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Spain's Citizens Assess Their Health Care System

by Robert J. Blendon, Karen Donelan, Albert J. Jovell, Laura Pellise, and Enrique Costas Lombardia

Spain is a country of thirty-nine million people with a per capita gross national product (GNP) of $8,668 (1988). The country ranks eighteenth in income among industrialized nations of the Organization for Economic Cooperation and Development (OECD). Between 1965 and 1980, Spain had one of the fastest-growing economies among industrialized nations, averaging 4.6 percent per year real annual growth, compared with 2.1 percent for the United Kingdom and 2.7 percent for the United States. Since 1980, Spain’s rate of growth has slowed to 2.6 percent per year, a figure that is now below that of the United Kingdom (2.8 percent) and the United States (3.0 percent). This slowdown in the economy is placing economic pressures on the current Socialist government. On the one hand, the socialist nature of the base of the party creates expectations for increased health and human services spending; on the other, the reduced rate of economic growth does not make new resources available to meet these expectations.

Currently, Spain spends 6.3 percent (74 percent public, 26 percent private) of its GNP on health care and reported per capita spending of $644 on medical care in 1988. For its limited health expenditures, Spain has achieved an impressive level of health status. Life expectancy at birth in Spain is seventy-seven years, compared with seventy-five in the United States and United Kingdom. Its infant mortality rate is identical to that of the United Kingdom (nine per 1,000) and less than the U.S. rate of ten. It also reports one of the lowest proportions of low-birthweight infants among industrialized countries: 1 percent, versus 7 percent in the...
United Kingdom and United States. Only in deaths among pregnant women does Spain’s health record appear unimpressive: eleven maternal deaths per 100,000 births in Spain, versus nine in both the United Kingdom and United States.\(^1\)

### The Spanish Health Care System

**History.** Joesp A. Rodriguez and Jesus de Miguel have divided the development of the Spanish health system into five periods: postwar (1939-1966), expansion (1967-1975), democratization (1976-1981), first Socialist government (1982-1986), and the health care reform initiated in 1987 with the creation of the National Health System.\(^2\)

Following the Spanish Civil War in the late 1930s, the Franco government established in 1942 a national mandatory sickness program called Seguro Obligatorio de Enfermedad, to be managed through the newly created Social Security system. Funds for the program came from compulsory premiums paid by workers. Eligibility was limited to industrial and manual workers participating in the Social Security system. By 1975, this initiative had grown to encompass 85 percent of the population.\(^3\)

In the second period, between 1967 and 1975, the Franco government built thousands of fully equipped hospital beds, predominantly in urban areas, as part of the centralized Social Security system. At the same time, local governments were required to develop their own public institutions for the indigent, maternity care, psychiatric needs, and public health. These services, most of them charitable, were completely or partially excluded from coverage by the national Social Security system. The Ministry of Education built its own medical school teaching hospitals independent of the other health care developments; a separate health care system emerged from the care of employees injured at the workplace; and, at the same time, a private sector developed to provide selective medical services to upper-income populations.

**Democracy and health care.** Franco’s death in 1975 triggered the democratization period that resulted in the monarchial and parliamentary constitution of 1978. The Spanish Constitution required the creation of a universal, general, and free national health system with guaranteed equal access to preventive, curative, and rehabilitative services for all Spanish citizens. In 1977, the first Ministry of Health and Social Security was instituted; in 1981, it changed its name to the Ministry of Health and Consumption. The entire Social Security system was structured in 1978 and renamed INSALUD.

After the first Socialist government took office in 1982, it made a commitment to making the health system more equitable and responsive
to community health care needs. The government tried to rationalize both the highly centralized INSALUD structure and the whole public-sector health system but, at the same time, had to implement cost containment policies resulting from the pressures created by a slowing economy. This led to the enactment of major health legislation in 1986 that reflects the constitutional mandate guaranteeing universal access. The 1986 General Health Law (also known as the National Health Care Act) made four major changes. First, it extended universal coverage to the remaining uninsured population. Second, it provided the basis for the transfer of the management of INSALUD from the central government in Madrid to the seventeen Spanish regional governments and established a process for integrating other local government health care institutions into the newly created regional health services. Third, it provided support for the establishment of a nationwide network of primary health centers. Finally, it changed the financing basis for the national health system. As of 1989, there would be an increase in the financing that was to come from general tax revenues, and the portion of funds to be raised from Social Security would remain fixed.

