

Spain's health care system and the crisis: a case study in the struggle for a capable welfare state

O sistema de saúde espanhol e a crise:

um estudo de caso na luta pela capacidade do Estado Social

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Abstract

The economic crisis (2009-2014) and the austerity policies (2010-...) have notably affected Spanish society, its public services and the public health system. Unemployment and labor regulation has deteriorated the labor market, creating poverty and inequality, and consolidating low salaries, part-time work and contractual precariousness. No short-term impact on health (morbi-mortality and perceived health) was observed (except perhaps in mental health), but problems are expected in the medium-long term.

The austerity has significantly affected the National Health System (NHS), imposing budget cuts close to 10%, through linear reductions in salaries, hiring and spending; but the NHS has been resilient, although it has accumulated structural tensions, has exhausted its reserves, and has accumulated waiting lists and criticism from patients. The need for reforms is clear, but distrust among all agents prevails. The political change of 2015 (end of bipartisanship), the Catalan conflict since 2017, the change of government in 2018 (PSOE), and the elections of 2019, will influence the next future agenda, oscillating between a liberal-conservative model (public health stagnant with increasing flight from the middle classes to private health care), and a social reformist one (reinvestment in health care, although with controversies in management models).

Key Words:

Austerity, public health system, private health care, need for reform, Spain.

Resumo

A crise económica (2009-2014) e as políticas de austeridade (2010-...) afetaram fortemente a sociedade espanhola, os seus serviços públicos e o sistema de saúde público. O desemprego e as leis de trabalho deterioraram o mercado de trabalho, gerando pobreza e desigualdades, consolidando baixos salários, trabalho a tempo parcial e precariedade do vínculo laboral. O impacto na saúde (morbi-mortalidade e perceção de saúde) não se verificou a curto prazo (exceto talvez na saúde mental), mas esperam-se problemas a médio-longo prazo.

A austeridade afetou significativamente o Sistema Nacional de Saúde (SNS) impondo cortes orçamentais perto dos 10%, através de reduções lineares dos vencimentos, da contratação e da despesa. Contudo, o SNS tem sido resiliente, embora tenha acumulado tensão estrutural, tenha esgotado as suas reservas e tenha acumulado listas de espera e críticas por parte dos doentes. A necessidade de reformas é óbvia, mas a desconfiança de todos os agentes envolvidos prevalece.

A mudança política de 2015 (fim do bipartidarismo), o conflito catalão desde 2017, a mudança para um governo dirigido pelo partido socialista em 2018 (), e as eleições de 2019, marcarão a agenda futura, que oscila entre um modelo liberal-conservador (estagnação da saúde pública com o crescente êxodo da classe média para o setor privado), e um modelo social reformista (com reinvestimento no sistema de saúde, embora com dúvidas quanto aos modelos de gestão).

Palavras Chave:

Austeridade, sistema público de saúde, sistema privado de saúde, necessidade de reformas, Espanha.

VERY BRIEF CHARACTERISATION OF THE NATIONAL HEALTH CARE SYSTEM

1 – From the bismarckian origins to decentralisation and (unfinished) reforms under democracy

Spain, together with other Southern European countries had as a reference the social security model in its origin (1940s). Its process of universalization resulted from a progressive extension of the coverage of Social Security to different groups and layers of workers.

The General Health Law of 1986 is cited as the starting point for changes in the concept of health citizenship, with the creation of a National Health System (NHS), designed with a highly decentralized configuration (according to the institutional framework established by the 1978 democratic Constitution).

The operational changes took place over many years: in 1989, the poor were included in the coverage of the NHS. In 1999 the NHS goes on to finance itself completely by taxes, abandoning the contributions of workers and employers. In 2002, the transfer of all health care competencies and resources to the Autonomous Communities was completed.

The changes observed were incomplete: a small percentage of the population with resources and not related to the labour market was left out of coverage (1%); civil servants of the central administration (including elite, university, teachers, military, judges...) maintained a separate coverage regime with the possibility of using public health or private insurance alternately, and enjoying higher per-capita financing (2.2 million insured).

2 - Counter-reforms vis-à-vis a competent and resilient national health system

During the crisis, the transition from a Bismarckian to a Beveridgean was partially reverted: when in 2012 the Popular Party launched its battery of health austerity measures (Royal Decree Law - RDL 16/2012), the labour insurance origin of the NHS was invoked to allow the National Institute of Social Security to limit and manage the rights of access to the public services of the NHS (limiting, for exam-

ple, the access of undocumented immigrants).

The revitalization of the Social Security regulatory framework also served as an instrument for the recentralization of various functions related to economic control in times of austerity. Central Government retook control over the Autonomous Communities (17 regional governments), on issues such as co-payments, portfolios of benefits entitled to public financing, pharmaceutical management, etc.

The 2018 Spain's HIT Report of WHO's European Observatory on Health Systems and Policies depicts clearly the strengths of the Spanish NHS [1]. Another good reference is the synthetic and graphic report (2017), named Country Health Profile, of the EU-OECD-WHO-Observatory [2].

