adoption and blood relationship), brothers and sisters, relatives in the ascending line and their spouses and, exceptionally, de facto dependants. Divorce, judicial separation and annulment do not forfeit entitlement to health care of spouse and descendants, or of cohabitants if they are not entitled to a benefit themselves.
Conditions	No qualifying period required. Duration of benefits is unlimited. In the general scheme, in case of cessation of contributing membership, benefits will be continued under certain conditions for a certain time.
Organisation	
Doctors	The Public Health Services (Servicios Públicos de Salud) appoint doctors to vacancies on the basis of competitive examinations. General practitioners and specialists working outside hospitals are, in general, paid on the basis of a lump sum (fixed by decree) determined by the number of insured persons entered on their list, thereby guaranteeing a minimum level of earnings. Hospital doctors are, in general, paid on the basis of a monthly salary plus certain supplementary payments.
Hospitals	Hospitals of the National Health System (Sistema Nacional de Salud). Public or private hospitals operating under agreement with the Autonomous Communities (Comunidades Autónomas) or with the National Institute for Health Management (Instituto Nacional de Gestión Sanitaria, INGESA).
Dental care	Comprising extractions and certain types of treatment. In the event of an employment injury or in the case of an occupational disease, oral and facial surgeries are also covered. Certain financial aids for dental prosthesis.
Pharmaceutical products, prosthesis, spectacles and hearing aids	Beneficiaries pay 40 percent of the price of medicaments. There is a 90 percent reduction of the price for certain special medicaments, with a maximum limit of € 2.64. No charge whatsoever for: pensioners, patients undergoing inpatient hospital care, residents over 65 years of age with insufficient means of existence, and for victims of employment injuries and occupational diseases. Provision and normal replacement of prosthesis, orthopaedic apparatus and wheel-chairs. Certain helps with purchase of spectacles, hearing aids and other special types of prosthesis.
Other benefits	Other types of benefits available either to all beneficiaries or to certain categories of beneficiary: home care for retired people, invalids, the mentally disabled, etc.; ambulance for sick people, in emergencies and under other special circumstances; and thermal cures: Precautionary measures. Thermal baths possible under certain conditions.

Source: European Union Mutual Information System on Social Protection.
Available at http://ec.europa.eu/employment_social/spsi/missoc_en.htm.

At this respect, pensioners, poor people and chronic ills are exempted from the standard 40 percent copayment affecting medicines. With a few remarkable exceptions operating when there is private production, doctors working in the public health care are salaried employees, being paid in a lump-sum basis fixed by decree and several supplements (associated to the number of patients and exclusive dedication to public health practicing, among others). The system has become more complex in the last years with the decentralisation of health care competences in favour of regions (Spanish Autonomous Communities, *Comunidades Autónomas*). While the basic normative framework, the minimum set of covered benefits and funding comes from the Central Administration, regional governments are free to choose the particular way of organising and managing health care resources. There are not many differences regarding primary health care, usually provided by salaried doctors and other health care staff in public health centres. However, there are more differences regarding hospitals management, an area where it is not uncommon that regional authorities outsource many services (e.g., medical tests). Private insurance companies operates in parallel to the public system under a much simpler mechanism of funding, based on collecting health premiums from insured population and paying for health treatments to private hospitals and physicians on a fee-for-service basis.

The organisation of the system in terms of funding is not simple. In the first place, the system gravitates now around the regions, which receive money from general taxation revenues transferred by the Central Administration and are in charge of their own regional health systems. They are responsible for organising and remunerating primary and hospital health care. While public primary health care centres and public hospitals are usually funded on a global budget basis, medicines are purchased in the market and outsourcing of health services takes the form of payment arrangements in the case of private hospitals and a fee-for-service scheme for private physicians. In the second place, public health is logically an issue where the central government and even the local ones-still play a very significant role, for example, in those issues concerning public health. Thirdly, a non-negligible proportion of population, represented by most of

civil servants and armed forces personnel, access to health care through a system of public mutual insurance societies funded through payroll taxes and general revenues. As mentioned, workers can choose between joining the public system (in which case the mutual insurance society pays to the regions) or a private insurance which is contracted by the mutual insurance society on a collective basis, reducing thus–but not eliminating, since private companies do their best at attracting young or relatively healthy people- the risk of cream skimming.

