



**AUDITA  
SANIDAD**

# REPORT

## Jiménez Díaz Foundation – Fresenius

(Community of Madrid)

Work Group

**Auditoría Ciudadana de la Deuda en  
Sanidad (Audita Sanidad)**

**(Citizen Healthcare Debt Audit)**

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### **Jiménez Díaz Foundation – Fresenius**

Compiled by the Auditoría Ciudadana de la Deuda en Sanidad (Audita Sanidad). The Citizen Healthcare Debt Audit work group on behalf of the ENCO network

[www.corpwatchers.eu](http://www.corpwatchers.eu)



**Madrid, October 2021**

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## CONTENTS

Abbreviations and acronyms .....	6
Acknowledgements .....	8
1. Introduction .....	9
2. Objectives .....	11
3. Fresenius.....	12
4. Jiménez Díaz Foundation .....	15
4.1. Special Accord .....	17
4.2. Economic circumstances.....	21
4.3. First modification of the 2006 Special Accord .....	22
4.4. Second modification of the 2006 Special Accord .....	26
4.5. Third modification of the 2006 Special Accord .....	27
4.6. Review of Additional Clauses of the 2006 Accord .....	28
4.7. <i>Ad hoc</i> funding.....	29
4.7.1. Additional costs generated by the Accord signed between the SERMAS and the JDF.....	33
4.8. Comparison with the Gómez Ulla Military Hospital .....	36
4.9. Conclusions regarding the Accord signed between SERMAS and the JDF.....	39
5. PPP Hospitals .....	41
5.1. Some basic considerations.....	41
5.2. PPP hospitals belonging to the German company Fresenius Helios .....	44
5.2.1. Villalba General Hospital .....	46
5.2.2. Rey Juan Carlos Hospital (Móstoles) .....	48
5.2.3. Hospital (Valdemoro).....	51
6. The “Free Choice of Hospital” system .....	53
7. Illegitimate debt generated by the Fresenius Helios hospitals .....	57
8. Conclusions .....	60
9. Proposals and recommendations.....	61

10. Glossary .....62

## AUDITORÍA CIUDADANA DE LA DEUDA EN SANIDAD (CITIZEN HEALTHCARE DEBT AUDIT)

We aim to offer civil society and social movements a rigorous instrument contributing firstly to estimating the quantity of **healthcare debt** and identifying **illegitimate debts** in order to demand their non-payment, and secondly to understanding and transforming healthcare to make it **truly public** in terms of ownership, provision and service management; funded by our taxes without “repayments”; **universal** without exclusions or inequalities and with a much higher level of quality, equity and humanity.



*"Time and time again it must be insisted that the key,  
and in these historic times, even more so,  
lies in **knowing how those who do not stand for election exercise control.**"*

MANUEL MONEREO (Cuarto Poder 28/03/2015)

*«Enormous problems with corruption have come to light. And this corruption  
has nothing to do with morality, nor is it a disease which can be cured.  
**Corruption is a structural part of the system. And it could prove explosive.**»*

ANTONIO NEGRI (EL PAÍS 11/05/2015)

***"If they won't let us dream, we won't let them sleep"***

15M (15/05/2011)



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## INDEX OF ABBREVIATIONS AND ACRONYMS

AME	Asociación Madrileña de Enfermería Independiente (Madrid Independent Nursing Association - trade union)
BOCM	Boletín Oficial de la Comunidad de Madrid (official gazette of the Community of Madrid)
CAP	Centro de Atención Personalizada (Personalised Care Centre)
CEP	Centro de Especialidades Periféricas (Peripheral Specialised Treatment Centre)
CM	Community of Madrid
CPI	Consumer Price Index
DRG	Diagnosis-Related Groups
ENCO	European Network of Corporate Observatories
EU	European Union
GUH	Gómez Ulla Military Hospital
JDF	Jiménez Díaz Foundation Quirónsalud Group University Hospital
IDIS	Instituto para el Desarrollo e Integración de la Sanidad (Institute for the Development and Integration of Healthcare - IDIS Foundation)
ISFAS	Instituto Social de las Fuerzas Armadas (Armed Forces' Social Institute)
LGS	Ley General de Sanidad (General Health Law)
MATS	Movimiento Asambleario de Trabajadores/Trabajadoras de la Sanidad (Healthcare Workers' Movement - trade union)
MBDS	Minimum Basic Data Set
MIR	Médico Interno Residente (Resident Doctor)
MOS	Major Outpatient Surgery
MUFACE	Mutualidad de Funcionarios Civiles del Estado (State Civil Servants' Mutual Society)
MUGEJU	Mutualidad General Judicial (General Judicial Mutual Society)
ODG	Observatori del Deute en la Globalització (Debt Observatory in Globalisation)
PACD	Plataforma Auditoría Ciudadana de la Deuda (Platform for Citizen Debt Audit)

PFI	Private Finance Initiative
PPP	Public-Private Partnership
SERMAS	Servicio Madrileño de Salud (Madrid Healthcare Service)
UCH	Unidades de Complejidad Hospitalaria (Hospital Complexity Units)
UTC	Unidad Técnica de Control (Technical Control Unit)
UTE	Unión Temporal de Empresas (Temporary Business Association)

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We would also like to show our appreciation of the [Librería Traficantes de Sueños](#) bookshop for providing space for us at the Auditoría Ciudadana de la Deuda en Sanidad (Audita Sanidad), Citizen Healthcare Debt Audit to present and disseminate our work.

# 1

## Introduction

Under the successive presidencies of Esperanza Aguirre of the Popular Party [Partido Popular] (2003-2012), the Community of Madrid has seen a wave of privatisations under legislation which promotes both privatisation (Law 15/97) and types of indebtedness which do not appear in calculations of the public deficit. In this way, instead of making optimum use of public hospitals (as stipulated in the 1986 General Health Law), services have been contracted out to third parties, diverting public funds to the detriment of public hospitals.

Starting in 2004, seven new hospitals were built under the Private Finance Initiative (PFI) model and four as Public-Private Partnerships (PPPs). In fact, in 2008 healthcare authorities in the Community of Madrid openly stated that public healthcare was a “*business opportunity for private companies*”, in the words of Juan José Güemes, Head of the Regional Health Department from 2007 to 2010.

During these years, mandatory Regional Health Department inspections have been systematically circumvented, with avoidance of parliamentary control and the suppression of information. This has led to undemocratic management, resulting in elevated additional costs and strong evidence of illegitimate debt. We are facing a conflict of interest in which public servants are acting in the interests of private companies, both domestic and international, to the detriment of the population of Madrid.

In this way, the concession of a considerable portion of healthcare management and service provision to the private sector coupled with an absence of oversight deliberately enables the politicians and civil servants involved to systematically plunder the public healthcare sector.

As a consequence of this, public hospitals and healthcare centres are underfunded, leading to the deterioration of facilities, and staffing cuts. This then favours the diversion of resources to private hospitals which then absorb the patients who originally attended public hospitals. This demonstrates connivance between political powers and economic elites to convert public healthcare into a business niche, a process with is not free of corrupt practices.

### THE POPULAR PARTY AND PUBLIC HEALTHCARE

The healthcare policy of the Popular Party in the Community of Madrid favours the redirection of resources to private hospitals which then absorb patients originally assigned to public hospitals.

At the same time, financial actors interested in moving into public healthcare are spreading a narrative which discredits public healthcare and aggrandises private healthcare, without the support of rigorous, evidence-based comparative evaluations.

In addition, Madrid's public administration is avoiding carrying out appropriate comparative studies (preliminary studies required by current legal regulations) through a lack of transparency in data management: private hospital funding is fragmented into various budget headings which are settled in different financial years, whereas public hospital accounts are settled every financial year. This hides the higher costs of private care and the unjustified special treatment given to private hospitals contracted by Madrid's public administration.

# 2

## Objectives

The objectives of this report are to:

1. Undertake a citizen audit of the agreement or agreements signed between the Madrid hospitals owned by Fresenius Helios and the Servicio Madrileño de Salud (Madrid Health Service, SERMAS), in particular the Jiménez Díaz Foundation.
2. Understand the services and activities which these carry out for the SERMAS and their economic value.
3. Expose the role which the company Fresenius-Quirónsalud plays in healthcare in Madrid, now and in the future, and the way in which the Community of Madrid healthcare administration (the SERMAS in particular), are handing over chunks of the public healthcare system to private healthcare companies and investment funds, undermining the SERMAS' duty to determine public healthcare strategies, development plans and targets.
4. Identify the debt generated by the Fresenius Helios hospitals contracted by the SERMAS and integrated into the Single Public Healthcare Network (Red Sanitaria Única de Utilización Pública) and assess whether there are features of illegality or illegitimacy in this debt.

# 3

## Fresenius

In this report we will analyse the activities of Quirón SA Hospital Group, a company which was absorbed by the German company Helios Kliniken GmbH (referred to in all national media as Fresenius Helios, a name we will also use in this publication) in March 2016<sup>1</sup>. Helios Kliniken GmbH is a member of the German Fresenius SE & Co KgaA group which comprises four strands of activity: Fresenius Vamed (project development – not active in Spain), Fresenius Helios (private hospital management), Fresenius Medical Care (dialysis services) and Fresenius Kabi (healthcare products for hospitals). These last two are also contractors to the Community of Madrid Regional Health Department, but we will not address them in this report (see Figures 1 and 2).

Fresenius SE & Co KgaA, with its headquarters in Bad Homburg (Germany) is a powerful multinational private healthcare group with a 2020 operating income of some €36 billion<sup>2</sup>. Fresenius Helios, in turn, enjoys a near monopoly in public hospital healthcare contracting in the Community of Madrid.

Over the past decade it has managed to create healthcare network in parallel to the SERMAS public network, feeding off Madrid's population and professionals to build a booming and lucrative business.

This is a clear example of what the linguist Lakoff termed **privateering**, a combination of privatisation and profiteering.

*"Privateering is a special case of privatisation in which the capacity of government to carry our critical moral missions is systematically destroyed from within the government itself, while public funds are used to provide capital for private corporations to take over those critical functions of government and charge the public a great deal for doing so, while avoiding all accountability."*<sup>3</sup>

### WHAT IS FRESENIUS

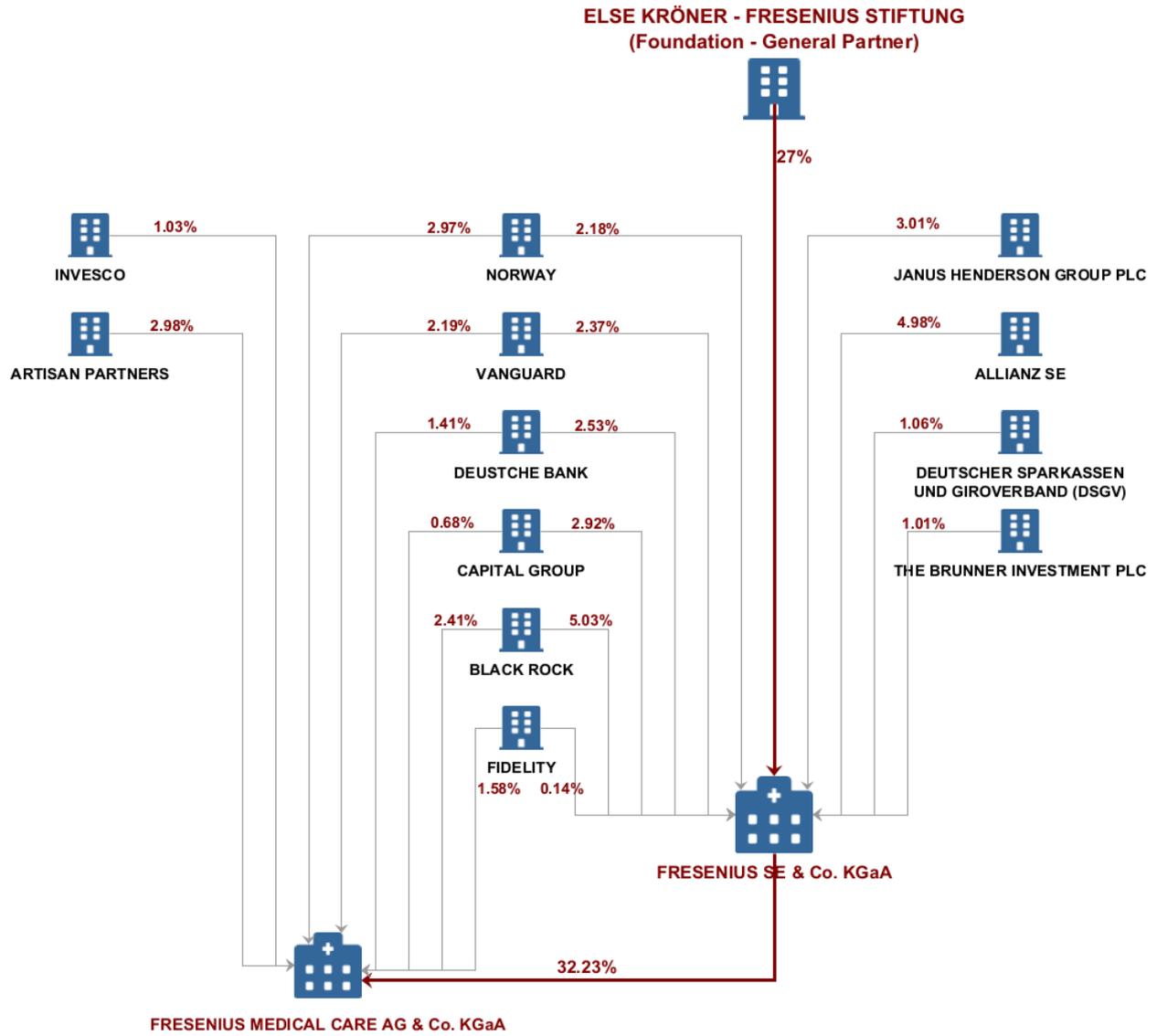
In 2016, the private hospital group Quirón SA was absorbed by a subsidiary of the German healthcare multinational Fresenius SE & Co KgaA. In 2020 the operating income of the group was € 36 billion.

