Parity in the Spanish healthcare system: An analysis of the policies of the Aznar and Zapatero governments of 1996-2008

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ABSTRACT

Patrick Sung-Cuadrado: Parity in the Spanish healthcare system: An analysis of the policies of the Aznar and Zapatero governments of 1996-2008
(Under the direction of John D. Stephens)

Disparity within the Spanish healthcare system has been prevalent since the inception of the democracy after the fall of Franco. This disparity has particularly affected the poorer regions of Spain, which did not have the resources or infrastructure of the wealthier regions, such as the Basque Country and Catalonia. This thesis sought to analyze the policies of the national-level governments of the Popular Party's Jose Maria Aznar (1996-2000 and 2000-2004) and social democratic leader Jose Luis Rodriguez Zapatero (2004-present). After research on the policies of the governments and collection of data on healthcare expenditure per capita at each time point (the status of the healthcare system in 1996 before the first Aznar government and at the end of each government's term) in all regions of Spain, it was found that the PSOE government of Zapatero was more successful in promoting parity than the PP governments of Aznar.

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A vehicle carrying a family of four travels home through the Spanish autonomous community of Pais Vasco (the Basque Country) at midnight on a rainy evening. The driver takes the turn as he normally does, but the water causes him to hydroplane into a tree. After being taken to one of the community's hospitals, the family is placed in intensive care and, eventually, all survive. In a country with a system of universal healthcare, parity between regions should not only be a desire, but one of the three key goals of the Spanish state in terms of healthcare (in addition to up-to-date modernization of facilities and maximization of capabilities), however, this is currently not the status quo in the Spanish healthcare system. If this hypothetical situation were to occur in one of the poorer performing healthcare autonomous communities in Spain, such as the Baleares Islands, health and survival of said patients could very well be affected.

Disparity in the Spanish healthcare system has existed since the implementation of universal coverage with the passage of the General Health Law of 1986. Though lessened throughout the years with several legislative efforts, disparities remain in various autonomous communities. These disparities affect much of the populace of Spain and are a source of great concern for the Spanish government. Though decentralization has brought about much control on the regional level, national governmental legislation still affects regional healthcare. This analysis seeks to explore the degree to which national-level legislation positively affects institutional parity between regions in Spain in the field of healthcare with minor analysis of local "effort-based" parity-inducing measures. It is my assertion that national-level legislation affects community-level

healthcare to a significant degree; specifically, my hypothesis is that the social democratic Spanish Socialist Worker's Party (PSOE) of Jose Luis Rodriguez Zapatero (2004-present) has promoted more effective parity-inducing healthcare measures than the conservative Popular Party (PP) of Jose Maria Aznar (1996-2004).

First, the paper will aim to describe power resource theory as an explanation for both the historical disparities in the Spanish welfare state and the political movement of the government towards parity therein, specifically in terms of healthcare. The analysis will proceed to provide a historical account of healthcare in Spain and movement towards parity until the first Aznar government of 1996. It will provide a description of the healthcare system and its status in 1996 before Aznar comes to power, as to provide a starting point for analysis of the achievements of the governments under analysis. Legislative policy measures approved by the governments will then be detailed and their effects analyzed through two important healthcare effort measures: regional healthcare expenditure per capita and change in expenditure for each government. These will then be presented in table form at the end of each section. An analysis of the results will be performed at the end of the policy description sections and determine which of the two governments performed better. Finally, a brief speculative section discussing the result of the analysis and featuring a projection on the future of disparity in the country will conclude the paper.

The sources used for this paper are numerous. Peer-reviewed articles constitute many of the sources, as they will provide historical analysis of the healthcare system in Spain, a source for the power resources theory section of the paper and some further analysis of the parity-inducing effects of the legislative measures passed by the two

parties. Government databases and documents from the Ministry of Health and Consumption (MSC) will provide both the facts used for the outcomes at the time changes of the governments in each of the four case studies (1996, 2000, 2004 and 2008) and for the legislative measures approved during each of the legislative periods (1996-2000, 2000-2004 and 2004-2008), as well as their content. A lecture on the history of Spain from the late 1700s until the democratic transition will be used for the historical account section. The legislative database 060.es will be used as well to reference some of the laws. Newspaper articles will be used for some legislative background. Finally, the Chapman (2005) thesis will be used as a source for other sources and some basic information about the history of the autonomous regions and financing of healthcare systems.

Power resources theory and historical progression of disparity in Spain's welfare state

Reforms in governments and the welfare state are often described to arise through different means, or theories. One of the three most widely accepted theories is a "class-analytic" (Stephens 1979) explanation of welfare state variation, or power resource theory. Supported by Korpi, Stephens and Esping-Andersen, PRT is valuable in describing the social beginnings of the movements and reforms in Spain and will be used in depth in this analysis. Developed in the late 1960s by Gerhardt Lenski, power resource theory described a phenomenon where the lower classes could unite and overcome the powerful elite in the state to "claim a larger share of the social surplus" (Myles and Quadagno 2002). However, difficulties arise in elections due to the fact that the wealthy are property owners and control much of the resources available. The solution to this obstacle lies in the organization of the lower class into unions and parties in a system of "universal suffrage and free and competitive elections" (Myles and Quadagno 2002), where they exercise their franchise to elect "explicitly class-based (i.e., labor) parties to represent their interests" (Hewitt 1977).

The theory, further developed by Walter Korpi, who formally labeled the theory by Lenski as the "power resource theory," soon became the "dominant paradigm in the field" (Myles and Quadagno 2002). Korpi and others (Stephens 1979; Esping-Andersen 1985; Myles 1984) began empirical studies on the theory and found that "major differences in welfare state spending and entitlements among the capitalist democracies could be explained by the relative success of left parties aligned with strong trade unions"

(Myles and Quadagno 2002). More recent research, such as that of Van Kersbergen in 1995, finds that left parties and unions also generate high levels of social spending in center or right-controlled governments, such as social Catholicism and Christian Democratic governments. A problem arises in this explanation because social Catholicism and Christian Democratic parties are more readily willing to expend GDP on social services than liberal welfare states because of the Catholic tradition of eliminating poverty. However, it cannot be ignored that competition is created by left parties and unions that probably cause these centrist and center-right parties to concede more social services than they would prefer to fund or legalize, such as abortions and/or gay marriage. Broadly, power resource theory provides a good framework for researching the development of the welfare state in Spain, especially the healthcare system, of which will be the focus of this analysis.

The Spanish welfare state is classically defined as a Christian-democratic welfare state, but the history towards this classification is more complex than a simple relationship to the Catholic Church. Since the times of the Moors, Ferdinand and Isabella until the Constitution of 1812 (*La Pepa*), Spain had been ruled under monarchs. Establishing partial suffrage, freedom of print, industrial freedom, and abolishing the Inquisition, the Constitution of 1812, for the first time in Spanish history, had given the rural proletariat some basic rights. These rights lasted until 1820 when Ferdinand VII returns from his exile in France and imparts an absolute monarchy on Spain. Some liberties were renewed under Isabella II from 1833 until 1868, but civil war befell Spain that lasted from 1833 until 1876. During the last years of the Carlista Civil War from 1873 until 1874, the First Republic was formed under the Constitution of 1869, which

established universal suffrage and freedom of the press in addition to the accomplishments of *La Pepa*. The First Republic was the first proletariat-run government in Spain in history, but this accomplishment for the lower classes was subjugated once again to a monarch, albeit the constitutional monarch, Alfonso XII, in 1875 (Amador Carretero 2008).