Health indicators are good; life expectancy at birth (80.5 years in men and 86.3 in women in 2016) is at the top of the European Union (EU), far surpassing the average (78.2 years and 83.6 years respectively). The mortality vulnerable to the action of the health services is also very good, being consistent with the general mortality data. Self-reported unmet need for medical care (2017, 0.1%) shows the great accessibility of health care services [3].

3 - Accessible and competent primary health care and acute care hospitals

The 1982 Primary Health Care (PHC) reform consolidated a highly accessible network of health centres, acting as gatekeepers to hospital specialists, with well-trained doctors and nurses (remuneration based on salary and capitation), good clinical problem resolution and ability to cope and control chronic patients. Nevertheless, the 21st century has not been favourable to PHC: up to 2010 the hospital network benefited more than the health centres network; after the 2010 austerity, the distance between PHC and hospitals increased.

During 1986 the Spanish NHS inherited an excellent network of hospitals from the Social Security network, mainly for acute patients; other public hospitals were added to this core of acute care hospitals, and all of them were devolved to Autonomous Communities for the creation of 17 Regional Health Services. The statutory contract of health personnel (coming from Social Security civil servants' contracts), prevailed as the dominant system of contracting professionals.



There are a relatively small number of hospital beds: 2.42 per 1000 inhabitants, being 1.98 public (most acute -99.4%-) and 0.44 private (year 2016); this low figure is compensated by an intense use of beds, day hospital beds, outpatient care and ambulatory surgery.

In order to expand the hospital network for better accessibility, and to gain degrees of managerial autonomy, between 2000 and 2010, a wave of small-medium size new hospitals was opened or launched, under different institutional models (foundations, public enterprise...). In some regions (Popular Party dominated), the priority become contracting out to PPP (Public-Private-Partnerships). Corruption cases have emerged after 2012 surrounding some of these big-money contracts.

4 - Too much medication, but a cost-efficient system

A traditional feature of the Spanish public health system is the high consumption of medicines, as well as the large proportion of the budget devoted to them (24.4% of Public Health Expenditure in 2017), with the highest expense for prescriptions (10.170 billion euros) rather than hospital expenses (6.354 billion euros), although the latter are growing at a faster rate.[4]

2017 OCDE data shows a volume of compulsory contributions to public health care of US\$ 2,386 per capita representing 6.3% of the GDP and 70.8% of total expenditure on health care. Public health care expenditure is below EU average. The percentage of private health expenditure is high, particularly in out-of-pocket (OOP) expenses (24% of total costs) and in voluntary health insurance (5%).

Good health indicators in the numerator, and low costs in the denominator place the Spanish health system very well in international comparisons. But it is worthy of note that the low costs are partly related to the low coverage for oral health, and the limited development of medium-long-term care and home care (lay care assumed by families). The system of allocation of resources (budget), and payment of personnel (salaries) tends to control the costs, although it tends to generate distortions (undersupply and waiting lists) and discomfort (low wages for doctors and nurses).

5 – Most recent developments

At present, despite limited parliamentary support and funding restrictions (related to the difficult approval of the 2019 budget), the Socialist Party's government and PM Pedro Sanchez (since June 2018) is reversing some of the content of previous health regulations related to universal coverage and economic accessibility.

The Spanish government's national adjustment programme and the health care system

1 - The economic adjustment programme (EAP)

The main objective of the EAP, was to reduce public spending, in order to compensate for the sharp drop in fiscal income that produced since 2009 a huge primary deficit (without taking into account the payment of interest on the debt) and which accumulated a significant public debt.

The austerity policies were implemented in an acute and radical manner, following a collapse in public revenues. The previous overheating of the economy produced from 2000 to 2008 by the so-called "real estate bubble", came from a credit affluence to families and companies, and produced extraordinary revenues to public administration. Sharp changes in revenues happened in one year: from a 2% surplus in 2007 to an 11% deficit in 2009 (in the euro area the deficit was 6.3%).

The financial collapse, the crisis in the banking sector and the paralysis of the real estate sector led to an extraordinary growth of unemployment: from 8.23% in 2007, to 24.79% in 2012. Currently, 2017, the figure is still at 17.26%.[5]

The reduction in revenues (up to 2009) and the increase in spending (up to 2012) led to continued deficit figures, which produced a rapid growth of sovereign debt: from 35.5% of GDP in 2007, to 99.8% of GDP in 2015.

2 - Implementation of general and health austerity measures

In June 2012, the Spanish government asked for a

bailout for its banks and savings banks (up to 100 billion euros, of which 41 have effectively been used). The government argued that this was not a “country rescue” (such as in the cases of Ireland, Greece, Portugal or Cyprus) but an inter-governmental loan to provide a restructuring fund to Spanish banks.

However, in the Memorandum of Understanding signed in 2012 (clauses 30, 33, 34 and 36) there were extra-banking conditions, and in practice they put in place control visits by the “troika”. At present, 16% of the loan has been returned, and only when 75% is recovered will these visits cease.