Probably the major shortcomings of the NHS nowadays are not related with the quality of the medical service itself but with the existence of "long" waiting times for specialist and surgeries. This situation often produces, as collateral damage, the crowding of urgency room services, often used as a back door to a given medical service.

As it is known, waiting lists are the tangible result of the existence of an excess of demand in a context where the lack of a price impedes the elimination of such excess of demand by the traditional market mechanism of price increase and the subsequent reduction of the demand (those unable or unwilling to pay a higher price for a given good or service) and increase in the supply (now profitable at a higher price). The existence of a waiting list is not *per se* a sign of inefficiency, if health problems follow a cyclical pattern (like the flu, for example). In this case, having no waiting list would imply to plan the installed capacity to attend the picks of demand, facing a problem of underutilisation the rest of the year. In fact, the issue of waiting list is a feature of "productive capacity" of the health system: the shorter the time that passes between the demand for a medical act and the performance of it, the higher the capacity, and therefore the expenditure, needed. The standard economic analysis shows that as long as the benefit for patients derived from a short waiting time is lower than the cost (in term of higher productive capacity) of attending them in short notice, the existence of a waiting list would be efficient. Unfortunately, this approach is difficult to operationalise, as both, cost and benefit, but especially the latter, are difficult to measure. [4]

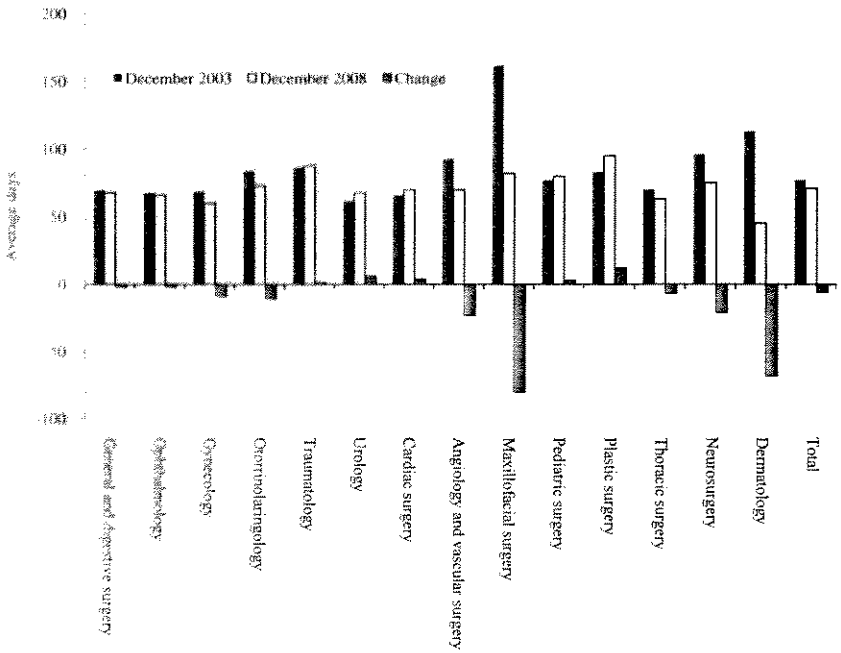
The problem arises when waiting list become "too long", becoming a structural problem of the system, or the rationing that implicitly supposes inefficient in terms of not giving preference to those more in need of medical treatment. If that is the case, waiting lists could have implication in terms of efficiency and equity. Furthermore, some beneficiaries could resort to the private system in order to resolve the health problem faster, undermining the loyalty to the public health system.

To our knowledge, the issue of the waiting lists of the NHS has not been studied rigorously from an economic point of view, so we cannot say to what extent they are an inefficient way of rationing the demand. Having a look at Spanish statistics of waiting times for *non-urgent* surgeries and specialized health care (Figure 17.5), it is evident that the existence of waiting lists are certainly long for some medical acts (above three months in several specialities).