<sup>1</sup>: <https://www.cnmc.es/expedientes/c081316>

<sup>2</sup>: [https://www.fresenius.com/media/Fresenius\\_Q2\\_2021.pdf](https://www.fresenius.com/media/Fresenius_Q2_2021.pdf)

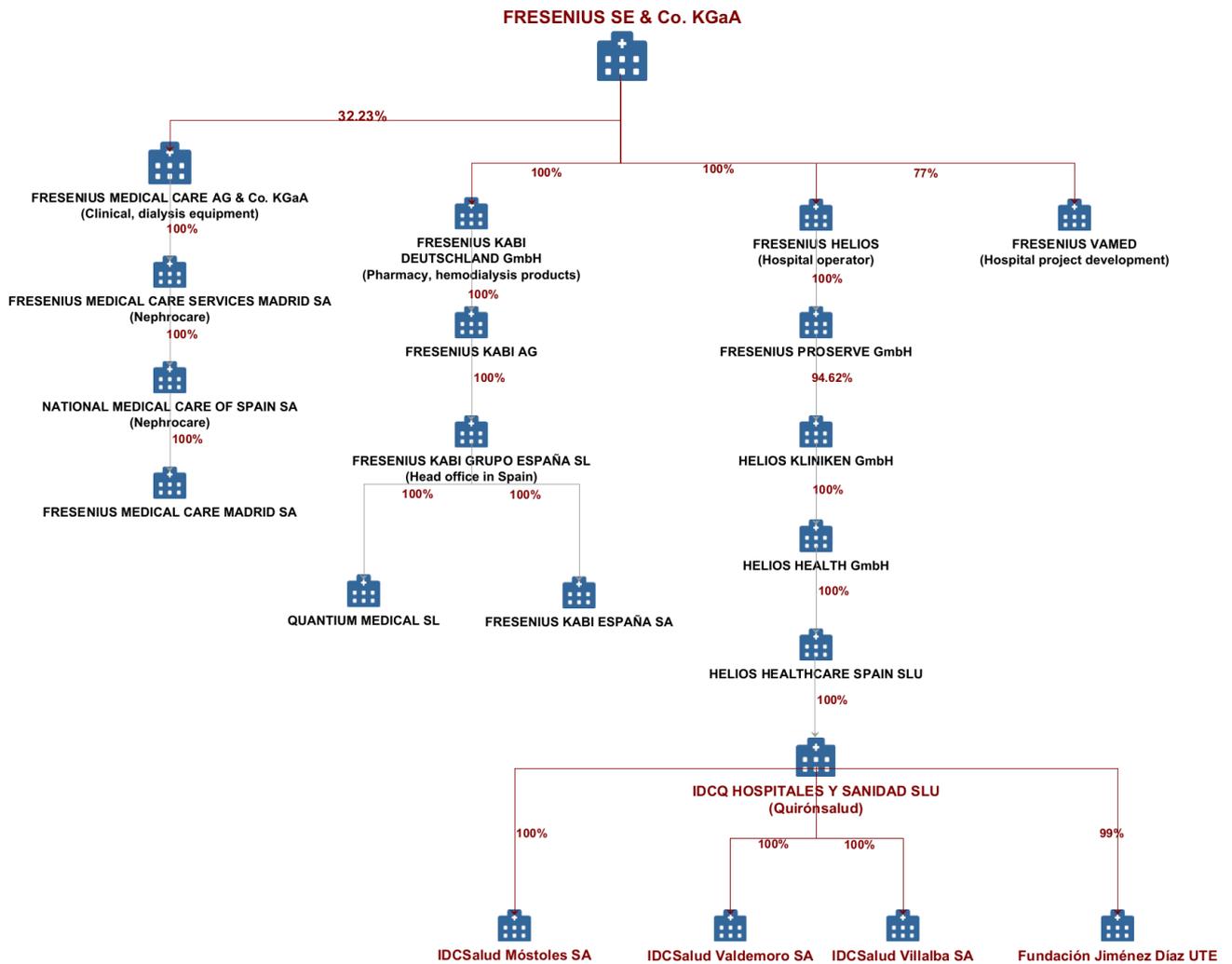
<sup>3</sup>: LAKOFF GEORGE, (2009). *The Political Mind*, Penguin Books.

**Figure 1**  
**Shareholders owning more than 1% in Fresenius SE & Co. KGaA**



Source: Created by the authors based on ORBIS data.

**Figure 2**  
**Subsidiaries of Fresenius SE & Co. KGaA\***



\* We have highlighted only the subsidiaries required to understand the connections relevant for this report. At a global level, the Fresenius group involves many more companies.

**Fresenius SE & Co. KGaA** has **1,678 companies** in its corporate group.  
**Fresenius Medical Care AG & Co. KGaA** has **1,980 companies** in its corporate group.

Source: created by the authors based on ORBIS data.

# 4

## Jiménez Díaz Foundation

The Jiménez Díaz Foundation in Madrid (whose full name on its website is the Jiménez Díaz Foundation Quirónsalud Group University Hospital – JDF from this point forwards) is a flagship of the modernisation and transformation of the Spanish healthcare system. In 1955, Dr Jiménez Díaz’s modern vision of medicine led to the creation of a private clinic using pioneering diagnostic and therapeutic techniques, strongly supported by biomedical teaching and research. In 1963, this clinic, known as the Clínica de la Concepción, became the Jiménez Díaz Foundation and it has been linked to the public healthcare system since its inception, through various accords and agreements signed with public administrations.

The economic management of the JDF had a chequered history throughout the 1990s, to the point that on the 26th of December 2001 its own Board unanimously agreed to legally request “quita y espera” (a grace period for the repayment of debt) from its creditors: in business terms this amounts to the suspension of payments. This aimed to restructure a debt of around 15,000 million pesetas (around €90,101,000) and coincided with the beginning of the transfer of competencies in healthcare matters from the Spanish State to the Community of Madrid, through [Royal Decree 1479/2001](#).<sup>4</sup>



Jiménez Díaz Foundation Quirónsalud Group University Hospital

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<sup>4</sup>: In Spain, the National Health System comprises 17 Health Services, one for each Autonomous Community. Each Autonomous Community receives resources from State budgets to autonomously manage their Health Service.

At this time, the Popular Party was in power in the Community of Madrid, under the presidency of Alberto Ruiz-Gallardón with José Ignacio Echániz as Head of the Regional Health Department.

Led by the Regional Health Department, a viability plan was put into place which led to the creation of a “Unión Temporal de Empresas” o UTE (a type of temporary business association) to ensure the JDF’s survival.

In April 2003, the JDF signed an agreement with Ibdycsa Servicios Médicos SL to create the UTE. In this agreement it was established that Ibdycsa would take on the JDF’s debt and that the JDF would limit its share of any potential profits for 20 years. This company formed part of the IDC Salud group which had the British investment fund CVC Capital Partners amongst its shareholders, which later sold it to the Swedish multinational Capiro in 2005. It was then bought back in 2011 by CVC, which also took control of Quirón Hospital Group in 2014 by purchasing 60% of the British investment fund Doughty and Hanson’s share of the Group, leading to the later merger of IDC Salud and Quirón under the new brand Quirónsalud.

On signing, IDC Salud would take on all the JDF’s debt and participate in a tiered share of profits with the JDF: initially 95% for the group and 5% for the JDF, rising to 50% each in 20 years.

After the agreement was signed, a Regional Health Department spokesman indicated that the Community of Madrid would sign a new Accord with the JDF which would be a substantial improvement on the previous one.

Indeed, it was this agreement between the JDF and Ibdycsa Servicios Médicos SL which allowed this new Accord to be signed, as public administrations cannot contract with companies undergoing a suspension of payments.

A series of changes in ownership of the JDF began with the creation of the JDF - Ibdycsa Servicios Médicos SL UTE in 2003, and the contracts with the Madrid healthcare administration, governed by the Popular Party from 1999 until the present day (2021), were constantly modified from this year forward.

Furthermore, the construction of 4 PPP hospitals, three of which are owned by companies enmeshed in the ownership and management framework of the JDF (and therefore IDC Salud, now Fresenius Helios) and subsequent transactions by various companies have turned the CM into a flag-bearer for the speculative privatisation model still operating.

## WHAT DID THE CONTRACT SIGNED WITH IDC SALUD MEAN?

Thanks to the Accord signed in 2003 between the Jiménez Díaz Foundation and **Ibdycsa Servicios Médicos SL** (part of the **IDC Salud** group which came under the control of the Quirón group in 2014) the Foundation is now controlled by the German multinational Fresenius.

In the following sections, we will analyse the characteristics and circumstances of each of the hospitals now owned by Fresenius Helios and connected with the SERMAS by two types of contractual relationship:

- Jiménez Díaz Foundation is connected by the Special Framework Accord set out in the General Health Law 14/1986.
- Infanta Elena University Hospital, Rey Juan Carlos University Hospital and Villalba General University Hospital are connected through administrative concessions (PPPs) under Law 15/1997 on Enabling New Forms of Management of the National Health System<sup>5</sup>, a law which enables the indirect provision of public healthcare (that is to say, the use of private companies). Administrative concessions for public services were later regulated by Law 13/2003 of the 23<sup>rd</sup> of May on Public Works Concessions and Law 30/2007 of the 30<sup>th</sup> of October on Public Sector Contracts.

#### 4.1. Jiménez Díaz Foundation, Special Accord

After the approval and implementation of the viability plan culminating in the creation of the JDF-Ibdycsa UTE, a Special Framework Accord was signed on the 30<sup>th</sup> of April 2003 between the SERMAS and the UTE<sup>6</sup>. The Accord involves an amount of **€1,025,720,718.93**, over the period from 1<sup>st</sup> May 2003 to 30<sup>th</sup> April 2013.

This type of accord, set out in the General Health Law, is distinctive in that it assigns the private hospital a catchment area, in which it acts for all intents and purposes as a default alternative hospital or "Area Hospital." The catchment area allocated to the hospital is known as its "alternative care area" in the contract wording.

The contractual relationship is set out in two types of documents:

- The text of the Special Accord itself
- Annual Additional Clauses

This Accord was signed by an interim government led by Alberto Ruiz-Gallardón, with José Ignacio Echániz as Head of the Regional Health Department, Carmen Navarro as director of the SERMAS and Leticia del Moral as director of the Instituto Madrileño de Salud (Madrilenian Health Institute). This was an interim government, since the elections in the CM had been called through Decree 4/2003, passed on the 31<sup>st</sup> of March, and published in the official gazette of the CM on the 7<sup>th</sup> of April.

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<sup>5</sup>: <https://www.boe.es/boe/dias/1997/04/26/pdfs/A13449-13450.pdf>

<sup>6</sup>: [https://www.bocm.es/boletin/CM\\_Boletin\\_BOCM/2003/06/14/14000.PDF](https://www.bocm.es/boletin/CM_Boletin_BOCM/2003/06/14/14000.PDF)

As we will see, in an undemocratic use of power, decisions of great importance binding future governments are repeatedly taken by interim governments. This irregular practice would be repeated throughout the history of the Accords and Additional Clauses signed between the SERMAS and the JDF.

The Accord (still valid today) was signed on the **28<sup>th</sup> of December 2006<sup>7</sup>**, with Esperanza Aguirre as president of the CM and Manuel Lamela as Head of the Regional Health Department. The validity period of the Accord was 10 years.

This agreement replaces the one signed in 2003 and was justified through the reallocation of “basic health zones” (the smallest catchment area subdivision in the Spanish health system) initially assigned to the Puerta de Hierro University Hospital in the city of Madrid. The relocation of the hospital to the municipality of Majadahonda (in the north-eastern part of Madrid) meant that certain zones needed to be revised to maintain optimum accessibility isochrones.<sup>8</sup>

In the eyes of the Regional Health Department, as is stated explicitly in the accord, the JDF “is the most suitable centre, as it already has an alternative healthcare agreement signed with the SERMAS and has amply demonstrated its capacity to satisfactorily meet the Specialised Care needs of its assigned population.”

It is also indicated that, given the complexity of the reassignment process, the reassignment would happen step-by-step.

The technical report which justified this as the best option has not been made public, which leads us to conclude it was an arbitrary decision.

This Accord initially assigned the JDF a population representing a total of **402,000 healthcare cards**.

## INTERIM POPULAR PARTY GOVERNMENTS AND THE JIMÉNEZ DÍAZ FOUNDATION

The majority of the modifications to the 2003 Accord were passed by interim Popular Party governments in the Community of Madrid: that is to say, in the pre-electoral period.

<sup>7</sup>: <http://www.madrid.org/cs/Satellite?blobcol=urldata&blobheader=application%2Fpdf&blobheadername1=Content-disposition&blobheadername2=cadena&blobheadervalue1=filename%3DConvenio+Singular+JDF+2006.pdf&blobheadervalue2=languag e%3Des%26site%3DPortalSalud&blobkey=id&blobtable=MungoBlobs&blobwhere=1352906975109&ssbinary=true>

<sup>8</sup>: In healthcare, isochrones refer to the time required to get to a hospital from a given point in its catchment area.

The first consequence of this increase in assigned population is the corresponding increase in funding. And, recalling the conditions set out in the agreement set out between the JDF and Ibdycsa, this implies increased profits for the latter.

The JDF has an activity-based funding model, as we will see further on, with specific rates for each type of service.

There is no data in the Accord with the JDF which justifies it as an ideal hospital for the population to be reassigned to maintain the isochrones (a population which was previously assigned to other hospitals like the Clínico San Carlos or Doce de Octubre hospitals due to their proximity).

Furthermore, there is no financial study on the potential impact of the funding increase the Clínico San Carlos or Doce de Octubre hospitals would have received if the 402,000 health cards had been assigned to them instead of the JDF. Neither is there mention of whether or not these hospitals had surplus capacity to attend to a larger population.

For the Auditoría Ciudadana de la Deuda en Sanidad (Audita Sanidad), Citizen Healthcare Debt Audit this is a clear indicator of illegitimate debt, as the Public Administration has chosen the Jiménez Díaz Foundation (a private foundation) over the nearby public hospital arbitrarily and without justification. This constitutes the dispossession of public facilities and services.

Various types of care are set out in the contract documents.

“**Alternative**” healthcare (care associated with the assigned catchment area) includes care provided to:

- Patients from assigned basic health zones, including the population to which Law 4/2000 on the rights and freedoms of foreigners in Spain applies.
- Planned care for displaced people within the National Health System referred from Primary Care centres in the assigned basic health zones.
- Diagnostic tests (laboratory, imaging, anatomy, pathology, and endoscopy) requested by professionals in the assigned basic health zones.

## INCREASE IN THE JIMÉNEZ DÍAZ FOUNDATION'S PROFITS

The new agreement signed in 2006 included the arbitrary and unjustified decision to reassign basic health zones to the Jiménez Díaz Foundation instead of the nearby public hospitals, which implies diverting resources to the Foundation at the expense of the other hospitals.

- Emergency care, regardless of the background of the patient and when a third party is not liable for payment (mutual insurance funds, MUFACE<sup>9</sup>, MUGEJU, sports federations, etc.)
- Patients included in international agreements signed by Spain.
- In this same section it is stated that the JDF will gradually take charge of the specialised care provided through the Peripheral Specialised Treatment Centres (Centros de Especialidades Periféricas, CEPs)<sup>10</sup> (starting from 2007 for the Quintana CEP and from 2008 in the Pontones CEP).

Care provided to patients coming from other health areas and to those referred by Regional Health Department organisations is defined as **additional care** and is not assigned specific funding. In these cases, the JDF can refuse to provide the care requested, except where the CM Healthcare Standards Law applies (in particular, care under the free choice of hospital system - although this had not been created at that time - and second opinions).

Finally, the third type of care, which is assigned specific funding, is **complementary care** which includes specific healthcare programmes (support / winter beds, programmes to reduce surgery waiting times, specific tests, or techniques) requested by the general management of the Madrid Health Service (SERMAS).

The various care modalities set out in the contract documents are an additional indicator of the clear will of the Popular Party government to prioritise privatisation over providing more resources to public hospitals.

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<sup>9</sup>: There are currently three mutual funds: MUFACE, the “Mutualidad de Funcionarios Civiles del Estado” (State Civil Servants’ Mutual Society); ISFAS, the “Instituto Social de las Fuerzas Armadas” (Armed Forces’ Social Institute) and MUGEJU, the “Mutualidad General Judicial” (General Judicial Mutual Society). The level of protection includes, amongst other things, contingencies, and **healthcare** provision, which includes medical and pharmaceutical care for both the insured person and their family.