Within this time period, the working class of Spain was experiencing difficulties. Agriculture and industry were still under aristocratic rule and the workers had no rights and disparity was extremely prevalent in this time. In particular, agricultural workers in rural areas were cultivating aristocratic land in a situation akin to the sharecropping of the southern United States in the early to mid 20th century (Amador Carretero 2008). Two types of agricultural workers existed: *jornaleros*, whom were daily contracted laborers, and *arrendatarios*, whom were given land to live on and cultivate, but were given an insignificant portion of profits and were constantly in debt. Living conditions were atrocious and families suffered immensely, even with the newly given rights; as a result, workers began to organize in the mid 1870s (Amador Carretero 2008). Informal union meetings began occurring more frequently and, eventually, on May 2, 1879, the Spanish Socialist Worker's Party was founded in Madrid with Pablo Iglesias as its designated party leader. In addition to PSOE, Young Socialists (Juventudes Socialistas) was founded in 1879 in Bilbao, the capital of the Basque Country. PSOE did not achieve any goals, let alone merit attention, until 1886 with the publication of the "El Socialista" (The Socialist) newsletter, which spread socialist ideas throughout the working class population of Spain (Amador Carretero 2008). Taking advantage of the growing organization and fervor developing in the worker population, Antonio Garcia Quejido founded the General

Worker's Union (UGT) on August 12th, 1888. Generally known as the Worker's Movement (1879-1908) and based primarily in the South and in Catalonia, the foundation of these three entities signaled the beginnings of proletariat organization (Amador Carretero 2008).

In this time period, specifically in 1883, the state, under Alfonso XII, created the Commission for Social Reforms (*Comision de Reformas Sociales*) to "investigate all questions that related to the benefit or welfare of the working class and that affected the relationship between Capital and Work" (MSC website 2008). PSOE and UGT pressured the Spanish crown with the need of care and support of workers who have been injured, and the monarchy relented in the form of the Law of Work Accidents of 1900 (*Ley de Accidentes de Trabajo*), which was the first social protection legislation in Spanish history. The Commission changed titles in 1903 to the Institute of Social Reforms (*Instituto de Reformas Sociales*) and in the next year was promptly given the charge to pass a comprehensive reform law after meeting with various officials in the Popular Forecast Conference held in October of 1904. Deciding better infrastructure was needed to handle the reform needed, they developed the model for the future National Forecast Institute (*Instituto Nacional de Prevision*, or INP), which was approved on February 27, 1908. With the establishment of the Institute, worker pensions became a topic of great interest, eventually culminating in the passage of the Mandatory Retirement Insurance for Workers (*Seguro Obligatorio del Retiro Obrero*) on March 11 of 1919 (INGESA website 2008).

Monarchic rule was in place until the coup of 1923 by General Primo de Rivera, who remained in power in a dictatorship until 1930. During General Rivera's rule,

however, two important parity-inducing legislative measures emerged in the form of maternity subsidies, such as loans, assistance during and after pregnancy. These measures could be seen as placation to the pressure from leftist organization, which was strong at this point in time. Upon the resignation of Primo de Rivera, General Dámaso Berenguer took power under what the Spanish called "dictablanda" (literally meaning 'soft rule'). This form of governance is a play on the word for dictatorship in Spanish, "dictadura" (literally meaning 'hard rule'). General Berenguer ruled under the title of dictator, but was very liberal in his allowances, eventually paving the way for the Second Republic in 1931 (Amador Carretero 2008). Power resource theory can explain the allowance of General Berenguer to eventually found the Second Republic because immense pressure from the left began swelling after the dictatorship of Primo de Rivera. During the Second Republic, another parity-inducing measure was passed, the Law of Accidents in Industry Work (*Ley de Accidentes de Trabajo en la Industria*) on July 4th, 1932, which brought about renewed hopes about the future of the Spanish welfare state (INGESA website 2008).

The power of the people, however, once again failed because of a coup, this time led by General Francisco Franco in 1936. The resulting Spanish Civil War from 1936 until 1939, in which Franco claimed victory, crushed the morale of the working class, who backed the Republican army, and Spain entered the worst period of its history. Rural worker unions and parties were eliminated, usually by violent methods, such as forceful removal of teeth and nails of the union and party members. As a result, the fledgling PSOE had to go in exile to France in order to survive. This, in addition to violent repression of opponents, effectively eliminated any hope of leftist influence within the

country to strive for distribution of services and wealth (Amador Carretero 2008). A dictatorship ensued with the only influential people being the wealthy, aristocratic class that supported Franco. While the dictatorship could not be said to have been a welfare state model, Franco installed a pseudo-Christian democratic regime that benefited his supporters and punished the rural working class based on his fanatical views on Catholicism and the male breadwinner family in 1963 through the passage of the Basic Law of Social Security of 1963. This law provided social security for salaried workers (mostly, supporters of Franco), insignificant transfers to the extremely poor, a very marginal network of healthcare for salaried workers and heavy employment protection laws (Guillen 2006).

As stated earlier, the historical roots for disparities in social classes grow until very recently and present a complicated yet fascinating background for the disparities existing in the Spain of today. While a worker's movement, in the form of PSOE, was breeding within Spain in the latter parts of the 19th century, the arrival of Franco's regime restrained progress towards parity in social circles and in social services. In the next section of the analysis, I will describe the historical account of healthcare in Spain until the first Aznar government in 1996, keeping in mind the historical roots of disparity within social networks.

Growth of the Spanish healthcare system

The current disparities in the Spanish welfare state are historically bound to the inequalities between the classes in the monarchic structure of the state since centuries ago. The lower classes had no representation or organization in government until the advent of PSOE and the other two labor organizations, UGT and the Young Socialists, in the latter half of the 19th century. These organizations represented proletariat interests and pressured the ruling class to make concessions, leading the way for the Second Republic of 1931. However, the arrival of Franco and the Spanish Civil War disrupted and, eventually, eradicated organization and brought about a regime representing the traditional ruling hierarchy of Spain's history: absolute power in the hands of one figure (in this case, *Generalisimo* Franco) with a Catholic ideology shaping the traditions of the country. With this new regime in place, healthcare remained where it had always been: either a part of the life of the lower classes with traditional cures or hospitals in larger city centers, which only the aristocratic could access. I believe that Franco's strong Catholic beliefs, however, formed a pseudo form of the Christian Democratic state of the modern era that initiated the healthcare system in Spain and other social transfers. Although these transfers mainly benefited Franco's supporters, they provided a foundation for the growth of the Spanish healthcare system into the future democracy and into the 21st century.

Franco began his reign in 1939 by removing any opposition in his attempts to consolidate power. Through the methodical brutality that ensued, most public vestiges of

leftist thinking within Spain were eliminated and forced into exile in France. With the state completely under his control, Franco needed a system of basic coverage of healthcare for new workers, mostly, presumably, for his supporters. On December 14th of 1942, Franco developed the Mandatory Sickness Insurance, or the *Seguro Obligatorio de Enfermedad* (SOE), a rudimentary healthcare system designed for his workers to be covered in case of sickness (Rodriguez et al. 2000). The program was financed exclusively through social security contributions and was intended primarily for coverage of "industrial workers and their dependants" (Rodriguez et al. 2000), however, it also sought protection for the extremely poor, whose salaries did not surpass the designated limits (INGESA website 2008). Benefits included medical assistance in case of sickness or maternity and economic compensation for the previously stated reasons (INGESA website 2008). The program is placed under INP responsibility upon its inception and compulsory coverage was soon extended to other labor groups, including "miners, seamen, landowners and agricultural workers" (Rodriguez et al. 2000). The program was extended to civil servants later on in Franco's rule, but included "special interesting features" for civil workers, amounting to extra benefits (Rodriguez et al. 2000).

