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COST -CONTAINMENT IN HEALTH CARE: The Case of Spain from the eighties up to 1997

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ABSTRACT.

The purpose of this paper is to provide an overview of the evolution of health care expenditure in Spain during the period 1980-1997, and henceforth to comment on the cost containment measures put forward to control its growth. The paper is divided into three separate sections. The first offers a brief description of the Spanish Health Care System, with emphasis placed on the issue of expenditure control and health planning targets. The second part outlines a set of cost containment measures that has accompanied the process of extending universal health care coverage which occured during the mentioned period and which has helped keep public expenditure under control. Finally, the third part describes some of the more recent proposals for reform of the Spanish Health Care Sector.

INTRODUCTION

The policy measures on cost containment we will focus in this paper are:

* Changes in the financing system of the hospitals in Spain, by moving from reimbursement methods to a purchasing of services based on activity (the evolution since 1986 of the Catalan contracting-out method, the 1991 State Hospital Contrato Programa and some other proposals in the Basque Regions).

* The creation in 1993 of a negative list of drugs which could no longer be reimbursed by Social Security (800 speciality groups), some very recent experiments (Valencia, 1997) on reference pricing (the maximum that the authority is willing to pay) for the most prescribed drugs, and some proposals for new increases on co-payments for drug consumption.

* Changes derived from the Primary Health Care reform (started in 1984 and not yet concluded), departing from a system based on capitation and a few hours of work to a system closely related to salaries and a full time schedule in the new Health Centres.

* Efforts for the creation of a basic package of publically provided health care (or the Guaranteed Health Care Entitlement of 1995).

* Analysis of the diversity in the way health services are managed among the decentralised regions in Spain.

* Potential effects from extending the MUFACE system (a public financed choice of public or private health insurer), now restricted to civil servants, to the rest of the population.

An introduction with a brief description of the Spanish Health Care System will try to frame the commented measures in the appropriate context.

1. BRIEF DESCRIPTION OF THE SPANISH HEALTH CARE SYSTEM

General Overview

Health care provision in Spain is a mix of public provision (approximately 4/5 of total health care spending) and private (the other 1/5). These figures have been stable during the period 1980 and 1997. In 1995 total health expenditure amounts to 5 billion pesetas, around 7.6% of the Spanish Gross Domestic Product. In per capita terms, the figure was close to one thousand dollars PPP, which is 10% below the corresponding UK figure and 40% below the average of OECD Western Countries. However, when adjusted for income, the fit with the standard OECD pattern is almost perfect, with no gap on it.

TABLE 1: Main sources of financing the system:

Public Expenditure

1986: General taxation (23.77%), social insurance contributions (74.27%), Other sources (1.96%).

1995: General taxation (77.28%), social insurance contributions (20.43%), Other sources (2.29%).

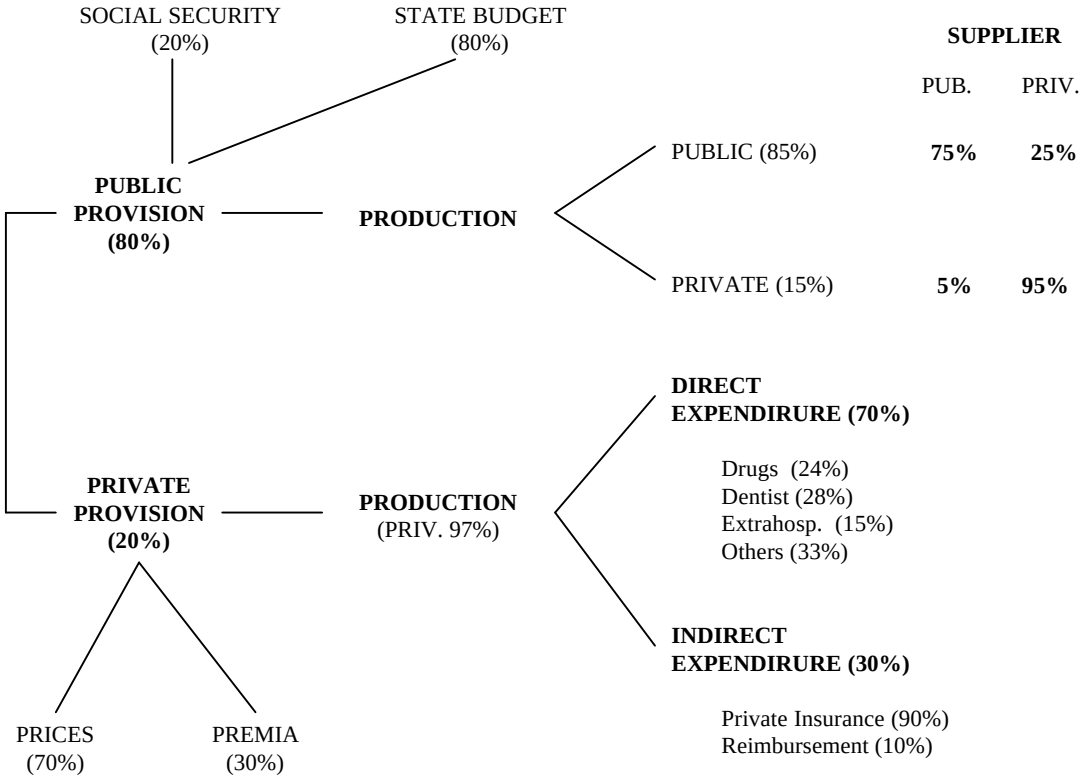
Private expenditure (in thousand million current pesetas and %)

1986: Health insurance Premia (71.1; 24%) with 4.301 thousand enrolees and out of pocket (228.9; 76%).

1995: Health insurance Premia (293.7; 30%) with 6.700 thousand enrolees and out of pocket (685.3; 70%).

Financing of public provision occurs both through state transfers to INSALUD (the social security body in charge of a 90% of total public health delivery[1] and through social security contributions (payroll taxes) at a ratio (of the former to the latter) of 4 to 1. Over the 1980 to 1996 period, this figure was not stable. In fact, at the beginning of the eighties the ratio was 1 to 4 and at the middle of the nineties 4 to 1. This change is mainly due to financial efforts to move health care out of the social security budget crisis.

FIGURE 1: MAIN FEATURES OF THE SPANISH HEALTH CARE SYSTEM (1995)



Key words: <u>Finance</u> refers to the revenue sources; <u>provison</u> to the service responsabilities; <u>production</u>, regards to who produces the service; and <u>supply,</u> to the inputs ownership. Prices can be identified with direct expenditure and premia with indirect expenditure.

Source: own elaboration, from different sources.

Public health expenditure

We can see from Figure 1 that the Spanish Health System is based on a significant for large role of public provision, and a relative prominence of public production. The share of private expenditure of the total is slightly below the OECD average, even after adjusting for differences in Gross Domestic Product.

Despite this broad picture, some important variations exist among different Spanish regions. For instance, in Catalunya, more than half of hospital expenditure is contracted out to non profit private producers and to non social security public hospitals (municipality -owned, Red Cross and similar). Private expenditure also experiences relatively significant variations (higher in richer regions), and particularly as concerns private insurance expenditure, although the same patterns can be observed within region [2].

Overall, the reasons for such a financing mix in the past are not clear, given the fact that the Spanish Health Care was designed as a National Health Service type of system. Why then does Spain have this financing mix?. It is difficult to think that this is due to the potential role of payroll taxes, as an earmarked tax to health expenditure, on individual behaviour and collective choice. In fact, the INSALUD financing coming from social contributions represents a small proportion of nominal taxation, and is believed not to have any effect on public perception. In any case, the decision to discontinue with social security contributions and to finance the Spanish health care system solely through general taxation which was to begin with the 1997 budget as a way to reduce financial pressures on social security expenses, has been postponed to the year 200 [3]. It could also be argued that the resistance to financing health services completely from taxes is the result of the desire of the Socialist Party, at the beginning of the political decentralisation process, of not generalising the transfer to all autonomous communities, thus keeping health care provision within the auspices of the social security (not transferable) and not the state (transferable).

TABLE 2: Public Health Expenditure (1986-1995) at 1986 constant prices

1986:	1.434.485	1991:	2.346.687
1987:	1.523.997	1992:	2.340.686
1988:	1.809.475	1993:	2.466.688
1989:	1.965.153	1994:	2.620.286
1990:	2.214.532	1995:	2.677.551

Source: Ministerio de Sanidad y Consumo 'Descripción y estado de situación del Sistema Nacional de Salud' (mimeo, 1997).

