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HEALTH CARE SYSTEMS IN SPAIN AND PORTUGAL – ECONOMIC APPROACH

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INTRODUCTION

The observation of the Polish health care system leads to the conclusion that its already not sufficient condition is deteriorating or at least is not improving significantly. According to the latest Euro Health Consumer Index (which takes into account 50 criteria) Poland occupies the 32nd position, losing its 30th position in 2018 and 29th in 2017. It proves that increasing expenditures on the Polish health system (this year about PLN 90 milliard) do not change the situation in the proper direction. Poland dramatically needs a completely new health care system. The aim of the cycle of the articles on European countries' health care systems is to find and point out their outstanding organisational and economic arrangements, which make them effective and which may be used to build the fundamental features, arrangements and tools of a new efficient health care system for Poland.

The main hypothesis of the research is that in the existing health care systems of other European countries there are such outstanding solutions which may be transferred to the new Polish system and implemented in it without enormous difficulties. The cycle of articles was started with the description of health care systems in the Netherlands and Luxembourg and now proceeds to Portugal and Spain. Spain has the area of 506 thousand square

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kilometres and population of 46.5 million (2017) and Portugal 92 thousand square kilometres and population of 10.3 million (2015). According to the European Health Consumer Index, Portugal has the 13th most effective health system in Europe and Spain the 19th (Health Consumer Powerhouse 2019).

The Portuguese health care system consists of three parts: the general publicly financed National Health Service (*NHS*), insurance schemes for specific professions, occupations or companies (*the health subsystems*) and private voluntary health insurance entities (*VHI*). The National Health Service was envisaged in the new democratic Constitution (1976) and established in 1979. Its principle was that all citizens have access to health care regardless of their economic and social status. In the next years some changes were made in it. The most important one was the introduction of charges to be paid by users and social exemptions from the charges (Simoes et al. 2017: 17).

The Portuguese health policy was evolving from establishing the centralised NHS (late 1970s), through incentives to increase alternatives to public service (early 1980s), promotion of market mechanisms (mid 1990s), tools which took off the health care from the market oriented status (late 1990s) up to the mixed system with interaction of public and private sectors and combination of common coverage (guaranteed by the NHS) with efficiency (the beginning of 2000s) (Simoes et al. 2017: 17). The contemporary legal framework of the health care system was established by the 1990 Basic Law on Health (*Law No. 48/90 of 24th August 1990*). It introduced the following new arrangements:

- regionalisation of health service by creating (finally in 1993) five Regional Health Administrations (*RHAs*) which are responsible for strategic management of health of the citizens, supervision of hospitals, management of National Health Service primary care centres and fulfilment of the national health policy objectives;
- possibility of privatisation of sectors of health care by allowing the state to promote private suppliers of medical goods and services and private management of public health facilities;
- possibility of introducing private health care financing by promoting private voluntary health insurance firms (*VHI*) and other options of health insurance;
- integration of health care with simultaneous establishing of regional units which will gather local hospitals and care units (Simoes et al. 2017: 16–17).

Next significant modifications of the Portuguese health care system were connected with the aim of the country to overcome the international financial crisis which began in 2008. After a long period with low economic growth (the average Gross Domestic Product grew by 0.8% between the

years 2001 and 2010), the country's economy experienced severe recession in 2009, 2011 and 2012 (Perelman, Felix, and Santana 2015: 307–315). The economic decline was connected with a continued rise of unemployment and public debt. As a result of the simultaneous economic turmoil in other countries, Portugal had increasing difficulties with access to international financial markets. The country could not re-finance both private and public obligations. Consequently, Portugal asked the European Commission, the European Central Bank and the International Monetary Fund for financial assistance. In May 2011, the three institutions and the Portuguese government agreed on the Economic and Financial Adjustment Programme and signed the Memorandum of Understanding (the MoU) that granted Portugal the Euro 78 milliard loan.

The MoU was connected with number of policy conditions (measures) which had to be fulfilled by Portugal. The most important among them were:

- austerity arrangements with a decrease in public spending and a rise in tax income to cut budget deficit;
- other measures to stabilise the financial sector;
- structural reforms in many areas including labour, goods, services and housing (Maresso et al. 2014).