- **MUFACE** is an autonomous organisation which manages social services for State civil servants.
- **ISFAS** covers people connected with the armed forces including career military personnel in the Armed Forces, standby military personnel, troop, and navy military personnel while they remain in the Armed Forces, and civil servants in bodies attached to the Ministry of Defence who have not opted to join MUFACE.
- **MUGEJU** covers judges, magistrates, prosecutors, lawyers, clerks of court, coroners, management staff and probationers.

<sup>10</sup>: **CEPs** provide care of medium to low complexity and/or refer more complex cases to hospitals. They are termed “peripheral” as they are not located within the hospital complex.

#### 4.2. Jiménez Díaz Foundation, economic circumstances

The JDF's economic regime is regulated in a general sense by the Special Accord and more specifically by the Additional Clauses which are signed each year.

Furthermore, during 2007 and 2008 **economic increases applying permanently from that point forwards** were incorporated (not quantified in the text and modifiable in the same way as the tariffs), corresponding to the **increase in activity** required to fully integrate the population of the newly assigned basic zones.

The following are financed separately:

- Postgraduate training linked to the medical specialist training system (for resident doctors – MIR after the Spanish acronym)<sup>11</sup>.
- The medicine dispensing programme (HIV treatments, etc.) for hospital outpatients use (that is to say, for patients who do not stay overnight).

Payment for services is carried out as follows:

- A twelfth of 95% of the total budget for alternative and additional healthcare is paid each month.
- This also happens for postgraduate training.
- Pharmaceuticals for hospital outpatients are paid in arrears, on submission of invoices.
- Complementary healthcare is remunerated on presentation of an invoice for the service carried out.

However, there is also a settlement process applying to all invoicing lines, involving an activity verification audit to be carried out in the first six months of the following fiscal year. This audit is the responsibility of the general management of Healthcare Coordination in the CM Regional Health Department, through the Technical Control Unit (Unidad Técnica de Control, UTC)... which has been privately managed since 2007.

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<sup>11</sup>: The MIR (Médico Interno Residente, Internal Medical Resident) examination is obligatory for doctors, Spanish or otherwise, to obtain a position as a specialist doctor in training in the Spanish National Health System.

After this audit, the necessary adjustments are made and the remaining 5% of the payment for alternative and additional healthcare is paid. As these audits are not published, we do not know if they have been carried out. Therefore, there is no way to know how the CM is monitoring compliance with the Special Accord.

## OPACITY AND AUDITS

The information available both in the webpages of the hospitals analysed in this report and in the Regional Health Department Transparency Portal changes frequently, and not only due to updates. Some audits previously available on the webpage and vital for understanding the situation of the hospitals and their control have disappeared from these webpages.

The audits set out in the Auditing Plans for indirectly managed healthcare centres, services, and facilities (which includes those discussed in this report) are not all available either. Only the 2015-2016 and 2017-2018 reports are available. If they were not compiled nor demanded, this is a breach of the administration's responsibility for monitoring and oversight. If they were compiled but are unavailable, this is a lack of transparency.

Only the inter-hospital invoicing audits (see chapter 6 on free choice) from 2012 and 2013 are available. We do not know if more have been carried out or what the results were. If they have not been carried out, we are dealing with a hidden debt, which could be worsened by interest on arrears.

### 4.3. Jiménez Díaz Foundation, first modification of the 2006 Special Accord

Since the Accord was signed in 2006, it has undergone various modifications which will be analysed here. All are favourable to the JDF.

On the **3<sup>rd</sup> of March 2011**, 26 days before the publication of the CM official gazette calling the elections in the Autonomous Community and two months before the election was held, a novation agreement was signed<sup>12</sup>. This agreement was signed while Esperanza Aguirre was president of the Community and Javier Fernández-Lasquetty was Head of the Regional Health Department.

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<sup>12</sup>: Legally, "novation" means to replace a previously agreed commitment with a new one.

The justification for the novation agreement is<sup>13</sup>:

- The modernisation Plan created by the CM which sets out the Activities, Spaces and Equipment Operational Plan for the JDF includes a requirement, set out in the text of the agreement, that the JDF implements a significant programme of investments.
- The ongoing stability of the contractual relationship should be ensured, which will “ensure that the investment programme associated with the Functional Plan is carried out with the strongest guarantees.”
- In addition, the CM guarantees the long-term availability of a care resource of particular significance (sic), satisfying the care needs of the assigned population and allowing the repayment of the investment established in the Functional Plan and the generation of replacement investment (sic).

THE 2011 ACCORD IS  
EXTENDED UNTIL  
**2041**

The CM Ministry of Health is tied to the Jiménez Díaz Foundation until the year 2041, guaranteeing the business volume of what is now Fresenius Helios, at the cost of diverting funds from public healthcare.

This 2011 novation agreement modifies the Accord signed in 2006 in the following ways:

➤ **Validity:**

Changes from 10 to 30 years starting from the 1<sup>st</sup> of January 2011.

This means that the CM (the SERMAS) has a **valid contract** with the JDF until **2041**.

The **compensation for loss of earnings** which would be due if the Accord were to be ended before this date would be practically unpayable from the Regional Health Department budget.

According to the justification for the novation agreement itself, this extension of the validity of the agreement until the legally allowable limit fundamentally safeguards the investment in the refurbishment plan undertaken by the JDF and facilitates the repayment of this investment, all to the detriment of the administration whose hands are tied by an agreement which is impossible to revoke before the end of planned period due to the huge compensation for loss of earnings for which it would become liable.

<sup>13</sup>: [https://www.comunidad.madrid/sites/default/files/doc/sanidad/hosp/novacion\\_convenio\\_JDF\\_capio\\_3mar2011.pdf](https://www.comunidad.madrid/sites/default/files/doc/sanidad/hosp/novacion_convenio_JDF_capio_3mar2011.pdf)

In summary: this change in the validity period of the agreement not only protects the JDF's investments (which treats private patients and members of mutual societies and other healthcare entities well as the population assigned by the SERMAS) but also guarantees the business volume of the company which owns the JDF, today, Fresenius Helios, at the cost of diverting funds from public healthcare.

➤ **Assigned population for alternative healthcare:**

Increases by 32,754 healthcare cards from 402,000 to **434,754**.

As the hospital is funded by activity, the increase in population results in increased funding. Furthermore, this population must be maintained, even if there are changes in the basic health zones: *"the allocated global population eligible to receive alternative healthcare must always be guaranteed."*

This means that even if the population of the CM decreases, the JDF will **always keep the population promised** in the Accord and therefore the same level of funding, even at the expense of neighbouring public hospitals. This is an "innovative" mechanism to guarantee the business volume of a private entity, which is damaging to the public purse and to public hospitals, as public resources are transferred to private healthcare.

➤ **Free choice of hospital:**

This is defined according to the contents of Law 6/2009 and Decree 50/2010 and will apply to patients who did not have an existing clinical history with the JDF or the Pontones and Quintana CEPs (both of which are privatised) before the 1<sup>st</sup> of December 2010.

Free choice does not include referrals from specific programmes, nor emergency admissions (see chapter 6 on free choice of hospitals).

➤ **Financial regime and invoicing for services:**

- a) The novation agreement modifies the tariffs. They are updated in line with the CPI (however, it is not defined if this is the CPI in the CM or Spain as a whole) and cannot be reduced. The CPI can be modified upwards or downwards in exceptional circumstances when there are changes to healthcare staff remuneration affecting the JDF. However, the Accord states that the modification of the index will only be reflected in the tariff when it results in a larger uplift than the original CPI.

- b) From 2013, and applying to the settlements from 2012, alternative healthcare services beyond the initial projections will be paid with determined reductions (15% if the surplus is smaller than 10% and 25% if it is larger). This was originally not so. Furthermore, from this same year, if alternative healthcare services do not exceed 2012 levels in real terms (including adjustments), the entire sum will be paid. This modification actually means **breaking the previously established funding ceiling**.
- c) The calculation of alternative healthcare services will be done based on the population assigned and the average attendance rate for hospitals in the CM.
- d) A spending ceiling is fixed for the 2011 and 2012 financial years, only applying to alternative healthcare and medicines for hospital outpatient use, except new ones which are funded separately. This criterion will be applied throughout the validity period of the agreement.
- e) A rental rate is set out which the JDF is liable pay to the administration for use of the CEPs. The rental rate will be set by the Directorate General for Heritage. The investments made by the JDF are to be deducted from these payments.

It must be noted that the Horizontal Operational Audit Report on healthcare and pharmaceutical spending in the CM 2011-2015<sup>14</sup> approved by a Council Accord of the CM Accounts Chamber in March 2019 does not include invoices for the use of the CEPs, justified by the investments made.

➤ **Additional Clauses:**

Sets out the automatic renewal of payments in line with the last applicable Additional Clause until the Additional Clause of the current financial year has been agreed.

➤ **Rights and responsibilities:**

It is specified that the rights and responsibilities derived from both the Accord and the novation agreement cannot be ceded to third parties without the **express** previous consent of the Administration.

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<sup>14</sup>: <http://www.camaradecuentasmadrid.org/admin/uploads/informe-gto-sanitario-y-farmaceutico-aprobado-cjo-040319.pdf>

*“The transfer of participation in the JDF UTE by its current members by any means will require the previous communication to the Administration of the essential elements of the transaction, including as a minimum notification of the participation in the UTE to be transferred, the legal mechanism to be used to carry out the transaction and the identity of the acquirer. In the case that the nature and characteristics of the operation require the transfer of the Special Accord of the 28<sup>th</sup> of December 2006, the Administration will require the JDF UTE to submit, within 30 days of receiving the request, all the documentation deemed necessary to obtain **express previous consent** to the transfer”.*

This is important given the multiple changes in ownership of the signatories of the JDF Accord which, according to this clause, have the consent of the competent administration – that is to say, the CM (the SERMAS).

➤ **Change of name:**

The sixth stipulation of the new agreement between the SERMAS and the JDF changes its name from Special Accord to Special Agreement.

#### 4.4. Jiménez Díaz Foundation, second modification of the 2006 Special Accord

On the **21<sup>st</sup> of November 2013**, with Esperanza Aguirre as president of the Community and Javier Fernández-Lasquetty as Head of the Regional Health Department, a new modification agreement<sup>15</sup> was signed affecting only invoicing and payments.

This establishes that payments for alternative healthcare and MIR training are to be paid in monthly instalments of a twelfth of a certain percentage of the maximum annual budget, with any differences to be made up in the annual settlement. Usually, this percentage will be 95% with reductions possible if agreed by both parties.

This modification is justified by reference to the economic situation, which is said to require effort on the part of the Administration and the companies working with it to guarantee optimal use of economic resources.

In any case, the possible breach of the maximum funding ceiling is not modified, and nor are the tariff updates or the rental rates.

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<sup>15</sup>: [https://drive.google.com/file/d/1nuVd2\\_bvEsgKmbgHOGIOzM--oEmgiYF/view?usp=sharing](https://drive.google.com/file/d/1nuVd2_bvEsgKmbgHOGIOzM--oEmgiYF/view?usp=sharing)

#### 4.5. Jiménez Díaz Foundation, third modification of the 2006 Special Accord

Finally, another new modification agreement<sup>16</sup> was signed on **31st March 2015**, still in force today (September 2021).

This was again signed by an outgoing government (this time presided over by Ignacio González with Francisco Javier Rodríguez as Head of the Regional Health Department), as the decree calling the elections, Decree 8/2015, was approved on the 30<sup>th</sup> of March and published in the CM official gazette on the 31<sup>st</sup> of the same month.

Again, the infrastructure and other investments the JDF had needed to make to ensure its viability were used to justify the modifications.

It was considered convenient to regulate the SERMAS' control over these investments as they lead to the improvement of services provided to users of the Single Public Healthcare Network, again alluding to the stability of the relationship, and envisioning a system where there is certainty in cases where an agreement cannot be reached during the negotiation of a new Additional Clause.

An Appendix is incorporated in this third modification containing a "Report describing planned infrastructure operations 2015-2019". However, this does not specify the cost of any of these operations.

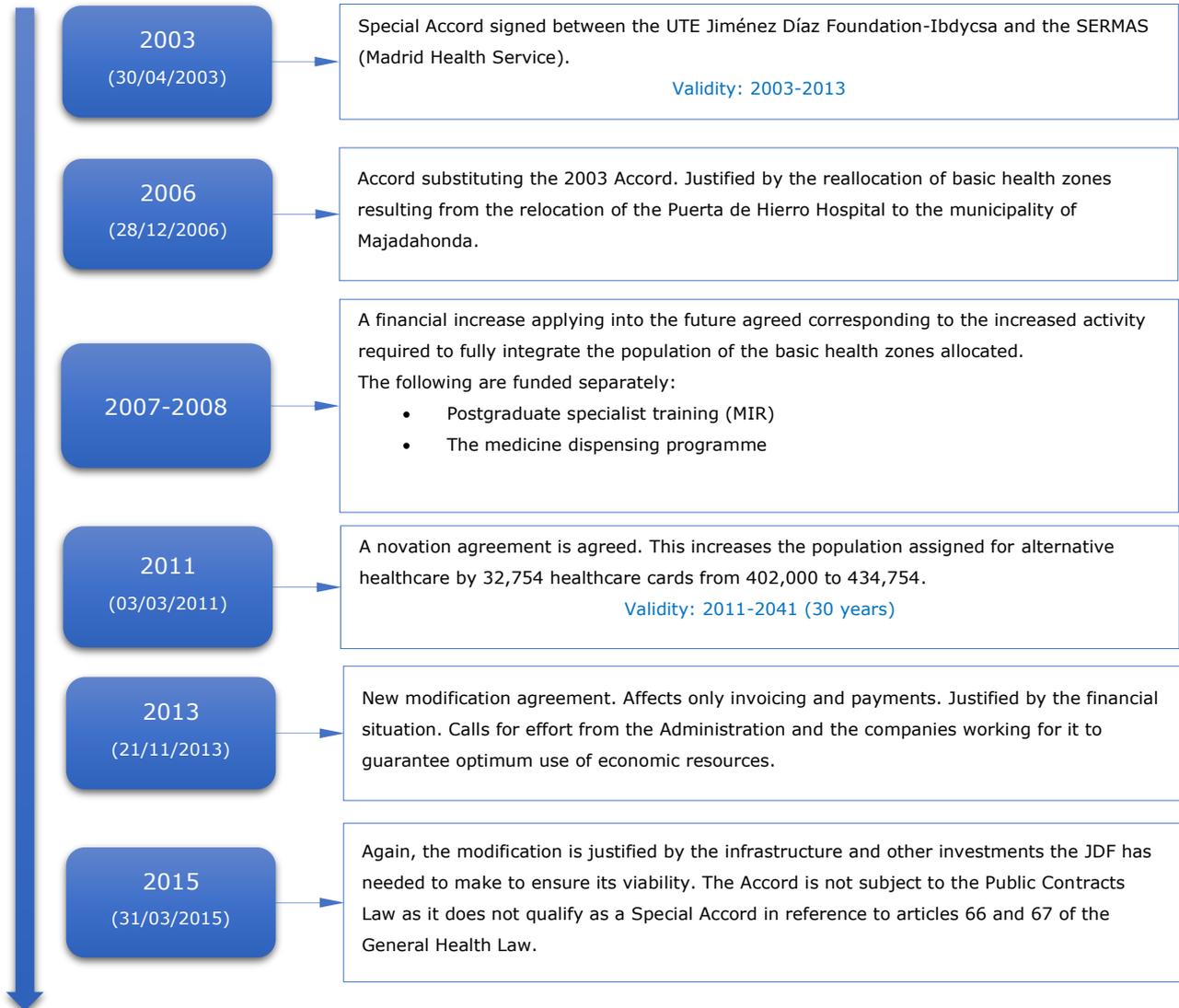
We still do not have documents allowing us to monitor or check the invoices for these infrastructure projects (see Figure 3).