When asked in polls, Spaniards are quite eloquent about the pitfalls they perceive in the NHS. For example, when questioned about their preferences between public and private health care (if the choice were at no cost) considering several dimensions of

health care, Spanish users show a relatively important bias towards the private sector in the case of specialists, comfort of health care facilities and waiting times (Figure 17.6). At the same time, the worst valued issues of public specialised health care are the long time passed since the appointment to the visit (which receives a mark of 4.67 over 10) together with waiting times for non-urgent medical tests (4.65), while other possibly more substantive aspects such us time spent by doctors with patients, the number of available specialities, technology or treatment given by medical staff, among many others, receives a good mark from Spanish population.

Figure 17.5: Waiting Lists for Specialists and Surgeries by Specialty (Average Days) (2003-2008)



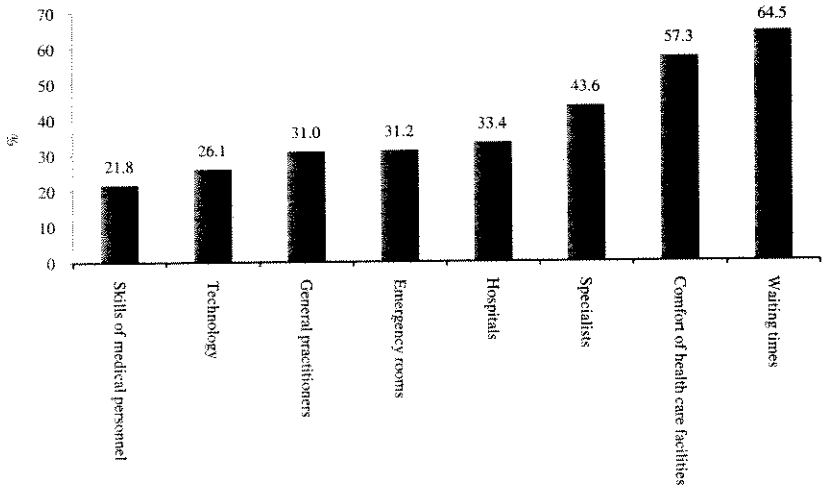
Source: Authors' Analysis from Ministry of Health and Social Policy Statistics.

4. The Challenges Ahead

As in most of European Union countries, the access to health is not source of worry in Spain and its citizens are reasonably satisfied with the NHS in spite of the existence waiting lists and other-probably non-structural-problems. Nevertheless, there are several

factor posing challenges on the budget sustainability of public health in the near future. In this section, we pick up and review some of them: the decentralisation of the NHS, the possible effect of the recent immigration wave experienced by Spain and the impact of ageing on public health spending.

Figure 17.6: Percentage of People who would Prefer Private Health Care over Public Health Care considering Several Issues if Choice were Possible at No Cost for Citizens (2008)



Source: Authors' Analysis from Health Barometer, 2008.

In the first place, the evaluation of the outcomes of the decentralisation of health care to regional authorities will be certainly one of the main challenges faced by Spain in the near future. Theoretical arguments and existing empirical evidence on the outcomes of centralised versus decentralised health care, not reviewed here for reasons of space, are in general largely inconclusive (González and Barber, 2006; Saltman, Bankauskaite and Vrangbaek, 2007), being a larger variation in health care across regions the most remarkable fact observed across developed countries. This finding can be interpreted very differently depending on the level at which social welfare evaluations or, in more general terms, social judgments are made. It seems reasonable to assume that if decentralisation is carried out, it is because eventual differences in access and benefits by regions are viewed as tolerable. Nevertheless, it is worthy to remember that the configuration of policies–such us health care- more tied to local preferences does even

not guarantee, in general, a more efficient outcome at country level if regions are very heterogeneous. [5]

As most of the other competences transferred to Autonomous Communities since the return to democracy, the decentralisation of health services did not obey to efficiency or equity issues but it was politically driven, aiming to fulfil the demand for self-government of Spanish regions, especially the Basque Country and Catalonia. The decentralisation of competences in health care began in the middle 80s in the regions with a higher degree of autonomy (the Basque Country, Catalonia, Navarra, Galicia and Andalusia) and, by the late 1990s, each of the seventeen regions conforming the Spanish State had developed its own health care system. While the funds continues being largely raised by the central government, which also regulates the existence of a minimum set of services provided to all citizens irrespectively of their area of residence, regional authorities are responsible of designing the particular organisation of health care, including contracting private providers, paying medical staff and even financing the construction of hospitals and primary health centres. At this respect, though in most cases it has passed less than a decade since the decentralisation took place, there are very relevant differences across regions: while in some of them the system closely follows the philosophy of the classical national health systems (public production and public provision), in others have proliferated new forms of management care, including internal markets, contracts with private hospitals, primary health centres owned and run by doctors, etc. To what extent this has resulted in a better or a worse health care delivery is a matter of study.