Although the collapse in tax revenues was observed since 2009, mechanisms for reducing the funds allocated from the State to the Autonomous Communities only became effective from 2010. It is important to remember the 2002 devolution of the health system to the Autonomous Communities, and that their funding is not earmarked, but rather integrated into a package of welfare services for which there are a series of taxes transferred and shared; there are also levelling subsidies to ensure minimum guaranteed spending for fundamental public services.

The measures that were put in place to reduce public spending were structured in two periods, and were channelled directly to health spending, or indirectly to public spending (affected thereafter to health).[6]

Initial phase of health austerity policies: soft, incremental and rationalistic (2009-2010)

In the period 2009-2010 there is already a clear awareness of the seriousness of the economic crisis among health authorities and health agents. The answers sought are incremental (in the sense of promoting evolutionary changes) and not radical. The cut in medicines was a reasonable and more feasible option: reasonable because the increase in spending on pharmaceutical products in the previous decade had been very important; and more feasible, because it could be exercised in the short term, by affecting external agents of an outsourced service. Other measures included: digital clinical records; reference prices and generic drugs; aggregate purchasing procedure; issuance of shadow bills to users and educational actions to influence demand and utilization; common criteria for remuneration of the staff; design systems to recover costs in patients covered by labour; traffic and other European countries health

care; health technology assessment; etc.

Some of these measures targeted savings directly, namely: the reduction of the price of generics (from 15% to 30%), the prohibition of discounts of industry to community pharmacies, the improvement of the system of reference prices, and price reduction at the expiration of the patent of drugs. RDL 9/2011 made compulsory prescription by active pharmaceutical ingredient.

General measures to correct the deficit with impact in health care (2010-2012)

Near the end of the mandate of the Socialist Party (PSOE), the government of the President José Luis Rodríguez Zapatero, launched several policies and regulations in the economic, fiscal and financial fields worthy to mention. The starting point is May 2010: on this date there is a substantial change in the attitude of European and Eurozone authorities, offering access to refinancing the debt on condition of adopting a consolidation plan for the deficit and the debt.

The RDL 8/2010, adopted extraordinary measures to reduce the public deficit, as for instance: reduction of 5% on the wage bill of the public sector, non-revaluation of pensions in 2011, and the 7.5% discount of the on the price of medicines (outside the reference price system).

A very controversial Government measure in September 2011, was the Reform of article n° 135 of the Spanish Constitution that established the primacy of budgetary stability, obliging all administrations to respect the structural deficits indicated by the EU and that the credits to satisfy the interests and the capital of the public debt will enjoy absolute priority in the payment.

This constitutional change was the basis for the intervention of the Government of the Popular Party (elected in December 2011) in the expenditures of the Autonomous Communities and the municipalities and to establish measures to freeze salaries and public contracting of staff, reduce increase of pensions, increase weekly working hours from 35 to 37.5 in the public sector and introduce new taxes (RDL 20/2011), without constraints from other constitutional principles.

The imposition of central government measures on regional and local governments was facilitated by the publication of Organic Law 2/2012, of April 27, on



Budget Stability and Financial Sustainability; it established the new constitutional principle of budgetary stability and regulated preventive, corrective and coercive measures for the control of regional and local administrations.

Other additional regulations were taken on July 2012 (RDL 20/2012): reducing the number of days off and cancelling the extraordinary pay of December for public employees; reducing the amount of benefits for new unemployed; reducing coverage and benefits of the dependency care system; increasing VAT (rise from 18% to 21% in the standard rate and from 8% to 10% in the reduced rate). Moreover, the RDL 21/2012, created The Autonomic Liquidity Fund for credit operations to the Autonomous Communities. An extraordinary financing mechanism for payment to suppliers was also developed.

Finally, in July 2012 the “Agreement For External Financial Assistance For Bank Restructuring And Recapitalization” was signed. The Government, the European Commission, the European Central Bank and the International Monetary Fund agreed on a kind of limited rescue operation of recapitalization and restructuring of the Spanish bank sector (Memorandum of Understanding), with a contribution of the European Financial Stability Facility up to € 100,000 million.

Health austerity policies that reform the NHS (2012-2013)

In the context of this limited rescue, the government passed one regulation that was particularly important for the healthcare: The “Urgent Measures To Guarantee the Sustainability of the National Health System and Improve the Quality and Safety of Its Benefits” (RDL 16/2012) that were complemented by the redefinition of entitlements of citizens to NHS coverage (RDL 1192/2012). The main changes introduced by the RDL 16/2012 were the following:

- **Chapter I:** Altered Law 16/2003 (Cohesion), Organic Law 4/2000 (foreigners) and Law 33/2011 General Public Health (Additional Provision 6 - extension of the right to public health care): determining that the insured and beneficiary status became linked to Social Security, with exclusions to non-legalized residents and people with incomes higher than € 100,000. The Social Security agency assumed the role of certifier of NHS coverage rights.

