LOOKING TO EUROPE

Spain: a decentralised health system in constant flux

The Spanish healthcare system is one of Europe's most efficient, but urgent reform is needed if it is to cope with changing demands and rising costs, argue **Jose M Martin-Moreno and colleagues**

The Spanish health system offers almost universal coverage, a wide variety of services, and a high quality network of hospitals and primary care centres. Although it is a national system, financed with general tax revenue, the devolution of health services to the country's 17 autonomous communities has led to a variety of management models.

Spain, like most countries in the European Union, has seen big increases in life expectancy over recent decades thanks to improved living conditions, public health interventions, and progress in medical care.[1 2] Spanish citizens born in 2005 can expect to live to 80.4 years old, slightly more than the average in the 15 countries that were members of the EU before 2004 (79.7 years). Maternal and infant mortality as well as other main health indicators and trends are also better than the European average (table).[3] Virtually all citizens consider the social support mechanisms in place positively (96.6%) and believe that they have good family support (93.4%).[4] The success has been achieved with comparatively low expenditure; despite the trend of increasing costs, a performance analysis shows the Spanish health system to be efficient compared with health systems of neighbouring countries.[2 3]

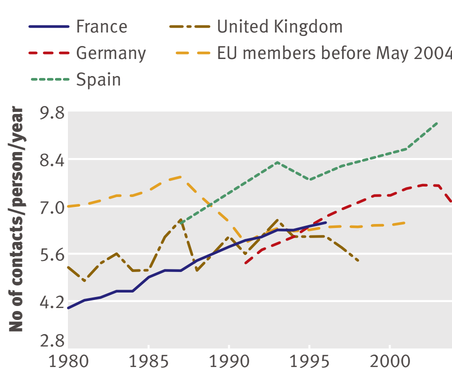

Fig 1 | **Outpatient contacts per person per year, 1980-2004[5]**

The system is not without its shortcomings, however. The sustainability of universal coverage is being tested as rising demands lead to rising costs (figs 1 and 2). As well as changes in demographics, patients are expecting more from health services and there are problems with professional satisfaction and resource management.

Organisation and financing

Since 2002, the organisation of the Spanish health system has been mainly controlled by the 17 autonomous communities, whose populations range from 312 000 in La Rioja to 8 million in Andalusia (fig 3).[6] The national ministry is in charge of general coordination of national health matters, legislation on medicines, border health issues, and international health relations and agreements, but each community has a health department responsible for key areas such as healthcare planning, public health, and management of health services. The communities are divided into health areas, each of which has a general hospital, according to demographic and geographic criteria that have the primary aim of ensuring proximity of services for users. The health areas are then subdivided into basic health zones that provide the framework for primary care services.[7]

The main advantage of decentralisation is that it is easier to implement necessary reforms and creative initiatives. Costa-Font and Gil suggested that decentralisation enhances health equity,[8] although this has been intensely debated, both nationally and

Main health indicators in Spain and EU average for member countries before May 2004[5]

	1975		1980		1985		1990		1995		2000		2005	
	Spain	EU	Spain	EU	Spain	EU	Spain	EU	Spain	EU	Spain	EU	Spain	EU
Life expectancy at birth	73.26	72.69	75.6	74.18	76.48	75.32	77	76.48	78.11	77.51	79.49	78.74	80.44	79.74
Life expectancy at 65 (in years)	15.15	14.9	16.58	15.71	16.96	16.22	17.54	17.06	18.33	17.67	19.03	18.38	19.52	19.05
Infant deaths/1000 live births	18.88	18.1	12.41	12.42	8.92	9.46	7.6	7.6	5.49	5.63	4.38	4.75	4.38	4.25
Maternal deaths/ 100 000 live births	21.66	22.06	11.14	13.08	4.38	8.59	5.48	7.84	4.4	6.06	3.77	5.36	3.86	5.29
Age standardised death rate*:														
Ischaemic heart disease		169.37	78.78	152.77	78.35	145.91	73.66	128.19	71.65	117.22	65.3	97.49	56.31	82.26
Cerebrovascular diseases	165.35	137.39	133.9	119.95	114.43	106.37	89.72	86.85	71.62	74.39	55.8	61.01	45.7	51.29
Malignant neoplasms	169.11	200.2	162.56	200.11	166.75	201.82	175.92	199.91	179.81	193.51	170.38	183	159.73	173.56

*All ages, per 100 000 population.