Public health expenditure is, in principle, cash limited, despite the fact that overruns are frequent. For this reason most of the actual expenditure figures we include here refer to 1995 the latest, according to the available information. Public budgets have been increased over initial levels mainly by modifying some budget items, and particularly, the figures for pharmaceutical expenditure (usually underestimated), since its amount can be modified without complex legal procedures (see table 6).

In brief, total health expenditure, according to OECD data for 1995, amounts to 7.6% of Spanish GDP, with per-capita health expenditure being just below one thousand dollars PPA. Four-fifths of this figure is public health expenditure and around 20% is used to pay for private health care service provision [4].

TABLE 3: Evolution (1970-1995) of the Total Health Expenditure to GDP ratio (1) and of the Percentage of total Public Expenditure on Total (2).

	1970		1980		1985		1990		1995	
	1	2	1	2	1	2	1	2	1	2
Spain	3,7	65.4	5,7	79.9	5,7	81.1	6,9	78.7	7,6	78.2
Average European Union(*)	5,0	75.5	6,9	80.6	7,1	78.2	7,3	78.6	8,3	74.5

(*): non weighted

Source: Ministerio de Sanidad y Consumo 'Descripción y estado de situación del Sistema Nacional de Salud' (mimeo, 1996).

The budget distribution for INSALUD in 1994 was the following: Primary care (14.5%); Pharmaceuticals (18.1%); Inpatient and Outpatient hospital care (63.2%); Research and Training (2.2%); Administration (2.0%). No explicit mechanisms exist for allocating resources to each of these areas, either for INSALUD or for Regional Health Authorities with management responsibilities in health services. For them, the single financer allocates resources on a regional basis, approaching to a per capita basis criterion. Conflicts on the total actual amount of public health expenditure (the distribution basis) occur each year.

Private health care expenditure

Private health care expenditure (around one-fifth of the total) can be broken down into payments for voluntary health insurance (around 10% of the total) and direct payments, which are mostly for extra-hospital care (around 14%), medications (22%) and other pharmaceutical supplies (10%) and dentistry (25%) and prostheses (9%) and others (10%)[5] Private health expenditure is subject to an income tax deduction of 15%.

In real terms this implies an annual average increase in real terms from 1980 to 1990[6] of 2.6%, enlarging the share of private expenditure on family budgets (although from relatively low levels: 2.65% in 1980 and 3% in 1990[7]. Expenditure on dental care and on drugs are the expenditure items with the highest increases (in nominal terms:18.8% and 24.4%, respectively). Despite the commented increases, the share of private to total health expenditure stayed constant or decreased slightly during the eighties, due to a higher increase in public expenditure (15.3% in average annual nominal rate versus 13.5% for private health expenditure).

TABLE 4: Evolution of private insurance premia and number of insurees.

year	Private Insurees	Civil servants	Total (000s)	Pre-paid private insurance m M ptas	Reimburs private insurance m M ptas	Total m M ptas
1984	n.a.	n.a.		54	n.a.	
1985	n.a.	n.a.		60.3	2	62.3
1986	3.449	1.852	5301	71.1	2.1	73.2
1987	3.490	1.841	5.331	87.7	2.5	90.2
1988	3.773	1.922	5.655	93.5	3.6	97.1
1989	3.800	1.974	5.744	109.6	5.1	114.7
1990	3.914	1.992	5.836	129.1	6.6	135.7
1991	3.865	2.022	5.887	173.1	9.4	182.5
1992	3.866	2.069	5.965	207.4	11.6	219
1993	3.713	2.098	5.811	228.9	15.5	244.4
1994	3.785	1.968	5.753	246.0	23.0	269.0
1995	4.230	2.470	6.700	266.7	27.0	293.7

Source: Own elaboration from 'Sistema gráfico de Información Sanitaria', MSD, 1996, and other sources.

m M ptas.: thousand milion current pesetas.

1.1 Regulation of Public Provision of Health Care

The Spanish Constitution of 1978 provided for the decentralisation of some responsibilities to the 17 Spanish autonomous communities (CCAA). Seven of these (the Basque Country, Navarra, Catalunya, Galicia, Andalucia, Valencia and the Canary Islands) now have responsibility for health care services, managing approximately half of total health care spending. With the exception of the Basque Country and Navarra (which have their own special system of financing[8], the tendency for resource allocation to the regions has been that of using capitation criteria, however this process has varied from region to region.

The present system evolved from health care services that were largely fragmented, having scattered competencies and involving a multitude of bodies. Recently there have been moves towards an increased integration of services (allowed for by the “Ley General de la Sanidad”, LGS, of 1986). The trends have been to universalise public health care coverage, decentralise management and public financing has increased by almost 1.5 points in terms of GDP during the1982 to 1996 period. However, despite the efforts made to improve the system, there is still much unsatisfaction with it among different groups:

for consumers, as regards the perceived quality of certain services, mainly in primary care;

among professionals, pressing for higher wages and whose strikes of 1987 and 1995 resulted in significant INSALUD salary increases (20% and 10% respectively). The 1997 budget however has again frozen wages in the public

health care sector;

among autonomous communities (excluding the Basque country and Navarra), due to present resource allocation and budgetary mechanisms. Some claim to be receiving insufficient health care resources, while others argue that the present method for resource allocation is far from equitable, as it does not sufficiently correct for regional differences.

Without a doubt, the resource allocation dilemma is one of the main reasons behind the push for health sector reform in Spain, as it is a significant concern in both the on-going political debate questioning the legitimacy of the present model and in the necessity of controlling the public deficit. Despite the fact that macro health indicators in Spain for the most part are higher[9] and health care spending is lower than the OECD average, the question of how to reform resource allocation remains a key element in future reform.

In fact, the one feature of the Spanish health care system that probably stands out the most is the fact that Spain is one of the western nations in which the correlation between the apparent effectiveness of the health care system, the cost of health services and the level of satisfaction among citizens is lowest[10]. The reason for this low correlation is possibly to be found in the excessive regulation exerted by health authorities over the utilisation of health care services. In other words, the supply and demand for health care, with controls supposedly directed towards the improvement of the population=s health status, today are highly bureaucratic. Direct production and finance of the services, inspection of health care services through the regulation of patient flows, the assigning of population quotas (despite the recently introduced measures - 1994 and 1995 - of election of specialists), fixed referral centres etc., and the administrative regulation regarding manpower policies and retribution schemes to health care personnel, use of equipment -including amortisation-, in health care producers, are examples of this bureaucratisation.

All this regulation is supposedly established in favour of “citizens welfare”. However, it is not clear that it always works to the benefit of the consumer. It is more likely that, in reality, those who decide and finance the production of health care services put more emphasis on ensuring the viability of the centres they administer and keeping their professionals satisfied than on attending to the desires and needs of citizens.

1.2- Recent Evolution of health care spending and level of financial sustainability

Financing through taxation and contributions has been linked since 1978, when revenues and payments were joined[11]. In 1988, resources transferred to INSALUD by the state represented 28% of total resources. The 1989 Budget Bill (“Ley de Presupuestos Generales del Estado”) established a new system which contained a specific contribution by the state to INSALUD. Therefore the breakdown in financing for 1995 was more than the reverse of 1988: being 80% and 18%, for taxation and contributions respectively[12].

The percentage of per-capita health care spending over total expenditure in Spain reveals an average annual increase of 2.63% from 1981 to 1991. For total INSALUD public expenditure, this number was 14.45% between 1986-93. This translates to an absolute average spending per-capita of 13.12%, a figure much higher than the GDP nominal growth rate.

TABLE 5: Public National Health System Expenditure (current prices, in million pesetas) 1982-1996

YEAR	INITIAL BUDGET EXPENDITURE	% increase	RECOGNISED EXPENDITURE	% Increase	ACTUAL EXPENDITURE	% Increase	GDP nominal increase
1981	605.401		654.313				12,37
1982	695.447	14,8	762.498	16,5	...	...	15,7
1983	800.436	15,1	843.590	10,6	...	...	14,24
1984	875.214	9,3	900.756	6,8	...	...	13,26
1985	970.354	10,9	1.015.666	12,8	...	...	10,51
1986	1.049.032	8,1	1.154.811	13,7	...	...	14,66
1987	1.155.019	10,1	1.307.647	13,2	...	...	11,78
1988	1.350.682	16,9	1.497.547	14,5	1.640.000	...	11,11
1989	1.574.005	16,5	1.795.841	19,9	1.892.000	15,4	12,17
1990	1.851.144	17,6	2.065.984	15	2.171.000	14,7	11,32
1991	2.108.863	13,9	2.259.351	9,4	2.474.869	14	9,48
1992	2.389.141	13,3	2.564.707	25,9	2.755.858	11,4	7,47
1993	2.671.321	11,8	2.988.417	5,1	2.933.240	6,4	3,23
1994	2.845.480	6,5	3.225.516	7,8	2.982.301	1,7	6,23
1995	3.224.068	14,0	3.314.456	3,2	3.228.734	8,9	7,85
1996	3.484.068	8,1	3.526.045	6,4	na	na	6,40

Note: The actual recognised expenditure for 1992 and 1993 does not include expenditure recognised

These figures are determined once the accumulated debt of previous years is taken into account, adding the excess spending to that initially budgeted[13].