- **Chapter II:** Reordered the portfolio of common and complementary (supplemental benefits granted by Autonomous Communities) services: common and basic benefits referred to the services provided directly by a health professional to a patient; supplementary benefits (pharmacy, orthoprosthesis, diets and non-urgent sanitary transport) were open to co-payments.

- **Chapter III:** A Welfare Guarantee Fund was established for compensation between regions, to bill patients resident in one Autonomous Community who were treated in another.

- **Chapter IV:** Introduced exclusion criteria for publicly funded drugs and a new system of co-payments with contribution by categories (assets-pensioners, unemployed without subsidy), income brackets (€18,000 / ... / € 100,000) and monthly contribution ceilings for pensioners.

Other regulations established that 417 drugs were excluded from public financing, most of them “because they are indicated in the treatment of minor symptoms” (August 2012). In 2013 another regulation (Law 29/2006) reinforced the role of central government in the pharmaceutical purchasing, limiting the initiatives of Autonomous Communities to make local savings through auctions of certain medicines under prescription.

3 - Health care austerity – opportunities and threats: apparent pragmatism, but ideology under the surface

The main impacts on the health system were generated by general regulations that reduced funding and public system resources, contracting public health expenditure by 11.9% (9,002 billion) between 2013 and 2019 (in current euros per capita it is down from 1,634 to 1,424).

Reduction in contracted staff was estimated in 28,000 persons (10% budget reduction between 2011 and 2013). Cuts in investments were sharp and dangerous: 2013 expenses were only 30% of 2008 ones. In 2015 capital expenses had not yet reached the level of 2008.

The lack of formal systemic reforms and the incrementalism of spending cuts do not mean that there is not a growing ideological bias in the transformation

that has been introduced progressively on the political agenda.

First of all, it is important to consider that the National Health System, with very reasonable operating expenses and good results (see data presented in the first section of this article on the cost efficiency of the system and below in the section “Good health ... in the short term”), became a very attractive sector to apply cuts by the public treasury due to the volume of its total expenditure.

Secondly, in the process of austerity there was a progressive change of narrative by the government: what began as an adjustment of spending became a challenge to all welfare services, under the accusation of “unsustainability”, and what began as a challenge of external sustainability (forced reduction in the allocation of resources), became a narrative of an unmanageable public health care system.

The increasing flight of patients from the middle and upper classes to VIH and utilization of private health care (2.3 of GDP in 2010 and 2.7% in 2014), as well as the increase of co-payments for public health medicines and pay for health care represent a transition from a scenario of great confidence in society as a collective agent of protection of health risks, towards a model where the individual and his family must worry to a large extent to cover a part increasing of such risks and expenses.

Taking 2009 as base 100, the evolution of public health expenditure in current euros fell to 88.1% in 2013, and in the latest available data (2016) the previous level had not yet recovered (95.8%). Private health expenditure has grown steadily, to be at 121.2% of the level of 2009; its main component, direct OOP payment, has grown by 26.2%, reflecting the direct effect of the increase in medication co-payments.[7]

Along with the liberal ideological bias that has been instilled in public and health services, the pragmatic style has meant neglecting reform processes that were on the agenda. It is true that reforming health in Spain is as necessary as it is difficult, since power and authority are widely distributed, and it is easy to organise blocking minorities. It is also true that an acute economic crisis has the effect of legitimizing extraordinary measures, which displace the processes of structural change that require more comprehensive and internally consistent solutions from the agenda. But the effect of reformist paralysis is a remarkable fact and a striking legacy of the past decade, which, moreover, has generated a fatalis-

tic and defeatist attitude regarding rational and planned systemic changes.

In addition to freezing the NHS reform processes, the austerity measures may have entailed risks of worsening social conditions, whose health effects will not be evident in the short term, but which may lead to increases in morbidity in the medium term (such as then it will be commented).

The health care system performance under the Spanish government a djustment programme

1 - Good health... in the short term

There has been much interest in the past few years in demonstrating the effect of the crisis and austerity policies on the health of the population. From a perspective of social activism, it was a highly plausible and expected effect; For governments it was a worrisome perspective that led them to hide the information and minimize the importance of the problems. However, the scientific literature is not conclusive on the immediate effects of the crises on the health of the population, finding contradictory effects, including improvements in some important indicators of perceived health, morbidity, use and lifestyle.