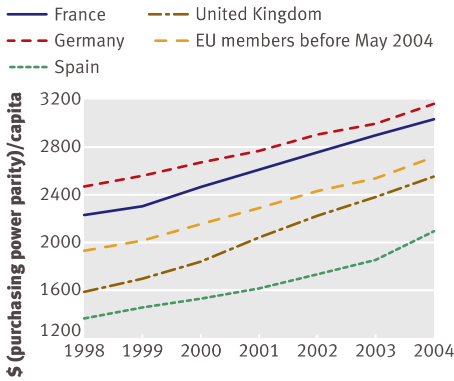

Fig 2 | Total health expenditure per capita, 1998-2004[5]

internationally.[9] In many cases, autonomous management has facilitated initiatives that are tailored to the regional population. Catalonia and the Basque Country (two communities with an older than average population) have increased the number of beds for long term patients and Castile-La Manche emphasised prevention efforts as these were judged to be especially effective because access to medical facilities can be difficult for its sparse population.[10]

In a recent study exploring socioeconomic health inequity in 22 European countries, the Basque region had the least inequity related to income or education.[11] This is partly because although the autonomous communities are responsible for managing resources, funds are provided by the central government based on population (with some adjustments for socioeconomic factors). Devolution of healthcare management was also combined with an increasingly progressive financing scheme with accessibility and "pro-poor" policies as cornerstones.[8]

Health outcomes are also linked to lifestyle factors such as diet, physical activity, and tobacco consumption, making it problematic to reach definitive conclusions about the influence exerted by the health system on population health. Nevertheless, it is still possible to identify successful policies. Extremadura, for example, has carried out positive initiatives in its territory, where health and social resources for elderly people are interconnected.[12 13]

Catalonia (7 million inhabitants) is another region that seems to have benefited greatly from the decentralisation of healthcare services. This is partly because of its strong sense of community involvement within a historical background of social and complementary healthcare structures. Market mechanisms have been introduced in a way that preserves a great degree of public control, using different kinds of private service providers (70% of hospitals in this region are privately managed) contracted by local health authorities.[8] The Catalan hospital consortia function like private enterprise, but they are publicly funded and their policies are overseen by a community representative. Another type of service provider is the Catalan Hospital Foundations, which are non-profit and independently managed but subject to the same auditing processes as government institutions. This system allows operational flexibility in hiring practices, compensation issues, and managerial freedom (often with a strong degree of personal accountability in financing). At the same time, the risk of an uncoordinated healthcare network is mitigated by a financing scheme which uses capitation to pay regional groups.[14]

National policies are another story. Although there are examples of successful countrywide initiatives in Spain—most notably the world's leading organ transplant programme[15]—in general, decentralisation has diminished the ability of central government to implement, coordinate, and enforce its legislative priorities in the autonomous communities, leading to sharp inequalities in access to some specialties or treatments, such as palliative care.[16] Informational networks are also negatively affected, as the communities do not have the joint financial infrastructure to fund the effective exchange of data. Purchase of supplies would also probably be more cost efficient if there was a national system rather than regional purchasing.[17]

Fig 3 | Autonomous communities of Spain

Funding the system

Spain is proud of its highly decentralised model and relatively low expenditure. However, it cannot be complacent. Total healthcare costs rose 10% a year between 2003 and 2006, when they reached €48 650.89m.[18]

This is partly due to a rise in population (with an annual growth rate of 5.5% between 1999 and 2005, particularly due to immigration) and an ageing population. Higher workforce salaries and expanding staff numbers have also contributed to rising costs. In addition, new, increasingly expensive health technologies have created higher public expectations, which in turn provoke demand and raise costs. Although Spain has been identified as one of the countries that is best able to incorporate innovative medicines into the public healthcare system,[19] this is sometimes accomplished by local decisions to restrict access to expensive drugs rather than solely through health technology assessments. This strategy often displaces the budgetary burden from one area to another and limits access to innovation in primary care.[20]

Concern about the rising healthcare expenditure has led the autonomous communities and central government to explore different ways to reduce deficits, which are currently sustained by postponed payments to service providers and the private sector as well as additional funds from other sources in the autonomous communities.[21] The state has recently increased its contribution to help reduce the health debt, and regions are adopting several measures to rationalise spending, including purchase management, better use of medicines, promotion of healthy lifestyles, reinforcement of assessment agencies and incentives for professionals, development of information systems, and an increase in primary care resources.

Most regions have also incorporated these measures into "pay for performance" formulas for clinical staff, although professional pay is not yet linked to integrated care or management of disease.[22] Evaluating the impact of many of these measures is difficult and the outcomes are uncertain or minimal (in primary care, for example), except in the case of purchase management, which has achieved savings of over 10% in most regions.[21]

ANGEL MARTINEZ/GETTY IMAGES

The Spanish health system offers almost universal coverage and a high quality network of hospitals and primary care centres, but numbers of staff and investments in infrastructure have not kept pace with increases in workload and services

Primary care

In the early 1980s, the recognition of family medicine as a specialty contributed to a rise in professional standards. This led to a distinct professional identity and improvement in areas such as teamwork skills, accessibility, comprehensive care and follow-up, and community participation. Numerous studies confirmed the positive changes and established primary care doctors as the legitimate gateway to specialised care. Primary care is universal and provides a wide variety of quality healthcare services that citizens view positively.