Unlike U.S. Medicare, which is strictly a health insurance program, the Spanish Social Security system developed a highly centralized national system of hospitals and clinics. In most parts of the country, every person eligible for Social Security selects a general practitioner. This physician is linked to an identified group of medical specialists for specialty referral. Almost all doctors practice in Social Security facilities. Primary care physicians are paid on a combined salary and capitation basis, while hospital physicians are paid by salary, with different incentives known as complements that represent a provider’s exclusive dedication to the system, years of work, and so forth. Physicians are paid by INSALUD or by the newly created regional health services. Currently, this ongoing decentralization has spawned six regional health services that provide all health care to 57 percent of the Spanish population. Alongside this public system, a new private sector is emerging in the most developed urban areas. A number of people in certain sectors, such as civil servants, veterans, and a variety of employment groups, now contribute both to Social Security and to nongovernment insurance schemes. Almost all outpatient physicians engage in some form of private medical practice through their private offices or private health care organizations. Similarly, nonprofit and for-profit hospitals have multiplied across Spain. The extent of private hospital facilities varies by region, and many private hospitals have contracts with the government for use of their beds by public-sector patients.

**Health care in the 1990s.** In the 1990s, the newly reorganized Spanish
NHS faces a crisis arising from the financial and managerial pressures produced by the system’s inability to deal with the high costs of health care. These rising costs result from an increase in the size of the elderly population, the development of new social services, new health technologies, universal coverage, and the restructuring and decentralization of the system. In response, the Spanish public sector has been rapidly expanding in all areas of health care. On the other hand, the Spanish NHS still lacks chronic care beds, adequate primary care services, nursing homes, and an even geographic distribution of services across the nation.

The need to find new approaches to health financing and reimbursement, control health care costs, and attend to new health needs of the population have led to the establishment of a Parliamentary commission to evaluate the Spanish National Health System. As part of its overall review of these changes occurring since the enactment of the 1986 law, the commission and the Ministry of Health requested that an external study, the results of which are presented here, be conducted to provide insight into the need for and direction of continuing health care reforms in Spain. A key focus of this study was to compare the satisfaction of Spaniards with their health care system to that of citizens of other industrialized countries.

The Survey

Methods. In January 1991, the Harvard School of Public Health and Cuanter, a survey organization in Madrid were commissioned to conduct a nationwide survey in Spain to measure citizens’ satisfaction with the health care system. The study was intended to elicit views on quality of medical care, access to health services, and preferences for reform. The request for this study was made by the Spanish Commission on Analysis and Evaluation of the National Health System and the Ministry of Health. The commission is a special ad hoc body established by the Spanish Parliament following the model of the British Griffiths Commission and the Dutch Dekker Committee on health care reform. Its purpose is to identify the deficiencies of the current NHS and to formulate a plan for major improvement.

The original data reported in this DataWatch come from a survey conducted in April 1991. The findings are based on interviews with a random sample of 1,445 Spaniards ages eighteen and over, whose responses were weighted to represent the adult population of the country. Study interviews were conducted in person. For results based on samples of this size, one can say with 95 percent confidence that the error due to sampling could be approximately ±3 percent for each question.
Here we compare selected findings of this study with previously reported results from surveys conducted in several nations, including the United States, the United Kingdom, Canada, the Netherlands, western Germany? France, Sweden, and Italy. The majority of these comparative findings have been reported in three articles published in Health Affairs.  

**Health care as a national priority.** According to the most recent data available, Spain spends 6.3 percent of GNP on health care and has per capita health outlays of $644 per year. This latter figure is lower than those found in twenty-three other industrialized countries. Only Portugal and Greece spend less for health services ($464 and $37 1, respectively).

The survey data reveal that Spaniards think their nation spends too little on health care and that increases in national spending for health care rank first as a priority for new government spending-ahead of education (22 percent), old age pensions (12 percent), housing (16 percent), and defense (1 percent). In comparison with the United States, Canada, and the United Kingdom, only in the United Kingdom is health spending a higher priority on this list of five issues (Exhibit 1).