Without considering outstanding credit, in 1994, a financial gap of 68 thousand million pesetas was recorded for 1992 and 56.5 thousand million for 1993. The Working Group for Health Finance, which was created with the mandate of evaluating the lack of health care funding, established a programme of measures to close this gap. This was to be met partly through additional resources and partly through credit supplementation over the following four years. All of the above greatly complicates knowledge about real health care expenditure. For example, after hearing the results of the above-mentioned Working Group, the September 1994 agreement of the Financial and Fiscal Committee (Consejo de PolRtica Fiscal y Financiera) ended in recognising a general debt of 290 thousand million pesetas between 1992 and 1993 which had not been included in any previous health care calculations and was not initially included. For 1996, 152 thousand million pesetas were added (90 thousand million in 1995). Some estimates show an overall deficit for the entire system of between one hundred and two hundred thousand pesetas a year and an already accumulated debt of around half a billion pesetas.
Consequently, figures on public health expenditure have to be analysed very cautiously. Table 6 shows the complexity of analysing the financing of public expenditure using existing records.

TABLE 6: Recent evolution of the deviations in public health expenditure for the National Health System (%)

	Recognised over initial budget Expenditure		Recognised over initial budget Expenditure	% Actual versus initial budget Expend.
1981	8,08	**1989**	14,09	20,2
1982	9,64	**1990**	11,61	17,3
1983	5,39	**1991**	7,14	17,4
1984	2,92	**1992**	19,09	15,3
1985	4,67	**1993**	11,97	9,8
1986	10,08	**1994**	13,38	4,8
1987	13,21	**1995**	2,8	0,1
1988	10,87	**1996**	1,2	na

Source: Own elaboration from "Cuentas y Balances de la Seguridad Social" and "Presupuestos de la Seguridad Socia" published by the Ministerio de Trabajo y Seguridad Social, and given the "Acuerdos de liquidaci\n del Presupuesto del INSALUD" (several years).

1.3- Public health expenditure by components

As commented in previous sections, in 1994, **Hospital expenditure** accounted for 63.2%% of total public expenditure (from 59,6% in 1988 and 61,6% in 1991).

The large size of **pharmaceutical expenditure** as a share of total public expenditure is one of the ways in which Spain is different from other OECD countries. (see Table 7 below). Since the Medicines Act of 1990 there has been a significant effort for cost control with little success. Recent measures, commented on later in this paper, try to reduce unit costs (acting on the pharmaceutical industry and on privately-owned pharmacies) and prescription rates of Spanish physicians. Since 1980, the number of prescriptions has increased by 12% and consumption at current prices has multiplied by six. The expenditure evolution in the last years is included in Table 7.

TABLE 7: Recent trend in public health expenditure and expenditure on drugs* (thousand million pesetas, current prices)

	Public Health Expenditure	Pharmaceutical Expenditure	%
1990	2.171,0	419,9	19.3
1991	2.475,0	491,6	19.8
1992	2.736,0	565,0	20.5
1993	2.933,0	609,4	20.7
1994	2.982,0	643,7	21.5
1995	3.164,0	718,0	22.7

(*)-Total pharmaceutical expenditure minus out of pocket payments and pharmacies commercial profits.

Source: "Indicadores de la Prestación Farmacéutica del Sistema Nacional de Salud" INSALUD, 1997.

López (1997) proves that the real increase in the type of prescriptions rather than price variations in drugs explain this actual pattern of growth: "While real drug expenditure increased by 264% between 1980 and 1996, relative price of drugs fell by 39% and the number of prescribed items rose by only 10%. Most of the increase can be attributed to new products, whose impact on health expenditure trends increased by 442% between 1980 and 1996" (page 680).

Primary health care represents around 15% of total public expenditure. Nowadays it tends to be organised as an integrated system of production at the territorial level of the health area. However, this 'new' model still coexists with a traditional quota system on a part-time and sole-practice, paid on a per capita basis. In contrast, the primary health care teams are essentially a group practice, mainly paid by salaries. Two thirds of the population is covered at present by these teams, but again there exists a large range of differences by region, with lower levels in Catalunya, where it has been more difficult to voluntarily change the GP doctors status.

Spain shows in primary care an average position in terms of direct referals per one thousand inhabitants: 54.6 (80.5 for Norway, 24.4 for France). In a similar way for the ratios of successive versus first visits, proving, in general, a relevant role of specialists in hospital health care. The average time between the referal nad the actual medical visit is 12 days; again an average position in the European context. Workloads ratio show an extremely low percentage of home visits: just 6% (15% in UK, 39% in France) and a low number of visits per capita and year: 4.0 (11.5 for Germany, 11 for Italy, 7.5 for Belgium and 4.5 for UK) (see Lopez and Ortun, 1998).

Dental care is not covered by the public system, other than tools extractions. This is indeed an important component of private expenditure on health. According to the Spanish Survey on Family expenditure, inequality in utilisation of dental services is very high (the ratio of dental expenditure between the highest and the lowest income deciles was 4 in 1990, which has decreased from around 7 in 1980).

1.4- Some specific references to the Hospital Sector

The latest available data on the Spanish hospital system (the Cat<logo Nacional de Hospitales, 1997, referred to 31 December 1995) as regards the number of hospitals, sizes and bed number, reveal that, at that time, the Sistema Nacional de Salud was composed of 198 hospitals (of a total of 787 in Spain) which provided 86 thousand beds (of a total of 169 thousand), concentrated for the most part in hospitals with more than 200 beds (which differs considerably from private non-profit hospitals which mostly have less than 200 beds) and, most importantly, with a high concentration of acute care patients (and less geriatrics and long-term care cases[14]. In 1980 the number of hospital beds per thousand inhabitants was 5.4 (5.8 for the average

unweighted European Union) which decreased to 4.1 by 1994 (4.4 for the E.U.). Despite the fact that for the same period the hospital admissions per 1000 population have increased from 9.3 to 10.4 and the bed occupancy rate has gone up from 70 to 77.8, the average length of stay in day has decreased from 14.8 (1980) to 11.0 (1994).

Data contained in the "Catálogo Nacional de Hospitales" reveals that 68% of beds are publicly owned[15]. Of this subtotal, 83% are for acute care. Public hospitals account for 73% of total days of stays and 75% of discharges. The majority of people working in these centres (98%) work 36 hours or more, while this percentage for the private sector is significantly lower (66%). Hospital specialists are paid by salary. A small amount can be added, in a similar way to that used for the rest of Spanish civil servants, with some complementary additions. These are determined by law according to particular responsibility posts (head of service, section, performed extra duties, etc.).

In brief, until recently acute care hospitals belonging to the Social Security were financing their current expenditures from a baseline calculated from previous expenditures, without any formal evaluation process being carried out. This was accompanied by negotiation between the financing body INSALUD and the management authorities of the health centres. Until recently, the cost per day of stay and per admission were the only two economic criteria used as external references of activity, collected in the "Informe Economico Funcional of INSALUD" (the INSALUD Report). Financing was thus through a global budget, without any distinction between programmes, services or hospital departments. Expenditure at a disagregated level in each centre came from separating inpatient care, outpatient services, teaching and research, although not in a very reliable way for cost comparison purposes.

In 1993, the INSALUD (see Gavilanes, 1993) hospitals set up the so-called "contratos-programa" (year by year agreements linking activity to global budgets and provided in the ten regions that are still controlled centrally). These are determined on an annual basis, outlining:

the objectives of production (measured in Unidades Ponderadas de Asistencia - UPAs - and other related procedures);

the financing, based on actual (average) costs, as well as additional sources of revenue (from coverage of third parties, traffic accident, private sector, etc.).

The weighting results are as follows: Medical stay: 1 UPA, Surgery 1.5 UPAs, Obstetrics 1.2 UPAs, Paediatrics 1.3 UPAs, Neonatology 1.3 UPAs, Intensive care, 5.8 UPAs, Emergencies without admission 0.3 UPAs, First consultations 0.25 UPAs, Successive consultations 0.15 UPAs and Ambulatory surgery (minor procedures) 0.25 UPAs.