The Memorandum of Understanding contained also thirty four measures which referred to the health sector. Major measures are listed in Table 1.

The most essential health measures, which influenced the other ones, were the strengthening of regulations and improving of health quality and safety and the National Health Plan 2012–2020. The National Health Plan underlined the principles of the desired health system i.e. the equity, the access to health care, health quality and the health policies. They should be implemented together with the continued austerity measures.

Table 1

Major policy measures referring to the health sector

Policy measures	Goals
<i>Regulation and governance</i>	
Reinforcement of the HRA's powers (2014)	Strengthen regulation; improve health quality and safety
Reorganization of the Ministry of Health structure, including merge/extinction of some entities (2012–2014)	Improve efficiency; cost-containment

Policy measures	Goals
<i>Health promotion</i>	
National Health Plan 2012–2020	Health gains, focusing on equity and access to health care, health citizenship, health quality and healthy policies
Priority Health Programmes (2012 onwards)	Health gains through prioritization of 11 health programmes: diabetes, cerebro-cardiovascular diseases, oncological diseases, mental health, tobacco control, respiratory diseases, healthy nutrition, physical activity, prevention and control of antimicrobial resistance and infections, viral hepatitis, and HIV/AIDS
<i>Pharmaceutical market</i>	
Changes to the structure of distribution margins (since 2012)	Reduce public pharmaceutical expenditure
Promotion of generic drugs (since 2012)	Reduce public pharmaceutical expenditure
Revision of chosen countries for setting reference price (since 2012)	Reduce public pharmaceutical expenditure
Revision of reimbursement rules in the NHS (2010–2015)	Cost-containment
Use of clinical guidelines for prescription (since 2010)	Improve effectiveness and efficiency
<i>Long-term and palliative care</i>	
Expansion of the National Network for Long-term Care (2012 onwards)	Expand long-term coverage through contracting with private and social providers; reduce the length of stay in acute care hospitals
Creation of the National Network of Palliative Care (2012)	Improve access to palliative care; more effective delivery of palliative care
<i>Primary and hospital care</i>	
Benchmarking analysis of hospitals (since 2013) and primary health care groups (since 2014)	Improve effectiveness and comparability of performance among providers
New rules for contracting both with primary health care and hospitals (since 2012)	Pay by results; cost-containment
‘Strategic Plan for Primary Healthcare Reform’ (2016)	Reprioritize 2005 primary care reform
Improved patient choice across NHS hospitals (2016)	Reduce waiting times; improve patient information

Source: Simoes, J., Augusto, G. F., Fronterria, I., and Hernandez-Ouevedo, C. (2017) *Portugal Health System Review 2017*. Health Systems in Transition, 139.

The Spanish health care system consists of public and private segments. The public one is divided into three subsystems: the common national health system (*Sistema Nacional de Salud, SNS*), Mutual Funds for civil servants, members of the army and judiciary (*MUFACE, MUGEJU, ISFAS*) and Mutualities specialised in accidents and professional illnesses (*Collaborating Mutualities with the Social Security*). The SNS is based on universality, free access and equity. It is financed by taxes. It has a country level and a regional level (*seventeen Autonomous Communities, AC*). The country level (*the Interterritorial Council*) is responsible for general coordination of the health system, some strategic areas and national monitoring of health performance.

The private part of the Spanish health care system is gradually growing. It provides dental, hospital, optical and pharmaceutical care, frequently in combination with the public sector.

Planning and regulation of health care on the national scale is done by the Ministry of Health and their local implementation, regional regulation and regional policies by the Departments of Health of the seventeen Autonomous Communities (Bernal-Delgado et al. 2018: XX). The most essential components of the Autonomous Communities dedicated to health care are the Departments of Health. Their roles consist of planning, budgeting and regulating. They are supported by a number of agencies (for example the health technology assessment agency).