The caveat to these findings showing public support for more health spending is that 91 percent of Spaniards want any new money that goes to health care to be reallocated from other areas of government activity; only 7 percent say that these funds should come from new taxes. Spaniards seem to believe there is considerable waste and inefficiency in government in general, and there is a strong sense that funds can be reallocated to health care without requiring new taxes.

**Satisfaction with health care system.** Of citizens surveyed in seven European nations, Spaniards express the next to lowest degree of satisfaction with their current health care system (Exhibit 2). Only the Italians are more disenchanted with their country’s health care arrange-

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### Exhibit 1

**Priorities For Government Spending In Spain, United States, Canada, And United Kingdom, 1988-1991**

<table>
<thead>
<tr>
<th></th>
<th>Spain</th>
<th>United States</th>
<th>Canada</th>
<th>United Kingdom</th>
</tr>
</thead>
<tbody>
<tr>
<td>Defense</td>
<td>1%</td>
<td>9%</td>
<td>3%</td>
<td>1%</td>
</tr>
<tr>
<td>Education</td>
<td>22</td>
<td>34</td>
<td>29</td>
<td>12</td>
</tr>
<tr>
<td>Health care</td>
<td>39</td>
<td>24</td>
<td>28</td>
<td>56</td>
</tr>
<tr>
<td>Housing</td>
<td>16</td>
<td>20</td>
<td>16</td>
<td>8</td>
</tr>
<tr>
<td>Old age pension / Social Security</td>
<td>17</td>
<td>21</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td>None/not sure</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>2</td>
</tr>
</tbody>
</table>


**Note:** The survey question read: If the government were to spend more money on only one of the following, which would you want the money spent on?
Exhibit 2

<table>
<thead>
<tr>
<th>On the whole, the health care system works pretty well, and only a few changes are necessary to make it work better</th>
<th>Netherlands</th>
<th>Germany</th>
<th>France</th>
<th>Sweden</th>
<th>United Kingdom</th>
<th>Spain</th>
<th>Italy</th>
</tr>
</thead>
<tbody>
<tr>
<td>47%</td>
<td>41%</td>
<td>41%</td>
<td>32%</td>
<td>27%</td>
<td>21%</td>
<td>12%</td>
<td></td>
</tr>
</tbody>
</table>

| There are some good things in our health care system, but fundamental changes are needed to make it better | 46 | 35 | 42 | 58 | 51 | 49 | 46 |

| Our health care system has so much wrong with it that we need to completely rebuild it | 5 | 13 | 10 | 6 | 17 | 28 | 40 |

| Per Capita health expenditure ($U.S.) | $1,041 | $1,093 | $1,105 | $1,233 | $758 | $644 | $841 |


ments. Compared to the Netherlands, where only 5 percent believe their health care system requires “total rebuilding,” 28 percent in Spain express these sentiments. Similarly, whereas almost half of the Dutch (47 percent) are content with their current system, only 21 percent of Spaniards feel this way. 10

Within Spain, satisfaction with the health system varies considerably by income. Whereas 35 percent of low-income Spaniards think their system “works well,” 11 percent of those in upper-income brackets feel this way. Perhaps stemming from this high level of dissatisfaction, three out of four Spaniards believe that reorganization of the system—not just adding more money—is necessary to make the major improvements they think are needed (Exhibit 3). These results, including resistance to increasing taxes for health care, point to a public perception that the Spanish health system contains considerable waste and bureaucratic ineffectiveness, problems solved not by more money but by better management of existing resources. The survey cannot provide specific information about the types of reorganization that would be acceptable to Spaniards; it can only point to the high priority placed on the need for change.

We contrast these findings with the results from an earlier survey conducted in the United Kingdom.11 As in Spain, the British public also show relatively high levels of dissatisfaction with their current National Health Service. However, as distinct from Spaniards, they do not believe that a major reorganization is needed, rather, that their government spends too little on medical care (Exhibit 3).