“The evidence available on the impact of previous crises on health reveals different patterns attributable to study designs, the characteristics of each crisis, and other factors related to the socioeconomic and political context. There is greater consensus on the mediating role of government policy responses to financial crises. These responses may magnify or mitigate the adverse effects of crises on population health. Some studies have shown a significant deterioration in some health indicators in the context of the current crisis, mainly in relation to mental health and communicable diseases. [...] In addition, this crisis is being used by some governments to push reforms aimed at privatizing health services, thereby restricting the right to health and health care ... These measures are often arbitrarily implemented and based on ideological decisions rather than on the available evidence. Therefore, adverse consequences are to be expected in terms of financial protection, efficiency, and equity”. [8]



A group of prestigious experts has recently concluded a profound and extensive review on the effects of the crisis and austerity policies on health (not yet published), with the following conclusions:

“The recent economic crisis experienced in Spain [...] does not seem to have affected in a severe way, at least in the short term, the mortality and self-perceived health of the general population. However, there has been a negative impact on mental health, especially among men. Likewise, there are vulnerable population groups whose health has worsened during this period, and social inequalities in health have intensified. Given the alarming evolution observed in the social indicators of income inequality and poverty rates and risk of social exclusion, the identified short-term results should be seen with reservation and the evolution of the health of the population in the medium and long term should be observed with utmost intention. This is of particular importance for the appropriate conclusions on the policies and interventions to be implemented in future crisis situations.”[9]

More specifically: Mortality (general and infant), morbidity, life expectancy, and perceived health, have not worsened after 2009 and in the years of the crisis. The interpretation of data on suicides is controversial and not conclusive.[10] Suicides and mental health have received much attention in the Spanish published literature, with results that suggest a relationship between economic crisis and mental health, but with limitations and caution. The authors of the aforementioned review conclude that:[11]

“There is consistent evidence among studies that mental health worsens during the crisis, particularly among men, that this worsening could be associated with unemployment and deteriorating working conditions, and that social inequalities in mental health have been maintained during the years of crisis or could even have increased.”

The analysis of the health of the population by factors like age, by socio-economic groups (unemployed, and

low educational level), by sex (women), by diseases and risk factors (hypertension, dyslipidaemia), or by habits of life (alcohol, cannabis), suggest that social inequalities in health have played a relevant role in the evolution, but they are far from conclusive in their attribution to the crisis and austerity policies. Nonetheless, evidence regarding the relationship between factors of socio-economic risks and health may appear during the coming years.

2 - Good response of the health care system... But exhausting the reserves

Although between 2009 and 2015 around 10% of budget was drained out of the public health care system, the volume of activity remained quite stable. Hospitalization, surgery, ambulatory care, day care, ambulatory surgery, emergencies, primary care visits, etc. showed the continuation of the level of performance.

Primary care was maintained in the usual high frequencies; 5.57 annual visits to the doctor and 2.51 to the nurse in 2009 (adjusted to age structure); in the years of the crisis, and subsequently, there was a smooth and sustained decrease in utilization: 4.78 visits to the doctor and 2.36 to the nurse in 2014; in 2017, the trend for physicians is maintained (4.70 consultations/year adjusted).[12]

Hospital discharges in public sector (4,047 million in 2010) were reduced by 1% in 2014, although in

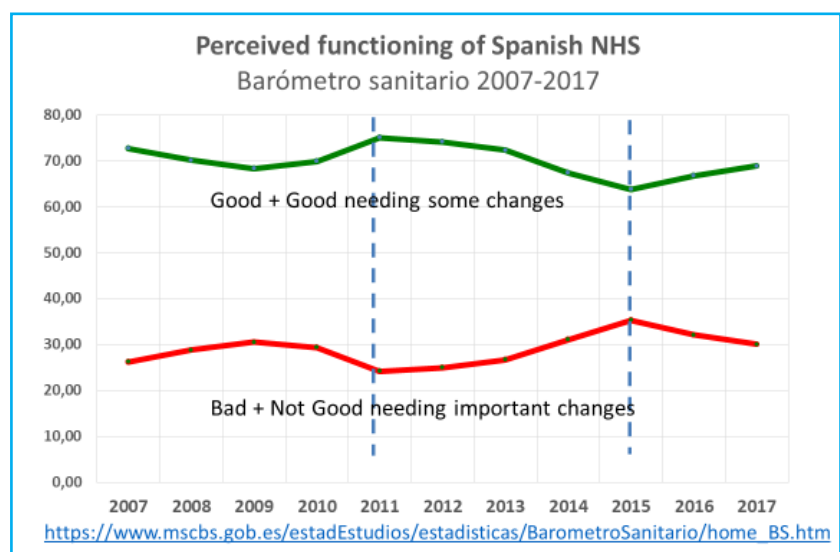


Figure 1

Source: Opinion Survey of the NHS. https://www.msrebs.gob.es/estadEstudios/estadisticas/BarometroSanitario/home_BS.htm