On December 28th, 1963, Franco's government approved the Law of Social Security Bases (*Ley de Bases de la Seguridad Social*) that replaced older systems of social security and replaced them with the current system in place (INGESA website 2008). During this time, Franco began to be faced with increasing pressure from within the country from laborers and outside the country by leaders and PSOE, which was located in France during Franco's reign. Concessions, such as the social security reform and the opening of the country in the late 1960s, were a direct result of pressure from

these entities. After the death of Franco and during the democratic transition (of which will not be explored in this analysis), the Ministry of Health and Social Security (the predecessor of the Ministry of Health and Consumption, or MSC) was founded in 1977 on July 4th (INGESA website 2008). In 1979, the newly formed democracy approved the creation of the National Health Institute (*Instituto Nacional de Salud*, or INSALUD), which handled everything related to health within the Spanish social transfer system (INGESA website 2008). At this time, in the early 1980s, SOE transferred under INSALUD oversight and covered, after various extensions in coverage (the last significant addition being the self-employed in 1984), 83% of the population under public provision (Rodriguez et al. 2000).

The Spanish healthcare system in the early 1980s was firmly established and covered a large majority of the country. The disparity between the elite and the proletariat was decreasing and healthcare was at the forefront of the change. However, sentiments began going through the country about making certain social transfers, such as education and healthcare, at least partial concerns of the State. Thus, on April 14th of 1986, the Congress of Diplomats, led by the socialist PSOE, approved the General Law of Health (*Ley General de Sanidad*), eliminating the social security funded healthcare system and creating a National Health Service provided by the State (INGESA website 2008). The goals of this new conception and construction of the healthcare system in Spain were to increase the coverage rate from 83% to universal, shift finances for the system to a partially tax-driven system and to eventually devolve the healthcare sector from a INSALUD responsibility to a autonomous community responsibility by first establishing administrative centers in each region, which would eventually be given fiscal expenditure

freedom from the central government in Madrid (Rodriguez et al. 2008). The First General Budget Law changed healthcare financing in December of 1989 from a system primarily funded by social security payments (80% from employers and 20% from employees), representing roughly "75% of total public health financing while transfers from the State's tax revenues made up for the rest" (Rodriguez et al. 2000) to a system where the inverse occurred: tax revenue constituted 72% of healthcare financing with social security accounting for the rest (Rodriguez et al. 2000). Gradually, throughout the next ten years, financing was provided exclusively through the State's tax revenues, but this will be explored later in the section of Aznar's first government.

The inception of the National Health Service in 1986 was a landmark accomplishment by leftist groups, who through years of pressure and protest during the Franco regime finally became the leading party of the government in the 1980s. Before that time, national healthcare spending was extremely low in the middle part of the regime: 37.283 million equivalent euros (labeled EE for the rest of the analysis) for roughly 30.529 million inhabitants representing a per capita spending figure of 1.22 EE per inhabitant (MSC 2006a). Growth of healthcare spending in the latter part of the regime grew exponentially due to the corresponding economic boom of the 1970s: for example, in 1970, spending grew to 383.693 million EE for 33.956 million inhabitants representing a figure of 11.30 EE per inhabitant, and in 1975 (when the regime ended), spending grew to 1.373 billion EE for 35.849 million inhabitants resulting in a figure of 38.30 EE per inhabitant (MSC 2006a). By 1986, healthcare spending grew to 8.720 billion EE for 38.800 million inhabitants, or 224.74 EE per inhabitant (MSC 2006a), marking the beginning of large-scale healthcare spending in Spain.

After the advent of the NHS, funding for the various autonomous communities became an important issue, especially with the future plans of fiscal decentralization on the horizon. From 1986 until 1993, the Congress of Diplomats (Parliament) began analyzing various methods of determining how much funding each community would receive. Negotiations were difficult due to nationalist party interests wanting to keep the status quo and the socialist desire to form criteria based primarily on regional need, but socialist diplomats eventually ceded to nationalist interests that assured that no region would receive less than it previously received and also ensuring continued disparity in funding (Garcia-Mila 2003). However, this funding scheme did not provide the low-performing regions with more money and maintained the pre-existing disparities between regions (Garcia-Mila 2003). One last reform added before the Aznar government in 1996 and approved by the social democratic PSOE party, led by Felipe Gonzalez, was the passage of a new financial distribution formula that changed funding to a "demographically based scheme" (Chapman 2005). The next section seeks to analyze the politics of the Aznar administration and will track the progress of these four autonomous communities through regional GDP per capita spent on healthcare and two other healthcare effort measures that will be described briefly at the beginning of the next section.

The politics of equity and parity in healthcare of the first Aznar administration (1996-2000)

The data presented in this analysis is comprehensive. It contains information on each of the seventeen autonomous communities of Spain, is organized (from top to bottom) by the wealthiest regions to the poorest regions in average GDP per capita in 1996 and involves two measures, which will further be explained below. This comprehensive data set is being used to present the best possible picture of the Spanish healthcare system at the four time points (1996, 2000, 2004, 2008) to allow for better analysis of the three governments and their effects on parity in the healthcare system. The variables being used to analyze each autonomous community and their healthcare are "effort-based." These variables are healthcare expenditure per capita and change in expenditure. The motivation for choosing an effort-based variable is that this paper aims only to analyze the effects of legislation on removing institutional disparity between regions. Also, many commonly used variables for measuring healthcare parity, such as morbidity, mortality and life expectancy, have other influencing factors that have little correlation with institutional parity, which can not be explored in depth in a paper of this concise length.

The Spanish NHS, as we have seen, is the culmination of much effort, time and impetus from proletariat organizations, such as UGT and the political party, PSOE, which was governing from the early 1980s until 1996. In 1996, the Popular Party came to power in a coalition government with regional nationalist parties, such as CiU and PNV, on a

platform of largely economic issues, which were plaguing the country. At this time, the state of the healthcare system was varied depending on which of the autonomous communities one analyzed. On the following tables, certain terminology must be defined for best understanding the data. By underperformance, I mean to indicate that the expenditure level of an autonomous community is lower than the national average. Correspondingly, an over performing region is one that spent higher than the national average on healthcare per capita.

What the figures on table 1 suggest is an interesting situation. At this point in Spanish history, the numbers indicate that only two of the wealthiest eight regions underperformed in healthcare expenditure, including the wealthiest region in GDP per capita, the Balearic Islands. Meanwhile, five of the nine poorest regions underperformed. This pattern supports the historical tradition of the Southern regions being of the poor, working proletariat and the Northern regions being wealthy and having access to more resources in healthcare. A noteworthy observation is that with the establishment of the NHS ten years prior to these measures and constant social democratic rule during that tenure, one would be surprised that the disparity is so high at the beginning of the Aznar government. However, this is without analyzing prior benchmarks that could indicate social democratic success in this field, but the lack of statistical data prior to 1995 in this field does not allow for this study. Needless to say, the Aznar government was presented with a difficult challenge during its first term in power until 2000.