One particularly relevant initiative is the Programme of Preventive Activities and Health Promotion (PAPPS in Spanish). Launched in 1988, this programme aims to integrate health promotion and prevention activities into the daily routine of primary healthcare centres. It issues recommendations and promotes enrolment of centres in the programme. Currently, there are over 600 member centres, which are regularly evaluated by programme representatives. Professionals in the programme have helped develop regional policy on clinical prevention.[23] The National Health Survey reflects the positive effects of the programme, which has encouraged the use of preventive procedures such as blood pressure measurement, flu vaccinations for elderly people, and mammography screening—over 90% of women aged 50-64 have had at least one breast examination.[4]

However, further reform of primary care is long overdue. Free access has led to overuse and abuse.[24] Demand has gradually been rising, and the system's ability to meet population needs is severely strained. The amount of bureaucracy needs to be reduced, and steps need to be taken to modulate demand by providing non-medical alternatives for people with long term or social support needs. These changes should be accompanied by reassessment of staffing needs.[23 25] Epidemiological and demographic changes have also increased the number of people with chronic conditions, necessitating new approaches to delivering social and health care.

Changing roles for professionals and patients

While policy makers are trying to cut costs, service users and professionals are growing increasingly more dissatisfied with the health system. The discontent among many doctors is apparent by protests throughout the country.[26] Staff increases and investments in infrastructure have not kept pace with workload increases and expansion of offered services. Healthcare workers have criticised both the quantity and the quality of available staff, the lack of professional career paths, the scarcity of incentives, and pay.

Although it is difficult to say why the fuse has been lit now, this dissatisfaction is clearly not new and has several causes. Big social and demographic changes are important factors—working women's need for working hours compatible with family commitments, a rapidly ageing workforce resulting from peaks in hiring (hospital staff in the 1970s and primary care in the 1980s), and the transformation of professional roles that has led to tense and sometimes uncomfortable changes in the workplace. This is combined with relative shortages in some specialties, such as family medicine, general career stagnation after civil service exams, and the consumerism and income expectations of younger generations.

For patients, waiting times and information provision are the worst rated issues. Because of the increasing complexity of patient morbidity, often requiring management by different specialties, people do not always know the steps needed to get to services. They are also often unaware of their rights and the channels for complaints. Patient and citizen involvement in decision making and in public health policy requires immediate attention.

Patient expectations have been fed by a higher quality of life as well as more access to information. The traditional roles of patient and doctor have been transformed, and professional training needs to reflect this change in order to increase trust and communication. The health system must build a consensus among citizens, patients, and professionals, guaranteeing equity, transparency, accountability, and citizen empowerment.[27] The decentralised social healthcare model can be successful only with the cooperation and support of all actors.

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We welcome contributions to this series. Please send your suggestions to Tessa Richards (trichards@bmj.com).

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ANSWERS TO ENDGAMES, p 897

For long answers use advanced search at bmj.com and enter question details

PICTURE QUIZ 1

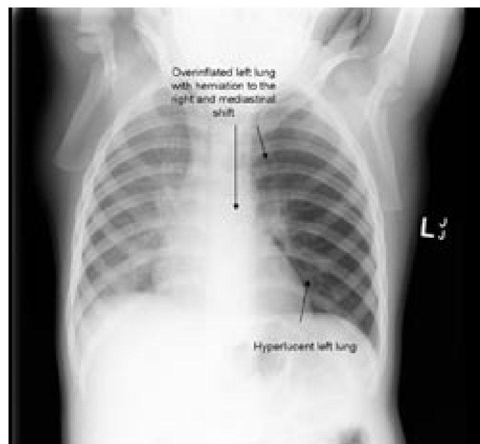
A skin lesion on the back of a young woman's hand

1 Russell's sign, after Gerald Russell. It is seen in bulimia nervosa, which Russell described in 1979, and in the bulimic subtype of anorexia nervosa. Abrasions on the dorsum of the hand result from using the fingers to induce vomiting.
2 Hypokalaemia is virtually pathognomonic of vomiting in patients with eating disorders, and it may be reflected on electrocardiography as flattening of the T wave.
3 The treatments endorsed by the National Institute for Health and Clinical Excellence (NICE) in 2004 for bulimia nervosa are a version of cognitive behavioural therapy specifically adapted for this disease, a specific version of interpersonal psychotherapy, or high dose antidepressants (usually fluoxetine 60 mg daily).

STATISTICAL QUESTION

Interpreting a low P value

b



Chest radiograph of 20 month old girl with respiratory distress showing unilateral hyperinflation of the left lung. The radiograph is rotated to the right, which may slightly accentuate the left sided overinflation and lucency

PICTURE QUIZ 2

A 20 month old girl with respiratory distress

1 The chest radiograph shows a hyperlucent, unilaterally hyperinflated left lung and a degree of midline shift (figure).
2 Foreign body aspiration.
3 Rigid bronchoscopy.