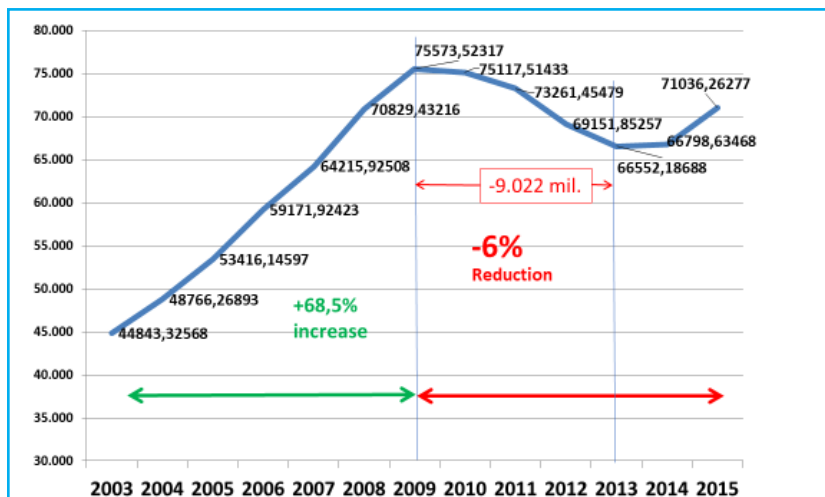


Figure 2 - Public Health Expenditures. Spain, 2003 - 2015 (million €)

Source: Sistema de Cuentas en Salud. Serie histórica 2003-2015. Ministerio de Sanidad.

2016 they have recovered. Hospital discharges in private health care did not increase during the crisis, but, in relation to 2010 (1.19 million discharges), production increased by 3% in 2014, and by 6% in 2016.

Surgical interventions in public hospitals maintained the same level (one million programmed and 400,000 urgent), but ambulatory surgery grew continuously in the period, increasing by more than 6 percentage points (from 39.8% of total surgical operations in 2010 to 45.94 in 2016).

There were no variations in the frequency of outpatient visits to the public hospital (and its associated outpatient specialty centres), with figures of 1.6 consultations per inhabitant per year. Hospital emergencies remained at the usual high level of attendance (0.46 per inhabitant per year), with slight decreases in the worst years of the crisis (0.45 in 2014) and a rebound in the post-crisis (0.48 in 2016).

According to the public hospital statistics, the health staff does not suffer significant reductions (only in the ancillary staff with a 6% reduction), but in contrast to these data the Active Population Survey for the whole of the public health sector registered a decrease of 3.5% (20,700 jobs) between 2012 and 2013.[13]

Waiting lists did not worsen alongside the years of the most acute crisis.[14]

The perception of users, as assessed in the yearly survey called "Health Barometer", shows a clear negative impact, easily attributable to crisis and austerity.[15] In the following image the effects of budget cuts on perceived quality are clearly visible.

The statistically detectable trends presented above occurred against the background of a significant reduction in public health system funding. The graph below shows a remarkable contrast between a time of rapid growth (until 2009) and a period of acute reduction (2010-2013).

3 - Impact of austerity policies in the NHS: did the cuts affect fat, muscle or bone?

Although the National Health System has been "resilient", its reserves are getting smaller, patients notice that the service is worsening (more than improving) and they have to endure longer waiting periods.

The growth of VIH spending is indicative of the deterioration of the perceived quality and accessibility. The higher co-payments are an additional effect of the RDL 16/2012 that require an increase in private health expenditure.[16]

The contraction of expenses and the maintenance of a broad and competent health have not been the result of a virtuous model of good governance. Public healthcare has undoubtedly used reserves (in the language of austerity "accumulated fat") that had been created in the period of rapid growth (2003-2009). But the model of linear budget cuts has not been able to distinguish between "fat" and "muscle". One striking example is the rule that retired employees could not be substituted. This norm affected the centres and units in an unequal way depending on the age of their staff, creating multiple functional and operational problems. This type of cuts frequently failed to reduce "fat" and harmed instead "muscles" or even with "bones".

Despite this lack of specificity of the austerity measures, wage cuts and worsening working conditions, the NHS managed to overcome the tough times without the population suffering damage to their healthcare. This speaks well of its organizational architecture, more solid than expected, and of the effort made by its staff and professionals, as well as their commitment to maintain the standard of quality and accessibility of public services. Health workers and many patients are convinced that the militant response of health personnel has contrasted with the negligent attitudes of many political, economic and health authorities.