Some services are separated from the total amount, and have a separate set fee, such as: teaching, hemodynamics, hemodyalisis (patient/month), renal extractions, renal transplants, hepatitis, cardiac and some ambulatory surgery.

As mentioned above, “notional” prices were determined using average costs, including only running costs (chapter I and II of the budget), due to the lack of a normalising accounting plan. Prices for some activities were tentatively fixed centrally, such as those for interconsultations, laboratory services, extractions and transplants. In 1993, decentralisation in contracting for some services (dialysis, litotricia, CAT Scanner) occurred in favour of hospitals to which were added the corresponding credits. These measures affected the activity of professionals through the development of incentive systems. In the past few years it appears that they may have resulted in an increase in day surgery and day hospitalisation, thus reducing the existing waiting lists (Cabases and Martin, 1997[16]. The Catalonian, Basque and Andaluz Health Services have taken similar measures, although differing in specific measurement tools.
Additional innovation can be pointed out for the Basque Country and Andalucia: the former is pursuing Patient Management Categories while the latter has opted for using DRGs, although the application in both cases can not be considered definitive, since it has not yet passed the experimental stage. A new payment system for the Catalonian hospitals is expected to be implemented in 1997. Real incentives for developing alternatives to inpatient care can only be found in this catalan proposal, since this is not the exclusive reference payment. For the moment, case-mix adjustments in Catalunya are mostly based on DRGs, although its weight in financing hospitals is still low .

In summary, while hospital financing claims to be prospective, the lack of evaluation of actual spending results in it being retrospective. In reality, and despite the creation of the “contratos-programas”, budgets still are not linked closely enough to activity. In the majority of cases, resources are simply related to expected activity, while variations in activity are only slightly compensated for by variations in resources. Undoubtedly, this step is a gradual advance, but real risk decentralisation to managers and professionals has not yet occurred.

As regards hospital decentralisation, it should be pointed out that, within the margins of approved budgets, the management of health care centres has control over variable personnel costs (extra hours and eventual substitutions basically), although there are restrictions on levels of payment. Personnel modifications are determined centrally, although possibilities exist to substitute among categories at the hospital level. Hospitals are in charge of opening disciplinary procedures, yet not for their resolution. Trade unions are still very strong as concerns manpower policies and with regard to decisions as to how variable productivity has to be distributed. Regarding contracting of goods and services there are certain expenditure restrictions on the quantity of purchases directly allowed by centres (50 million ptas. in INSALUD, 250 in Andalucia).
As a result many centres seek to fractionize direct small contracts in order to elude the fixed limits in the law of public contracting (Cabases and Martin, op. cit.). The centres cannot autonomously decide how much to invest, which is planned and authorised centrally. Due to the lack of a real inventory for fixed assets, no plans for adequate reposition exist.

Of the 135 thousand personnel having “estatutario” status (“estatuto” implies a sort of self-protecting law), hospital doctors are paid by salary, with the majority

of them having a contract of 36 hours or more. There is a 'numerus clausus' university policy, that has decreased the number of graduates to around five thousand a year in the nineties (4914 for 1997) (in between half and one third of the figure for the eighties) -see González 1997-.

Moreover, a system of incompatibilities exists. For personnel maintaining more than one post within the public sector there exists a system of authorisations. Work schedules in the public sector actually permit further practice within the private sector (losing, in this case, a specific complement for voluntary exclusive dedication to the public sector). A system of partial dedication also exists which allows for making the implications of these incompatibilities more flexible (this is particularly the case in Catalunya, and presently a proposal exists to extend it to the rest of Spain).

Over the past two decades, there has been a significant decrease in the salaries of hospital doctors, (when related to either IPC or GDP), although this has not followed a consistent pattern. If the evolution of salaries is divided into two periods, a better relative salary in real terms is observed for the period of 1986-1991, and a loss is recorded for the years from 1991 to the present. Joining both periods results in a practically neutral effect, except for the least qualified health care personnel who have not managed to recuperate the salarial losses experienced.

The above data, which are analysed in more detail in López and García Cestona (1995), seem to reveal that, between 1970 and 1986, hospital personnel policy was tough as concerns salary control, with a clear loss of acquired power, while employment policy could be considered bland, with important manpower increases in hospitals. In any case, this combination seems to have diluted itself during the past five years, during which the salaries catching up ended with incremental levels and most probably entailing today a relatively slower productivity for health professionals.

1.5- Health Technology Assessment

The Spanish National Office of Technology Assessment was formed in 1994 (regional agencies also exist: in Catalunya since 1991, which became an independent agency in 1994; in the Basque country since 1992, in the Valencia Community since 1994 and in Andalucia since 1996). In the early stages, these offices are looking for eliciting data on the effectiveness of medical treatments (not so much on costs) and they try to disseminate available evidence on them. So far, examples of the job to be done can be observed given the high variation in clinical practice (amongst regions, and between Spain and other countries of the European Union), for instance in home oxigenotherapy for chronic patients and others (Conde, 1996, BorrBs et al. 1996).

2.- SOME COST CONTAINMENT MEASURES IN THE SPANISH HEALTH SECTOR

Reforms over the past decade have skirted the idea of introducing strong cost-containment measures in Spain. In particular, under the socialist government, the Abril Martorell Report in 1991 (so named after the man who headed the Commission set up to evaluate and offer suggestions to the health sector) raised several recommendations to improve efficiency within the national health system, including: (i) introducing a purchaser/provider split; (ii) creating a basic package of publicly provided health care; (iii) increasing funding from taxation yet maintaining social security contributions at around 30% of total funding in order to increase cost-consciousness among consumers; (iv) searching for the introduction of nominal fees for some services such as pharmaceuticals (also for pensioners who now pay nothing, however offsetting this measure with an increase in pensions), more as a cost-consciousness measure than one to generate further resources.

The central health organisation (INSALUD which, as mentioned above, has responsibility for the ten remaining regions) has run up against larger difficulties in changing the status quo. As a result, the purchaser/provider split has been unsuccessfully pursued (contracting is only in its initial stages of development) and health care provider budgets still follow incremental routines. A basic package ("Catálogo de Prestaciones Sanitarias") was approved in 1995. However the effectiveness of this basic package can be called into question as the publicly financed group of health services does not disclude anything but, in fact, adds services to the presently available care. Social security contributions have been maintained at around 20% of total health care financing. The introduction of nominal fees for some services (including for pensioners), has not been taken forward.

These and other more recent reform proposals are analysed below.

2.1- Types of expenditure effects derived from changes in health interventions:

In a rather systematic way, we will analyse the following set of effects:

a) Changes that generate a slope effect: a change in the growth rate between before and after the reform;

b) Changes in the level, once-off: a one-off step drop and, starting from this lower level, an observed equal trend as existed prior to the change;

c) Perverse changes: that is, an initial drop and a rate of increase higher than before the change, with a final impact on the expenditure level of higher values than those forecast if the change would not have been taken place;

e) Successful Changes: an initial downward shift followed by a lower slope in the rate of increase.

The policy measures on which we will focus, (some of them have been described in greater detail above), are:

a) Changes in the financing system of the hospitals in Spain, by moving from reimbursement methods to a full purchasing of services based on activity, as measured by UPA ("Unidad Ponderada de Asistencia", or Weighted Care Unit), in the so called "Contratos-Programa" INSALUD, starting around 1991.

b) The 1993 Drug Bill which created a negative list of drugs which could no longer be reimbursed by Social Security (800 speciality groups).

c) The effects of past policies on drug consumption by the Spanish population at large (not those drugs dispensed in hospital), looking at co-payment increases over time: from 10% in 1978, to 30% in 1979 and to 40% in 1980.

d) Changes in pharmaceutical costs per capita between the population under the MUFACE system[17] in relation to the rest of the population (see below).

e) Per capita costs under the new Primary Health Care reform (1984), departing from a system based on capitation and a few hours of work to a system closely related to salaries and a full time schedule in the new Health Centres.

f) Diversity in the way health services are managed among the decentralised regions in Spain.

g) The Valencian experiment on reference pricing (the maximum that the regional authority is willing to pay) for the most prescribed drugs.

h) Creation of a basic package of publicly provided health care (or the Guaranteed Health Care Entitlement (1995)).

2.2- Proposals and facts

In short, these are the more relevant features of the Spanish proposals and facts for cost containment:

1- Policy reforms for setting overall financial constraints.

