HealthManagement
Promoting Management and Leadership

Volume 5 / Issue 1 / 2010 - Country Focus: Iberia

Healthcare in Spain

Author

Tosh Sheshabalaya,

Spain's General Health Care Act of 1986 constitutes the foundations of the Spanish healthcare system. It provides universal coverage, free access to healthcare, and is principally funded through taxation. It also has a regional organizational structure. A guaranteed healthcare benefits package is stipulated by the Cohesion and Quality Act of 2003.

The shape of Spain's current healthcare system has its roots in the country's transition to democracy in the late 1970s, after a prolonged period of dictatorship. This led to several changes in its political structure, which directly impacted on the healthcare system. One of the key issues has been decentralisation.

Since the 1986 General Health Care Act, the process of reform to the Spanish healthcare system has been phased, with a focus through the rest of the decade on rationalization of the system and cost-containment, and in the 1990s, on management and governance, coordination and convergence with the EU, as well as the introduction of some market-oriented elements such as competition. Since 2000, there has been considerable emphasis on clinical management and evidence-based policy making, as well as improving coordination between central and regional levels.

As a result, the role of healthcare technology has become increasingly central in Spain.

Distribution of Roles and Responsibilities

The federal Spanish government in Madrid shares power with 17 highly autonomous regions (Comunidades Autónomas), each with its own regional government and legislature.

The federal government, through the Ministry of Health and Consumer Affairs, is responsible for strategic coordination and cooperation in the health sector. Its mandate covers basic health legislation, the financing and guaranteed benefits under a National Health Service scheme, pharmaceutical policy, as well as medical education and international cooperation. The Comunidades Autónomas organise their own health services in their regions.

An NHS Interterritorial Council (known by its Spanish language acronym CISNS), promotes homogeneity in the system. It is composed of representatives of both the federal Ministry of Health and Consumer Affairs as well as the Comunidades Autónomas.

Real-world health policy power in Spain lies at the regional level. Each of the Comunidades Autónomas has a so-called Health Map, which breaks up the region into areas and basic health zones. Health areas have between 200,000 and 250,000 residents, and are responsible for both the management of facilities and the delivery of health services within their limits. Basic health zones form the bottom rung of the Spanish healthcare system, and generally consist of a single Primary Care Team.

Primary Healthcare

A key element of Spanish healthcare delivery is the primary healthcare (PHC) sector, which has undergone a major process of capacity building and reform since the mid-1980s. The system consists of about 3,000 PHC centres and multidisciplinary teams, providing both personal and public health services.

The bulk of preventive medicine is integrated within the PHC system and undertaken by GPs and practice nurses within their normal workload.

Specialized care is provided by hospitals, with the GP functioning as a gatekeeper.

Hospitals and Regions

In 2004, there were about 780 hospitals in Spain, with 320 (or a little over 40 percent) were part of the NHS. However, the NHS hospitals account for two-thirds of all beds, and are generally far larger than private hospitals.

There are major differences in hospital density between one region and another. Catalonia had the largest number of hospitals with 185 in 2004, corresponding to about five times the national average. Nearly 80% of these were private, again significantly above average. On a per capita basis, Madrid, too, stands out with a total of 70 hospitals.

Bed Distribution Trends

In terms of beds per capita, Catalonia leads other regions, while Aragon, Castilla- La Mancha and Andulucia have the lowest. Regional differences in per capita bed availability are however lower. This is principally because higher densities of smaller private hospitals (as in Catalonia) are compensated by larger public hospitals in other regions. Catalonia indeed has the lowest density of public hospital beds (1.9 in 2003), while Aragon had the highest (3.6).

Since 1980, there has been a steady drop in the number of hospital beds in Spain, as well as a significant change in the ratio of acute care versus other beds, principally due to mental health reforms, that havemoved care to an outpatient setting.

The below figures, however, conceal one significant development. After a steady decline through the 1980s and

1990s, acute care bed numbers rose in 2000, from 28.4 per 10,000, to over 30. This was not the case in other categories

Lack of Homogeneity Between PHC and Hospitals

The current two-tier healthcare delivery system (PHC/hospital) is accompanied by a significant level of systemic problems, principally in terms of coordination between hospitals and PHC centres, duplication of clinical records and diagnoses, delays in treatment, and waiting times. A 1:4 ratio of staff between PHCs and hospitals indicates an emphasis on specialized care and a corresponding overload on PHCs.

One specific complaint due to this lack of homogeneity is a high number of emergency hospital admissions.

Healthcare Financing and Reimbursement

The transition to a National Health System in the mid-1980s in Spain also involved a major overhaul of healthcare financing, which transformed a former social health insurance (SHI) system into one financed by federal and regional taxes with near-universal coverage; the only exception consists of civil servants who are free to choose between NHS coverage or full private insurance.

A new financing model, adopted in 2001, seeks to guarantee both continuity and financial sustainability. One of its key elements is an effort to contain pharmaceutical costs, which had been rising at 5-6 percent a year and accounted for a fifth of healthcare spending.

Previously, hospital expenditure was reimbursed retrospectively. In the early 1990s, Spain introduced prospective financing of targeted activities to enable comparison and differentiation between hospitals. Hospitals in the NHS are now financed by means of a global budget, set against individual spending headings.

In spite of the new model for funding hospitals, health spending leaped up sharply in 2003, and has since continued to grow inexorably.

Private Spending

In Spain, private spending on healthcare accounts for about a quarter of spending.

There are two components: co-payments to both the public and private sector, as well as voluntary health insurance. The latter have a relatively minor role within the Spanish health system, with the exception of civil servants, who can choose between the NHS or publicly-funded mutual funds, which in turn rely on private firms. There has been some debate about civil servants seeking high-technology interventions at public hospitals.

Private insurance schemes cover about one-tenth of the Spanish population. Since the mid-1990s, reforms have

Sought to expand their role, especially in the field of occupational health services. In 1999, the government provided a variety of tax sops for employer-purchased private insurance.

Healthcare Staffing

According to 2007 statistics from the OECD, Spain had 3.7 physicians per 1,000 inhabitants (in line with the EU average). This is a significant rise from 2.9 in 2002. Nurse densities are low, at 7.5 per 1,000 in 2007, notwithstanding a sharp rise from 2.95 in 1995.

Physician Payment

GPs receive a salary plus a capitation component, which depends, among other factors, on the over-65 year share in the population covered, and amounts to approximately 15% of the total. Private physicians are paid on fee-for-service basis. Specialists working at hospitals and in ambulatory settings are salaried.

Public sector physicians have the status of civil servants and their salary is regulated by the national government. However, the region can provide certain supplements, and this has led to significant variations the autonomous communities.

Hospital Stay on the Decline

The average length of acute care hospital stay in Spain has decreased steadily in recent years, from 7.1 days in 2000 to 6.6 days in 2006, largely driven by hospital financing reforms (see above).

Outlook for the Future

Despite significant achievements, key challenges which Spain faces in the future include cost-containment, a need to boost staffing and efficiency at the core primary healthcare centre level as well as the political challenge to achieve a reduction in sometimes dramatic regional inequalities.

Published on : Mon, 5 Apr 2010