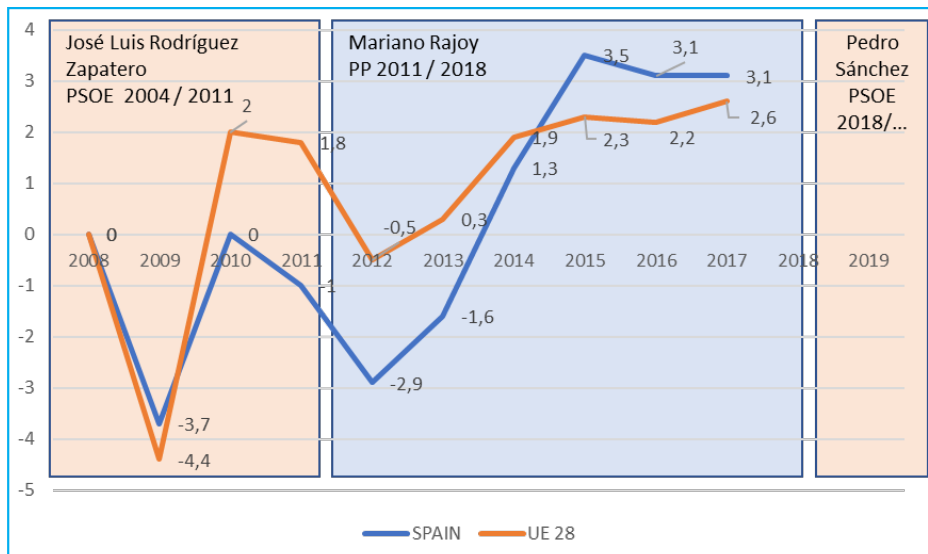


Figure 3 - GDP Variation 2008-2017 Spain/UE-28

Source: Eurostat, <https://ec.europa.eu/eurostat/web/national-accounts/data/database>, complemented with political terms.

The institutional architecture of the NHS had important problems and imbalances before the crisis. Its “skeleton” was originally created in the 1950s based on the Bismarck model and evolved in the 1980s towards a decentralized and bureaucratized Beveridge model. This gradual transition produced growing tensions that worsened after the crisis. Many experts believe that the time has come for structural reforms that redefine the NHS and establish a set of explicit and internally consistent rules and structures. The crisis and the austerity policies have delayed these necessary reforms and have sowed mistrust among all relevant actors. Fat, muscle and bone have been affected in this period. Getting out of the crisis will be much more difficult because it is not possible to go back to the starting point. The forces that might promote the needed reforms of the NHS are not easily identified.

4 - Government policies and the trends in inequality and poverty

In the following graph we can see the of variation of the Spanish and European GDP, and the chronology of governments in Spain.

The Socialist Party managed the first part of the crisis with a half-hearted response, based on a Keynesian public spending strategy, but it was not able to resolve the problem of the credit financed speculative real estate bubble that generated economic overheating.

The Popular Party managed the second part of the crisis and the post-crisis, and progressively incorporated its ideological perspective into what could initially be explained as exceptional measures of adjustment in spending.

The bank rescue was basically financed by cuts in public spending, with a net transfer of welfare from citizens to financial institutions. Unemployment surpassed the 20%-mark, more unemployed lost eligibility of subsidies, social protection and the support for families and dependent persons was reduced. The crisis and these measures led to a progressive impoverishment of the less prosperous parts of the population and reduced the families’ disposable income.

The pressure of unemployment, and the deregulation of the labour market by Law 3/2012 (precarious work relations, wage devaluation, weakening of collective bargaining, and increased inequality), produced a reduction in salaries, tightening of working conditions, and extending working hours, often without extra payment.

“Since the beginning of the crisis in 2008, the Gini index has barely experienced a variation of 0.1 points in the EU-27 as a whole, while in Spain has increased by 2.2 points, well above countries like Portugal, Greece or Italy, countries who have suffered the crisis with a similar intensity, or even higher, to the Spanish, which shows that the increase in inequalities is not an inevitable consequence of a crisis situation, but the result of the policies that are applied to management it.”[17]

5 - The need for a change

The growth of the economy after the crisis is not correcting the increased inequalities and maintains the risk of poverty and social exclusion. The three main ideas of the recent OECD-report on Spain raises three major challenges: [18]

- The recovery is underway but making growth more inclusive remains a challenge

Function	Código COFOG	2016	2017	2018	2019	2020	2021
		% del PIB					
1. General public services	1	6,09	5,58	5,34	5,23	5,13	5,05
2. Defence	2	0,97	0,89	0,87	0,87	0,87	0,85
3. Public order and safety	3	1,90	1,83	1,81	1,77	1,74	1,72
4. Economic affairs	4	3,94	3,83	3,87	3,59	3,52	3,47
5. Environmental protection	5	0,82	0,85	0,84	0,83	0,81	0,80
6. Housing and community amenities	6	0,48	0,48	0,47	0,46	0,46	0,45
7. Health	7	6,04	5,95	5,87	5,77	5,66	5,59
8. Recreation, culture and religion	8	1,11	1,09	1,08	1,06	1,04	1,03
9. Education	9	4,02	3,95	3,89	3,82	3,75	3,70
10. Social protection	10	16,83	16,57	16,47	16,43	16,15	15,88
11. Total Expenditure	TE	42,20	41,02	40,51	39,84	39,13	38,55

Sources: National Institute of Statistics, Ministry of Economy, Industry and Competitiveness and Ministry of Finance and Civil Service.

Figure 4 - Update of Spain's stability plan 2018–2021. Change in General Government expenditure by function

Source: Actualización del programa de estabilidad reino de España 2012-2015; Página 49;

http://www.thespainiseconomy.com/stfls/tse/ficheros/2013/noviembre/Stability_Programme_2018_2021_es_1.pdf

- *Fostering innovative business investment is crucial to unlock productivity growth*
- *Reducing unemployment and improving job quality can make growth more inclusive*

The purposes of the government at the beginning of 2018 were very similar to previous years in relation to the path of containment of the growth in health spending (and in the rest of functions) with a clear logic of reducing the size of the State and the public economy. In the following table we can see the expected reduction in the percentage of GDP for health until 2021. The general elections of December 2015 and June 2016 did not result in the fall of the conservative government under PM Mariano Rajoy, but they marked the beginning of a new era with four major parties in the Parliament, in contrast to the previous decades of alternation between only two major political forces (PP and PSOE). In 2017, the crisis in Cataluña aggravated the precarious situation of the conservative government.