The Aznar government assumed control of the government in summer of 1996 and began initiatives to reform the previously lagging economy of Spain, which allowed for their successful election. However, the Popular Party also came into power with a political platform that stressed the improvement of "quality in public health services, increase

Table 1

Regional statistics in 1996	Regional expenditure on healthcare per capita (euros)
Balearic Islands	485.50
Madrid	590.24
Catalonia	592.78
Navarre	743.71
Basque Country	654.41
La Rioja	544.83
Aragon	607.23
Cantabria	615.96
Valencia	549.55
Castile-Leon	568.28
Canary Islands	604.30
Asturias	595.40
Murcia	543.45
Castile-La Mancha	534.83
Galicia	581.33
Andalusia	573.47
Extremadura	591.00
Spain	580.39

Source: Author's calculations, MSC 2006, INE website 2008

customer satisfaction and to improve overall efficiency" (Lopez-Casasnovas 1998). Stated preliminary reform proposals included "a purchaser/provider split; greater autonomy for health centers and hospitals; more efficient management at all levels of the health system; [and] a more equitable distribution of resources to correct territorial inequities" (Lopez-Casasnovas 1998). According to the MSC annual health report of 2003, close to 40% of Spaniards in 1995 felt that the healthcare system needed "fundamental" changes or a complete overhaul. With this significant percentage of Spaniards believing that the healthcare system needed large reforms in the mid 1990s, the Popular Party and Aznar took action in their second year in office. In 1997, the Popular Party approved several new legislative measures in an attempt to improve the healthcare system through several means. The first was a tax measure, which increased community ceded taxes, such as income tax, the value added tax and certain product taxes (alcohol, tobacco, etc.), to allow a greater revenue stream for non-foral autonomous communities (those communities that did not have much revenue authority) (Puig-Junoy and Rovira 2004). This could be said to increase autonomy within the regions and allow, perhaps, better management of funding or additional funding for services or infrastructure, not only in healthcare, but in other sectors of the community, where ceded taxes constituted 10% of regional income (Puig-Junoy and Rovira 2004). The increase of revenue authority to the communities was a prudent decision because individual autonomies would understand their budgetary needs more than on the national level and this supplemental revenue stream would aid in accomplishing the actual need. Later, this measure was further reformed to increase the ceded taxes to a further extent in 2002, but will be explored later in the next section as it occurred in the majority Aznar government.

A second legislative action approved by the Aznar government was a restrictive budgetary measure to prevent healthcare budget increases. Before the restrictive policy, preliminary community health budgets would be increased without approval when "effective pharmaceutical expenditure (and other minor expenses) exceeded the initial

budget" (Puig-Junoy and Rovira 2004). This practice typically led to underbudgeting by parliament due to the public sector of the communities "circumventing financial restrictions" and using this loophole in the law to finance programs, doctors and other costs for the regional healthcare system (Puig-Junoy and Rovira 2004). However, the passage of the measure from Aznar's government closed this financial loophole and prevented the increase of certain budgetary measures without decreasing another budgetary need by the same amount of the increase, thereby saving large amounts of money on the national level (Puig-Junoy and Rovira 2004). This reform caused a great deal of controversy within labor unions, especially the healthcare worker union, due to other sections of the reform that dealt with the organizational model of administrative healthcare workers. The additional reforms of the measure allowed administrative officials of primary care clinics to "allow centers to be run under other than public social security rules" (Lopez-Casasnovas 1998). The healthcare worker unions and leftist parties (social democratic PSOE and communist IU) complained that these measures undermined their collective bargaining agreements and, possibly, quality of service by allowing private insurers to "partially take on a larger role in the delivery of health care to the population" (Lopez-Casasnovas 1998).

A third legislative measure action taken by the Aznar government was the establishment of a national financial audit of the healthcare sector to "calculate the pending debt of the system" (due to frequent overrunning of community budgets) and to "eliminate this debt and formulate a realistic method of financing public health care in Spain" (Lopez-Casasnovas 1998). An audit of infrastructure, technology and personnel was also performed for the purpose of future modernization of facilities and resources for two reasons: a) to assure the most up-to-date equipment for Spain's healthcare system in the future for the end of better performance in supposed outcomes, such as infant mortality and life expectancy and b) to be able to later promote parity within and between autonomous communities by renovating infrastructure and providing more personnel to underserved areas.

Once these three legislative reforms had been passed, particularly the third, a familiar challenge to the central government arose. Upon the completion of the financial audit of the healthcare system, the historical problem of distribution of funding to each autonomous community (briefly mentioned earlier in the paper) arose and arguments occurred between the opposition left and the ruling right on how to distribute provisions in an equitable manner between autonomous regions. After much debate within the Fiscal and Finance Politics Committee (*Consejo de Politica Fiscal y Financiera*), consensus finally arrived in November of 1997 with the establishment and founding of the General Fund for Territorial Distribution and two other smaller funds (the Compensatory Fund and the Fund for Cross boundary Flow of patients). The General Fund constituted 98.5% of total funding and was given out on a per capita basis to each individual region, for example, Andalusia received 18.07% of the fund and Catalonia received 15.75% (Lopez-Casasnovas 1998). The other two funds, meanwhile, were created to "compensate those communities which could argue for an unfair treatment under the pure capitation system" (Lopez-Casasnovas 1998). The result is a "very complex strategy" that Lopez-Casasnovas deems absent of any "real reform."

The most significant problem with the entire financial aspect of the healthcare system was the search for funding for the ambitious spending of the government in their modernization projects. The audit revealed the significant public deficit that had accumulated due to overrunning of the budgets and that future planned transfer payments from the central government to the regional governments exceeded projected spending allotment for healthcare by 1.9 billion euros. The fiscal year of 1998 was the result, with the 1.9 billion euros being raised from various sources: 1.2 billion euros of additional funding from the central government general budget, 452 million euros from raised tax revenues and 248 million euros coming from "fighting fraud in sick day leave" (Lopez-Casasnovas 1998). With these reforms, the Spanish healthcare system began cutting extraneous costs. Even with increased effort at raising budgetary measures to provide additional funding for various

projects at the regional level, the ambitious plans of the 1996 Popular Party platform to reduce inequity were not realized. Focus then shifted, as Puig-Junoy and Rovira (2004) indicate, from parity in access, infrastructure and quality to "cost-containment."

The goal of cost-containment changed in the last full year of the first minority Aznar government with the passage of the legislative reform changing the structure of health financing. As described earlier, the General Budget Law of 1989 dictated that eventually healthcare be solely financed through tax, and the culmination was the 1999 law fundamentally that changed the funding system from a hybrid social security-tax finance system, where social security financed 28% and tax financed 72%, to exclusively tax driven (Rodriguez et al. 2000). Motivations behind the bill were that "unlike old age pensions, the amount of health services received is unrelated with the amount of contributions paid," so it is a sound decision to finance healthcare through taxes (Rodriguez et al. 2000), however, some experts argue that the motivation was to move healthcare out of a future social security crisis (Lopez-Casasnovas 1998). One other aspect of the reform in 1999 was the clause that changed the tax relief scheme. Until 1999, all private health care expenditures, even if funded by public transfers, led to a 15% tax relief reflected in a user's personal income tax, which has merely proven to be a "regressive fiscal expenditure" (Lopez-Casasnovas, Costa-Font and Planas 2005). The hope with this measure was to see if subsidized private healthcare consumption resulted in lower public healthcare consumption, however, the evidence of whether or not this actually occurred is lacking and the debate continues. Since 2000, the only subsidized private care that was tax deductible were "private health care [expenditures] financed by insurance premiums paid by firms (from corporate income tax)" (Lopez-Casasnovas, Costa-Font and Planas 2005). This was a significant contraction of the previous tax law, which now excluded private coverage sought by individuals through public funds

The policy measures enacted by the Popular Party and Aznar during his first term in office were very optimistic in terms of goals in their party platform at the beginning of their

tenure. The problem that arises out of the policies enacted by the Aznar government strayed from the end goal of equity and parity then settled for cost cutting measures (Puig-Junoy and Rovira 2004). While the Popular Party is traditionally credited with steering Spain to economic prosperity in their eight years in office, these first four years of policies only serve to further their image as willing to sacrifice equality throughout society for the interests of the wealthy. In terms of legislative effort seeking parity, the minority Aznar government performs quite poorly. However, it is necessary to look at the growth results of the sample communities to see any effect the policies could have had, or how to explain growth in sectors if they do not correlate directly with legislative measures.