The quasi-federal system with the seventeen Autonomous Communities which provide welfare state services to people was introduced by the Spanish Constitution of 1978. Since that time the significance of ACs has been growing. The financial tools incorporated in 2001 and 2009 increasing their autonomous status have resulted in the continued decentralisation of ACs and their growing role in planning, financing and provision of health care as well as education and services of social protection. In 2009, for example, the public spending done by Autonomous Communities on all their activities reached Euro 184.2 milliard, i.e. 17.1% of Spanish GDP. Since that year ACs have been balancing between adequate provision of welfare services and reduction of expenditures (Bernal-Delgado et al. 2017: 5–6).

The economic crisis of the country caused by the global economic recession resulted in policies which were reducing public spending on health. Between 2009 and 2015 they decreased by 5.3%. At the same time private expenditures on health were growing and amounted to 23.9% of the total health payments in 2015. Earlier, in 2012, new regulations were established to determine coverage conditions, the benefits package and the participation

of patient in SNS costs (Bernal-Delgado et al. 2017: XXI). There were also some small reforms (introduction of day-case care, increase of integrated care). The Public Health Policies have been modified intensely. For example, the General Law on Public Health implemented in 2013 increased taxes on alcohol and tobacco. It is worth noting that on 27 February 2018 Spanish government introduced an important decree in which it gave the right of free access to health care to all people living in the territory of the country no matter whether they have or do not have insurance cover and pay or do not pay the insurance premium. It restored the situation from before the year 2012 (PAP Rynek Zdrowia 2018).

1. ORGANISATION AND ECONOMICS OF HEALTH CARE IN PORTUGAL

The Portuguese health care system consists of three parts (*see Introduction*) and is headed by the Ministry of Health. The Ministry is responsible for developing health policies and watching their implementation. It plans, regulates and manages the state National Health Service and regulates, audits and inspects private health care suppliers. The implementation of health policy is the role of Regional Health Administrations.

The following central institutions support the Ministry of Health in its duties (Simoes et al. 2017: 18–21):

- 1) The Central Administration of the Health System (*Administracao Central de Sistema de Saude, ACSS*), which manages human and financial assets, equipment, facilities and IT of the NHS;
- 2) The National Authority on Drugs and Health Products (*Autoridade Nacional do Medicamento e Productos de Saude, INFARMED*), which controls and regulates quality, safety and efficiency of pharmaceuticals and health products;
- 3) The National Institute for Medical Emergencies (*Instituto Nacional de Emergencia Medica, INEM*), which coordinates the Integrated System of Medical Emergency;
- 4) The Portuguese Institute for Blood and Transplantation (*Instituto Portugues do Sangue e da Transplantacao*), which guarantees quality and safety of human blood and organs;
- 5) The Institute for Protection and Assistance in Illness (*Instituto de Proteccao e Assistencia na Doenca, ADSE*), which guarantees access to social and health services for employees of public administration and their families;

- 6) The National Institute of Health Doctor Ricardo Jorge (*Instituto Nacional de Saude Doutor Ricardo Jorge, INSA*), which is the reference laboratory of the health system of the country;
- 7) Regional Health Administrations (*Administracoes Regionais de Saude, RHAs*), which implement the national health policy and coordinate all participants of the health care system;
- 8) Hospitals belonging to the Public Administrative Sector (*Hospitais do Sector Publico Administrativo*), i.e. a small number of public institutions without a character of an enterprise;
- 9) Shared Services of the Ministry of Health (*Servicos Partilhados do Ministerio da Saude, SPMS*), which provide various services related to health care (logistics, human resources, financial management, communications, etc.) to entities which belong to the NHS or to other organisations connected with health care;
- 10) Local Health Units (*Unidades Locais de Saude*), created in 1999 to improve communication between primary care and hospitals and as a result integrate health care;
- 11) Hospital Centres and other Public Enterprise Hospitals (*Centros Hospitalares e Hospitais*), which have the character of public enterprises with a certain level of autonomy (Simoes et al. 2017: 22);
- 12) Private health insurance companies (VHIs), which were introduced in 1978 with group policies and from 1982 with individual ones. The number of people having individual policies grew from 500,000 in 1990 to 2,000,000 in 2015 (Portuguese Authority for Insurance and Pension Funds Supervision 2016);
- 13) Health subsystems (insurance schemes) for employees of various professions.