Satisfaction with personal health services. Spain has a relative abun-
dance of practicing physicians, compared with other industrialized countries, but a much lower availability of hospital beds. Among OECD countries, the average physician-to-population ratio is 220 per 100,000. In Spain, this figure is 355, compared with 265 and 204 in the United Kingdom and United States, respectively. On the other hand, the availability of hospital beds is relatively low in Spain. Average hospital bed capacity for all industrialized countries is 8.0 per 1,000 population. However, in Spain the average is 5.2, while in the United Kingdom it is 8.0 and in the United States, 5.9.\footnote{12}

Although three out of four Spaniards say they want major changes in their health care system, approximately 71 percent also report that they are generally satisfied with the personal health care services they and their families used in the past year. This dichotomy—satisfaction with personal health services and dissatisfaction with the organization of the health care system—has also been observed in the United States.\footnote{13} These two types of survey questions have been shown to measure different types of public concern. The question about satisfaction with the nation’s health system elicits concerns about the organization and financing of the system as a whole. The question that measures satisfaction with the personal health services used in the past year renders an assessment of quality of care received. In answer to a question about satisfaction with personal health services, responses in four countries indicate that overall satisfaction, while generally quite high, is comparatively lowest in Spain (Exhibit 4). Only one in four Spaniards (28 percent) say they are “very satisfied” with the health services they and their families received, compared with 35 percent of Americans, 67 percent of Canadians, and 39 percent of British. Similarly, Spaniards report the highest level of dissatisfaction (28 percent) with the organization of the health care system.


<table>
<thead>
<tr>
<th></th>
<th>Spain</th>
<th>United States</th>
<th>Canada</th>
<th>United Kingdom</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very satisfied</td>
<td>28%</td>
<td>35%</td>
<td>67%</td>
<td>39%</td>
</tr>
<tr>
<td>Somewhat satisfied</td>
<td>43%</td>
<td>45%</td>
<td>27%</td>
<td>37%</td>
</tr>
<tr>
<td>Somewhat dissatisfied</td>
<td>18%</td>
<td>11%</td>
<td>4%</td>
<td>11%</td>
</tr>
<tr>
<td>Very dissatisfied</td>
<td>10%</td>
<td>7%</td>
<td>1%</td>
<td>4%</td>
</tr>
<tr>
<td>Not sure</td>
<td>1%</td>
<td>2%</td>
<td>1%</td>
<td>9%</td>
</tr>
</tbody>
</table>


Note: The original question read: Overall, how do you feel about the health care services that you and your family have used in the last year? Would you say you are very satisfied, somewhat satisfied, somewhat dissatisfied, or very dissatisfied?

percent) with their own medical care of the four nations (the United States, 18 percent; Canada, 5 percent; and the United Kingdom, 15 percent). Spaniards’ dissatisfaction with their care is even higher among middle-income groups (33 percent).

Spaniards’ assessment of their most recent visit to a physician or hospital admission is more positive than their general assessment of their overall health care during the past year, notwithstanding some complaints about the amount of time the doctor spent with them and long waiting times to see the doctor. More than 55 percent report that their most recent doctor visit was less than ten minutes long. Compared with the United States, the largest difference in satisfaction is for waiting time for an appointment; 15 percent more Americans than Spaniards report they are very satisfied with this aspect of their care.¹⁴

Satisfaction levels are generally higher among hospital patients than outpatients, including quality of care received. Seventy-three percent are very satisfied with the medical care they received in the hospital, compared with 61 percent satisfied with care in doctors’ offices or clinics. Less popular aspects of the hospital stay include the food, the number of patients sharing a room, and the age and condition of the buildings. However, the majority surveyed are very satisfied with all of these factors. No substantial differences appear between Spaniards and Britons, with the exception of strong British dissatisfaction with hospital food.

These generally high levels of satisfaction with medical care in Spain mask the fact that most citizens believe medical care could be improved. Although only 14 percent of Spaniards seek health care from doctors in private practice or are hospitalized in private hospitals, 56 percent think private institutions and practitioners provide superior medical care to that rendered by national health program physicians, and 52 percent have
the same opinion about the quality of hospital care in the private versus
the public sector. These opinions are held by an even greater proportion
of upper-income Spaniards, wherein preference for private-sector medical
and hospital care is reported by 65 percent and 61 percent, respectively.

Access to care. Only 3 percent of Spaniards (9 percent of those living
in communities with 50,000 to 500,000 inhabitants) report that they
were unable to get the medical care they needed during the year prior to
the survey. Nearly half of those who had a problem getting care report
that they could not get an appointment or had to wait too long to be seen
by a doctor. The percentage of Spaniards (3 percent) who could not get
needed care in the past year is similar to that found in Canada (4 percent)
and the United Kingdom (5 percent), where national health systems also
purport to provide universal access. In the United States, 13 percent of
the population say they could not get the care they needed. The reasons
that some Spaniards had difficulty relate primarily to waiting times for
appointments and availability of certain medical services; few report
financial reasons as a cause for not obtaining needed care (Exhibit 5).