Given the intrinsically political nature of the decentralisation process, it would not be surprising to observe worsening in horizontal equity or even an increase of rent-seeking practises associated to a higher proximity between private suppliers and public purchasers, as long as they were not an issue in the reform. Few-if any-conclusions can be drawn at the moment on the goodness of the decentralisation of health care delivery. First, because, given that the political spectrum, including the two main national parties and all regional political parties, have supported the movement, academia has not risen to the occasion and has not raised any query on evaluating the system on the basis of their horizontal equity. [6] Even if this is not the aim of decentralising health care, it is certainly a parameter of interest for society as a whole. In addition, regional governments have hindered accountability, obscuring or even not facilitating homogenous statistics on outcome performance indicators, such as waiting lists. [7] Another worrying fact proving the improvised nature of the decentralisation process is the lack of coordination of health care delivery among regions. For instance, each national community tries to provide the whole range of benefits in hospitals and health centres placed in its territory, irrespective of the facilities present in the neighbour regions.

Due to these remarkable problems and the absence of proper performance indicators of regional health systems, we limit ourselves to offer some information on outcome variables of the different regional health systems (Table 17.4). This means ignoring inputs and the efficiency dimension. [8] Instead, as pointed in section 3, we have

computed and collected indicators from different sources of data on the conditions of access to health care delivery–and, particularly, waiting lists for different types of doctors and medical tests, which, as explained above, have been historically the sticking point of the NHS-that are presented in Table 17.4.

Table 17.4: Some Indicators of Performance of Regional Health Care Systems in Spain (2006)

Spanish Regions	Percent of population who could not visit a GP because of waiting times or difficulties for getting an appointment	Percent of population who waited more than 2 months for visiting a specialist	No. of days waiting a surgery	No. of days waiting for a blood test	No. of days waiting for X-ray appointments
Andalusia	1.0	40	61	15	16
Aragon	2.5	49	70	6	13
Asturias	1.2	51	61	14	24
Balearic Islands	1.9	---	51	9	20
Canary Islands	1.9	81	104	15	22
Cantabria	1.0	68	98	8	32
Castile-La Mancha	1.0	44	45	20	28
Castile-Leon	0.6	42	61	9	20
Catalonia	2.5	49	138	10	25
Valencia	2.9	59	31	9	14
Extremadura	0.9	68	62	6	26
Galicia	3.4	78	99	10	40
Madrid	1.4	41	42	8	19
Murcia	1.6	32	55	20	20
Navarra	3.1	---	63	2	5
Basque Country	1.2	33	47	5	5
Rioja	13.0	---	29	3	18
Ceuta and Melilla	3.9	---	47	16	20
Total	1.9	---	94	11	19

Sources: Authors analysis from Spanish National Health Survey 2006, Ruiz del Árbol (2008) and OCU (2009).

Extreme cases when people report not receiving health treatment because of the difficulties of getting an appointment or long waiting times are relatively infrequent and there is no substantial variation across regions (with the remarkable exception of La Rioja). However, the differences in terms of waiting times for visiting a public specialist physician, for a surgery or for a non-urgent medical act across regions are remarkable. Furthermore, what is more important, if one computes the correlation between the

different indicators of waiting times in most cases we obtain positive–though not high-correlations among them, which suggests that regions with good figures in one dimension tends to have good figures in the others, and, thus, subtly points to the existence of differences in quality of health services across Autonomous Communities. To what extent they respond to different availability of financial resources, different fiscal efforts of regional administrations, different efficiency in the use of such inputs or even whether those differences are desirable or not has not been determined; nevertheless, the main message envisaged here is that the scant available evidence at least questions the existence of horizontal equity across regions.