Since Sept. 94, within The Commission for Financial and Fiscal Policy

("Consejo de Política Fiscal y Financiera"), an agreement has existed for linking the overall growth in public health care expenditure to the GDP nominal increase. Up to the present, (including 1995 and 1996, as explained above), this rarely has been the case, with health spending rising quite a bit above that level. In order to achieve greater credibility for this policy, it has been agreed that all savings achieved by cost containment in the health sector will be added to the GDP nominal increase for the 1997 budget. The reduction in the prices of drugs has not been saved from public health budgets.

Linking public health spending and GDP is not a constitutional budgetary rule, but a political commitment that can change at any time. Indeed, the amount devoted to financing health care is the result of a political discussion process at the highest political level (Reunión de Subsecretarios, Vice-secretaries of the different Departments first, Consejo de Ministros, the Council of Ministers finally). At any rate, there exist doubts about how enforceable and respected these ceilings may be in the near future. Per capita health expenditure is well below the European average and almost no country (including the UK's NHS) has been able to invert the growth trend. However, in support of the present proposal, we should point to the fact that the Budget Law for 1997 changes the budgetary legislation making former spending overruns more difficult, since the legislation would not allow, in principle, additional finance for it.

2- Policy reforms on Drugs.

As mentioned above, co-payments are limited to drugs not dispensed in hospital, and have been maintained at 40% since 1980 (from previous rates of 10% in 1978 and 30% in 1979). Individual co-payments, in this or another related fields are not usually covered by supplementary private insurance. Pensioners are exempt and chronic patients almost so[18]. The evidence regarding the assumption that co-payments reduce demand has appeared only through the natural test (other tests related with expenditure or number of prescriptions per capita are "noisy"[19]) that is given by the case of the increase over time of the consumer share in costs for non pensioners and by the MUFACE system[20]. For the 1967-85 period, for which copayments were raised from a fifty ptas. up yo the 40% at present, Puig (1988) estimates a demand price elasticity between -0.13 and -0.15. This rather lower figure is probably due to the important transfers of prescriptions to the exempted elderly population and a potentially high income effects particularly during the first years of the analysed period. The transfer of prescriptions was estimated by Puig to represent between a 30 and a 40% of the elderly population (this is, a 15 or 20% of total). For MUFACE affiliates, the general co-payment is 30% for everyone, including pensioners (instead of 0% for pensioners within the general system). As a result, pharmaceutical per capita costs for MUFACE are 8% lower than the average (Ibern, 1997).

A more recent policy is that which created a negative list of drugs. A drug Bill (april 1993) was put into place in 1994 establishing a negative list of drugs no longer to be reimbursed by Social Security. This list excludes specific groups of medications for minor symptoms; in particular, anabolic drugs, dermatological products, nutritional and anti-obesity drugs. 1692 pharmaceutical specialties were then excluded (a 19.8% over the total), with an average price of 291 ptas (1247 was the total average price). These measures have created a shift (short

term) effect in the rate of increase of expenditure followed by a further catching up in 1995 to levels even higher than before the Bill was implemented. An increase in the number of prescription transferred to pensioners and a higher utilisation of substitutory and more expensive drugs were recorded too. The reduction partially affected some drugs actually out of use in any case.
An agreement establishing a system of profit reduction over an annual growth ceiling for public expenditure on drugs (7% for 1996, 4% for 1997) exists between the government and the pharmaceutical industry. In addition, pharmacies have been asked to offer discounts to the public payer (of around 2%).

The Valencian policy of a reference list for some drugs consists of an exemption from the 2% of the need of backing profits to the Ministry (the national agreement with the Pharmacist professional College, mentioned above), if they compromised to supply drugs according to the reference price set down for 38 drugs. These drugs produce 45% of the overall Valencian pharmaceutical expenditure[21]. For the moment, changing "copies" (a 30% of the prescriptions) is the only policy possible, since the present Spanish generic market constitutes only 3% of all prescriptions, and given how late the European legislation on patents was adopted, this does not allow for a rapid increase in the near future.

In short, the Valencian experiment of reference pricing for the most frequently prescribed drugs (accumulating to over 40 thousand million pesetas) is still in a too early stage to evaluate its effectiveness, despite the fact that Valencian managers argue that the experiment is resulting in 40% lower than the national average increase in pharmaceutical expenditure.

3- The Guaranteed Health Care Entitlement.

Lack of scientific evidence on safety or clinical effectiveness, redundancy with other more cost effective treatments, or not therapeutic value added (just comfort or leisure) are some of the reasons for the creation of the basic package of publicly provided health care or the so-called Guaranteed Health Care Entitlement (Catálogo de Prestaciones,1995).
As a result, explicitly excluded from public financing are: psychoanalysis, sex change surgery (with some exceptions), spa treatments and rest cures, plastic surgery not related to accidents, disease or congenital malformation. In comparison to services previously provided under public financing, this actually implies a slight enlarging of services (Cabasés, 1996). In particular, dental care has been extended to treatment of children (not only prevention and extraction), although the exact definition of this is difficult to determine given its likely financial impact. The basic package does not take into account waiting times. In general, conditions of provision (including geographical access) are rather ill-defined.
As far as we know, no health researcher has put any faith in the possibility of the existing "Catálogo" as a cost containment measure.

4- On investment and capital financing.

In relation to investment, no new developments in capital financing have occurred. Amortisation expenditure, opportunity costs of the investment and new investments are the key factors to understanding the process. No charge has been established on the utilisation of public capital. New investments have for the most part been sacrificed in order to avoid budget overruns by INSALUD during the last two years. This has meant that capital financing problems have simply been transferred on to the future. In this context, the significance of capital and amortisation expenditure is clearly doubtful or questionable. They are a fiction of budget accountability, given the spending possibilities of centres in this field. The sum of the notional amortisation costs for all centres is the spending of the central management body, but is treated as an accounting item

that is registered simultaneously as spending and revenue for the finance, without the receiving body having any autonomy in its application. Its significance at the level of the budget of the centre is low, as it doesn't necessarily respond to capital stock, valued with a predetermined coefficient. Neither does any relationship exist between amortisations at hospital level and capital expenditure. The annual increase between 1988 and 1993 on capital expenditure has been 13.21% for INSALUD, 24.9% for Andalucia, 22.6% for Catalunya and 21% in total. As said, there exists some criticisms of the fact that INSALUD cost containment may have been focused on a short term reduction of capital expenditure.

5- On hospital activity

The number of acute beds has slightly declined (in fact, to the levels of 1973) as the length of stay has decreased. In general, chronic patients have filled empty acute beds. Despite the fact that the present conservative government put forward some money for a drastic reduction in hospital waiting lists for surgery (no more than 6 months is the target), it has not empowered citizens with a charter of rights to allow patients to be treated in another hospital or even in the private sector if they have to wait over a predetermined period. No public beds are available for private use. This favours new developments of private investment that can make more rationalising of the existing facilities more difficult. Not only does duplication exist between public and private facilities, but also amongst Regional Health Authorities; particularly when they have full powers to run health services and from a political view are tempted to become "self-contained NHS". Several Offices for Health Assessment, working under slightly different circumstances in Catalunya, the Basque country, Madrid or Sevilla illustrate the case. However, in our opinion, this has to be taken as a political restriction resulting from the Spanish Constitution, and not strictly speaking, as an efficiency issue.

Innovation in hospital finance has been mentioned above. We have to add here that day care and outpatient clinics are probably the most important innovations. For instance, Catalunya and Galicia have run experiments (Hospital of Viladecans and Fundaci\n Canalejo) that reveal the strength of the experience. However, due to the way hospitals are financed, the convenience of extending this policy has not yet been incorporated.
Administration costs may have increased (no data are available), but they

seem to have been mainly concentrated in the intermediate levels of care (Districts or Health Areas) rather than in sophisticated institutional management.

6- Analysis of the relationship between health care activity and hospital financing

González and Villalobos (1993) analysed the extent to which public hospital finance is sensitive to activity. The results[22] reveal a positive relationship between hospital size and case-mix of the centre, using a method which incorporates nine principle factors and which links heterogeneity in the "mix" of patients with average length of stay. The efficiency of beds by services is estimated using indicators based on the rates of global occupation of services. The conclusion reveals that average length of stay (the utilisation component) varies more due to the behaviour of doctors than to the possible lack of flexibility in changing the relative amount of resources available among services.

For the most part, the complexity, severity of cases treated, specialisation and organisational efficiency of different centres explain the average cost variations[23]. The authors also point out that the budgetary allocations do not seem to respond at all to the intensity of health care activities.

The scarce relationship between financing and activity, (using in this case index based on the Theory of Information, and related to complexity and speciality factors) was shown for the case of Catalunya by Lopez and Valor (1987), using 64 basic illnesses from the 1987 Encuesta de Salud of Barcelona, and by López and Wagstaff (1993) from a relatively homogeneous sample[24].