Government constraints on hospital budgets and inefficiency in the
use of health resources can lead to long waiting times for admission to
hospitals. To get a picture of this situation in Spain, several survey
questions addressed waiting times for hospital, surgical, and other medical
services. Twenty-one percent of those surveyed say they or a family
member had been hospitalized in the past year. Of these, 70 percent were
admitted without having to wait at all (likely patients with emergency or
life-threatening conditions); of the others, the average wait for a hospital

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**Exhibit 5**

Reasons Why Medical Care Was Not Obtained In Spain, United States, Canada, And
United Kingdom, 1988-1991

<table>
<thead>
<tr>
<th>Reason</th>
<th>Spain (n=49)a</th>
<th>United states (n=152)a</th>
<th>Canada (n=39)b</th>
<th>United Kingdom (n=91)a</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of money/insurance; couldn’t afford it</td>
<td>5%</td>
<td>58%</td>
<td>14%</td>
<td>2%</td>
</tr>
<tr>
<td>Couldn’t get appointment; too long waiting</td>
<td>47</td>
<td>10</td>
<td>47</td>
<td>22</td>
</tr>
<tr>
<td>Couldn’t get to doctor; lack of transportation</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>15</td>
</tr>
<tr>
<td>Doctor/hospital told me I couldn’t get what I needed</td>
<td>-</td>
<td>4</td>
<td>3</td>
<td>16</td>
</tr>
<tr>
<td>Other</td>
<td>33</td>
<td>24</td>
<td>23</td>
<td>36</td>
</tr>
<tr>
<td>Not sure/refused</td>
<td>16</td>
<td>3</td>
<td>7</td>
<td>9</td>
</tr>
</tbody>
</table>


**Note:** The original question read: What was the main reason that you did not get the medical help needed in this situation?

a Number who did not get needed medical care.

b Number who did not get needed medical care; findings must be treated with caution because of small base number.
bed was twenty-four days, although 13 percent of those hospitalized say they waited for more than a month.

Approximately 20 percent say they had surgery in the past five years or were told they needed surgery. Of these people, nearly half (46 percent) were put on a waiting list before they could have their operation. About one in six (16 percent) are still waiting for surgery. Among the others, the average wait was about six months.

Waiting times for hospital admission appear to be related to patients’ income level. Twenty percent of upper-income Spaniards, versus 46 percent of lower-income Spaniards, report they had to wait for admission to a hospital. When placed on a waiting list, upper-income individuals waited an average of ten days for admission, compared with thirty-nine days on average for lower-income persons. Similarly, there is little difference in the proportion of Spaniards, by income, who wait for surgery. When placed on a surgical waiting list, upper income Spaniards stayed on the list an average of 124 days, compared with 325 days’ wait for lower-income Spaniards. The survey data suggest that these variations are due in part to differences in access to private-practice physicians, who can help patients shorten the wait for admission. One in four upper-income Spaniards (29 percent) report that their usual source of care is a private physician or clinic, compared with 6 percent of low-income Spaniards.

People were also asked if, in the past year, they had to wait for any kind of medical test or service other than an operation or a hospital admission. About 13 percent say they had to wait for some service. Of these, 23 percent are still waiting for the service they need, and 75 percent eventually got what they needed but waited an average of seventy-four days. These figures correspond to answers to other questions about the availability of medical specialists and the latest medical technology. Only 10 percent of Spaniards believe they would not have access to a medical specialist if they needed one, but nearly one in four (22 percent) think they do not have access to the latest technology, and another 17 percent are not sure.

Overall, in the course of the year, most Spaniards perceive they get the medical care they need, and they generally are satisfied with it. However, it is clear that some will have to wait rather long periods, and this situation could well explain their dissatisfaction with the NHS’s organization. Also, Spaniards compare the quality of care they now receive with that found in the private sector and see the public system as less desirable.