The renewal mechanism for the Additional Clause already present in the 2011 novation agreement was also agreed, except the sections on the financial regime which would be updated in line with the novation agreement (the CPI-linked tariff increases).

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<sup>16</sup>: <https://drive.google.com/file/d/15WUNmUJINWRvDEMijBjoPCZujd1WcnaR/view?usp=sharing>

**Figure 3**  
**Modifications to the Special Accord with the Jiménez Díaz Foundation (JDF)**  
(2003-2015)



Source: created by the authors.

#### 4.6. Jiménez Díaz Foundation, a review of Additional Clauses of the 2006 Accord

To recapitulate, the Additional Clauses are revised annually and set out the details of the financial regime of the Accord between the JDF and the SERMAS.

Reviewing the **Additional Clauses**, it is noteworthy that the 7<sup>th</sup> Additional Clause (2013 financial year) modifies the definitions of the care types and includes as **free choice**:

- Care provided to the population to which Law 4/2000 applies, which regulates the rights and freedoms of foreigners in Spain.
- Care provided to displaced people or undocumented migrants.

Law 4/2000 recognises that illegal migrants have the right to the following types of healthcare: emergency care in all cases, complete paediatric care up to the age limit for paediatric care and pregnancy, birth, and postnatal care.

It is worth noting that public hospitals receive no specific funding for care provided to these groups. Therefore, including them as “free choice” is not only a very lax interpretation of the law regulating this type of care, but also an increase in funding allocated to the JDF.

Identical arguments apply to care given to displaced people or undocumented migrants.

The inclusion of these two groups in “free choice” care involves a funding increase for the JDF, as well as a possible distortion of the data on patients exercising their right to free choice with respect to the public hospitals which do not enjoy the same conditions.

This again distorts comparisons between public and private healthcare and distorted data could be used to argue that private hospitals are more attractive for the population in terms of the number of patients choosing them if free choice is defined *ad hoc*, especially as we do not know if it is included in the balance of patients registering and deregistering with the hospital.

#### 4.7. Jiménez Díaz Foundation, *ad hoc* funding

In this section we will analyse the funding of the JDF, that is to say the financial compensation it receives from the SERMAS for the services it provides. However, it is not an easy task to determine the amount the JDF receives for various reasons:

- Although the initial amounts planned in the annual budgets of the CM Regional Health Department in each Additional Clause are known, it is difficult to access the settlements made at the end of the financial year<sup>17</sup>.
- Free choice care is not included in these budgets and is subject to settlement after an activity verification audit, which is carried out after a delay of several years which can have various repercussions (including possible interest on arrears).

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<sup>17</sup>: The settlement of each annual budget is where the actual amount spent each year can be seen.

- The JDF also receives funds through other budget sections such as complementary healthcare or participation in waiting list reduction programmes.

These difficulties in monitoring the payments received by the JDF can only be called a lack of transparency.

Beyond making monitoring of the budget impossible, it prevents comparisons with other (public) hospitals and complicates the identification of additional costs.

However, the draft version of the Horizontal Operational Audit Report on healthcare and pharmaceutical spending in the CM 2011-2015<sup>18</sup> compiled by the CM Accounts Chamber shows that treatment in the Jiménez Díaz Foundation costs the Community of Madrid **six times more** than the same treatment in a public hospital. This figure clearly demolishes the neoliberal mantra that private services are cheaper than public services.

Other complications in the analysis of the total amount received by the JDF from the SERMAS are due to:

- Settlements which are made and paid out with a delay of up to two or three years, particularly those related to free choice.
- Audits which are not carried out, or if they are carried out, are not published.
- Different invoicing categories (treatments with specialist medicines).
- Costs validated by the Council of the CM<sup>19</sup> which (to take an example) reached an amount of €3,799,734 in 2015.

## TREATMENT COSTS IN THE JIMÉNEZ DÍAZ FOUNDATION

The Accounts Chamber of the Community of Madrid, La Cámara de Cuentas de la Comunidad de Madrid, in its draft Horizontal Operational Audit Report on healthcare and pharmaceutical spending in the CM 2011-2015, recognised that treatment in the Jiménez Díaz Foundation cost **six times more** than the same treatment in a public hospital.

<sup>18</sup>: This draft report would later give rise to the Accounts Chamber Report, approved by a Council Agreement of the Accounts Chamber on the 4th of March 2019. The draft is not available on the Accounts Chamber website but can be read at:

[https://auditasanidad.org/wp-content/uploads/2019/04/C%C3%A1mara-de-Cuentas\\_Informe-Gasto-Sanitario-2011-2015-Anteproyecto.pdf](https://auditasanidad.org/wp-content/uploads/2019/04/C%C3%A1mara-de-Cuentas_Informe-Gasto-Sanitario-2011-2015-Anteproyecto.pdf).

It is explained here: [https://www.eldiario.es/madrid/Camara-Cuentas-Fundacion-Jimenez-Diaz\\_0\\_874562955.html](https://www.eldiario.es/madrid/Camara-Cuentas-Fundacion-Jimenez-Diaz_0_874562955.html)

<sup>19</sup>: This is a collegiate body which initiates legislation, has an executive role and is a regulatory authority, in compliance with the Statute of Autonomy and the Law.

It must be taken into account, that according to the CM General Accounts Audit Report carried out by the Accounts Chamber<sup>20</sup>, between 2015 and 2018 inclusive, the SERMAS was **liable for a settlement of €722.5 million** to be paid to the Fresenius hospitals (JDF, Valdemoro Hospital, Villalba Hospital, Vallecas Hospital and Móstoles Hospital) and also the Torrejón and Gómez Ulla hospitals, not belonging to Fresenius. We estimate that the debt to Fresenius hospitals contracted by SERMAS alone could exceed €600 million for 2018.

Considering all of this, using data provided by the SERMAS board of directors and the budgets of the CM Regional Health Department, the quantities paid to the JDF are as shown in Table 1.

The amounts paid in 2013 and 2014 have not been published, as budgets only began to be published after Law 19/2013 on Transparency, Public Access to Information and Good Governance was published.

**Table 1**  
**Evolution of the initial Budgets and settlement Budgets of the Jiménez Díaz Foundation**  
(2013-2019)

Jiménez Díaz Foundation budget (€ million)		
Years	Initial budget (€ million)	Settlement (€ million)
2013	193.8	
2014	193.8	
2015	295.5	328.6
2016	295.5	281.0
2017	345.5	320.5
2018	372.0	242.4
2019	372.0	405.4

Source: CM Regional Health Department budgets

However, according to data appearing in the **Accounts Chamber audit report** for the 2011-2015 financial years already cited, the payments to the JDF in those years are as shown in Table 2.

<sup>20</sup>: The report can be accessed at:  
<http://www.camaradecuentasmadrid.org/admin/uploads/informe-cuenta-gral-2018-aprobado-cjo-261219-rectificacion-cjo-23012020.pdf>

We can see in this table how the final payments to the JDF according to the figures given in the Accounts Chamber audit report for the 2011-2015 financial years previously mentioned are higher than those which appear in Table 1.

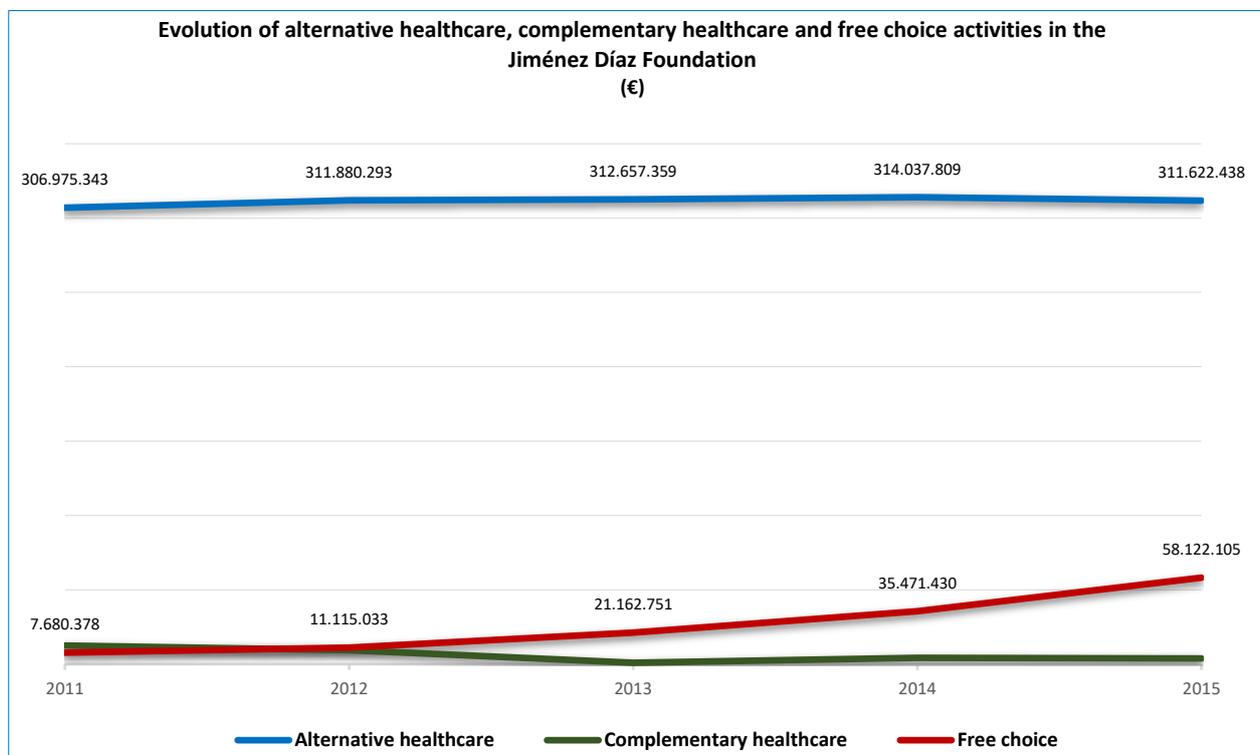
**Table 2**  
**Evolution of the amounts paid for alternative, additional and complementary healthcare**  
(2011-2015, in €)

TYPE	2011	2012	2013	2014	2015	TOTAL
<b>Alternative healthcare activities</b>	306,975,343	311,880,293	312,657,359	314,037,809	311,622,438	<b>1,557,173,242</b>
<b>Complementary healthcare activities</b>	12,470,346	9,323,805	892,111	4,266,174	3,799,734	<b>30,752,170</b>
<b>Free choice</b>	7,680,378	11,115,033	21,162,751	35,471,430	58,122,105	<b>133,551,695</b>
<b>TOTAL</b>	<b>327,126,066</b>	<b>332,319,131</b>	<b>334,712,220</b>	<b>353,775,413</b>	<b>373,544,277</b>	<b>1,721,477,107</b>

Source: CM Accounts Chamber. Horizontal Operational Audit Report on healthcare and pharmaceutical spending in the CM 2011-2015.

Graph 1 shows the evolution of the costs of the three types of healthcare mentioned in Table 2 over the period 2011-2015:

**Graph 1**



Source: CM Accounts Chamber. Horizontal Operational Audit Report on healthcare and pharmaceutical spending in the CM 2011-2015.

In Table 2 it is worth highlighting the notable increase in free choice spending starting in 2013, which is not included in the settlement budgets due to the delay in payments. From this year onwards, the definition of free choice care was altered, going above and beyond the definition used in the regulatory legislation and, of course, having an important financial impact.

As previously stated in the analysis of the contract documents, the modification of definitions of care types has funding implications which are highly beneficial for the JDF compared to other contracted hospitals.

#### 4.7.1. Additional costs generated by the Accord signed between SERMAS and the JDF and its subsequent modifications (2003-2019)

In 2019, it is noteworthy that there is a significant increase in the unit rates applicable to processes and procedures measured in Hospital Complexity Units<sup>21</sup> (UCH, after the Spanish acronym).

The increase in tariffs due to classification and coding alterations which have led to an increase in the JDF's budget is not paralleled in public hospitals, which have not seen their budgets grow.

Despite the difficulties in monitoring the various parts of the JDF's overall budget previously highlighted, validated, reliable data exists which shows a clear generation of additional costs.

#### LACK OF TRANSPARENCY IN THE MADRID ACCOUNTS CHAMBER

The Accounts Chamber of the Community of Madrid suppressed all references to additional costs at the Jiménez Díaz Foundation in its Horizontal Operational Audit Report on healthcare and pharmaceutical spending in the CM 2011-2015 finally approved in 2019.

<sup>21</sup>: **UCH** are used to measure the activity for a hospitalisation and express (in relative terms) the complexity of inpatients' pathologies. It is calculated by multiplying the number of discharges by an average weighting of the hospital:  $UCH = \text{No. of discharges} \times \text{average weight}$ .

The UCH is important as it is a measure widely used to determine funding levels. A common tariff is fixed for all hospitals in a certain group which is multiplied by their UCH (that is to say, by the forecast number of discharges multiplied by the hospital's average weight). The larger the weight of the hospital, the larger its consumption of resources for patient treatment.

In the Draft of the Horizontal Operational Audit Report on healthcare and pharmaceutical spending in the CM 2011-2015 previously cited (which was altered and finally approved<sup>22</sup> after **significant parts of the text had been removed**) the Accounts Chamber estimated the total cost of alternative, additional and complementary healthcare paid to the JDF between 2011-2015, after discounts, adjustments and penalties and taking into account the funding ceiling applied due to the need to reduce the public deficit, was **€1,721,477,107**.

This total includes, alongside healthcare activities, compensation for intern and resident doctors (the postgraduate training programme) and also invoices relating to the dispensing programme for medicines for outpatients and patients in treatment eligible for inclusion in the Resolutions of the Directorate General of Pharmacy and Healthcare Products, the Directorate General of Financial Operations, and the Directorate General of Healthcare and Pharmacy Product Procurement for prescription medicines, the dispensing of which is established through Hospital Pharmacy Services.

The additional costs involved in financing the JDF are even more evident in comparison with public hospitals in the same group and of the same level.

Hospitals are classified into groups according to the list of services they offer and how complex these are. The ratio of cost to “synthetic index” (a measure of activity) for the JDF in 2011 and 2012 is much higher than the average for tier 3 (high complexity) hospitals. The average for tier 3 hospitals (including the JDF) was €3,422 in 2011 and €3,274 in 2012. The same indicator in the same periods was €3,785 and €3,529 for the JDF.