In addition to health insurance provided by the NHS, 25.6% of the population (2015) were covered by individual or group private health insurance (Portuguese Authority for Insurance and Pension Funds Supervision 2016).

In Portugal there are also institutions connected with health which are not subordinated to the Ministry of Health and are free of its supervision. They are:

- The National Health Council (*Conselho Nacional de Saude*), which is a consultative entity for the Ministry;
- The Health Regulatory Agency (*Entidade Reguladora da Saude*), which is an independent regulator watchdog of health care market, controlling

- operating requirements, patients access to healthcare, defence of patient rights, quality of the health care service and promotion of competition;
- Professional associations in which membership is obligatory (*Ordem dos Medicos, Ordem dos Farmaceuticos, Ordem dos Medicos Dentistas, Ordem dos Enfermeiros, Ordem dos Psicologos, Ordem dos Nutricionistas*), which provide accreditation, certification and see to obeying disciplinary codes;
 - Professional unions (*Federacao Nacional dos Medicos FNAM, Sindicato Independente dos Medicos SIM, Associacao Nacional de Farmacias*), which advocate for the rights of certain professions;
 - Patient disease-based organised groups devoted to cancer, diabetes, haemophilia, hepatitis and other illnesses.

Three other ministries play certain roles in the Portuguese health care system. The Ministry of Finance prepares the government's annual budget and has to reconcile competing needs of the health system with expectations of other departments. It also accepts changes in the number of staff working in it. The Ministry of Labour, Solidarity and Social Security cooperates with the Ministry of Health in certification of sick leave, coordination of health care and social benefits, prolonging long-term care for elderly and disabled people and in other programmes. The Ministry of Science, Technology and Higher Education is responsible for preparing new professionals for the health system and for educating physicians, nurses and allied health specialists at undergraduate level and with academic degrees. However, the postgraduate medical training is provided by the Portuguese Medical Association (*Ordem dos Medicos*) and the Ministry of Health (Simoes et al. 2017: 22–23). The responsibilities of particular sectors and departments of government in the Portuguese health system are shown in Table 2.

The Portuguese health care system is financed by both public and private sources. The National Health Service is covered nearly totally from taxes. The health subsystems, which offer complete or partial health assistance to 20–25% of the country inhabitants, are financed by employees and employers. Private Voluntary Health Insurance companies provide health care to about 26% of the population and play supplementary role. Around one third of the total national outlays on health come from out-of-pocket payments of individual persons. They have a form of co-payments, full payments or premiums to private insurance schemes or mutualities. Patients pay a partial or full price for consultations, emergency and home visits, medical tests and therapeutics, but about 60% of inhabitants are exempted from these costs.

Table 2
Responsibilities in the Portuguese health system by sector

Sector	Legislation	Planning	Licensing/accreditation	Pricing/ Tariff setting	Quality assurance	Purchasing/ Financing
Public health services	Ministry of Health	Ministry of Health	Ministry of Health and Health Regulatory Agency	Ministry of Health	Ministry of Health and Health Regulatory Agency	Ministry of Health
Ambulatory care (primary care and secondary care)	Ministry of Health	Ministry of Health (for the public sector)	Ministry of Health (for the public sector); Health Regulatory Agency (for the private sector)	Ministry of Health (for the public sector)	Ministry of Health and Health Regulatory Agency	Ministry of Health (for the public sector), patients
Inpatient care	Ministry of Health	Ministry of Health (for the public sector)	Ministry of Health (for the public sector); Health Regulatory Agency (for the private sector)	Ministry of Health (for the public sector)	Ministry of Health and Health Regulatory Agency	Ministry of Health (for the public sector), patients
Dental care	Ministry of Health	None	Health Regulatory Agency	Depends on the provider	Health Regulatory Agency and Portuguese Dental Association	Patients, VHI, health subsystems
Pharmaceuticals (ambulatory)	Ministry of Health	Legislation defines pharmacies' location	INFARMED	INFARMED	INFARMED	Patients, VHI, health subsystems
Long-term care	Ministry of Health; Ministry of Labour, Solidarity and Social Security	Ministry of Health; Ministry of Labour, Solidarity and Social Security	Ministry of Health; Ministry of Labour, Solidarity and Social Security	Ministry of Health; Ministry of Labour, Solidarity and Social Security	Ministry of Health; Ministry of Labour, Solidarity and Social Security	Ministry of Health; Ministry of Labour, Solidarity and Social Security; patients
University education of personnel	Ministry of Science, Technology and Higher Education	Public and private universities	Ministry of Science, Technology and Higher Education	Ministry of Science, Technology and Higher Education; universities	Ministry of Science, Technology and Higher Education; universities	Ministry of Science, Technology and Higher Education; students (fees)