Systematic influences can explain differences in observed costs between the distinct centres which make up the sample. These should be taken into account when considering the correlation between financing and activity.
With the estimation of the frontier cost model, and using panel or longitudinal data, it becomes possible to distinguish the distinct determinants of hospital costs for the sample of INSALUD hospitals between 1986-89. The systematic influences are considered through the specification of a hospital cost function which expresses the cost per case as a function of the supply of beds, complexity of its case-mix, duration of average stay etc. The uncertain influences are considered using the temporal and transversal dimension for the panel data: basically the implicit idea is that, while the uncertain "shocks" can adversely affect the activity of the hospital in any given year, these uncertain influences should cancel themselves out. However, in contrast, inefficiency is assumed to vary between hospitals, yet not in the long-run. The resulting residual can be defined as "inefficiency" only once the systematic and uncertain effects which influence hospital costs are included, which certainly must not be protected and maybe even should be penalised when considering policies of hospital financing.

Their estimation reveals how a longer average stay, higher complex activity

and closeness to the campus of a university hospital are clearly associated with some of the highest costs per case. It was also found that, in practice, the fixed costs of hospitals are a function which increases with the number of beds, although this relationship between total fixed costs and supply of beds was not linear.

The results show that average inefficiency in the Spanish hospital sector is quite high, equivalent to about 45.2% of the average cost per case, with a substantial variation in inefficiency between distinct centres. The estimations also confirm the point of view that, in order to evaluate inefficiencies in hospital spending, it is not possible to only address costs per case; factors which exert a systematic (in particular those which look at the complexity of hospital activity) and uncertain influence on costs also need to be taken into account.

In a more recent study of INSALUD as a whole, González et al. (1995) found a positive correlation between the implementation of "contratos programa" and the reduction in the level of average inefficiency of the sample analysed. They carried out their analysis using temporal variations in efficiency (period prior to and following 1993) through the estimation of frontier cost functions and data envelope analysis. It should be pointed out that these decreases in inefficiency are around 13.5%, which is quite far below the results of López and Wagstaff, who find it to be around 30 to 35% of the best practice observed, although these results might be due to utilisation of prices as one of the explanatory variables in the cost function, approximated through average spending incurred in the inputs.

J. Quintana (1995) linked the impact of the territorial decentralisation to hospital efficiency. He concludes that the diversification of management has not translated into a wide-spread improvement in efficiency. In particular, it was found that the Catalan management body offers similar grades of inefficiency (these being quite low) within its own centres, while those centres that are directly managed by INSALUD and those run by the "Servicio Andaluz de Salud", show a much higher dispersion. Nor was an improvement in management detected following 1987 when the reforms following the "Ley General de Sanidad" of 1986 were introduced.

A more recent study, by Lopez and Wagstaff (1997) on the efficiency (cost frontier) of the entire health network of the "Servei Catala de la Salut" (Catalan health care purchasing body), reveals a higher level of inefficiency in public centres (one third higher than that pertaining to private centres). Despite this, a significant correlation between inefficiency and size or status (basically teaching) of the centre is not proven. Both are factors which relate more to the public centres (used to justify their higher relative cost).

The results of the above study, outlining efficiency costs and "prices" for lines of activity, indicate a much higher relative cost (when compared with that presently used, the UBA pricing mechanism based on stay) for emergencies. The opposite was concluded for ambulatory activity (although without case-mix adjustment here). The estimations practically favour the identification of

emergency care on one (average) inpatient stay**,** the third part of these values not reaching the average of ambulatory activity in terms of cost. In conclusion, López and Wagstaff argue that a regulation which bases finance (for both public hospital centres owned by the Social Security and for contracted centres) at the rate presently established for non public hospitals under public finance would save, when compared with presently recorded expenditure, around 17% less than the present amount.

Finally, Prior and Solà (1996), in a data envelopment analysis for hospitals in the Catalan network between the years 1987 and 1991, also show high levels of inefficiency, of around 30%, particularly as concerns excess health care personnel, specifically doctors. They point out that a reduction in inefficiency would result not so much from reducing the size of hospitals (through a reduction in beds) but by increasing consultations by a significant extent and applying a growth rate for discharges above that of stays (which would lead to a reduction in average length of stay). This would result in a reduction of waiting lists without increasing the maximum available capacity already installed.

7- Health Centres and the change in doctors remuneration in Primary Care.

Teams of General Practitioners, nurses and paediatricians (called “Equipos de Atención Primaria”), have been created following reform in 1984 in an attempt to establish a more prevention-focused primary care service, to increase consultation times, to promote team working among professionals and to eliminate ambulatory specialist care. In 1996 these teams covered about 60% of the Spanish population, although with significant variations by region. The Primary Care reform provided better working facilities for doctors (in new Health Centres), promoted team working conditions (seven hours a day instead of 2 and half) and provided a salary component with some incentives for following special programmes (such as smoking and breast cancer prevention). At present, the primary sector has been reformed under this new pattern but with significant differences between regions (particularly in Catalunya, where the opportunity costs for physicians for accepting the change of model are higher, and no extra billing is allowed).
It is not easy to evaluate the reform since the target is not exactly the same as that pursued under the former system (see Gervás and Ortún, 1997). Costs of primary care have increased, emergency activity in hospitals has not decreased, pharmaceutical costs seem to be lower but not significantly if we adjust for the characteristics (basically age) of the prescribers (young health professionals seem to prescribe less). In any case users seem to be more satisfied (as the time for attention has increased: from 3.5 to 6 minutes per visit, due basically to having extended the number of hours in work). However, this increase in the averare length of a visit is not regarded to have always a possitive medical effect since the extra-time may be devoted to a higher bureaucratic work and a lower productivity rate (a lower number of patients being visited).

8- Patient choice

Patient choice has been extended from General Practitioner to specialist care in Obstetrics and Gynaecology. This affects the list of people enrolled and, marginally (just the capitation component) the physician's remuneration. No restriction has been imposed for the moment on these changes. According to the information available,. however, no much use has been made, so far, of this right to choose.
For the rest of specialist care there is a referral system that requires a certificate from the practitioner in order to access hospital care. This takes time more than anything else and usually delays health care treatments, which results in low perceived quality. However, the MUFACE system that allows civil servants to choose between public or private insurer has not been extended to the rest of the population (see Pellisé, 1996).

On the effects of co-payments or excluding health services from public financing.

With regard to private premia for complementary health insurance, Murillo and González (1993) show that for the period 1972-1989, the price elasticity was -0.44. This is to say that a 10% increase in premia reduced private demand for health insurance around 5%. In fact, over the last decade, private expenditure in health insurance has increased (the income elasticity was 0.90) mostly due to larger increases in premia, in contrast to a significant reduction in insurees. Aggregation here hides the fact the demand for private insurance is highly concentrated (covering one fourth of the population in Catalunya, the Spanish average being just 8%). It corresponds strongly with the head of the family's status (education), income and age, all of them in a positive way (González, 1995, op. cit.)

At any rate, complementary insurance is too diverse for a refined estimation of its sensitiveness to income and prices, and premia at present are subsidised through income tax (a 15% deduction on the tax bill), thus not supplying to the enrolees full cost information. In addition, some policies are financially supported collectively by corporations as a component of fringe benefits.

For the dental services exempt from public coverage (approximately 16.8% of private health expenditure), a strong correlation exists with income. In terms of per capita expenditure, consumption of highly educated groups was in-between eight and seven times higher than that of the least educated group.

3.- THE NEAR FUTURE OF THE HEALTH POLICIES IN SPAIN: THE HEALTH CARE PLATFORM AND FIRST ACTIONS OF THE ELECTED CONSERVATIVE PARTY

The Partido Popular, in its 1996 political platform, stressed the need to improve quality in public health services, to increase consumer choice and satisfaction, to decrease waiting lists and to improve overall efficiency of what has traditionally been a very bureaucratic service. The party addressed the need to continue with ongoing reforms of[25]:

a purchaser/provider split;
a more equitable distribution of resources to correct territorial inequities;
greater autonomy for health centres and hospitals, with more efficient management at all levels of the health system;
increased participation and responsibility of health care professionals; and
larger freedom of choice of citizens of health providers (either public or private producers).