When comparison of 1996 and 2000 occurs, several interesting trends can be observed. First, table 2 indicates that of the top eight wealthiest regions, two regions remain underperformers, but Madrid is a newcomer, while La Rioja expands spending by an incredible 37.91% to rise above the national average, leaving the Balearic Islands as the sole underperformer from 1996 from the wealthiest regions, despite its status as the wealthiest region in GDP per capita in 1996. Additionally, five of the nine poorest regions underperformed, which is the same as in 1996. However, four of the eight wealthiest regions underperformed in change in expenditure, with only two of the poorer nine regions underperforming in this measure. This indicates that the government did promote some parity, however disparity is still prevalent in the actual figure of healthcare expenditure per capita. Therefore, there is no indication, from these numbers, that the policies of the first Aznar government had much effect on parity. On the contrary, the legislative policies enacted contain no language that strongly supports the argument that this data is the result of the policies of Aznar. More analysis will be performed in the results/discussion section, as we move to the policies of the majority Aznar government of 2000-2004.

Table 2

Regional statistics in 2000	Regional expenditure on healthcare per capita (euros)	% change 1996-2000
Balearic Islands	609.06	25.45
Madrid	690.44	16.98
Catalonia	756.22	27.57
Navarre	910.32	22.40
Basque Country	831.15	27.01
La Rioja	751.38	37.91
Aragon	769.07	26.65
Cantabria	799.56	29.63
Valencia	685.51	24.74
Castile-Leon	732.77	28.95
Canary Islands	790.62	30.83
Asturias	774.57	30.09
Murcia	715.23	31.61
Castile-La Mancha	683.17	27.74
Galicia	744.17	28.01
Andalusia	694.26	21.06
Extremadura	754.89	27.73
Spain	736.84	26.96

Source: Author's calculations, MSC 2006, INE website 2008

The politics of equity and parity in the healthcare system by the second Aznar government (2000-2004)

The previous Aznar administration performed extraordinarily well economically in their first term in office, and while their healthcare reforms did not actively promote parity, some of the autonomous communities in this study did improve levels of parity. Due to the success of the party in their first term in office, the Spanish populace reelected Aznar and the Popular Party to power again in 2000, but this time with an absolute majority in parliament. With no need to pander to nationalist parties and form coalitions, the Popular Party set out to pass reforms that they truly desired. As we will see in this section, this included several healthcare reforms.

During the first year of the Aznar majority government, no healthcare reforms were passed due to other priorities on the party platform. However, an important measure was passed on the 27th of December in 2001 with Law 21/2001, which devolved healthcare management exclusively to the autonomous communities, which had not already received those administrative powers (Andalusia, Catalonia, Navarre, the Basque Country, Galicia, etc.) (Miragaya 2004). The motivation behind this reform was simple: politicians wanted to allow the communities to formulate their own strategic plans; the extreme difficulty in national planning for each of the various communities was reflected in constant debate in parliament over what was the best course of action for each region (Miragaya 2004). This legislative measure was the most prudent decision for the government because it is logical that Extremadura would be able to determine what is the

best or most efficient reform to approve for Extremadura, as well as every other autonomous community that was not already included in the pre-2001 decentralization process. The law also included a fiscal aspect, which was divided into two equally significant parts.

The first of these fiscal aspects was the devolution of healthcare financing from State taxes to the budgets of the various autonomous communities. For this end, the aforementioned extension to the ceded tax law came into effect; the ceded law reform now fully transferred some authority over several taxes, whereas the 1997 law transferred the revenue to the communities. Autonomous communities began to have control over 33% of the income tax of their residents, 40% of some consumption taxes (alcohol, tobacco, petrol, etc.) of the products sold in their region and 35% of the VAT in their region (Puig-Junoy and Rovira 2004). It is important to note that this measure is questionable in its parity-promoting effects. The movement towards more regional control over funding, on first glance, appears to be positive. Regional governments know more about their needs, so they would be able to address their needs more effectively through spending in areas of weakness. However, the practice is inegalitarian because poorer regions would make less revenue from taxes than more wealthy regions, simply based on higher wages in the wealthier communities. This implies that poorer autonomous communities would have less funding to spend on programs and infrastructure than wealthier communities and that the policy measure would, in fact, amplify previous disparity, rather than promote parity.

The second fiscal reform of the 2001 policy measure was a limit on regional spending. This aspect appeared to have been reminiscent of the previous administration's

cost-cutting measures with the raising healthcare expenditures only being approved if the community could provide the funding in some other method, such as budget cuts from other sectors (education, for example), community-level tax increases or from regional growth in GDP larger than the percentage of Spain's growth (Puig-Junoy and Rovira 2004). In addition to these reforms, the Aznar government passed the General Law of Budgetary Stability that demanded of governments a "zero deficit rule" (Chapman 2005). According to Garcia-Mila (2003), criticism arose throughout the country, especially from PSOE and the healthcare sector, which indicated that healthcare had historically been underfinanced in Spain and every community now had a tremendous deficit from all of the previous borrowing. The widespread deficits now prevented communities from spending as much as planned and slowed developments of infrastructure and programs to promote parity throughout and between regions.

The following year, when most of these reforms officially began, the Aznar government made an addendum to Law 7/2001 with Law 53/2002 that assigned minimum expenditure figures for each autonomous community. The motivation for this law was to ensure that a certain percentage of Spanish GDP was going to the healthcare system. However, in retrospect, this minimum guideline seemed unnecessary as spending far exceeded these minimum guidelines. For example, Andalusia spent 765 million euros (14.19%) more than was asked in 2003, while Catalonia and Extremadura spent 796 (16.58%) and 163 million euros (19.40%) more, respectively; however, the most overspending region was Madrid, which spent 1.5 billion euros (51.07%) more than the so-called "minimum expenditure" level (Miragaya 2004). In total, the spending guideline was exceeded by 5.38 billion euros (19.34%) (Miragaya 2004). Another minor legislative

policy approved on August 2nd, 2002 was Royal Decree 840/2002, which changed INSALUD to INGESA (National Institute of Health Matters). The change could be aptly described as part-cosmetic and part-structural due to the dual nature of the law: cosmetic because the name change did not affect the workings of the institution, yet structural because it assigned the management of expenditures of the autonomous cities Ceuta and Melilla (Miragaya 2004). One last change in 2002 was legislation creating a Cohesion Fund, which would allow for the compensation of one community's resident going to another community and receiving healthcare there and for foreign European residents receiving care within Spain (Miragaya 2004). This fund, financed by the government's central budget, allows flexibility for residents who in certain instances need to go to another community to receive adequate care. However, this fund does not appear to promote parity because of its adaptation to the problem of healthcare disparity between regions, rather than seeking to solve the problem.

Perhaps the most significant law passed during both Aznar administrations was Law 16/2003, approved on May 28th for the cohesion and quality of the NHS. Among the stated goals of the law at the beginning of the legislation were to limit waiting lists for uses of the system in the communities for quality and the have "equal conditions and guarantees to patients sent to other Autonomous Communities for treatment" (Miragaya 2004). In the first chapter of legislation, entitled "Transfers of the NHS," recognition to the rights and guarantees to citizens of accessibility, movement, information, quality and security and a guarantee that the Interterritorial Council of the NHS (CISNS) would approve guidelines for waiting lists (Miragaya 2004). Chapter three, entitled "Professionals," creates a Human Resources Commission (HRC) that would participate

in both the State and community-level administrations and would dictate criteria for the movement and placement of healthcare professionals in certain autonomous communities (the criteria were later passed in November of 2003 with Law 44/2003 and Law 55/2003, which dictated coordination methods to facilitate ease of movement) (Miragaya 2004). Chapter six, entitled "Quality," dictates that yearly plans of quality will be handled by CISNS; allows yearly audits by public institutions or private companies of the quality and safety of NHS centers and health services; creates the Agency of NHS Quality that would be responsible for development and maintenance of the quality of facilities in communities; creates the NHS Observatory, which would constantly be assessing the quality of the NHS and was approved, along with the Agency of NHS Quality, with Royal Decree 1087/2003 (Miragaya 2004). Finally, in the second final disposition, the creation of inter-ministry council that would investigate potentially disparity-inducing fiscal matters for the NHS and report to CISNS and the Fiscal Policy Council (Miragaya 2004).