A more complex issue, which is not an intrinsic product of decentralisation, has to do with the lack of coordination of medical products purchasing. This is an issue not only at the national level, but also across hospitals within the same region. A report of the consulting firm Saniline (2007) points that the competition on the supply side is far from perfect (with around 10 percent of the firms accounting for 80 percent of purchases), while there are 220 public hospitals managed–and, hence, buying-in an independent way, which is likely to result in the lost of potential savings for the public sector (compared to an alterative situation associated to the exercise of market power from the demand side due to the existence of a unique purchaser). In addition, only 32 percent of the purchases of pharmaceutical products, medical and non-medical supplies and services in 2006–which accounted for 25 percent of the total public spending on health care are publicly tendered. When taking as reference the lowest price of the generic product, this lack of coordination resulted in a waste of public resources equivalent to 6 percent of the health expenditure on medical products. In some cases, average differences in terms of prices paid for a product rose up to 45 percent and, according to Saniline, overprices paid by some hospitals for certain products reached 300 percent. Although the lack of coordination in purchasing medical items was an issue existing in the NHS well before decentralisation, the arise of seventeen different regional health care systems is not likely to be a driving force of more coordination in purchases.

A second important challenge that has aroused the interest of both scholars and population has to do with the effect of immigration on the public health care system. According to different opinion polls (carried out before the crisis), immigration is seen by Spaniards as a source of concern, as long as foreign-born population would "abuse" or "over-utilise" public health care facilities. Empirical evidence does not support that assertion at all, pointing, at most, different patterns of utilisation among natives and foreigners; for example, while migrants visit general practitioners and specialists less than Spanish-born population, they tend to use emergency rooms to a larger extent (Hernández-Quevedo and Jiménez-Rubio, 2009; Antón and Muñoz de Bustillo, 2010). Nevertheless, it has to be acknowledged that the very fast increase in population produced by this unexpected increase in immigration (four millions in approximately a decade, accounting for 12 percent of the total population), and its concentration in few regions, has lead to an increase in the demand of health services that, in many occasions,

have not been matched by the corresponding increase in health expenditure (including investment in new health facilities).

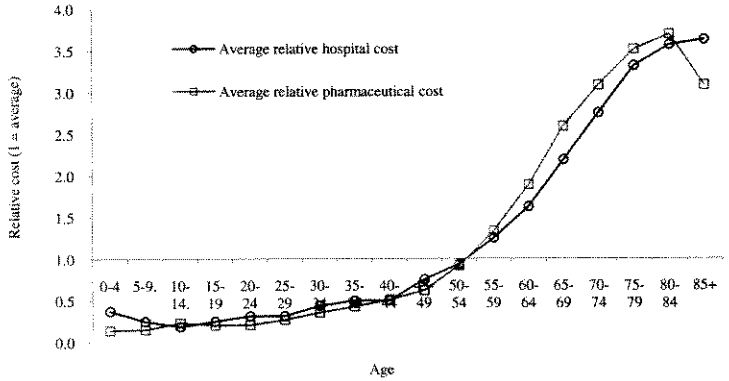
A third important challenge, this time shared by all developed countries, is the significant increase in the percentage of old-age population associated to the low fertility rates and increasing life expectancy. This increase has three implications for social policy. The first one is an increase in pension expenditure, the second, a rise in the demand of services for old-age dependent persons and, last, and a higher health expenditure. As it is well documented, health expenditure increases with age, especially in the few years prior to death. [9] For example, the relative hospital in-patient expenditure of population 65 and over in Germany is 2.24 (1 meaning the expenditure is equivalent to the participation of the age group in total population), 2.4 in the Netherlands and 2.7 in Sweden (OECD, 2009: 169). In Spain the relation age-health expenditure follows a similar pattern. Figure 17.7 shows the relative health cost of hospital treatment and medicines for different age cohorts in the region of Catalonia, Spain. Population over 54 incurs in higher cost in both items, rising steeply with age, up 3.6 (being 1 the average expenditure) for hospitals and 3 for medicines. Thus, *ceteris paribus*, with the increase in the proportion of population 65 and over, we should expect an increase in health expenditure.