3.1- The proposals

While stressing that it seeks to maintain the principles of universality, free at the point of use and solidarity, specific PP platform proposals included: a) to conduct a financial audit of the Spanish National Health System in order to calculate the pending debt of the system (budgets have consistently been overrun over the past decade), to eliminate this debt and to formulate a realistic and sufficient method of financing public health care in Spain. In addition to this, a financial audit of infrastructure, technology and personnel within the health sector would also be carried out; b) to control cost-escalation (i) through reinserting ambulatory care more closely to the hospital services, (ii) the establishment of a policy of generics in the pharmaceutical industry and (iii) through the more efficient use of resources by health care professionals; c) to maintain public financing with both public and private provision. Proposals here include breaking the traditional monopoly by introducing competition (the generalisation of the so-called MUFACE model, although specifics to this end were not outlined in the PP platform); d) to further decentralise the health care system to the remaining ten regions which, as of yet, do not have responsibility for the health care of their populations (although only after remaining regional debt has been calculated and paid off, as the lack of this step has caused many difficulties in the seven autonomous regions which presently have responsibility for health care); e) to improve information systems within the SNS and to finish replacing family cards for primary care with individual cards (spreading the policy of one card-one individual throughout the nation, instead of one card per family as was traditionally the case); f) to create nation-wide consumer choice for both primary care doctor and health centre and the creation of ambulatory surgery units and day hospitals; g) to complete the development of primary health care teams (which began in 1984 and in 1995 covered almost 90% of the Spanish population); and finally, h) to reduce waiting lists and depolitize management.

One other proposal which the PP outlined in its political platform would radically transform the Spanish health sector, yet, in practice, would probably

be very difficult to implement. At present civil servants in Spain are covered by special schemes. One such scheme, MUFACE, is exceptional as it allows insured civil servants the option of choosing between either being publically insured (through INSALUD) or of being privately insured. The Partido Popular's proposal consisted of expanding this scheme to around 3 million more workers (the self-employed), with the intention of further broadening it later to the entire Spanish population.
It is now uncertain whether the PP will seek to go forward on this measure.

3.2- From proposals to actions

The Partido Popular has now been in power since March 1996. Steps taken forward in the health sector include:

as mentioned in its platform, the PP has established an Audit (a 'ponencia') within the Commission of Health and Consumption of the Congress of Deputies with the mandate of analysing the National Health System and advancing its consolidation through study of the necessary measures for guaranteeing a stable financing mechanism and the modernisation of the system;

the government has recently approved a decree which has been accepted with an absolute majority in the Congress through which management of public health centres and social service centres would be modified, allowing for the centres to be run under other than public social security rules;

a specific budget has been approved to finance the reduction of the existing hospital waiting lists to a maximum of six months;

stronger pressure to squeeze pharmaceutical industry profits has been put forward (their revenue figures cannot surpass a predetermined amount). In addition, the legal authorisation to open new pharmacies has been relaxed (lowering conditions up to now based on population and distance criteria);

more recently the financial universalisation of health care, by suppressing the payroll contribution as a source of health care financing, and the introduction of an equivalent transfer from general taxation has been almost unanimously accepted.

In summary, the first year of the Popular Party in power has shown: a) the difficulty of implementing radical changes in the status quo of the health care system, no matter what the Manifesto proposed before the election: that the MUFACE system has neither been abolished nor extended is an excellent proof of this, b) the maintenance of the arguments from the literature on health care reforms (basically, the finance-provision split, the allocation of budgets and larger accountability of clinicians), c) some initial bits of success in facing the relatively high pharmaceutical costs: the present minister, a formerly adviser of the drug industry seems to be doing a more decisive job for this than past strong socialist cabinet members, d) a failure to depolitize management from public hospitals: almost all the managers are being changed, e) some contradictions with the initial ideario of a right wing party: Nothing new about

health services limitations (the “Catálogo”) neither about private production (“concertación”) nor on management of health care centres, suppression of the contributive source of finance of public health expenditure, and more opposition from the drug suppliers than from the public professionals. f) “Consolidation” of the Spanish Health System is now being substituted for 'Reform'.

3.3- The actions: The parliamentary “Audit” for a “modern and consolidated” Spanish National Health System.

Far from reaching a national consensus on the future of the Spanish Health Care Sector, the Parliamentary Commission, announced in the Partido Popular Manifesto, has finished its work with an open social debate on the future of the finance and regulation of the Spanish National Health System.
This new disagreement among the conservative and socialist parties, complicates the already confusing Spanish health policy. In addition to the lack of consensus on how to deal with the shortage of finance the health system suffers, doubts about the role of private insurers in health care delivery have now emerged, with the Communist and Socialist speakers on health affairs accusing the popular and regional parties of “destroying” the National Service. This is claimed to be due to the fact that the present ruling parties - conservatives and regionalists- are willing to allow private insurers to partially take on a larger role in the delivery of health care to the population. The option to choose a private provider, still through public financing, has been now for thirty years, but restricted to some civil servants.

In fact, health policy in Spain is at present a complex puzzle with cross fire resulting from two different main themes: First, different views on the extent of private production under public provision. Second, differences in the financing of health services, the way resources are distributed, and hence the struggle of the regions for raising additional money. Taking both factors together, we can see how political and not only regional financing problems are at the basis of health care controversy. Health policy is today a political tool in the fight for the electorate support. Under these circumstances, even minor and logical changes become impossible to implement and the status quo prevails.

The existing problems also emerge from the way health care services have been decentralised in Spain. Since the Spanish Constitution of 1978, 17 Spanish Autonomous Communities (CC.AA.) were created: some of them with an important cultural and historical background and some others as a simple administrative grouping of provinces. The first CCAA pushed for important devolution of powers. This was freely extended to the remaining regions by the central administration in favour of uniformity. Seven of these regions (the Basque Country, Navarra, Catalunya, Galicia, Andalucia, Valencia and the Canary Islands) have now responsibility for health care services. As commented earlier on, they manage approximately 60% of the total health care spending. Most of the remaining CC.AA. claim for the transfer too.
With the exception of the Basque Country and Navarra (which have their own special financing system), the allocation of resources to the regions has followed a capitative criterion, although the actual application of this measure, in practice, has

hardly been homogeneous. At present, no explicit adjustment is made for population age differences, cross boundary flows, teaching and research costs for regional hospitals, nor a weighting for differences in the cost of living is in place. This creates a large forum for debate, with each region favouring the particular solution that better suits its needs. In fact, it has proved to be possible for each Autonomous Community to look for some particular interpretation of "health need", consequently searching for some empirical variables to proxy them, that once "appropriately" measured, weighted and aggregated offers a solution for the regional financial deficit. Since the starting point in regional health expenditure is far from being equal, once the health services were transferred, a shortage of money appeared in some regions. Having learned this, the transfer of health care services to the Autonomus Community of Madrid is proving to be an almost impossible task under such a simplistic formula. In addition, in the past the government has followed a common practice of underbudgeting health expenditure for budget setting proposals which have artificially lowered the distribution basis. Pressures on public deficits now make it much more difficult to solve past problems. The 98 budget proposal increases health finance an 8.5%, well above the GDP nominal increase, but the revenue sources for this are not still decided: higher taxes on alcohol and tobacco, and the introduction of a new co-payment for pensioners drug consumption has been discussed so far[26].

3.4- The finance of the National Health Care Sector and the regional allocation of resources.

An agreement of The Consejo de Política Fiscal y Financiera was reached at last on Nov. 1997. It establishes a General Fund for Territorial Distribution (with the 98.5% of total resources), a Compensatory Fund (20 thousand million pesetas) and a Fund for Cross boundary Flow of patients (48 thosand million pesetas).
The distribution of the first fund follows a pure capitation basis. No age adjustment has been recognised. This has forced to add a second and third Funds, in trying to compensate those Communities which could argue for an unfair treatment under the pure capitation financing system. Their values have not been computed with any empirical calculation which could be the total allocation robust enough to future claims for additional changes.

The solution is a political rather than a technical one, favouring basically Andalucia, Galicia and INSALUD. In order to avoid financial losses for Catalunya, some political "amendments" have had to be made. All together this strategy has increased the cost of the "solution" and, unfortunately, has not resolved once for all the existing allocation problems, since no consensus exists on the finally adopted distribution.

Table 8 shows (1) actual population for 1996 without adjustments, (2) the resulting share after the three funds come to operate, and (3) the actual increases on the total finance received over the pre-existing arrangements (1997).

TABLE 8: Population percentage (1), per capita financing shares (2) and actual increases (3).

	(1)	(2)	(3)

Andalucía	18.07	18.07	+ 10.3%
Galicia	6.91	6.93	+ 7.0%
Canarias	4.07	4.02	+12.4%
Catalunya	15.75	16.27	+9.2%
Valencia	10.23	10.13	+9%

Finally, for the additional 315 thousand millions needed for regional distribution (the cost of the agreement), 200 will have to be raised from additional general budgetary funds, 75 from higher tax revenues and 40 by fighting fraud in working day losses due to sickness (the so called "incapacidad laboral transitoria", at present financed by the central social security but managed by the regional health authorities). An extra 65 thousand millions savings are expected from a new aggreement with the pharmaceutical sector (in terms of profits devolution), although it is not clear which balances will have to be made for this purpose with the important pharmaceutical lobby.
This makes for a very complex strategy since in absence of any real reform, additional health expenditure is recognised for future finance through extra funds coming from a present budget expansion extremely difficult to maintain in the future.