Furthermore, the amount allocated per resident in the catchment area for the JDF rose to €778 while the average for the 25 hospitals operating in 2012 was €741. That is to say, the JDF cost per capita was **5% larger** than the SERMAS average.

In fact, the Accounts Chamber Draft Report previously cited demonstrates that if the JDF was funded in line with the average SERMAS tariffs and the spending ceiling, **the estimated saving would be €58 million per year**.

This saving would be even larger if we take into account the tariff increases for the period between June and December 2019, which were practically 50% in the case of processes and procedures involving hospitalisation.

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<sup>22</sup>: Agreed by the Board of the Accounts Chamber on 4th March 2019.

In fact, comparative analyses of activities involving hospitalisation demonstrate that of the 585 Diagnosis-Related Groups (DRGs) analysed<sup>23</sup>, 426 (72%) surpass the average tariffs. DRGs are a healthcare evaluation method implemented in the US: each DRG contains processes and procedures involving an identical consumption of resources in terms of spending on staff, materials and so on.

A comparative analysis of the average cost of alternative healthcare in the JDF with the costs in other group 3 hospitals carried out at the end of the 2015 financial year in the Draft Report cited previously yielded the following results:

- ❖ The cost of the JDF, except for emergency care, is higher than the average for hospitals in its group.
- ❖ The largest discrepancy is for the cost of major outpatient surgery (MOS), which is **390%** higher than the average cost.
- ❖ The same can be seen in hospital discharges, where the cost in the JDF is over 23% higher than the average cost.
- ❖ Looking at initial and follow-up consultations, the discrepancy relative to the average is 42% and 6% respectively.
- ❖ Based on these data, the Accounts Chamber estimated in its Draft Report that the **differential cost** of services provided by the JDF in 2015 rose to **€73,008,586**.

It would be useful to carry out the same analysis at the end of the 2019 financial year, taking into account the significant increase in tariffs approved for the period between June and December 2019, but we do not yet know the amount of the free choice settlement. However, it cannot be ignored that there is a hidden debt, as the tariff updates proposed in the contractual documents have not taken place from 2016 until June 2019.

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<sup>23</sup>: The **Diagnosis-Related Groups (DRGs)** were created to evaluate the cost of healthcare treatments and the logic behind them is based on exactly this: cost. This means that the **DRGs** are based on the consumption of resources within hospitals and not on diagnoses or treatments (although they do use them).

According to the Draft of the Horizontal Operational Audit Report on healthcare and pharmaceutical spending in the CM 2011-2015 previously cited, *"The investments made by the JDF and discounted from the rental rates for the use of the Pontones and Quintana specialised treatment centre have not been certified, and for this reason this Chamber cannot determine the correct valuation that the SERMAS should have made of the work carried out, nor if it should proceed to be assumed by the Health Administration"*.

In the contract documents governing the relationship between the JDF and the SERMAS, it is explicitly stated that the former will pay the administration a fee for the use of the Quintana and Pontones CEPs, from which the investments made by the JDF will be deducted. If, indeed, the investments have not been verified and discounted from the fee, we may be looking at a situation involving covert financing of the JDF by SERMAS, as well as clear non-compliance with the contract by the JDF.

#### 4.8. Jiménez Díaz Foundation. Comparison with the Gómez Ulla Military Hospital

The significance of these changes in how care types are defined, and their financial repercussions are more evident if we draw a comparison with the only hospital which has a Collaboration Agreement signed with the SERMAS similar to the JDF (signed in 2007): the Gómez Ulla Military Hospital (henceforth GUH), a publicly owned hospital reporting to the Ministry of Defence and offering a wide range of services.

Before proceeding to analyse both contracts, it is important to clarify some terms related to their financing mechanisms.

- Activity-based funding: a specific tariff is established for each healthcare activity. At the end of the financial year a total amount is calculated including all verified activities.
- Per capita funding: an amount is established for each person in the catchment area. At the end of the financial year, all healthcare provided by other hospitals to people from the catchment area in question is subtracted, and healthcare provided by the hospital using this funding mechanism to people from other catchment areas is added.

According to the previously cited Draft Horizontal Operational Audit Report on healthcare and pharmaceutical spending in the CM 2011-2015:

*"Within the public spending reduction plan, the SERMAS has carried out various analyses between the 2013 and 2015 tax years of the impact that the modification of the financial regime of the Special Accord signed with the Jiménez Díaz Foundation UTE in relation to the provision of alternative healthcare would have on the Budgets of the CM.*

*Based on this analysis, carried out by the Sub-directorate General of Cost Analysis, the 2013 Draft Budget outlined two possible scenarios which would minimise this impact, with an estimated saving of 86 or 58 million euros, depending on whether funding was allocated based on the SERMAS per capita average or on public healthcare prices, respectively. Although per capita funding was recommended in the 2013 CM General Budget, this was not implemented, and this CM Accounts Chamber has not received a resolution from a competent body of the health Administration approving the non-implementation of the financial regime set out in the aforementioned Budget Law or an explanation of the motives for continuing to compensate for alternative healthcare services following the tariffs agreed in the annual Additional Clauses which entail higher spending".*

Therefore, we can conclude that, with no justification whatsoever (none was submitted in response to the Accounts Chamber's request), the Regional Health Department decided to continue funding the JDF using a model which leads to an overspend of between 58 and 86 million euros. This can be considered an illegitimate debt.

Comparing the care type definitions included in an Additional Clause of the Agreement signed with the GUH from the same date, there is sufficient evidence to believe that the JDF has an *ad hoc* funding model: it is part based on activity, rather than per capita funding, in terms of the population assigned to its alternative healthcare catchment area.

This funding model means that care provided by other hospitals to patients assigned to the JDF **is not subtracted** in the final funding calculation.

However, a per capita model does partially apply. Only the assigned population is taken into account within the activity-based funding, as care for displaced people and people included under Law 4/2000 regulating the rights and freedoms of foreigners in Spain is invoiced separately. For want of another category to include it in, it is included under "Free Choice" and charged under public price tariffs with the corresponding reductions.

In contrast, in the agreement signed with the GUH, the free choice category is strictly reserved for the cases set out in law.

In fact, the 2016 Additional Clause in the agreement with the hospital explicitly states that:

*“In line with other SERMAS hospitals, free choice healthcare is considered to be that provided to patients using the free choice mechanisms set out in Law 6/2009...*

*Activities related to unplanned emergency admissions will not be considered free choice activities.”*

In addition, the Agreement with the GUH, a publicly owned hospital, is valid for 10 years and not 30 as is the case for the JDF.

Table 3 provides a comparative analysis of both agreements.

**Table 3**

FEATURE	Jiménez Díaz Foundation	Gómez Ulla Hospital
<b>Ownership</b>	Private, included in the Single Public Healthcare Network.	Public (Central Administration)
<b>Contract type</b>	Special framework accord (General Health Law)	Collaboration agreement
<b>Validity period</b>	30 years (since 2011 novation agreement)	10 years
<b>Free choice</b>	Includes: <ol style="list-style-type: none"> <li>Free choice as set out in Law 6/2009 and Decree 51/2010.</li> <li>Patients in the Community of Madrid not assigned to the JDF for alternative healthcare, but who were treated at it before free choice healthcare came into effect.</li> <li>Emergency care provided to patients from other areas, Autonomous Communities, people with irregular documentation (TIR/DAR), displaced people and unregistered migrants.</li> </ol>	Strictly includes only activities as set out in Law 6/2009 and Decree 51/2010. Excludes emergency admissions.
<b>Alternative healthcare</b>	Not included under alternative healthcare: displaced people, people with irregular documentation (TIR/DAR) (Law 4/2000).	In addition to the assigned population, includes displaced people and emergency care to patients of any background included under Law 4/2000 regulating the rights and freedoms of foreigners in Spain and their social integration.  There is no explicit reference to international agreements, however they appear to be implicitly included within this care type.
<b>Assigned population for alternative healthcare</b>	434,754 healthcare cards (2011 Novation Agreement)	112,000 healthcare cards (2011 estimate)

Source: agreements with both hospitals.

From the analysis of the contract documents there is **evidence of favourable treatment** of the JDF, a private hospital, compared with the publicly owned GUH.

#### 4.9. Conclusions regarding the Accord signed between SERMAS and the JDF

Since 2006 modifications have been made to the Accord signed between the SERMAS and the JDF which are clearly beneficial to the latter:

- 1) The assigned population has been increased, with a subsequent increase in activity and therefore in funding, justified (according to the SERMAS) by the relocation of the Puerta de Hierro Hospital to Majadahonda and subsequent alterations of catchment areas in the interest of maintaining accessibility isochrones.
- 2) The criteria for updating tariffs have been changed, from the lowest CPI (State or CM) plus two points to an unspecified CPI.
- 3) The Additional Clauses show that there has been a de facto breach of the maximum funding ceiling as payments are made for alternative healthcare services exceeding those initially agreed, at a reduced rate.
- 4) The validity period of the contract has been extended to 30 years from the year 2011. That is to say, the SERMAS is tied to the JDF until the year 2041. The early termination of the contract, except for legally established reasons, would require the payment of an unpayable sum in compensation for loss of earnings.
- 5) The statement in the 2015 modification agreement that the Accord is not subject to the Public Contracts Law is concerning. Amongst other issues, it could limit the legally allowable reasons for early termination.
- 6) The Accord is regulated by the General Health Law, and this only outlines out two types of accord without covering relevant contractual aspects such as the legally allowable reasons for early termination and other aspects.
- 7) It is not known if the rental payment for the use of the Quintana and Pontones CEPs has been made, as investments made by the JDF are discounted from them and no documentation is available verifying the size of these investments.
- 8) The investments made by the JDF, recognised as appropriate by the SERMAS and quantitatively incorporated into the Agreement could be considered debts to the JDF incurred by the Regional Health Department.
- 9) Finally, according to the 2011 Novation Agreement, the CM should have given express consent for the purchase of the JDF by the Quirónsalud group and for this group's purchase by the German company Fresenius Helios.

From analyses of the various contractual documents in effect and comparison with the contract signed with the Gómez Ulla Military Hospital, it can be seen that the JDF enjoys a highly favourable funding framework compared with other hospitals, incurring significantly higher costs for the administration.

The guarantee to provide the Foundation a minimum catchment area population, independent of demographic changes occurring in the CM, demolishes the primary justification for contracting private companies to deliver public services: insufficient capacity of public facilities. If the population falls, healthcare should then be reorganised and delivered by public, not private, organisations.

This not only destroys an important pillar of the logic behind contracting private companies in the first place but ensures business volumes for the company owning the JDF.

It is conspicuous that important decisions committing large tranches of funding or involving significant contractual changes have been made by outgoing or interim governments, or in periods just before elections.

The conclusions detailed in the previous points show that the decisions taken by successive Popular Party governments under the presidencies of Alberto Ruiz-Gallardón, Esperanza Aguirre and Ignacio González were clearly **illegitimate<sup>24</sup>, explicitly favouring private healthcare** (represented in this case by the Jiménez Díaz Foundation and the Fresenius group) by the diversion of public funds to the detriment of the SERMAS public hospitals.

## ILLEGITIMATE PRACTICE BY POPULAR PARTY GOVERNMENTS

The decisions taken by successive Popular Party governments have been clearly illegitimate, explicitly favouring private healthcare (represented in this case by the Jiménez Díaz Foundation and the Fresenius group) by the diversion of public funds to the detriment of public hospitals.

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<sup>24</sup>: A law, mandate or decision can be legal but also illegitimate. A government can come into power by legitimate means, such as a popular vote in a democratic nation, and then go on to betray the confidence shown in it at the ballot boxes by looking after its own interests and not those of the public, trampling on rights and freedoms, or arbitrarily imposing its schemes and whims against generally accepted moral principles, all whilst giving the impression of legality.

# 5

## PPP Hospitals

### 5.1. Some basic considerations

Hospitals under the administrative concession or Public-Private Partnership (PPP) model have been set up in the Spanish State in the absence of specific legislation governing this contractual model. The model is included in more general legislation such as the 1986 General Health Law, the 2003 and 2007 Public Contracting Laws, EU law and, in particular, Law 15/1997. This law on enabling new forms of management within the National Health System, passed on the 25<sup>th</sup> of April 1997, opened the door to the privatisation of public healthcare management.

Experiences with PPPs in public healthcare have demonstrated that it results in underfunding of the public health system, which is subjected to budget cuts while private finance is promoted without sufficient regulation.

Healthcare lobbies (PPP Forum, Infrastructure Forum, IDIS Foundation, construction companies and private banks) have achieved a disproportionate and inappropriate level of influence on decision-making, strategy, and public healthcare facilities, in connivance with political powers.

These strategies were largely designed by private investors and transnational companies occupying the global apex of economic power, and their plans form part of the strategy of the globalised economic elites. In fact, funds such as the British CVC Capital Partners (shareholders in several hospitals in Madrid not analysed in this report) or the German health multinational Fresenius now have strategic competencies within Spanish healthcare: the nerve centres of public healthcare decision-making are moving further and further away from Spanish citizens. The process of privatising healthcare has involved practices which may be legal but can be considered corrupt.<sup>25</sup>

As public figures and business groups have prospered, some at the expense of the public purse (that is to say, at the expense of the public) and others at the expense of the public sector which has opened **revolving doors** to the private sector, public healthcare has operated with significant additional costs generated by PPP hospitals, leading to debt, precarious working conditions for healthcare staff and lower quality care for patients through the diversion of public resources from public healthcare to private companies. Here we will give two examples of revolving doors:

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<sup>25</sup>: EIGEN PETER (2004). *Las redes de la corrupción*. Ediciones del Bronce. Barcelona.

**Table 4**  
**Leticia del Moral Iglesias**

Period	Position	Organisation / Institution	Notes
1993 – 1996	Medical Director	Guadalajara Hospital	
1999 – 2000	Sub-director General of Specialised Care	National Health Institute (INSALUD).	
2001 – 2021	Director	<a href="#">Jiménez Díaz Foundation Board of Directors.</a>	
2002 – 2004	Director general	Instituto Madrileño de Salud (Madrid Health Institute).	In this period the IDC acquired the Jiménez Díaz Foundation.  Later, IDC was acquired by Capiro in a transaction valued at €331 million. This same company IDC Capiro, later hired the ex-director of the Madrid Health Institute.
2004 – 2013	Executive Committee	Asociación Española Contra el Cáncer (Spanish Association Against Cancer, AECC)	During her stay on the Executive Committee of the AECC an agreement with Capiro was signed for carrying out mammograms between 2013 and 2016.  The size of the contract was <b>€6,860,714</b> .
2004-2014	Consultant	Consultant specialising in healthcare in Latin America, the Middle East and Spain.	Projects mainly related to the planning, design and management of hospitals and hospital networks and the transformation of health systems.
2005	Director	IDC Capiro Spain	
2010-2013	Managing Director	Globesalud Gestión SL	Capiro contracted Globesalud Gestión SL as a consultant on the Valdemoro Hospital project.  Alongside <b>Paloma Alonso (1)</b> , Leticia del Moral is a partner in the consulting company Globesalud.
2011 – 2021	Sole administrator	Igmor Innovacion en Sanidad SL	
2014	Member	Quirónsalud (previously IDC Capiro) Board of Directors.	
2015 – 2021	Director general of Quality and Care	Quirónsalud.	
2016 – 2021	Representative Quality Director	IDCQ Hospitales y Sanidad SL	
2018 – 2021	Representative	Helios Healthcare Spain SL	
2020 – 2021	Joint representative	Radioterapia de Protones SL	At the end of 2019, <b>Quirónsalud</b> opened the Proton Therapy centre in Pozuelo de Alarcón.  The addresses of Radioterapia de Protones SL and IDCQ Hospitals and Health SLU match: C/ Zurbarán, 28 (Madrid).