As observed, the last piece of major healthcare legislation by the Aznar government was extremely ambitious in its effort for inter-regional healthcare parity. Chapter one represented mostly symbolic gestures as reassurances to the Spanish people that their concerns were being addressed with this piece of legislation. Chapter three begins two significant reforms that are pertinent to parity: the creation of the HRC and the criteria to dictate methods for the placement and movement of medical professionals is extremely useful for parity. If the government dictates where recent doctors have to go, then parity could be rapidly promoted within a region, if the infrastructure is there in the form of clinics and hospitals. Chapter six further promotes parity by creating a system of

frequent checks and balances of quality of facilities and of infrastructure, while also creating an agency that is responsible for the creation of more State and regional infrastructures and the maintenance of it. This section creates a synergy with chapter three by providing the infrastructure needed in underserved areas that can be filled by the doctors that the central and community governments distribute. The final legislative measure of the law creates the inter-ministry council that would investigate and research possible disparities in funding in the NHS throughout the country, which helps immensely by providing funding for infrastructure, personnel, technology, medicines and other services that could promote equity between regions.

The majority Aznar government of 2000-2004 certainly passed more effort-based parity-inducing legislation than the previous Aznar government. Solely off the merits of Law 16/2003, this government was far more successful than the first term government but, in addition, the majority Aznar government passed legislation decentralizing the healthcare system, allowing the communities to decide the best individual course of action for their region, as well as extending them partial control of ceded taxes. However, not all the legislation was positive for parity. The fiscal "cost-cutting" measures in 2001 (particularly the zero deficit rule) constrained regional governments in their healthcare spending, unless they could find the means, which did not indicate disparity in social democratic PSOE-run communities, such as Andalusia, which would just raise taxes to meet the demand. However, in the Popular Party run communities, such as the Balearic Islands, this implied disparity-promoting policy due to the PP's reluctance to raise taxes, especially on the wealthy. Also, the Cohesion Fund, while designed to allow patients access to other areas, possibly promotes keeping the status quo causing a client to move

from a high-performing region, such as Extremadura, to a low-performing region, such as Andalusia, because the smaller Extremadura did not have technologically advanced equipment available for use like the larger Andalusia might possess. Finally, the devolution of healthcare responsibilities might not be as effective as previously thought by Spanish politicians. While the logic of a region understanding what needs it has better than the central government is sound, according to research by Chapman (2005), Puig-Junoy and Rovira (2004) and the opinion of Spanish citizens (more than 50% of whom see differences between urban and rural areas), decentralization had not necessarily promoted equity between Spaniards by 2004, rather it still had fiscal responsibility deficiencies (Puig-Junoy and Rovira 2004) and highlighted, or even further entrenched, certain "socioeconomic inequalities and differences in political ideology, administrative capacity and revenue generating ability" (Chapman 2005).

Analysis of the numbers may support that Aznar's government did well in promoting parity during their second tenure in office. The trends seen in the table indicate several things. The growth in healthcare expenditure per capita increased by 33.28%, which is larger than the change of the first Aznar government. However, of the eight wealthier regions, three were now underperforming (compared to two in 2000). Of the eight autonomous communities posting below average expenditure, five were of the nine poorer regions, including three of the bottom four (Castile-La Mancha, Galicia and Andalusia). Galicia, in fact, had not been underperforming in healthcare expenditure per capita since the last Felipe Gonzalez PSOE government lost the elections in 1996. While the Aznar government once again displayed increased bottom-over-top-level spending (four of the wealthiest eight regions underperformed in change in expenditure compared

Table 3

Regional Statistics in 2004	Regional expenditure on healthcare per capita (euros)	% change 2000-2004
Balearic Islands	914.40	50.13
Madrid	877.15	27.04
Catalonia	971.35	28.45
Navarre	1,123.88	23.46
Basque Country	1,091.65	31.34
La Rioja	1,061.92	41.33
Aragon	1,036.10	34.72
Cantabria	1,177.31	47.24
Valencia	924.30	34.83
Castile-Leon	974.82	33.03
Canary Islands	1,083.93	37.10
Asturias	1,084.47	40.01
Murcia	993.38	38.89
Castile-La Mancha	914.04	33.79
Galicia	967.26	29.98
Andalusia	921.93	32.79
Extremadura	1,085.27	43.77
Spain	982.06	33.28

Source: Author's calculations, MSC 2006, INE website 2008

to three in the poorer nine regions), the case of Galicia and the fact that three of the poorest four regions in Spain were now underperforming indicate that the Aznar government did not promote parity effectively during their second term.

What we have seen in the second Aznar government is more legislation that appears to have increasingly focused on social changes to the healthcare system rather than the fiscal cost cutting that marked the first administration. What the data shows, however, is that the policies of the second Aznar government were extremely ineffective in reducing disparity between the wealthiest and the poorest of regions. While it is evident that the Aznar government generally performed poorly in both terms of governance, we must analyze the policies of the Zapatero government and continue to monitor the progress of the case communities through 2004-2008 before a resolution on the thesis may be concluded.

The politics of equity and parity in the healthcare system in the Zapatero government of 2004-2008

With the surprise victory of the PSOE in the 2004 elections, Jose Luis Rodriguez Zapatero became president, promising progressive social policies in various sectors, especially attention to the healthcare sector. The social democratic platform did not appear to appeal to Spaniards particularly well, especially considering the success of the Popular Party in their two terms. However, with growing discontent about the Iraq War and the occurrence of the March 11th bombings in Madrid, voter turnout was the highest in the history of the democracy and the social democrats won. As a result, what we see over the course of the following four years is a series of very progressive social healthcare policies with few types of the measures of the previous administration, which is to be expected from a transition of a Christian democratic ruling party to a social democratic ruling party.

The first policy of the Zapatero government was one such progressive social policy was Royal Decree 2132/2004 concerning stem cells and their usage and funding on October 29th, 2004. The second law of the PSOE government, however, provides supposed parity-inducing legislation in the form of Royal Decree 2198/2004. This decree modifies the Cohesion Fund, created by the Popular Party in their second term and modified by the significant Law 16/2003, by adding two important clauses. The first clause states that the State should distribute funding to finance tobacco prevention programs to the autonomous communities to lower tobacco usage, particularly amongst

healthcare professionals and educators (060.es 2004). The second clause covers the diabetes problem in Spain and seeks to provide funding to the communities for primary prevention programs and assistance to diabetic patients (060.es 2004). This program, while not creating parity between states, improves the quality of healthcare within the country and, due to its distribution to the regions needing the funding the most, does promote parity in the state of health of its citizens.

One of the campaign promises that the PSOE made during election season was a promise to provide every autonomous community with a "major injection of funding" (Chapman 2005), due to the widespread prevalence of healthcare deficits. The Zapatero government asked each autonomous community to partially become responsible for the healthcare debt, but the regions governed by the Popular Party showed restraint in accepting the proposal by the government (*El Pais* Sept. 1st, 2005). This result of the PP-controlled rejecting calls from the central government to accept the burden of part of the debt reflected sentiments of the Zapatero administration, which stated that if citizens want more funding or elimination of debt in their region, they must make better political choices (*El Pais* Aug. 24th, 2005). This is true in the sense that PP-controlled governments provide more tax breaks to the wealthy and, as a result, have less money for social transfers, while PSOE-controlled governments show ready willingness to increase taxes for the end of social programs.