Note: INFARMED: National Authority on Drugs and Health Products; VHI: voluntary health insurance.

Source: Simoes, J., Augusto, G. F., Fronterria, I., Hernandez-Ouevedo, C. (2017) *Portugal Health System Review 2017*. Health Systems in Transition, 37.

The Ministry of Finance prepares complete budget for the National Health Service and the Ministry of Health allocates it to all institutions of the NHS. It allocates funds to health regions taking into consideration past periods, their population and health programmes. Public hospitals are financed mainly from the budget, but more and more by health subsystems, private insuring companies and diagnosis-related groups (Simoes et al. 2017: 47).

The total health expenditure of Portuguese health system rose from 7.5% of Gross Domestic Product in 1995 to 9.0% in 2017 (OECD 2019b). The austerity caused by the global financial crisis led the country to the reduction of its spending on health care. Between 2010 and 2013 the Gross Domestic Product dropped by 5.4% and at the same time the total health expenditure went down by 12.4% (Simoes et al. 2017: 48). The country health spending per capita amounted to USD 2,888 in 2017 from which USD 1,924 were the government compulsory expenses and USD 964 the voluntary ones (OECD 2019a).

In 2014 Portugal had 225 hospitals. Half of them belonged to the National Health System. In the last years there was a decrease in the number of public hospitals, caused by their mergers, shorter time of individual hospital treatment and closing of the psychiatric ones. The essential government objective of that time was the involvement of private capital in building, maintaining and operating health facilities in the Private-Public scheme.

The number of physicians per 100,000 inhabitants amounted to 442.6 and was higher than the average of the European Union (349.6). The quantity of nurses amounted to 637.8 per the same amount of citizens and was lower than the EU average (864.3). The country has a significant problem with the distribution of health workers and evident shortages of health equipment (Simoes et al. 2017: 79).

2. ORGANISATION AND ECONOMICS OF HEALTH CARE IN SPAIN

The Spanish public health care systems consists also of three subsystems (*see Introduction*). The main one, the National Health System (*SNS*), covering almost the entire population, is financed predominantly from taxes and provides services by public hospitals and health centres. Medical goods and services provided by the *SNS* are free at the point of their delivery (with the exception of pharmaceuticals for non-patients and some orthopaedic items).

The National Health System is divided into seventeen health systems of Autonomous Communities (*ACs*), which are fully responsible for planning and provision of health services and goods to people living in their territories.

The second subsystem is composed of the Mutual Funds (MFs) of civil servants, armed forces and judiciary. The MFs were covering 2.2 million people in 2014 and were financing 3.4% of public health spending. Up to 85% of their funds come from the central government (as the employer) and at least 15% from the employees. The third subsystem dedicated to professional diseases and accidents is run by the Social Security System and works with Mutualities Cooperating with Social Security (*MCSS*). Their share in public health spending amounts to 2.4%. In addition to preventing and dealing with accidents and professional diseases, the Mutualities collect premiums and pay subsidies on behalf of Social Security and control sickness leave benefits (Bernal-Delgado et al. 2018: 18–19). The private part of health care system in Spain runs voluntary health insurance schemes for individuals. In spite of its slow growth its input into the total health spending of the country is relatively low. The expenditure (2015) on health according to the function and the type/source of financing is shown in Table 3.