**(1):** Managing director of the Móstoles-Alcorcón Hospital Complex, general sub-director of Specialist Care at the National Health Institute (INSALUD), in charge of 82 hospitals and 99 health centres. She was also sub-director general of International Relations at the Ministry of Health and Consumer Affairs.

Source: Compiled by the authors based on information from the SABI, CincoDías, BORME and Opentenea databases.

**Table 5**  
**Antonio Burgueño Carbonell**

Period	Position	Organisation / Institution	Notes
1990 - 2001	Care director	ADESLAS (Private health insurance company)	
1994 - 2021	Advisor	Eurofins Megalab SA	Owns shares in a whole series of clinical analysis laboratories.
1995	Advisor	Clinsa SA	
1999	Promotor of the project alongside Alberto de Rosa Torner <b>(1)</b>	La Ribera de Alzira Hospital	<p>One of the founding fathers of the controversial La Ribera de Alzira Hospital (Valencia), founded in 1999.</p> <p>The La Ribera Hospital alleged failings in its management and managed to persuade the Valencian government to accept a revised concession contract involving a putting out a new tender with increased rates and the inclusion of Primary Care. <b>The UTE itself</b> containing Adeslas and Ribera Salud won the tender.</p> <p>This demonstrates connivance between the Valencian government and private health interests once more: so-called "<b>crony capitalism.</b>"</p>
	Consultant	Capio	Provided consultancy to Capio for the development of the Valdemoro Hospital (Community of Madrid).
2008 - 2014	Director general (hospitals)	Madrid Health Service (SERMAS)	<p>Promoted the 2013 "<b>savings plan</b>" for healthcare in Madrid announced alongside the regional budgets which, amongst other measures, included the privatisation of the management of six hospitals founded in 2008 and the outsourcing of the management of 27 health centres.</p> <p>The Head of the Regional Health Department was Javier Fernández-Lasquetty.</p>
2015 - 2021	Sole administrator	Planning Business Big SL	Consultancy company – appears as the sole administrator.
2015 - 2021	Director	Saniges 2013 SL	Consultancy company. Other directors are <b>Antonio Bartolomé Sánchez (2)</b> and Julio Fernández García Balbino.
2020 - 2021	<p>COVID-19 pandemic Coordinator and Advisor.</p> <p>It is worth noting that his daughter, Encarnación Burgueño, was selected by Isabel Díaz Ayuso to manage the care homes crisis.</p>	Department of Health (Community of Madrid)	<p>Drafted a <b>key document</b> in the management of the coronavirus crisis in the Community of Madrid which is still an enigma.</p> <p>It was a guide developed in March 2020 containing 270 proposals. It is a plan containing information which is compromising for the Community of Madrid. It seems that it contains aid measures which were never implemented in care homes.</p>
<p><b>(1):</b> Alberto de Rosa first joined the Ribera Salud group in 1998 as the director of the La Ribera de Alzira Hospital (Valencia). In 2007 he was named Director General, from 2013 to 2020 he had a position as a managing director and since then he has been an executive director for Europe at Centene Corporation.</p>			
<p><b>(2):</b> Antonio Bartolomé was President of the Federación Nacional de Clínicas Privadas (National Federation of Private Clinics, FNCP) which later joined with the Confederación Nacional de Clínicas y Hospitales Privados (National Confederation of Private Clinics and Hospitals) to create the Alianza de la Sanidad Privada Española (Spanish Private Health Alliance, ASPE), a major employers' association for the representation and protection of the sector, representing 600 private health companies and centres.</p>			

Source: Compiled by the authors based on information from the SABI, BORME, Empresa y eINFORMA databases.

## 5.2. PPP hospitals belonging to the German company Fresenius Helios

After the purchase of the hospital group Quirónsalud by the German multinational Fresenius, we have seen how the SERMAS has become tied to this company until 2041 by the modification of the Accord signed between SERMAS and the JDF UTE. However, the CM Regional Health Department has also awarded three new PPP hospitals to the same companies – that is to say, IDC Salud, previously Capio, later Quirónsalud and today, Fresenius.

Beyond saying its resources are “*used optimally*,” the SERMAS has never justified the supposed lack of in-house capacity required to justify the outsourcing of healthcare services under Article 90 of Law 14/1986 (the General Health Law). Furthermore, this same Article states that “*priority will be given to healthcare centres and services owned by non-profit entities.*”

The contractual relationship involved in this type of indirect management (or Public-Private Partnership, PPP) is set out in two fundamental documents:

- Technical Specifications
- Specific Administrative Clauses

Both documents cover aspects ranging from hospital construction to the list of basic services, the conditions under which care is given and, of course, penalties for non-compliance with the contract.

Economic compensation is made as a fixed per capita payment for the assigned population. This per capita payment may change depending on the demographic characteristics of the population. For example, a more elderly population would consume more resources.

Analysing the budgets of the CM Regional Health Department, it is evident that the amounts assigned to these hospitals have not changed over time, as if there had been no change in the assigned population.

Furthermore, all National Health System services not available in these facilities should be carried out elsewhere and their value either subtracted from the annual payment due or paid directly by the hospital or health centre.

### THE POWER OF QUIRÓNSALUD-FRESENIUS IN HEALTHCARE IN MADRID

**Three PPP hospitals were** awarded to IDC Salud, previously Capio, later Quirónsalud and today, Fresenius: Villalba Hospital, the Rey Juan Carlos Hospital in Móstoles and the Infanta Elena Hospital in Valdemoro.

The patients themselves who attend these facilities have informed various Madrid-based platforms for the protection of public healthcare about care practices which demonstrate that the Fresenius Helios hospitals are colluding by passing more complex services to one another or centralising services in certain facilities belonging to the group.

This means that the patients are not referred to the default public hospitals but to other Fresenius Helios hospitals, even when these are far from patients' homes.

This collusion means that not only are patients but also staff are sent from one Fresenius Helios hospital to another, rather than the nearest public hospital (see the section on the Rey Juan Carlos Hospital).

In any case, according to the contract documents, referrals to other facilities for services which are not offered by a facility should be reported to and authorised by the Administration.

This means that the hospitals are either colluding with the knowledge and tacit approval of the Administration, or without reporting or authorisation, in a clear case of neglect of the supervision and monitoring role set out in the contract for the Administration, in this case the CM Regional Health Department.

Furthermore, studies of per capita funding allude to a demand control mechanism known as "adverse patient selection," by which pathologies with high costs and low returns (chronic pathologies) are referred to other centres in favour of using the free choice system to accept acute pathologies with lower costs and higher profit margins (medium to low complexity surgical interventions, obstetric care etc.).

From the information currently publicly available we have been unable to verify whether or not adverse patient selection is happening in the PPP hospitals, as patient data explicitly indicating pathologies is subject to the Data Protection Law.

However, it is possible to look at the balance of patients registering and deregistering with public hospitals and the PPP hospitals via the free choice mechanism (see Table 6).

We will now briefly outline the current situation at each of these hospitals.

### 5.2.1. Villalba General Hospital

Located within the municipality of Collado Villalba in the CM and built on a site measuring some 55,688 m<sup>2</sup>, a poplar grove protected by various regulations and ceded by Collado Villalba Council to the CM Regional Health Department, the construction of Villalba General Hospital has been surrounded by all kinds of irregularities and bad practices which have dragged down its image, despite efforts by the CM Popular Party to present it as a success. It can even be considered to be generating an **ecological debt**.<sup>26</sup>



Villalba General Hospital

In September 2010, the companies awarded tenders for the hospital complex were:<sup>27</sup>

- Ibérica de Diagnóstico y Cirugía SL (IDC Salud), the same company which forms part of the JDF UTE.
- Ghesa Ingeniería y Tecnología SA.
- Hospital Sur SLU (also part of the IDC Salud group).
- F. Forwart SLP.

In compliance with the Specific Additional Clauses, contracted companies are obliged to form a limited company before signing the contract, which (in this case) was called Capiro Villalba SA, with the name later changing to IDC Salud Villalba SA, which was a 100% subsidiary of IDC Salud, now Fresenius.

<sup>26</sup>: For a definition of ecological debt see this link [in Spanish]:  
<http://www.cadtm.org/IMG/pdf/GuiaAuditoriaCiudadanaMunicipalDeuda.pdf>

<sup>27</sup>: [http://www.bocm.es/boletin/CM\\_Orden\\_BOCM/2010/09/28/BOCM-20100928-29.PDF](http://www.bocm.es/boletin/CM_Orden_BOCM/2010/09/28/BOCM-20100928-29.PDF)

The managing company created has generated absolutely precarious employment, with wages and other conditions appreciably worse than those offered by nearby public hospitals: Guadarrama, El Escorial, Fuenfría and Puerta de Hierro. To take two examples, the average salary for nurses (after negotiations) was 75%-80% lower than in the public hospitals, and porters (who move patients) are considered warehouse workers and paid as such. Given these shameful working conditions, staff turnover is very high because no-one with an alternative would remain there for any length of time. This is a clear case of employment inequality, a cause of **social debt**.<sup>28</sup>

Furthermore, patients with complex pathologies are not referred to the nearest third-tier hospital (Puerta de Hierro University Hospital) but to the Jiménez Díaz Foundation 40km away belonging to the same company – but using public patient transport. The reason? For each patient that leaves the hospitals it owns, Fresenius Helios (and previously Quirónsalud) loses a corresponding amount of income. This is a clear example of the collusion previously discussed.

The CM Accounts Chamber report cited several times previously shows that the Villalba Hospital contract was modified four times.

The objective of these modifications was to delay the opening of the hospital after it was constructed by the concessionary company. The delay was said to be in the public interest as opening the hospital would incur significant costs which the CM would be unable to take on, being obligated to comply with budgetary stability targets. To avoid breaching the debt ceiling, the CM adjusted its budgets to the real income available, which was much lower than initially predicted. However, between March 2013 and October 2014 (when it opened), the SERMAS paid the concessionary company a sum of €15,185,246: partially to repay the investments already made, and partly for non-healthcare ancillary services required to maintain facilities in a usable condition.

This means that multi-million euros costs were incurred which, from our perspective at the Auditoría Ciudadana de la Deuda en Sanidad (Audita Sanidad), Citizen Healthcare Debt Audit, can be considered an **illegitimate debt**<sup>29</sup>, as the sole beneficiary has been a private company (in this case, IDC Salud), and not the general public, who were provided with no services whilst the hospital was closed.

Furthermore, the construction of the hospital led to an overspend of 86.1%. The investment originally planned was €108 million, but the final cost rose to **€201 million**.

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<sup>28</sup>: <https://www.cadtm.org/Deuda-social-De-que-estamos-hablando>

<sup>29</sup>: <https://auditasanidad.org/deuda-ilegitima/>

Finally, in 2018 two trade unions (Asociación Madrileña de Enfermería Independiente (Madrid Independent Nursing Association, AME) and Movimiento Asambleario de Trabajadores/as de Sanidad (Healthcare Workers' Movement, MATS)) made allegations to the Public Prosecutor for Corruption and Organised Crime that the pedestrian access to the hospital was paid for by Collado Villalba Council instead of by the concessionary company as specified in the Administrative Clauses of the public contract for the construction of the hospital.

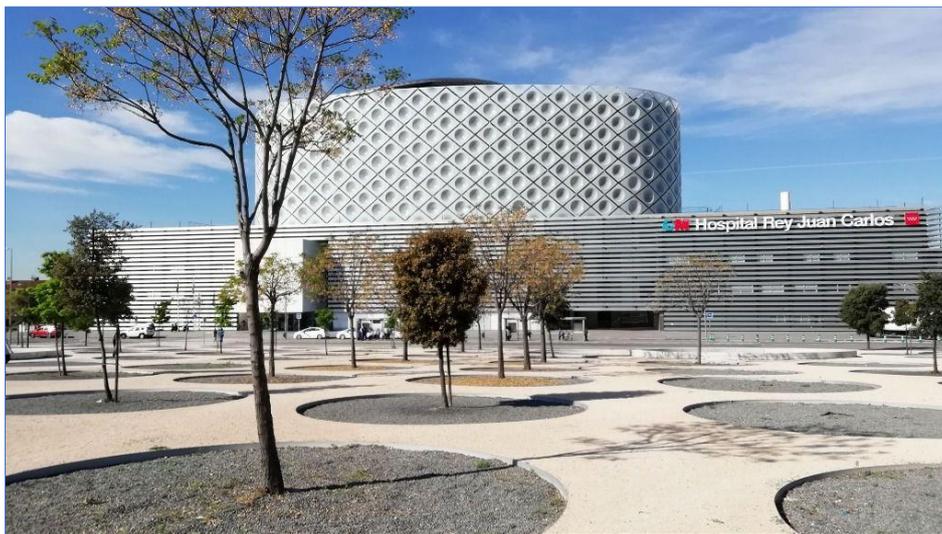
### 5.2.2. Rey Juan Carlos Hospital, Móstoles

The Rey Juan Carlos Hospital is the second PPP hospital awarded to the Quirónsalud group which was later bought by Fresenius Helios.

The contract was tendered without a public justification (for example, insufficient resources in the public healthcare system).

The implementation period for the contract was set at **30 years** after signing.

The base value of the tender was undetermined as rates were to be set once the contract had been awarded.



Rey Juan Carlos Hospital, Móstoles

The hospital was awarded in March 2010 to the following companies: <sup>30</sup>

- Ibérica de Diagnóstico y Cirugía, SL (IDC Salud), the same company which forms part of the JDF UTE.

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<sup>30</sup>: [http://www.bocm.es/boletin/CM\\_Orden\\_BOCM/2010/04/09/BOCM-20100409-42.PDF](http://www.bocm.es/boletin/CM_Orden_BOCM/2010/04/09/BOCM-20100409-42.PDF)

- Hospital Sur, SLU (also part of the IDC Salud group).
- Lener Grupo Asesor, SL.
- Ghesa Ingeniería y Tecnología, SA

The final value of the contract (over 30 years) was set at **€2,907,972,539.72**.

The assigned population included in this public services contract were previously assigned to Móstoles University Hospital or the Alcorcón University Hospital Foundation, both of which are publicly owned.

However, the criteria used for this rezoning and the accessibility isochrone analysis have not been published.

Like all PPP hospitals, the Rey Juan Carlos University Hospital is subject to a per capita funding regime comprising two components:

- A strictly per capita part, calculated by multiplying a price per capita by the size of the assigned population.
- A positive or negative part corresponding to inter-hospital invoicing (the free choice system). In this part, patients assigned to the Rey Juan Carlos University Hospital who are treated in other hospitals are subtracted from the total, and patients from other hospitals treated at the Rey Juan Carlos, displaced people and other patients are added.

The inter-hospital invoicing is verified by a corresponding audit process. In this case, the only available audits are those corresponding to 2012 and 2013.<sup>31</sup>

We do not know if the audits for later financial years have been carried out. Therefore, the most recent available audits are 8 years old. This is yet another example of obstruction in access to information which should be public.