In any case, it is important to stress that, according to different studies (for example Lubitz et al., 2003), the increase in life expectancy should not *per se* lead to a rise in expenditure per person in old age, as long as the improvement in health status associated with the increase of life expectance compensates to the increase in life years. [10] The analysis performed by Puig-Junoy, Castellanos and Planas (2004) for Spain confirms the relatively low impact of ageing on health expenditure in Spain for the period 1991-2001.

In Figure 17.8, we can see the projected evolution of the proportion of people 65 and over (and 80 and over) in the total population in Spain and the EU 27. Although the projections are a mere approximation and has to be taken with caution, in both cases the estimated results point to the huge increase of the population 65 and over, that doubles in half a century, and the population 80 and over, that triples in the same time. The trend is very similar in Spain and the EU27, with a lower increase in the old-age rate in the next 30 years, and higher afterwards.

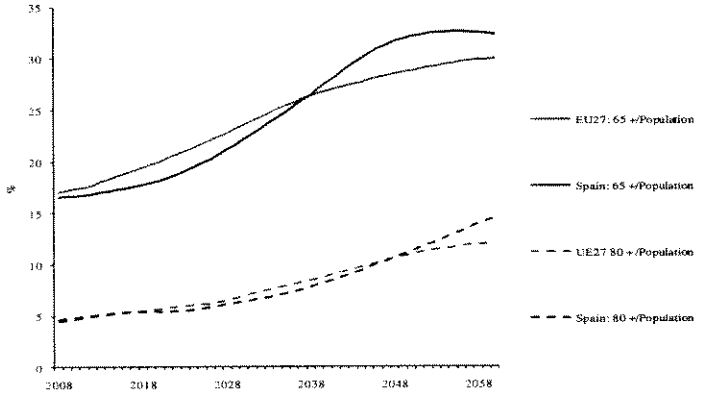
Fortunately, the combined effect of the expected increase in health status of the elder population and the decrease in their mortality rate, will greatly reduce the cost impact of the increase on the population 65 and over, leading to an impact in the long run, which, according to a recent survey (Casado, Puig-Junoy and Peiró, 2009) will be manageable, as it will be under 1 percent of the GDP per year in real terms until 2050. This figure, bearing in mind the relatively low health spending in Spain nowadays, should not be a big headache to the country. From a different perspective, together with the above mentioned implication of demography on health expenditure, this trend will also produce an increase in the need for geriatric care specialists, something that will have to be taken into consideration by the health authorities when planning the future needs of different types of health professionals.

Figure 17.7: Average Health Cost (hospitalization and pharmaceutical spending) by Age in Catalonia, Spain (2005)



Source: Author´s Analysis of Casado, Puig-Junoy and Puig (2009: 44-45).

Figure 17.8: Projections of Population 65 and Over and 80 and Over as a Proportion of Total Population in Spain and the European Union (2008-2058)



Sources: Authors' Analysis from EUROPOP 2008 (European Population Projections, base year 2008), Convergence Scenario, Eurostat.

5. Conclusion

In this work, we have tried to offer a picture of the past, present and future of health care in Spain. We have aimed to highlight a range of topics that, from our point of view and being aware of the unavoidable subjectivity in any selection, can be of interest for both academia and policy makers placed in other regions of the globe. Particularly, this chapter tries to emphasise several points.

First, Spain has a public health care system that is on a par of other OECD countries both in terms of access and the comprehensiveness of benefits. It is not by chance that the NHS is considered, both by social scientist and citizens, the most developed pillar of the Welfare State. Furthermore, this result is an achievement of surprisingly little time, barely two decades, which certainly gives us good reasons to look more carefully at the power of decisions made in the political arena.

Second, even though Spanish public health spending is relatively low compared to other OECD countries, Spain shows very similar health indicators associated to mortality and morbidity of most of European Union countries. Nevertheless, we must mention that the system is in no way free of problems, being the most important one the waiting list for some non-urgent medical treatments, mainly surgeries and visits to specialist physicians.