The Ministry of Health, Consumer Affairs and Social Welfare (*Ministerio de Sanidad, Consumo y Bienestar Social*) and the Departments of Health in the seventeen Autonomous Communities are the main institutions of the Spanish health care system (see *Introduction*). The Minister of Health with the assistance of the Interterritorial Council (*Consejo Interterritorial del Sistema Nacional de Salud, CISNS*), composed of seventeen Regional Health Ministers, manages the SNS and coordinates the whole health system of the country. He is supported by the following institutions:

- 1) The Agency for Medicines and Medical Devices;
- 2) The National Transplants Organisation;
- 3) The Agency for Consumer Affairs, Food Safety and Nutrition;
- 4) The Institute of Health Carlos III (*Instituto de Salud Carlos III*), which is responsible for the assessment of health technology, health scientific centres and biomedical research;
- 5) The Institute of Health Care Management (*Instituto de Gestión Sanitaria*), which centrally purchases medical goods and services for the Autonomous Communities;
- 6) Primary Health Care and the Specialised Care Divisions;
- 7) The General Council of Physicians;
- 8) The General Council of Nursing;
- 9) The National System of Dependent People (*SAAD*);
- 10) The Ministry of Labour, which has an impact on partial financing of the three health subsystems;

- 11) The Ministry of Public Administration, Justice and Defence, which supervises the subsystem of health insurance for civil servants and the network of health services for military soldiers and prisoners;
- 12) The Ministry of Economy and Enterprise (*Ministerio de Economía y Empresa*);
- 13) The Ministry of Finance (*Ministerio de Hacienda*) (Bernal-Delgado et al. 2018: 20–22).

The distribution of competences in the Spanish health care system is shown in Table 4 (page 54).

Table 3

**Expenditure on health (as % of total health expenditure)
according to function and type of financing, 2015**

Function and type of financing	Inpatient care	Outpatient care	Long-term care	Pharmaceuticals^a	Other devices	Public health	Admin.	Other services^b
General government	92.4	42.6	76	56.3	3.5	96.1	44.2	18.2
Mandatory health insurance	3	6.4	2.2	3	0.6	0	8	81.8
Private out-of-pocket	0.8	43.2	21.7	40.7	94.8	0	0	0
Private insurance	2.3	7.3	0	0	1	0	47.8	0
Other (e.g. non-profit institutions serving households)	1.4	0.4	0	0	0	3.9	0	0
Total expenditure (m€)	41 928	25 789	5 562	17 740	4 248	695	3 003	1 078

Note: ^a Includes outpatient prescriptions, as pharmaceutical expenditure in hospitals is included in inpatient care; ^b Social Security services provided in the household and other services provided by public institutions (not social security).

Source: Bernal-Delgado, E., Garcia-Armesto, S., Oliva, J., Sanchez Martinez, F. I., Repullo, J. R., Pena-Longobardo, L. M., Ridaio-Lopez, M., and Hernandez-Ouevedo, C. (2018) *Spain: Health System Review*. Health Systems in Transition, 51.

Table 4

Competence distribution in the Spanish health care system

Category	Legislation	Planning	Licensing accreditation	Pricing tariff Setting	Quality assurance	Purchasing financing
Public health services	ACs (*)	ACs	ACs	ACs	ACs	ACs
Primary health care (and dental care)	ACs (*)	ACs	ACs	ACs	ACs	ACs
Hospital and specialized ambulatory centres	ACs (*)	ACs	ACs	ACs	ACs	ACs
Pharmaceuticals (ambulatory)	ACs (*)	ACs+CG	CG	CG	ACs (*)	ACs (*)
Long-term care	ACs (*)	ACs	ACs	ACs	ACs	ACs
University education of personnel	CG	ACs+CG	CG	ACs (*)	ACs	ACs

Note: ACs: Competence of the Autonomous Communities; ACs (*): ACs role is mediated and framed by a national framework regulation common to all ACs; CG: Competence of the central government.

Source: Bernal-Delgado, E., Garcia-Armesto, S., Oliva, J., Sanchez Martinez, F. I., Repullo, J. R., Pena-Longobardo, L. M., Ridao-Lopez, M., and Hernandez-Ouevedo, C. (2018) *Spain: Health System Review*. Health Systems in Transition, 31.