The audit results on the availability of human resources deserve special attention:

- Some services have been set up without prior authorisation from the administration. As far as we are aware, the administration has not taken appropriate measures in this regard.

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<sup>31</sup>: <https://www.hospitalreyjuancarlos.es/es/transparencia/auditorias>

- The contract documents allow for complementary services to be subcontracted. All those not specifically listed as subcontracted in the tender documents must have prior approval from the administration. According to the results of the previously cited audit from March 2017, subcontracted services (therefore services considered to be ancillary) included:
  - ✓ Anaesthesia services.
  - ✓ Paediatric surgery.
  - ✓ Dialysis nursing.
  
- There is no evidence that this subcontracting of “ancillary services” was authorised by the administration, nor of the criteria used to classify these services as ancillary. If these services were reclassified without authorisation, it is also unknown if the administration took appropriate measures.
  
- Staff from other hospitals belonging to the group (JDF, Infanta Elena Hospital and Villalba Hospital) appear on the hospital’s roster. Again, we are unaware of any intervention on the part of the administration, and so we consider that this can be considered further proof of collusion between the hospitals.

All this information suggests that the CM Regional Health Department could be neglecting its duty to monitor and supervise these hospitals. This practice favours business interests to the detriment of the public interest, as these hospitals do not offer the services or the in-house staff they claim to have.

Furthermore, according to the previously cited Accounts Chamber Draft Report, *“the 2012 settlement with the Rey Juan Carlos Hospital was incorrect, as the per capita and MOS (Major Outpatient Surgery) components were calculated without taking into account that 2012 was a leap year. This led to the payment of an extra 218,764 euros which have not been reclaimed”*. Perhaps this is the cost of non-alternative healthcare carried out on the extra day. Again, these seeming details demonstrate the lack of rigour in the accounting process.

## LACK OF TRANSPARENCY IN ACCESS TO INFORMATION

Just as for the Jiménez Díaz Foundation, a large part of the documentation required to monitor the management of the companies owning the three PPP hospitals, today owned by Fresenius, has not been published.

In April 2017, the Head of the Regional Health Department, Sánchez Martos, proposed the use of part of the construction budget for upgrading the University Hospital in Móstoles to convert 130 acute care beds into mid- to long-stay beds.

This measure would clearly have been damaging for Móstoles University Hospital (a public hospital) as it would have lost acute care patients to the nearby Rey Juan Carlos University Hospital (a PPP hospital). Hospital staff and citizens mobilised against the measure and managed to stop it.

### 5.2.3. Infanta Elena University Hospital (Valdemoro)

This was the first PPP hospital to begin operating in the CM and, curiously, it is also the one about which the information is most scarce.



Infanta Elena Hospital (Valdemoro)

The concession contract was awarded in December 2005<sup>32</sup> for a period of 30 years. The contracted companies were:

- Capiro Sanidad SL (later IDC Salud).
- Capiro AB (Capiro Valdemoro SA)

The project was led by Antonio Burgueño Carbonell (see Table 5), who had already been involved in Alzira Hospital, a PPP hospital in Valencia. In 2008 he was made Director General of Hospitals in the CM, during Esperanza Aguirre's presidency and with Juan José Güemes as Head of the Regional Health Department.

<sup>32</sup>: <https://www.boe.es/boe/dias/2006/02/16/pdfs/B01542-01542.pdf>

Under an interim PP government, 12 days before the elections on the 4<sup>th</sup> of May of this year (2021), an update of the annual payment to the concessionary company was signed. Since 2005 (when the original contract was signed), this amount had been €25,242,360 per year. This has now been raised to €39,840,163 per year until the end of the contract in 2035, unless new updates are made.

We do not have evidence that all the required audits set out in the contract documents have been carried out.

The only inter-hospital invoicing audit available is the audit from 2013<sup>33</sup>. We do not know if the audits from the following financial years have been carried out.

Again, we find ourselves looking at a pervasive lack of monitoring of concession contracts and an increase in payments which is not sufficiently documented or justified.

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<sup>33</sup>: <https://www.hospitalinfantaelena.es/es/transparencia/auditorias>

# 6

## The “Free Choice of Hospital” system

The SERMAS “Free Choice of Hospital” system works through the Single Public Healthcare Network, created by Law 12/2001 (the CM Healthcare Standards Law) which gave patients the right to choose the specialists or hospitals involved in their treatment, created a Single Healthcare Area covering the entire CM and centralised all medical appointments through the Personalised Care Centre<sup>34</sup> (CAP after the Spanish acronym), a telephone service provided by the private company INDRA<sup>35</sup> since 2010 whose former Director of Operations and Vice-President were charged for illegal funding of the Popular Party in 2019.

Strangely frequently, the CAP refers patients to Fresenius group hospitals contracted by and integrated into the Single Public Healthcare Network. This can be seen in Table 6 (which shows a comparison of the number of patients registering and deregistering with public and contracted private hospitals respectively). For example, it can be seen that 75,889 new patients registered with the JDF in 2019, whilst the public Clínico San Carlos Hospital lost 21,525 patients in the same year. The hospitals are situated 100m from each other.

This phenomenon occurs through several fraudulent mechanisms: when the CAP contacts patients it tends to tell them that there is a long waiting list for the default public hospital (which is difficult for patients to verify), and then immediately offer a much sooner alternative appointment in a private hospital. This is current practice with Fresenius Helios hospitals, in particular with the Jiménez Díaz Foundation. This is an extremely concerning situation, as it effectively robs the Regional Health Department of the capacity to manage the healthcare of its patients.

### PRIVATISATION OF MEDICAL APPOINTMENTS

The **medical appointment management** system in the Community of Madrid, known as the “**Call Centre**” and privatised since 2010, refers patients to Fresenius group hospitals strangely frequently.

<sup>34</sup>: Also known as the “**Call Center**.” INDRA has managed the SERMAS Personalised Care Centres (CAPs) for several years at a cost of almost seven million euros per year.

For more information see this digital article from the newspaper “El Salto”:  
<https://www.elsaltodiario.com/sanidad-publica/el-call-center-de-indra-o-como-hacer-caja-con-la-sanidad-publica>

<sup>35</sup>: For more on **INDRA**’s history see this link from the CIVIO Foundation [in Spanish]:  
<https://civio.es/quien-manda/2014/05/21/indra/>

Let us not forget that after a decade of cuts and privatisation, the public hospitals are understaffed and have bed shortages, and their waiting lists are generally longer than those of the privately managed, contracted hospitals.

**Table 6**  
**Free Choice of Hospital system comparison**

Hospital	2015			2017			2019		
	Registrations	Deregistrations	Balance	Registrations	Deregistrations	Balance	Registrations	Deregistrations	Balance
Rey Juan Carlos Hospital* (Móstoles)	20,484	4,191	16,293	38,250	3,883	34,367	48,049	4,455	43,594
Valdemoro Hospital	2,280	1,140	1,140	6,200	1,064	5,136	18,369	2,178	16,191
Villalba Hospital	7,582	4,160	3,422	18,836	3,311	15,525	27,269	3,928	23,341
Jiménez Díaz Foundation	26,008	5,558	20,450	55,304	5,438	49,866	75,899	6,947	68,952
<b>Total</b>	<b>56,354</b>	<b>15,049</b>	<b>41,305</b>	<b>118,590</b>	<b>13,696</b>	<b>104,894</b>	<b>169,586</b>	<b>17,508</b>	<b>152,078</b>
Móstoles University Hospital**	2,336	9,466	-7,130	3,485	12,157	-8,672	6,082	13,410	-7,328
El Escorial Hospital	621	7,497	-6,876	537	9,780	-9,243	1,080	10,628	-9,548
Clínico Hospital	10,702	16,830	-6,128	10,851	17,849	-6,998	15,134	21,525	-6,391
La Paz Hospital	8,782	24,718	-15,936	11,489	33,029	-21,540	10,708	48,149	-37,441
<b>Total</b>	<b>22,441</b>	<b>58,511</b>	<b>-36,070</b>	<b>26,362</b>	<b>72,815</b>	<b>-46,453</b>	<b>33,004</b>	<b>93,712</b>	<b>-60,708</b>
*: Private hospitals **: Public hospitals	Patients registering with a hospital through the free choice mechanism. Patients leaving their default hospital.								

Source: SERMAS reports.

Using figures from the CM Accounts Chamber Report cited several times previously, it can be calculated that the 26,008 patients registering with the JDF in 2015 brought in a corresponding income increase of €58 million. Therefore, the 75,889 patients registering in 2019 would lead to an estimated increase of €169 million in the payments the SERMAS must make to the JDF, on top of the budgeted annual payment (€372 million).

To give an idea of the size of the additional costs these patient referrals impose on the public purse, we can compare a public hospital of equal complexity with the JDF, for example the La Paz University Hospital. This hospital has 1,268 beds and the JDF has 651 (SERMAS report 2019). In 2019, the JDF was to receive €372m + €169m = €541 million (the sum of the annual budget and the payment for “free choice” patients calculated previously), and the La Paz Hospital only €500 million according to the budgets from 2019.<sup>36</sup>

<sup>36</sup>: <https://www.comunidad.madrid/gobierno/transparencia/presupuestos-generales-2019>

Practices such as these have a very high cost for the SERMAS and use up public funds, as tests or treatments done in these contracted hospitals are invoiced to the Regional Health Department at higher prices.

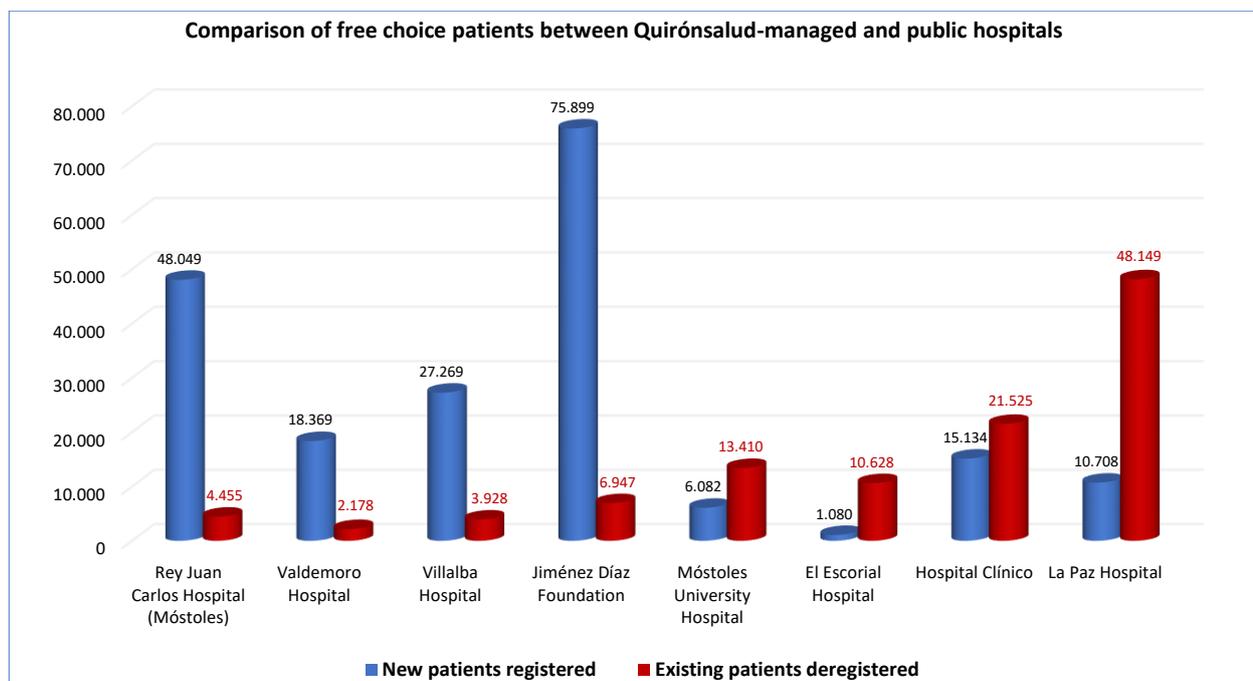
These costs have been denounced multiple times by the opposition in the Madrid Assembly<sup>37</sup>, and also demonstrated by the Accounts Chamber itself in the draft version of the “Horizontal Operational Audit Report on healthcare and pharmaceutical spending in the CM 2011-2015” which we have already cited several times, and from which, we are certain, several pages were redacted before the final Report was approved by a Council Accord of the Accounts Chamber on the 4<sup>th</sup> March 2019.

This “modification of the draft” happened after contact between the Accounts Chamber and the Regional Health Department, which in turn was aware of allegations made by the Jiménez Díaz Foundation on reading the draft.

Therefore, whichever way one looks at it it seems that “Free Choice” was not planned to allow patients to choose doctors or hospitals freely according to their preferences, but to increase the profits of certain private hospitals (also contributing to the decapitalisation of public hospitals). The way the “free choice” system is being used can be considered a corrupt appointments system mechanism and an abuse of power by the healthcare authorities for private gain which is damaging the public healthcare system. Graph 2 shows a comparison of the impacts of the “Free Choice of Hospital” system on various hospitals for 2019.

**Graph 2**

**Comparison of the impacts of the free choice system on various hospitals in 2019**



Source: SERMAS report.

<sup>37</sup>: The Madrid Assembly is the legislative assembly of the Community of Madrid but does not have executive power.

As Table 6 (compiled from SERMAS data) shows, the increase in patients (referred by the CAP) in the four concessionary hospitals (owned by Quirónsalud until 2016 and later by Fresenius Helios) in 2019 alone was 169,576 patients, which represents a 300% increase in patient income in the concessionary hospitals over the last five years. This translates into hundreds of millions of euros in public funds being distributed to these private hospitals.

It is surprising that of these hospitals which receive the largest volume of patients, two are second-tier (Rey Juan Carlos Hospital and Villalba Hospital, similar to the Móstoles University Hospital), one is first-tier (Infanta Elena Hospital in Valdemoro, similar to the El Escorial University Hospital) and only one is third-tier, the highest level of complexity (the Jiménez Díaz Foundation, similar to the remaining five public hospitals). These public hospitals are losing patients to private hospitals with a more limited range of services.

Therefore, we consider that the Regional Health Department of the PP government in Madrid has created a mechanism which generates immense additional costs for the public purse, as demonstrated in the draft Accounts Chamber Report, to the detriment of public hospitals.

Although it is true that patients in the Community of Madrid choose to be treated in the JDF due to its shorter waiting lists, it is no less true that this happens because conditions have been set up to make this happen, involving all the elements described in this report and connivance between PP governments and Quirónsalud/Fresenius Helios such that patients are referred by the CAP to the private contracted hospitals.

All of this means that publicly managed hospitals receive less funding, close wards, and stop taking on staff (a large percentage of which have precarious working conditions) and so waiting lists grow. Patients become restless on interminable waiting lists as their health conditions worsen, limiting their daily lives or causing pain which chips away at their well-being, until they end up accepting appointments in private hospitals proposed to them by the CAP.

# 7

## Illegitimate debt generated by the Fresenius Helios hospitals

Throughout this report we have laid bare the additional costs created by the modification agreements adopted into the Special Framework Accord signed with the JDF and by the PPP hospitals managed by Quirónsalud-Fresenius.