Third, the NHS faces several future challenges. A first challenge is associated to the risk than the decentralisation of health services might lead to a fragmentation of the system and a threat on horizontal equity. It is possible that this issue will not be judged as a problem for policy makers, but, in any case, it is our opinion that transparency and information in this area should be a priority in order to allow citizens to form their own judgments about such a relevant transformation of the NHS. Another hot topic, the eventual pressure put on health care by recent and massive immigration flows has also deserved some attention. Whereas the impressive arrival of foreign-born workers to Spain might have meant a larger population accessing health care services; utilisation rates among immigrants have not proven to be significantly higher than those observed among Spaniards. A final point that needs some comment is the likely increase of health spending linked to the larger proportion represented by the elderly among total population, a hardly unsurprising fact if one considers that old-age people requires -on average- more health services. At this respect, the cost increases envisaged by recent research works do not depict any dramatic scenario, considering the magnitude of the predicted rise (less than 1 percent of the GDP) and the moderate public health spending in Spain at the present moment.

End Notes

1. In fact, in 1967 more than a third of health expenditure was private.
2. The organ donors' annual rate in 2007 was 34.3 per million inhabitants, twice the European Union and the USA figures (ONT, 2008).
3. The countries are Australia, 42 percent, West Germany, 48 percent, UK, 71 percent, USA, 38 percent, Italy, 76 percent, Ireland, 77 percent, Sweden, 69 percent, Canada, 49 percent and France, 54 percent.

4. For a summary of the standard economic analysis of waiting list see, for example, Cullis and Jones (2000).
5. Casahuga (1982), using a simple and ingenious counterexample, showed that the general invalidity of the Oates' theorem (Oates, 1972) in the presence of internally heterogeneous regions and decision-making based on the median voter theorem.
6. A prominent Spanish health economist claims that differences in health care across regions– as mentioned not evaluated in rigorous way yet- can be used in order to vindicate recentralisation by people who are nostalgic of Franco's dictatorship. That is certainly an original statement considering that barely no public health care system (either at national, regional or local level) operated during such period, as we have seen above.
7. Note the following paradox: whereas the Ministry of Health and Social Policy offers figures for waiting lists at a national level computed using information provided by regional authorities, some of the latter obstacle the access to such information by researchers and journalists. In a recent report in a leading Spanish newspaper, a region denied information on waiting lists arguing that those data meant "politically sensible information" (precisely the reason why they should be released right away).
8. The relationship between inputs and outputs is certainly relevant, but less important from a social policy perspective like the adopted here and surely far beyond the scope of this chapter.
9. According to estimates by Lubitz and Riley (1993) the 5.1 percent of beneficiaries of Medicare that on average die in each year account for 29 percent of the total Medicare expenditure of the year.
10. Accordin g to the study of Lubitz et al. (2003) for the US "*Elderly persons in better health had a longer life expectancy than those in poorer health but had similar cumulative health care expenditures until death. A person with no functional limitation at 70 years of age had a life expectancy of 14.3 years and expected cumulative health care expenditures of about $136,000 (in 1998 dollars); a person with a limitation in at least one activity of daily living had a life expectancy of 11.6 years and expected cumulative expenditures of about $145,000*".

References

Antón, J.I. and Muñoz de Bustillo, R. (2010): Health care utilisation and immigration in Spain, *European Journal of Health Economics*, 11(5), 487-498.

Casado, D., Puig-Junoy, J., and Puig, R. (2009): *El impacto de la demografía sobre el gasto sanitario futuro de las CCAA*, Fundación Pfizer, Madrid.

Casahuga, A. (1982): La invalidez general del teorema de la descentralización, *Cuadernos Económicos del ICE*, 20: 37-52.

Crepaz, M.M.L. and Crepaz, N. (2004): Is Equality Good Medicine? Determinants of Life Expectancy in Industrialized Democracies, *Journal of Public Policy*, 24(3): 275-298.

Cullis, John G., Jones, P.R. and Propper, C. (2000): Waiting lists and medical treatment: Analysis and policies, In A.J. Culyer and J.P. Newhouse (eds.) *Handbook of Health Economics*, Elsevier, Amsterdam, pp. 1201-1249.

Cutler, D., Deaton, A. and Lleras-Muney, A. (2006): The Determinants of Mortality, *Journal of Economic Perspectives*, 20(3): 97-120.