Health policy changes after the end of the crisis

1 - Turbulent politics

In June 2018, the conservative government of PM Mariano Rajoy was ousted by the Parliament, and a new Socialist minority government under PM Pedro Sánchez was elected. This new cabinet is supported by a

small and unstable parliamentary majority (Podemos and nationalist parties) and tries to change the course of economic, labour and public services policies. A major factor in this effort is the 2019 budget that is designed to raise the ceiling on expenditure by between 5 and 6 billion.

The outcome of the negotiations between the different forces in the national Parliament and between the EU-institutions and the Spanish government about will be decisive for the immediate future of healthcare policies. The first legislative initiative of the new government has been the extension of the access to public health to irregular immigrants (RDL 7/2018), thus revoking the limitation introduced in 2012 by the previous government (RDL 16/2012). Before, several governments of Autonomous Communities had already created mechanisms to expand the coverage of the immigrant population up to levels similar to those of the resident population. [19] The central question for the future of healthcare in Spain is whether the general political conditions do allow structural reforms and what will be the outcome of the current power struggle at national level.

In relation to the general conditions, it is important that the NHS enjoys great support from the public, as shown by the studies of the Centre for Sociological Research [20]. In a review of micro-data regarding attitudes to Welfare State, Gómez-Franco found that:

“We have seen so far that neither political ideology nor social statuses are sociologically relevant, beyond their statistical significance, to explain differences in the massive support for public health in our country.” [21]



As a demonstration, we see the scarce differentiation of voters of the Popular Party and the Socialist Party in their support for public health.

Protagonists of a progressive alternative

In addition to the negative effects of the austerity-policies during the crisis (in particular the lack of confidence of all agents) there are some major structural obstacles for reforms in healthcare, namely the great fragmentation of administrative power and the strong influence of economic authorities which weakens the health authorities' capability to take reformist initiatives.

The broad popular support of the public healthcare system referred in the previous section and the structural constraints mentioned above limit the range of prospects for healthcare reforms.

In the possible case of early elections in 2019, a victory of the political right would consolidate the moderate trend towards disinvestment in public health. The slow and silent migration of patients from the middle and upper classes to the private sector would produce benefits for private companies in the sector. Simultaneously, public healthcare would suffer further deterioration. However, such a policy might have significant costs, as it was demonstrated by the so-called White Tide-Movement (Marea Blanca) against privatizations in Spanish healthcare (2012-2014). This could be a strong disincentive for a possible coalition between the Popular Party and the "Ciudadanos" (and possibly the Basque nationalists) to take the risks of this kind of privatization strategy.

A possible majority of the left, on the other hand, would try to improve the financing of welfare services, but the different perception of PSOE and PODEMOS with regard to the acceptable margins of deficit and indebtedness would be a factor of instability. Furthermore, there are significant differences between both parties' ideas of welfare reform. PODEMOS defends a more traditional conception of the organization of public services, with a preference for administrative man-

	2008 remind of vote	
	PSOE	PP
Must be public, and financed by taxation	90,1	82,1
Must be public, with mixed financing, taxes and cost sharing of patients	5,6	9,7
Must be publicly financed with private provision of health care services	2,2	4,2
Must be total or partially privatised, and payed directly by citizens when they use services.	0,5	1,6
N.S.	1,3	2
N.C.	0,4	0,4
(N)	787	497

Figure 5 - Opinion on the Public/Private nature of Health care System

Source: Estudio CIS n° 2765 sobre Actitudes ante el Estado de Bienestar.

agement and contracting and a refusal of outsourcing. In contrast, the PSOE has a different approach towards modernisation with strong elements of entrepreneurial public management. Many proposals have been made to address a set of reforms that facilitate the governance of the NHS and its 17 health services in the Autonomous Communities. The hostility of the economic and civil service authorities, the distrust of the Unions, and the conservatism of the key agents, are making it difficult for an institutional project of structural changes to mature. [22 e 23]

A practical alternative to the political difficulties to conceive, design and implement reforms may be the development of "Good Government" methods that may help to improve the conditions to manage the health centres and services with an umbrella of Governing Boards. In addition, the accountability based on the budget, the transparency of the management contracts, and the monitoring and publicity of the performance indicators can contribute to create dynamics for improvement based on comparative results. Some ongoing experiences (regulatory design of good governance bodies in Madrid) could be promising in the medium term.

The five principles of good governance (transparency, accountability, participation, integrity and capacity), can make the difference between clumsy and thoughtless austerity on the one hand and wise sustainability that helps to improve performance and increase efficiency. [24]

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