Table 7 shows a synthesis of these additional costs and the decisions made which, from our perspective at the Auditoría Ciudadana de la Deuda en Sanidad (Audita Sanidad), Citizen Healthcare Debt Audit can be considered to (indirectly) generate debts or involve practices identified as illegitimate.

**Table 7**

**Possible indirect causes of Illegitimate Debt or Illegal Debt identified in the report on the Jiménez Díaz Foundation**

AMOUNT	ACTIONS, PROTOCOLS	EXAMPLE OR CASE
<b>ILLEGITIMATE DEBT IDENTIFIED</b>		
<b>€86 million or €58 million</b>	In the 2013 Draft Budget, the Sub-directorate General of Cost Analysis proposed two possible means of minimising this cost difference which would have led to an estimated saving of €86 million or €58 million, <b>depending on whether rates were based on the average SERMAS per capita rate or on public rates, respectively.</b>	This could imply the indirect generation of an <b>illegitimate debt</b> associated with a potential saving of between €86 million and €58 million per year which the Community of Madrid did not make, leading to higher costs with no benefit to society.
<b>€600 million</b>	According to the 2018 CM General Accounts Audit Report, the debt incurred to the five Fresenius hospitals in the period 2015-2018 is estimated to be around €600 million.	This could imply the indirect generation of an <b>illegitimate debt</b> associated with the higher costs (relative to public hospitals) incurred for treatments carried out at the Jiménez Díaz Foundation.  It is not possible to quantify the exact amount using the information currently available.
<b>€405 million</b>	The most recent CM General Accounts Audit Report (2019) includes liabilities to the JDF for the 2019 financial year with a value of €405 million <sup>38</sup> .	This could imply the indirect generation of an <b>illegitimate debt</b> associated with additional costs (relative to public hospitals) incurred for treatments carried out at the Jiménez Díaz Foundation.  It is not possible to quantify the amount exactly using the information currently available.

<sup>38</sup>: For the liabilities to the Jiménez Díaz Foundation identified for the 2019 financial year, see the last paragraph on **page 191** of the 2019 CM General Accounts Audit Report:  
<http://www.camaradecuentasmadrid.org/admin/uploads/if-sellado-cta-general-2019-aprobado-cjo-29122020.pdf>

AMOUNT	ACTIONS, PROTOCOLS	EXAMPLE OR CASE
<b>ILLEGITIMATE DEBT IDENTIFIED</b>		
<b>€73 million</b>	The "Draft Horizontal Operational Audit Report on Healthcare and Pharmaceutical Spending in the CM 2011-2015" compiled by the Accounts Chamber includes a comparative analysis of the average cost of alternative healthcare at the JDF with the costs at other, public, third-tier hospitals, carried out at the end of the 2015 financial year.	The data compiled in the Draft Report indicate an <b>additional cost</b> of €73 million for the Community of Madrid, which could indirectly be considered to lead to <b>illegitimate debt</b> .
<b>To be estimated</b>	Investments made by the Jiménez Díaz Foundation, recognised by SERMAS as appropriate, and incorporated quantitatively into the Agreement can be considered to be debts to the JDF incurred by the Regional Health Department.	It could be considered that the value of these investments could indirectly generate an <b>illegitimate debt</b> .
<b>To be estimated</b>	The "Draft Horizontal Operational Audit Report on Healthcare and Pharmaceutical Spending in the CM 2011-2015" compiled by the CM Accounts Chamber demonstrates that treatment at the Jiménez Díaz Foundation <b>costs up to six times more</b> than the same treatment at a public hospital.	The available data suggests the indirect generation of <b>illegitimate debt</b> due to the payment of higher costs for the same treatment at the Jiménez Díaz Foundation without direct or indirect benefits to society.
<b>Amount not estimated</b>	"Free choice" healthcare is not included in budgets and is subject to settlement after an activity verification audit <b>which is not made public</b> and which is carried out after a delay of several years, with significant possible consequences (including interest on arrears).	"Free choice" healthcare can be considered to indirectly generate <b>illegitimate debt</b> due to the number of patients inappropriately referred by the Personalised Care Centre (CAP, "Call Centre"), which is not "free choice," and due to possible interest on arrears which may have to be paid once activity verification audits have been carried out.
<b>Amount not estimated</b>	There appears to be no evidence of the amount due for the use of the Pontones and Quintana CEPs, justified by the investments made by the JDF in the hospital itself.	
<b>Amount not estimated</b>	Lack of control over medicine procurement and dispensing.	The process used by the Jiménez Díaz Foundation to buy pharmaceuticals is unknown.
<b>Amount not estimated</b>	The novation agreement modifying the Accord from the 3 <sup>rd</sup> of March 2011 extends its validity to 2041. The compensation for " <b>loss of earnings</b> " which would become due if the accord were to be terminated before this date would be practically unpayable.	If this compensation became due it would indirectly generate an illegitimate debt as the compensation would exclusively benefit the JDF (Fresenius) and not the general public, who would need to pay the incurred debt through their taxes.

Source: Data from the report on "Fundación Jiménez Díaz – Fresenius" by the authors.

In addition, a series of decisions made by politicians which have clearly favoured the interests of the private healthcare sector (in this case, the Quirónsalud-Fresenius group) have been identified and are summarised in Table 8.

**Table 8**  
**Illegitimate practices identified**

AMOUNT	ACTIONS, PROTOCOLS	EXAMPLE OR CASE
<b>ILLEGITIMATE PRACTICES IDENTIFIED</b>		
	Proliferation of conflicts of interest and revolving doors, and clear cases of irregular practice in the novation of the Special Accord signed with the Jiménez Díaz Foundation by interim Popular Party governments.	Examples include Leticia del Moral, Antonio Burgueño, Manuel Lamela, Juan José Güemes and many others.
AMOUNT	ACTIONS, PROTOCOLS	EXAMPLE OR CASE
	Complete lack of reporting on the justifications behind public decision-making (e.g., demonstration of the benefits of private healthcare...)	Technical reports which justify the signing of the novation agreements relating to the previously signed "Accords" are not publicly available.
	Suppression of data and reports concerning fundamental issues.	Pressure on the CM Accounts Chamber to the extent that it removed a reference to the fact that private healthcare treatments were up to six times more expensive than equivalent public treatments.
	Use of protocols, from EU to Spanish State level, to hand over public property and services to the transnational global oligarchy.	<ul style="list-style-type: none"> <li>• Not including PPP and PFI model projects in debt ratios and public debt calculations.</li> <li>• Statutes and protocols from the European Central Bank (ECB) and the Banco de España (Bank of Spain, BE).</li> </ul>
	Lack of monitoring of non-compliance with the Special Framework Agreement signed with the Jiménez Díaz Foundation (interested negligence on the part of public authorities)	Based on available information, it seems that certain "Audits" of inter-hospital invoicing and "Free Choice" healthcare are not carried out. If they are carried out the fact that they are not published is a lack of transparency on the part of the Community of Madrid.
	Financial powers interested in moving private companies into public healthcare have spread a powerful narrative ( <b>including fake news</b> ) which discredits public healthcare and aggrandises private healthcare.	
	The result of the points previously described is that <b>decisions</b> made by successive Popular Party governments under the presidencies of Alberto Ruiz-Gallardón, Esperanza Aguirre and Ignacio González have been clearly <b>illegitimate</b> .	These decisions have explicitly favoured private healthcare (represented in this case by the Jiménez Díaz Foundation and the Fresenius group), diverting public funds to the detriment of the SERMAS public hospitals.

Source: Data from the report on "Fundación Jiménez Díaz – Fresenius" by the authors.

# 8

## Conclusions

- a) Despite the neoliberal argument which exalts the private and denigrates the public based on efficacy and efficiency criteria, there is no evidence of increased efficacy and efficiency in private healthcare. However, there is evidence that PPP management models lead to additional costs.
- b) The capacity for autonomous management has clearly been taken from public administrations; it is impossible for the public healthcare sector to make strategic decisions as its professional and technical capacity is being eroded.
- c) Public healthcare, a common good, is being taken from the general public. This loss is part of an intentional policy on the part of the Community of Madrid.
- d) Compared with the private monopoly, the CM has very little management or planning power remaining.
- e) A lack of transparency makes data difficult to obtain and frustrates (or even prevents) effective monitoring of payments made to contracted private hospitals and PPP hospitals.
- f) This same lack of transparency means that mandatory audits (if they exist) are not accessible, and that therefore they cannot be monitored.
- g) Settlements which are not calculated in a timely or proper fashion, as well as impeding financial monitoring, could result in the generation of debt (interest on arrears, for example).
- h) We have identified the generation of illegitimate debt and other possible causes of debt: ecological debt and social debt.

# 9

## Proposals and recommendations

1. **Citizen audits of accounts and privatisation processes**, especially where PPPs, accords, special agreements, framework agreements and so on are concerned.
2. **Propose strategies for the deprivatisation of resources and services, returning them to the public sector**, shielding the SERMAS from indirect management by hedge funds, businesses, etc.
3. **Create a Law which impedes the activities of hedge funds and vulture funds** in sectors providing basic public services (in this case, public healthcare).
4. **Repeal national laws which enable and promote the privatisation of public healthcare**, including articles 66, 67 and 90 of the General Health Law and Law 15/97 which allow the private sector access to public healthcare.
5. **Increase budgets and resources** controlled by the public sector.
6. **Repeal article 135 of the Spanish Constitution** which prioritises debt repayments over social welfare spending.
7. **Start a public debate about the non-repayment of the illegitimate debt** identified in this report. This non-payment would not be for legal reasons, but due to the unjust and morally illegitimate character of the debt, which creates large inequalities and goes against the public interest.
8. **Deprivatise the SERMAS Personalised Care Centre (CAP)**, the appointment booking centre for patients which refers them to various services and hospitals, usually giving priority those which are privately owned and managed.

# 10

## Glossary

### **Activity-based funding**

Care activities are categorised, and a tariff is set up for each category. At the end of the financial year all verified activities are included in the final payment.

### **CAP**

Centro de Atención Personalizada (Personalised Care Centre) in the Community of Madrid. Also known as the “Call Centre.” Centralised medical appointment management system.

### **CEP**

Centro de Especialidades Periféricas (Peripheral Specialised Treatment Centre). The CEPs provide appointments with specialists for medium to low complexity treatments and form an intermediate step between Health Centres and hospitals.

### **CSM**

Concierto Singular Marco (Special Framework Accord). In this context, an accord is an administrative contract regulating the provision of services outwith the facilities owned and managed by the healthcare administration itself, as set out in article 90 of Law 14/1986 (the General Health Law).

### **DRG (Diagnosis-Related Groups)**

Diagnosis-Related Groups is a system whereby patients are classified into clinically cohesive groups based on the resources consumed by their pathology and is used to measure the complexity (by casemix weight or average weight) of treatments provided by a hospital. It also used to measure the efficiency and appropriateness of resource consumption, evaluate performance, analyse risks to patients etc.

### **Ecological debt<sup>39</sup>**

Ecological debt is an obligation brought on by the degradation of biodiversity or the environment, pollution, or the depletion, appropriation, or control of natural or animal resources or traditional knowledge.

In the same way that over-indebtedness was considered a problem only affecting countries in the South, the term “ecological debt” has habitually been used by environmental organisations to refer to debts which countries in the North owe to countries in the South.

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<sup>39</sup>: For more information on different types of debt, including ecological debt, see the following book [in Spanish]:

ÁLVAREZ BARBA, YAGO (2016). *Descifra tu Deuda. Guía de Auditoría Ciudadana Municipal*. Madrid.

However, in recent years the term has been used by environmental and social organisations to refer to the obligation to repair environmental damage caused by the policies of our own Government.

At a municipal level, ecological debt is huge and difficult to quantify. Environmental damage caused by the reclassification of agricultural or forested land into land for development, the destruction of natural habitats for the construction of motorways and other megalomaniac projects or pollution caused by local policies implemented with no regard for their environmental impacts are just a few examples of ecological debt.

### **Illegitimate debt**

The concept of illegitimate debt is an evolving concept, and changes depending on the context where it is used. An illegitimate debt is a debt incurred by a government which has not used its resources in the interests of society. It is a political concept, rather than a technical or legal one. Its key reference points are justice, ethics, and morality, rather than national or international law.

### **(I)legitimacy versus (I)legality**

According to the Platform for Citizen Debt Audit “We don’t owe! We won’t pay!” (Plataforma Auditoría Ciudadana de la Deuda, PACD), (il)legitimacy is a step below (il)legality which recognises that some circumstances, practices, or structures should be changed due to their immorality, arbitrariness, or interestedness, or because they are abusive, undesirable, harmful, unjustifiable, or inconsistent; that is to say, because they are unjust.

Illegitimacy expresses a generalised consensus about a particular unjust circumstance. This consensus is therefore based on justice, rather than legality.

### **Isochrone**

An isochrone is a contour line passing through all the points from which it takes the same amount of time to get to a specific other point. In this case, the lines are based on the time required to reach a health facility from a given point in its catchment area. Therefore, isochrones can be used to assign catchment areas to hospitals or health centres.

### **MOS**

Major Outpatient Surgery. This is a procedure where the patient is discharged on the same day as the operation, without needing to be admitted to the hospital.

### **Per capita funding**

Based on an average cost per person in the catchment area. At the end of the budget year all healthcare treatments carried out by other hospitals for patients from the catchment area are subtracted from the calculation, and all healthcare treatments carried out by the hospital in question for patients from other catchment areas are added.

### **PPP (Public Private Partnership)<sup>40</sup>**

PPPs are medium- to long-term contracts between the public and private sectors. Backed up by government guarantees, the private sector constructs and/or manages goods and services traditionally provided by public institutions (at national, regional, or local levels) such as hospitals, schools, motorways, railways, water, sewerage, and energy (among others).

In this way, the risks involved are shared between the public and private sectors or assumed entirely by the public sector. The contract may cover one or several of the design, construction, funding, operation, or maintenance phases, with the private company receiving payments from users or the public administration.

### **PFI (Private Finance Initiative)**

Participation of private sector companies in funding public sector projects.

### **Social debt**

Debt incurred through privatisations which damage capacities, goods and services which are essential for autonomous human development, social cohesion, and citizenship.

### **UCH (Unidad de Complejidad Hospitalaria, Hospital Complexity Units)**

UCH are used to measure the activity involved in hospital care and express the relative complexity of in-patient pathologies. They are calculated by multiplying the number of discharges by the average weight for the hospital:  $UCH = \text{number of discharges} \times \text{average weight}$ .

The most commonly used system for classifying discharges is based on hospital discharge reports, taking into account the complexity and workload of the entire case history.

Diagnosis-Related Groups can be determined by categorising diagnoses and primary and secondary treatments using the International Classification of Diseases (ICD-10) and using the rest of the Minimum Basic Data Set (MBDS).

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<sup>40</sup>: For more information on PPPs, illegitimate debt and financialisation see:

**DEBT OBSERVATORY IN GLOBALISATION** (Observatori del Deute en la Globalització, ODG) (2019). *Public-Private Partnerships (PPPs) as tools for privatisation*. 3 volumes. Barcelona.

<https://odg.cat/en/publication/ppp-privatization-tools/>