As a result, the government proposed a direct transfer of 500 million euros and 1.2 billion more in various funds from the central government's budget and increases on tobacco, alcohol, gas and electricity as both a way to curb usage of these goods and to help finance the system debt (*El Pais* Sept. 1st, 2005). Although financial responsibility of

the healthcare budget had been passed to the community level, the government announced its willingness to cover half of the regional healthcare debt. It was at this time that the Zapatero government and the Fiscal and Finance Policy Council decided on September 13th, 2005 to approve the tax increases: one cent per liter of beer, thirty cents per liter of spirits and 10 cents per pack of tobacco (*El Pais* Sept. 17th, 2005). This policy helped promote parity between states because it permitted them to be able to spend money and not have to worry about overhanging deficit. The distribution of the funding, however, maintained the scheme of the second Aznar government (legislated in 2002 and to last for a duration of at least five years) that weighed every region equally, mostly by the basis of population and area (94% and 4.2%, respectively). While this system appears to be fair, it does not take into consideration large, populous and wealthy regions, such as Catalonia, which would receive funding they do not need over a smaller, poorer community, such as Murcia, which needs more funding to bring its infrastructure to the level of the high performing regions. Additionally, the distribution scheme excludes weighting of income inequality in the formula, which was a component in the previous schemes of 1987, 1991 and 1996. This will have to be an area of reform in the future for continued increases in parity.

Later in the year (December), the government passed Law 28/2005, preventing various tobacco promotional and vending techniques to lower usage within the population (another progressive social policy rather than exclusively parity-inducing). After the passage of more progressive health services, such as the May of 2006 Law 14/2006 regarding technical regulations for assisted human reproduction, the Zapatero government passed Royal Decree 1207/2006 in October of 2006 that extended coverage

of the Cohesion Fund to other services in healthcare and to change the wording of the law so that every citizen would be covered by the Cohesion Fund (060.es 2006a). This extension ensures that every region would be ensured of coverage so that deficits would not occur on the community level and that expenditures could continue in a relatively uninterrupted process to promote parity between regions by the creation of new infrastructure, hiring of more doctors, etc.

The final law of significance for this analysis from the Zapatero government (due to the two future legislative measures concerning biomedical investigation and medication, areas not related to this study) was Royal Decree 1302/2006, which sought to expand the hallmark healthcare parity legislation of the majority Aznar government, Law 16/2003. The stated objective of the law was to "guarantee the equity in access to healthcare that is characterized by quality, efficient and safety to people with certain conditions that require specialized attention that are available to a reduced number of centers;" the objective later states that the royal decree is to provide a process for the development and accreditation of centers to be able to provide better care to underserved areas (060.es 2006b). Article four creates a "Committee for the designation of centers, services and reference points" that would perform various functions for parity: a) study community needs and propose strategies; b) propose the procedure for the designation of centers, services and reference points for the NHS; c) propose criteria for the designation and accreditation of centers; d) inform communities over the procedure of accreditation; e) evaluate solicitations for designation from centers on need-based criteria; f) study and propose renovations for centers to keep them state-of-the-art; and g) propose procedures for the derivation of system users (060.es 2006b). The legislation closes with financing of

the project in article nine. The article states that the Cohesion Fund will finance the measures enacted and distribute funding to the regional governments for the explicit use of this project (060.es 2006b).

This legislation is representative of the social platform of the Zapatero PSOE government and indicates a strong desire to increase parity between the autonomous communities. Royal Decree 1302/2006 explicitly was formulated for parity between regions through assistance to underserved, poor performing healthcare regions. While most of the policies enacted by the government were social in nature, there seemed to be a genuine attempt for regional equity without concerns of cost, while the Aznar governments, certainly not averse to parity between regions, displayed a sense of "parity-for-the-right-price" attitude. The extension of coverage and duties of the Cohesion Fund and the 2005 actions to remove healthcare deficits from the autonomous communities through taxation and fiscal transfers from the central government to the regional level indicate the willingness and attempts to reduce debts so that the communities could spend to improve their healthcare systems. The evidence strongly supports that the PSOE government led by Zapatero did promote more parity than the PP governments led by Aznar.

The first facts seen from the data point of 2008 (table 4) are the changes in regional expenditure. The 30.53% increase in healthcare expenditure per capita is higher than the first Aznar government. While it is a lower rate than the second Aznar government, the bottom four regions during Zapatero's 2004-2008 government all increased spending over the national average, mostly by large margins, while two of the bottom four in the second Aznar government underperformed. More revealing is that the

Zapatero government only had two of the poorest nine regions underperforming in healthcare expenditure per capita (compared to five under the second Aznar government), including now having only one of the poorest four regions (Andalusia) under the national average (compared to three of four under Aznar). The other underperforming region of the poorest nine in Spain, Valencia, is a case that will be discussed later in the conclusion due to influences away from national level politics, especially in light of its underperformance in *both* measures by particularly large amounts (12.11% lower in expenditure and 8.63% in change in expenditure). Another interesting fact the data reveals is that only two regions that underperformed under the Zapatero government changed their expenditure by less than the national average: Valencia and the Balearic Islands, which has appeared to be a problem case for each government since 1996. This number is compared to four under the first Aznar government and five under the second Aznar government. All these numbers indicate a much stronger effort on the part of the Zapatero government to promote parity within the Spanish healthcare system.

Table 4

Regional Statistics in 2008	Regional expenditure on healthcare per capita (euros)*	% change 2004-2008
Balearic Islands	1,154.67	26.28
Madrid	1,178.84	34.39
Catalonia	1,274.32	31.19
Navarre	1,441.80	28.29
Basque Country	1,542.05	41.26
La Rioja	1,486.60	39.99
Aragon	1,392.82	34.43
Cantabria	1,348.61	14.55
Valencia	1,126.71	21.90
Castile-Leon	1,386.61	42.24
Canary Islands	1,411.23	30.20
Asturias	1,307.18	20.54
Murcia	1,302.31	31.10
Castile-La Mancha	1,349.37	47.63
Galicia	1,374.25	42.08
Andalusia	1,229.93	33.41
Extremadura	1,553.82	43.17
Spain	1,281.92	30.53

Source: Author's calculations, MSC 2008, INE website 2008
*Initial budget figures used since fiscal year 2008 has yet to end

Results/Discussion

The data from the various time points suggest that neither government particularly affected the growth and parity between regions. It could also suggest that both governments passed legislation that positively affected parity between the regions. In fact, the improvement in population per doctor and regional expenditure on healthcare per capita were better in the second Aznar government than in the Zapatero government. However, these statistics may be slightly misleading. It was established earlier in the analysis that the healthcare system was devolved to the various communities for their management. Valencia is a case where it is especially important to note this. The Community of Valencia has been a bastion of Popular Party support since the municipal elections of 1995. Every other community has similar patterns: Andalusia has been a PSOE stronghold since the inception of the democracy; Catalonia has been majority socialist since 1996; and Extremadura was socialist from 1996-2000 and 2004-2008 (MIR 2008). This indicates that, during the terms of these three governments, the regions used in the study were all socialist, for the exception of a minority PP government in Extremadura during Aznar's second term and Valencia. Social programs from the community level should be considered as either a partial or significant cause of the improvement or, in the case of Valencia, underperformance in the measures.

Although this should be taken into consideration, it does not render the results void of any merit. Table 5 summarizes the information in Tables 2-4. The figures in the second column are correlations between regional GDP per capita levels in 1996 and the

change in healthcare expenditure in each government. Negative numbers indicate convergence, or rather, that the poorer regions are increasing healthcare expenditure per capita at a higher rate than the wealthier regions. As the table indicates, the negative correlation for the Zapatero government is higher than for either Aznar government, suggesting a more successful effort at promoting parity during the PSOE term in office.