3.5- How all these actions reflect on health policy problems

Following the regional devolution process, and despite past efforts to maintain a cohesive National System for Health Care, results are not so far promising. Holding an uniform central policy on health care in Spain does not seem today to be possible nor it is anymore, perhaps, desirable. As a matter of fact, the Basque country, with a different regional finance well rooted in its history, is able to finance health services with almost a twenty per cent rate above the per capita state average. The capitation system that initially benefited Galicia and Canarias, greatly improving their regional health infrastructure, is today obscured by current expenditure needs, arguably due to the lack of budgeting. The pure capitation has always made life very difficult for Andalucia and Catalunya, overrunning budgets from year to next. The main effects of this are: different waiting times for access to similar services, several standards for quality in hospital health care, wage disparities amongst health professionals, different utilisation rates for equal episodes, and even different services provided at large. Examples are: vaccination for meningitis C, rates in hip and knee replacement and on services offered with some public education campaigns (breast cancer detection for example) are recent illustrations of the iceberg.

However, it is perhaps difficult to expect a different outcome other than disparity from any real devolution process of health care. There are several reason for this: first, the already existing territorial inequalities appear explicitly with devolution, though they may not be caused by it. Secondly, in general, fiscal federalism has to do with disparity: different menus improve community welfare, against the imposition of an unique central pattern of health care. In this sense, cultural and social differences among Spanish regions are very large. Thirdly, the relevant health inequalities in Spain still relate to individual social class rather than to region: A never- ending redistribution will possibly never close the gap in regional

health indicators. Some studies show that inequality reduction as a whole is 90% explained by personal rather than by territorial income redistribution (Ruiz-Huerta, et al., 1995).

Therefore, the relevant strategy for a country that undertakes a decentralisation process, as Spain, did may be somewhat different. A more modest and suitable approach is, first, to define its basic policy, i.e. what the public package of health care must include in any Spanish region for any Spanish citizen, following the *desiderata* of the effectiveness criteria. An "uniform average" in a decentralised context is in fact a "moving average" and hence it is politically unenforceable.
Second, in any decentralisation process it is very important that regional differences are financed by different regional fiscal efforts, and that the equalisation policies are well defined and their implementation well monitored.
"Free lunches" in health care delivery for CC.AA. do not help for a sensible management, value for money health expenditure.
None of these factors are well addressed today in Spain. This makes the definition of any health policy at a general level much more problematic.

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Footnotes

[1] The amount of the transfer has been linked to health care spending (instead of being unconditional to the overall social security budget) since 1989. This process has seen itself reinforced in the budget for 1995 and 1996.

[2] See González, 1995, Rodríguez, Murillo and Calonge, 1993 and the Report for the Advisory Comission on the Distribution of Resources in the Regional Health Service of Catalonia (P. Ibern, G. López and V. Ortún), published in Fulls Económics, 18, 1994.

[3] Indeed, the so-called "Pacto de Toledo" (a consensus agreement among all the political parties to reform the Spanish Social Security) removes social security contributions for health care and imposes finance by taxation, as was originally intended in the Ley General de Sanidad of 1986.

[4] However there are considerable differences in spending between autonomous communities (of which there are 17 in Spain). For 1994, the last available year, the P15-P85 percentile difference rank was 19.130 ptas, with an average per capita value of 80.110 and a mean of 78.877 ptas. Between 1986 and 1994, the annual average rate of increase was 13,17% and its rank increased an 11,69%.

[5] Data from the Encuesta de Presupuestos Familiares of 1991 (see M. Rodriguez, C. Murillo and S.Calonge, 1993. *Hacienda Publica Espanola*, n1127. Madrid. Instituto de Estudios Fiscales).

[6] Last year available from the General Household Expenditure Survey (The complete survey is every five years).

[7] Rodríguez et. al. (op. cit).

[8] Under the 'Concierto' (general agreement) the Basque country and Navarra collect their own taxes in the region and, later on, pay for the services not transfered to the region ruled by the central state. These payments ('cupos') relate to income. Whenever a public service is decentralised, the region does not pay anymore to the central state for this contribution, and it can entirely keep the revenues collected. If the state was financing less than the corresponding amount of the share in the regional income on total (as usually happens in rich regions with regard to capitation), the transfer of a service implies additional money to the region.

[9] Life expectancy at birth was in 1994 81.0 for women and 73.3 for men, perinatal mortality per 100 live births is 0.66 and the infant mortality 0.6% (ECO-SANTE, OCDE, 1996).

[10] See for example, the Blendon Report, commissioned by the Comision de Analysis y Evaluacion del Sistema Nacional de Salud, which allows for comparisons between different countries regarding satisfaction with health care services (R. Blendon at al., Health Affairs, Spring, 1991). See Mossialos (1997) for the Health Eurobarometer.

[11] In fact, until the implementation of a single type of contribution in 1979, there were specific contributions for each Social Security Service. As of 1979, the contribution from

the state was dedicated to financing the deficit of the entire system. From 1989 on, the state decided to increase its contributions to social security, thus ending its responsibility for the social security budgets.

[12] The remaining 2% is mostly revenues from third parties such as traffic accidents.

[13] In order to understand some relevant details of the budgeting process in health care before 1994, see N. Sanfrutos. "El presupuesto sanitario en el contexto de la Seguridad Social". *Presupuesto y Gasto Publico* (1993) 10: 101-112.

[14] The beneficiary private sector (Red Cross and Church) total about 135 centres, of almost all sizes and types of assistance (including maternal, infant and psychiatric care and oncology etc.).

[15] The distribution of public beds is less homogeneous in the Autonomous Communities with health care responsibility, as both concerns the status of hospitals (i.e.: dependent on the social security, municipalities or lucrative entities) and as concerns the number of beds per inhabitant (for example there are 0.78 beds which depend on the social security per 1000 inhabitants in Catalunya, compared with 2.55 in Aragon and an overall average of 1.68 and, as regards total numbers of beds there are 4.95 in the Basque Country and 6.1 in Navarra compared with 3.8 in Galicia and 3.2 in Castilla la Mancha, the average being 4.35. Analysis of the private sector reveals 3.04 beds per 1000 population in Catalunya compared with 0.2 in Extremadura and an overall average of 1.4).

[16] NSALUD surgery waiting list was 53.828 patients in June 96 with an average wait of 207 days. Extraordinary measures were put forward by the Conservative Government.

[17] At present civil servants in Spain are covered by special schemes. One such scheme, MUFACE, allows insured civil servants the option of choosing between either being publically insured (through INSALUD) or of being privately insured with no extra cost in relation to the rest of the population.

[18] Here is a range of medications for chronic diseases for which only 10% of the cost is paid, with a ceiling of 439 ptas. per prescription, updated annually. This reduced contribution has been extended recently to AIDS patients.

[19] The resulting effect seems to consist of increasing the weight of drug consumption for retirees coming from the rest of the population, today closed to the ratio of 9 to 1 in terms of the per capita cost (retirees versus non retirees).

[20] As commented earlier on, for MUFACE affiliates, the general copayment is 30% for everyone, including pensioners (instead of 0% for pensioners within the general system). As a result, pharmaceutical per capita costs for MUFACE are 8% lower than the average.

[21] Valencia has a per capita pharmaceutical cost almost 35% above the national average.

[22] To this end, they applied diverse approximation methods to synthetic activities and costs for 68 INSALUD hospitals. It is thus a proposal of methods for studying variations observed in cost and activity found in complexity - methods of concentration and relative severity - and allocative efficiency. This analysis is alternatively based on information theory, on factoral analysis and on multiple regression.

[23] However, the authors call attention to the fact that, even in 1991, financing of medium-large INSALUD hopitals continued to hardly be a service-specialized, especially as the variable of interhospital average length of stay tended to follow general, organisational factors that affected the hospital as a whole.

[24] Hospitals owned and managed by INSALUD, with more than 100 beds and a hospital supply that is not distorted by the proximity of large regional hospitals.

[25] An early version of this section can be found in Lopez and Beith *Eurohealth*, vol 2, number 3, sept. 1996.

[26] The forecasted expenditure for the National Health Service in 1998 amounts 3.835 thousand milion current pesetas (3.520 was the figure for 1997).