The total expenditure of the Spanish health system reached 8.9% of Gross Domestic Product in 2017 (OECD 2019b) and amounted per capita to USD 3,370 in 2017 (from which USD 2,386 was the compulsory public expenditure and USD 984 the private one) (OECD *Health* 2019a).

In 2015 Spain had 765 hospitals. Less than half of them (around 45%) belonged to the public sector. Between 2000 and 2015 the number of hospitals per 1 million population fell from 19.2 to 16.5. The number of hospital beds also decreased from 368 per 100,000 inhabitants in 2000 to 298 in 2015 with the share of public beds staying nearly constant (79.5 in 2015). The number

of primary health care physicians per 100,000 assigned insurees amounted to 75 in 2010 and 76 in 2014 while the number of the same kind of nurses to 62 in 2010 and 65 in 2014. The similar tendency may be observed in the case of physicians working in hospitals or outpatient centres. Their number per 100,000 population increased from 176 in 2010 to 189 in 2014 (Bernal-Delgado et al. 2018: 78–85).

CONCLUSION

Both health care systems, the Portuguese one and the Spanish one, contain a significant amount of solutions which make them effective. At the same time both apply measures that may be called dissolutions as they diminish their effectiveness. As a result (*see Introduction*) according to the European Health Consumer Index, Portugal has the 13th most effective health system in Europe and Spain the 19th (Health Consumer Powerhouse 2019). The most visible dissolution is the mixture of common and universal national health care systems with subsystems dedicated to privileged professional groups like civil servants, the judiciary and members of the army. This mixture has the roots in the former political systems that existed in both countries before the introduction of democratic changes in Spain and the Carnation Revolution in Portugal. The mentioned professional and occupational groups had had privileged positions before these big transformations and were able to transmit them to the new reality.

The mixtures of common and universal national health care systems with subsystems for different groups of the population (and companies) cause numerous interlockings and negative reciprocal feedbacks which complicate and cloud their transparency and efficiency. This is probably one of the main factors due to which the Portuguese and Spanish health care systems are classified much lower than the Swiss one (the first position) and the Dutch one (the second) in the Euro Health Consumer Index (Health Consumer Powerhouse 2019). This is why they are not the best systems to be benchmarked by other countries intending to improve their ones.

However, there is one organisational solution in the Spanish health care system (which is applied to various extents in some other systems) which is worth being noticed, examined in details and introduced to the foundations of Polish new health care regulations. It is a permanent prescription for medicines and drugs. It is not a bunch of prescriptions a person being treated can obtain in quite a complicated administrative procedure in the Polish health system

and not an electronic prescription which is its latest form and which requires some repeated activity from the physician. It is one prescription which is kept by the patient at home and only presented to the pharmacist when the next package of the same medicine is being purchased or it is bound to him in the electronic form. This prescription seems to be available to each person in treatment without a special administrative procedure and seems to be the solution which in the scale of the country spares thousands of working hours of physicians (10–25% according to author's estimation) and may decrease the deficit of physicians more and more evident in the Polish health care system.

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HEALTH CARE SYSTEMS IN SPAIN AND PORTUGAL – ECONOMIC APPROACH

Abstract

The article is a preliminary analysis of the economic conditions of health systems in Spain and Portugal. It describes their organisational structures and lists entities functioning in them. It presents changes that have taken place in the economic situation of both countries in recent years (including the impact of the global financial crisis that began in 2008) and the consequences that these changes have had for their health policy. The article lists the basic numbers referring to both systems and describes some organisational solutions improving their effectiveness. It also presents elements derived from before the democratic transformation, lowering this efficiency. Probably the most important of them are separate ‘subsystems’ of health care for some professional groups (including, for example, administration, the judiciary and army employees), which collaborate with common health care, but also hinder its uniform and clear operation. Probably to a large extent, as a result of leaving these elements in both systems and the related lack of sufficient optimisation of their operation, Portugal holds the 13th and Spain the 19th position in the European ranking of health systems – the Euro Health Consumer Index – examining these systems using fifty detailed criteria. A permanent prescription, used in Spain for many years, is worthy of more thorough research and transfer to the Polish healthcare system as it significantly reduces doctors’ workload not directly related to treatment, and consequently their shortage.