Table 5

Correlation of 1996 regional GDP to change in spending	Correlation of 1996 regional GDP per capita with regional change in spending during the governmental period
Aznar government 1996-2000	-0.18
Aznar government 2000-2004	-0.14
Zapatero government 2004-2008	-0.22

Source: Author's and John Stephens' calculations

As I have described above in the corresponding sections of each government, however, the policies of the Popular Party and Aznar seemed to have hindered regions more than they benefited them. The insistence of fiscal policies that restrained spending, while benefiting the national economy and growth in other sectors, hindered the process of building parity through infrastructure and personnel in the healthcare sector. Although the PSOE government of Zapatero did not pass significant amounts of legislation dictating explicitly for healthcare parity between regions either, the government of 2004-2008 showed substantially more willingness to spend finances to allow the regional governments to remove themselves from the deficits that plagued them since the inception of the healthcare system in Spain. Finally, as well as passing many socially

progressive measures for social liberties in the healthcare field (stem cell research, abortions, tobacco prevention, etc.), the Zapatero government approved a law that did explicitly seek to promote parity between regions through development of care centers for specialized needs and rare illnesses.

It could be argued that Spain has been developing its current healthcare system over a general time period of roughly thirty years of democracy; in this light, it is understandable why such disparity still exists in such an advanced, industrialized country. As discussed throughout the analysis, healthcare has traveled a long path towards parity. Through the efforts of the Aznar government and the Zapatero government, equity in the Spanish healthcare system seems more approachable every passing year. The future holds much promise for this area of social need in the Spanish welfare state, particularly with the reelection of the Zapatero government in March of 2008. The government has promised to keep promoting equity in all sectors of Spanish society, especially the healthcare sector. However, with the recent economic downturn and the extreme concern of the Spanish people for this "crisis," it appears the second Zapatero government will have a difficult time fulfilling the potential developed over the past few decades.

References

Aizpeolea, Luis R. "Sevilla pregunta a Rajoy si pretende que las autonomias no asuman el deficit sanitario." El Pais. 24 Aug. 2005.2 Sept. 2008 <http://www.elpais.com/articulo/espana/sevilla/pregunta/rajoy/pretende/autonomias/asuman/deficit/sanitario/elpepiesp/20050824elpepinac_11/tes>.

Amador Carretero, Pilar. "La Historia de España." Universidad Carlos III de Madrid, Madrid. 22 Jan. 2008.

Chapman Osterkatz, Sandra. "Untitled Thesis on Effect of Decentralization to the Spanish Healthcare System." Thesis. Chapel Hill, NC, 2003. 1-18.

EFE. "Las subidas de impuestos sobre alcohol y tabaco para financiar la Sanidad entran hoy en vigor." El Pais. 17 Sept. 2005. 3 Sept. 2008 <http://www.elpais.com/articulo/espana/subidas/impuestos/alcohol/tabaco/financiar/sanidad/entran/hoy/vigor/elpepuesp/20050917elpepunac_1/tes>.

"El Gobierno propone subir los impuestos de tabaco y alcohol para financiar la Sanidad." El Pais. 1 Sept. 2005. 2 Sept. 2008 <http://www.elpais.com/articulo/economia/gobierno/propone/subir/impuestos/tabaco/alcohol/financiar/sanidad/elpepueco/20050901elpepueco_6/tes>.

"Elecciones Congreso de los Diputados Marzo 1996." Lista de Ambitos Territoriales. 2008. Ministerio del Interior. 5 Sept. 2008 <http://www.elecciones.mir.es/mir/jsp/resultados/comunes/detalleeleccion.jsp?tipoeleccion=0&cdeleccion=2&anio=1996&mes=3&numvuelta=1&nombreeleccion=congreso+de+los+diputados&horacierre=20:00&horaavance1=14:00&horaavance2=18:00&tipoambito=n>.

Garcia-Mila, Teresa. "Fiscal federalism and regional integration: lessons from Spain." Thesis. Barcelona, 2003. 1-36.

Gasto Publico en Sanidad (1988-2005): Gasto Sanitario Publico Territorializado por CC.AA. Spain. Ministerio de Sanidad y Consumo. Estadistica del Gasto Sanitario Publico. Madrid, 2006. 1-26.

Gasto Publico en Sanidad: Serie enlazada 1960-2005. Spain. Ministerio de Sanidad y Consumo. Estadistica del Gasto Sanitario Publico. Madrid: Ministerio de Sanidad y Consumo, 2006. 1-4.

Hewitt, Christopher. "The Effect of Political Democracy and Social Democracy on Equality in Industrial Societies: A Cross-National Comparison." American Sociological Review 42 (1977): 450-64.

Instituto Nacional de Estadistica. 2008. Instituto Nacional de Estadistica. 20 Aug. 2008 <http://www.ine.es/>.

Lopez-Casanovas, Guillem. "Cost-Containment in Health Care: The Case of Spain from the eighties up to 1997." Ms. 6. Centre de Recerca en Economia i Salut, Barcelona, 1998.

Lopez-Casasnovas, Guillem, Joan Costa-Font, and Ivan Planas. "Diversity and regional inequalities in the Spanish 'system of health care services'" Health Economics 14 (2005): 221-35.

Miragaya, Laura C. Anexo IX: Reformas Sanitarias Recientes. Spain. Ministerio de Sanidad y Consumo. Madrid, 2004. 3-64.

Myles, John, and Jill Quadagno. "Political Theories of the Welfare State." Social Service Review (2002): 34-57.

"Nuestros origenes." Instituto Nacional de Gestion Sanitaria. 2008. Ministerio de Sanidad y Consumo. 16 Aug. 2008 <http://www.ingesa.msc.es/organizacion/origenes/home.htm>.

Puig-Junoy, Jaume, and Joan Rovira. "Issues raised by the impact of tax reforms and regional devolution on health-care financing in Spain, 1996-2002." Environmental and Planning C: Government and Policy 22 (2004): 453-64.

"Real Decreto 1302/2006, de 10 noviembre, por el que se establecen las bases del procedimiento para la designacion y acreditacion de los centros, servicios y unidades de referencia del Sistema Nacional de Salud." 060.es. 10 Nov. 2006b. The Government of Spain. 5 Sept. 2008 <http://www.060.es/te_ayudamos_a/legislacion/disposiciones/35991_leg-ides-idweb.html>.

"Real Decreto 1207/2006, de 20 octubre, por el que se regula la gestion del Fondo de cohesion sanitaria." 060.es. 20 Oct. 2006. The Government of Spain. 4 Sept. 2008a <http://www.060.es/te_ayudamos_a/legislacion/disposiciones/35814_leg-ides-idweb.html>.

"Real Decreto 2198/2004, de 25 noviembre, por el que se determinan los colectivos a los que se dirigen las políticas de cohesión a efectos de su financiación por el Fondo de cohesión sanitaria durante el ejercicio 2004." 060.es. 25 November 2004. The Government of Spain. 24 Aug. 2008 <http://www.060.es/te_ayudamos_a/legislacion/disposiciones/30781-ides-idweb.html>.

Recursos del Sistema Nacional de Salud. Spain. Ministerio de Sanidad y Consumo. Subdireccion General de Analisis Economico y Fondo de Cohesion. Madrid: Secretaria General de Sanidad, 2008. 1-67.

Rodriguez, Marisol, Richard M. Scheffler, and Jonathan D. Agnew. "An update on Spain's health care system: is it time for managed competition?" Health Policy 51 (2000): 109-31.

Stephens, John D. The Transition from Capitalism to Socialism. Urbana, IL: University of Illinois P, 1979.