Based on interviewees’ self-reported health status as the principal measure of the need for health services, serious illness is considerably more common among Spanish citizens of low income (earning less than
$660 per month). Prior studies have shown that health status is a sensitive indicator of a population’s actual physiological need for medical care. Spaniards were almost three times more likely to report themselves in fair or poor health as Americans (36 percent versus 12 percent) (Exhibit 6). It is not clear whether this reflects cultural differences in defining ill health, the higher actual illness rates in Spain, or even minor variations in the interpretation of the self-reported health status scale in translation.

Earlier studies have shown that the volume of physician care received by low-income populations is highly sensitive both to the presence of financial barriers to health care and to the availability of medical resources in the community. Low-income Spaniards receive care from physicians more frequently than individuals in high income brackets (earning more than $2,200 per month)(Exhibit 6). People in this highest income group, who have the fewest reported health problems, saw physicians 3.7 times last year, compared with an average of 9.1 visits for Spaniards in the lowest income group. Based on their level of ill health, other studies suggest this group’s use of physician care would be even greater if there were not some financial, cultural, travel, or other barriers to care. But in general, the data suggest that Spain’s national health program provides a reasonable level of access to care for its low-income citizens.

In geographic access to care, the data suggest more troublesome variations. Spain is a country with a large number of small, relatively isolated communities. People living in these smaller communities see physicians 20 percent less frequently than those who reside in the large cities such as Madrid, Barcelona, or Seville. Residents of these large cities (more than 500,000 people) see physicians at a rate of 6.4 doctor visits per person per year, versus 5.5 doctor visits for those in smaller communities who report higher rates of ill health. Half of the population (5.5 percent) living in these smaller communities perceive that there are not enough practicing doctors in their communities.

**Private insurance coverage.** Today, 17 percent of Spaniards report that

<table>
<thead>
<tr>
<th>Exhibit 6</th>
<th>Number Of Visits To A Physician. Per Person. For Spaniards. By Income Level. 1991</th>
</tr>
</thead>
<tbody>
<tr>
<td>All incomes</td>
<td>5.9</td>
</tr>
<tr>
<td>Highest income group (more than 200,000 pesetas)</td>
<td>3.7</td>
</tr>
<tr>
<td>Middle income group (60,000 to 200,000 pesetas)</td>
<td>5.4</td>
</tr>
<tr>
<td>Lowest income group (less than 60,000 pesetas)</td>
<td>9.1</td>
</tr>
</tbody>
</table>
they have some form of private health insurance coverage, a figure similar to that currently found in the United Kingdom. Private insurance is designed to provide patients with access to private doctors and hospitals in Spain for relatively less serious elective admissions and treatments. It is not used for testing or high-technology care because these services are concentrated in the public sector. Coverage is found mostly among upper-income families—31 percent of the highest income group have private policies. Another 9 percent of the population (14 percent of middle-income Spaniards) report an interest in purchasing private insurance sometime in the future.

At least for the moment, most of the Spanish middle- and upper-income public are not opting for a two-tiered health system in which the financially well-off would have private-health insurance and the public-sector hospitals and clinics would be used exclusively by those with the lowest incomes. Whether or not this long-term possibility exists, barring some perceived improvement in public-sector services, is currently a question of considerable debate in Spain.

Conclusions

The survey found substantial citizen dissatisfaction with Spain's health care system and considerable support for going beyond the government's 1986 reforms. Clearly, the government can be proud of its success in achieving more equitable access to care for its lowest-income citizens. Although evidence of some barriers to care remains, low-income Spaniards are actually seeing physicians considerably more frequently than those of higher incomes, which might reflect their higher burden of illness and their reliance on medical services to provide certain other social services. These data are especially impressive, given the comparatively low level of per capita health expenditures and percentage of GNP that is spent on health care in Spain.

These survey results portend increasing pressures on the Spanish government to expand the availability of high-technology medicine, reduce queues for care, and lengthen the time health professionals spend with individual patients. As Spain's per capita income grows closer to that of Europe as a whole, so will the size of its middle and upper classes. It is clear from this study that Spanish citizens have expectations that will not be easily satisfied by the performance of the current health system.

The authors gratefully acknowledge the contributions of Santiago Luengo Gómez and Miguel de la Fuente Sanchez of Guanter S.A., and Rosario Arevalo Sanchez to the design, conduct, and analysis of this survey.
NOTES