Key words: health care systems, Portugal, Spain, economic approach, organisation, economics

SYSTEMY OCHRONY ZDROWIA W HISZPANII I PORTUGALII – PODEJŚCIE EKONOMICZNE

Streszczenie

Artykuł jest wstępną analizą uwarunkowań ekonomicznych systemów ochrony zdrowia w Hiszpanii i Portugalii. Opisane są w nim ich struktury organizacyjne oraz wymienione podmioty w nich funkcjonujące. Przedstawione

są zmiany na przestrzeni ostatnich lat w sytuacji gospodarczej obu krajów (w tym wpływu na nie światowego kryzysu finansowego, jaki rozpoczął się w roku 2008) oraz konsekwencje, jakie zmiany te miały dla polityki ochrony zdrowia. W artykule podane są podstawowe dane liczbowe odnoszące się do obu systemów oraz opisane są niektóre rozwiązania organizacyjne służące podnoszeniu ich efektywności. Przedstawione są również ich elementy wywodzące się sprzed transformacji demokratycznej, obniżające tę efektywność. Prawdopodobnie najważniejszy z nich to odrębne „podsystemy” ochrony zdrowia dla niektórych grup zawodowych (w tym dla przykładu pracowników administracji, sądownictwa i wojska), które współpracują z powszechną opieką zdrowotną, ale też utrudniają jej jednolite i klarowne działanie. Prawdopodobnie w dużej mierze, na skutek pozostawienia tych elementów w obu systemach i związanego z tym braku dostatecznej optymalizacji ich działania, Portugalia znajduje się dopiero na trzynastym miejscu, a Hiszpania aż na dziewiętnastym miejscu w europejskim rankingu systemów ochrony zdrowia Health Consumer Index (badającym te systemy przy użyciu pięćdziesięciu szczegółowych kryteriów). Godna dokładniejszych badań i przeniesienia do polskiego systemu ochrony zdrowia jest „stała recepta”, stosowana od lat w Hiszpanii, znacznie obniżająca obciążenie lekarzy pracą niezwiązaną bezpośrednio z leczeniem, a w konsekwencji ich niedobór.

Słowa kluczowe: systemy ochrony zdrowia, Portugalia, Hiszpania, uwarunkowania ekonomiczne, organizacja, ekonomia

СИСТЕМЫ ЗДРАВООХРАНЕНИЯ В ИСПАНИИ И ПОРТУГАЛИИ – ЭКОНОМИЧЕСКИЙ ПОДХОД

Резюме

Статья представляет собой предварительный анализ экономических детерминант систем здравоохранения в Испании и Португалии. Она содержит характеристику организационных структур и указание на функционирующие в них субъекты. Представлены изменения, произошедшие за последние годы в экономической ситуации обеих стран (в частности, в контексте воздействия на них мирового финансового кризиса с 2008 года), а также последствия этих изменений для политики здравоохранения. В статье представлены основные количественные показатели, касающиеся обеих систем, а также описаны некоторые организационные решения для повышения их

эффективности. Нашли своё отражение также их элементы, имеющие место до демократических преобразований и снижающие их эффективность. По всей вероятности, самый значительный из них – это отдельные «подсистемы» здравоохранения для некоторых профессиональных групп (включая, например, сотрудников администрации, судебной системы и армии), которые функционируют в рамках универсального здравоохранения, осложняя, однако, его равномерную и чёткую деятельность. Очевидно, в значительной степени, вследствие наличия этих элементов в обеих системах и связанного с этим отсутствия необходимой оптимизации их деятельности, Португалия занимает всего лишь тринадцатое место, а Испания – девятнадцатое место в европейском рейтинге здравоохранения *Health Consumer Index (Индекс здоровья потребителей)* (исследующий данные системы с использованием пятидесяти основательно разработанных критериев). Требуется более тщательного исследования и заимствования польской системой здравоохранения так называемый «постоянный рецепт», используемый в Испании в течение многих лет и значительно снижающий нагрузку врачей работой, непосредственно не связанной с лечением, что в результате приводит к их нехватке.

Ключевые слова: системы здравоохранения, Португалия, Испания, экономические детерминанты, организация, экономия

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