Hernández-Quevedo, C. and Jiménez-Rubio, D. (2009): A comparison of the health status and health care utilization patterns between foreigners and the national population in Spain: New

evidence from the Spanish National Health Survey, *Social Science & Medicine*, 69 (3): 370-378.
Lubitz J. and Riley G.F. (1993): Trends in Medicare payments in the last year of life, *New England Journal of Medicine*, 328(15): 1092-1096.
Lubitz, J., Cai, L., Kramarow, E., and Lentzner, H. (2003): Health, Life Expectancy, and Health Care Spending among the Elderly, *New England Journal of Medicine*, 349(11): 1048-1055.
Muñoz de Bustillo, R. (2007): Perspectivas de la política social y de empleo en la UE, In: S. Salort & R. Muñoz (eds.) *El Estado de Bienestar en la encrucijada*, Publicaciones Universidad de Alicante, Alicante, pp. 129-170.
Oates, W.E. (1972): *Fiscal Federalism*, Harcourt Brace Jovanovich, New York.
OECD (2009): *Health at a Glance 2009*. OECD, Paris.
Organización de Consumidores y Usuarios (OCU) (2009): Encuesta sobre servicios sanitarios, *OCU Salud*, 87.
Organización Nacional de Trasplantes (ONT) (2008): International Figures on Organ Donation and Transplantation, *Transplant*, 13(1): 3-22.
Puig-Junoy, J., Castellanos, A. and Planas, I. (2004): Análisis de los factores que inciden en la dinámica de crecimiento del gasto sanitario público. Registro histórico y proyecciones 2004-2013, In J. Puig-Junoy and López-Casanovas and V. Ortún (eds.) Más *recursos para la salud?* Masson, Barcelona, pp. 93-130.
Ruíz del Árbol, M. (2008): Cántabros, catalanes y gallegos, los pacientes que más esperan, *El País*, 5th May, pp. 38-39.
Saltman, R.B., Bankauskaite, V. and Vrangbaek, K. (eds.) (2007): *Decentralization in Health Care. Strategies and Outcomes*, Open University Press, New York.
Saniline (2007): Spanish Health Care Market, In: Albo del Fornitori, *Il mercato della Pubblica Administrazione. A confronto con i numeri*, Parma, Italy 19-20th April 2007.
Shaw, J.W., Horrace, W.C. and Vogel, R.J. (2005): The Determinants of Life Expectancy: An Analysis of the OECD Health Data, *Southern Economic Journal*, 71(4): 768-783.

18

Brazilian National Health System

Ciro Augusto Floriani

1. Introduction

Brazil is a country of continental proportions, covering a territorial area of 8,514,876.599 km^2 and with an estimated population of 192,015,594. Split into five regions (North, Northeast, Central-West, Southeast and South), the country is composed of 26 States and 5,563 municipalities plus the Federal District, where the capital, Brasília, is seated (Instituto Brasileiro de Geografia e Estatística n.d.).

The health care system established in Brazil, known as the Unified Health System, or SUS (*Sistema Único de Saúde*), is a recent system which is still under construction (Buss and Gadelha 1996, Campos 2003). Its name is derived from the fact that the system is the result of the unification of several health care subsystems which operated in Brazil, and its aim is the promotion, protection and recovery of health.

The system was politically conceived and proposed between the 1970s and the late 1980s–in the midst of a global scenario featuring the welfare state crisis and the fall of communism–by means of a social movement that fought for the reimplementation of democracy in Brazil, known as the *Movimento Sanitário* (*Public Health Movement*), which composed a series of changes in the field of health care based on social participation in the legislative and executive bodies, known as the *Reforma Sanitária* (*Public Health Reform*).

This intense political and social movement led to the development of a report during the VIII National Health Conference in 1986, which would serve as the reference document in the field of health care for the legislators of the Federal Constitution, promulgated two years later (Carvalho, 1999; Campos, 2007).

The historical landmark for this new health care system, established in the Federal Constitution, was the determination of "health care as a right for all and a duty of the State" and the system is based on the principles of equality, universal access and comprehensiveness, which should guide the reorganization of health care through decentralized health care actions and social participation (Brasil, 1988). Thus began the construction of a democratic instrument of social inclusion for thousands of Brazilians who, until then, had been excluded from the health care system.

It is this new model of health care, founded 20 years ago, and under a constant improvement process, that shall be presented below.