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Cuts drive health system reforms in Spain ☆☆

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ABSTRACT

The economic crisis is largely shaping health policy in Spain. This paper reports on major changes in the health care system, both nationally and regionally, as a consequence of sizable cutbacks and new pieces of legislation. The most relevant changes to the system introduced during the last year are having an impact on who is insured, which benefits are covered, and what share of the cost of service provision is contributed by the population, while at the same time reducing salaries and working conditions in the sector. We further report on the consequences these changes are having, and the roles played by key actors and organisations in the system.

The "Partido Popular", the Spanish right wing party led by Mr. Rajoy, won the November 2011 general elections in Spain. The economic and social scenarios inherited from Mr Rodríguez Zapatero, former Spain's Prime Minister, included low expenditure in social protection, high unemployment, below OECD average expenditure in health care, increasing public debt, and high public deficit. Before Mr Rajoy took up office we reported a number of public services cutbacks and poorly coordinated policy actions in areas such as human capital, activity, outsourcing and investment [1]. The present paper reports on major reforms and measures under Rajoy's cabinet and some of their main consequences to date.

1. Political and economic background

According to the latest official statistics, social protection in Spain in 2009 accounted for 25.0% GDP, which was well below EU-27 (29.5%) and EuroZone (30.2%) averages [2]. Further, Spain is heading unemployment in Europe. Figures are 25% overall (2012), and particularly high among young people (53.2%), when compared to the EU-27 (10.5 and 22.8% respectively) [3]. Total health care expenditures accounted for 9.6% of the GDP in 2010, public health expenditure being slightly below the OECD average for the same year [4]. The ratio of public gross debt to GDP was 69.3% in 2011, and although estimated to increase to 88.4% in 2012, it remains below the EuroZone averages both years (88.1% in 2011, and estimated to be 93.1% in 2012) [5]. The ratio of public deficit to GDP remains high when compared to the EU-27 average (9.4% vs 4.4% in 2011) and the 2012 estimates show an even wider gap with European countries [5].

Although Spain as a country is facing an important deficit problem, it appears to be a consequence of revenues plummeting rather than of an excess in social spending. The OECD reports that Spain dropped in total tax revenues as a percentage of GDP from 37.3% to 31.6% of the GDP in the period 2007–2011, failing to collect an estimated 60,000€ million as a result of the economic crisis [6], and the Consejo Económico y Social (a consultancy agency on socio-economic and labour issues for the Spanish

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Table 1
Increased cost-sharing in pharmaceuticals in Spain.

	Workers		Pensioners	
	Old	New	Old	New
Long term unemployed and non contributory pensioners	0%	0%	0%	0%
Income < 18,000€/year	40%	40%	0%	10% (cealing 8€/month)
Income > 18,000€/year	40%	50%	0%	10% (cealing 18 €/month)
Income > 100,000€/year	40%	60%	0%	60% (cealing 60 €/month)

Source: Own elaboration based on RD 16/2012 [9].

central government) has estimated the size of the shadow economy in Spain to be 19.2% GDP in 2012 [7]. In addition, income inequality as measured by the Gini coefficient of equivalised disposable income rose from 31.3 to 34.0 in the period 2008–2011 [8]. This is one of the highest Gini coefficients among EU-27 countries, only exceeded by Bulgaria, Latvia and Portugal [8].

2. Reforms and policies in health care

In April 2012, the Spanish government passed the Royal Decree Law (RDL) 16/2012 labelled as "Urgent measures to guarantee the sustainability of the National Health System and improve the quality and safety of services" [9]. Royal decrees are considered and used as government emergency pieces of legislation that requires on no previous parlamentary nor consensus with other parties. Taken together, the measures contained in the RDL aim at three targets, namely (i) increasing financial resources for the system, (ii) controlling expenditure, and (iii) increasing efficiency. This RDL could be judged as one of the most important pieces of legislation on Spanish health care in the last forty years. Below, we present the main changes it introduces in the system, the consequences they are having, and the roles played by key actors and organisations. Following a framework developed by Mladovsky et al. [10] for analysing health policy responses to economic shocks, we have classified the RDL measures, as well as other related measures, into three groups: policies intended to change the *level of contributions* to publicly financed health care, policies intended to affect the *volume and quality* of publicly financed health care, and policies intended to affect *costs.* This framework is based on results coming from a survey of health policy responses to the financial crisis in the European Region's Member States.

2.1. Policies intended to change the level of contributions to publicly financed health care

In the first place, the central government has raised new revenues by means of introducing changes in fiscal policy. Particularly relevant is the increase in VAT from 18 to 21% (standard rate), and from 8 to 10% (reduced rate). This together with a number of other actions in direct, indirect and corporate taxation have raised an estimated 11,237€ million in 2012 according to the government [11]. However, revenue from these taxes is not earmarked for health care.

Second, the last two years have been characterised by significant budget constraints in health care, at both national and regional levels. In 2012 and 2013 central government health budgets decreased by 13.7% and 22.6%, respectively [12,13]. However it is mainly the responsibility of regional governments to provide health care in their territories and thus they are in charge of allocating the vast majority of resources. Overall, in 2012 the seventeen regions in the country allocated 56,740€ million to health care, and accumulated a reduction of 5% since 2010 [14].

Finally, specifically referring to measures in the RDL, there has been a substantial change in user charges in health care. This has probably been one of the most controversial measures implemented. Table 1 shows the magnitude and details of the increase in cost sharing for pharmaceuticals as stated in the RDL. Two issues should be mentioned in this respect. First, that by linking copayment to individual income the legislator appears to be improving progressivity in the model. Second, it is unclear how much revenue this measure will generate, to what extent drug consumption will be reduced, and which groups will be most affected by extended copayments. Some regions in Spain – i.e. Catalonia and Madrid – have approved the payment by workers and pensioners of an additional charge of 1€ per box of drugs delivered at the pharmacy, with a ceiling of 61€/year per person. Central government authorities argue that these regions have no competencies in setting additional copayments in drugs and warn this could potentially increase inter-regional inequality. The central government consequently asked the Constitutional Court of Justice to study the legal bases of this extra charge, and the Court has recently ruled that this regional policy should be suspended pending further deliberations.

2.2. Policies intended to affect the volume and quality of publicly financed health care

Public expenditure in health care is largely conditioned by the health benefits being covered, that is, what the population is entitled to receive. In this respect, the RDL re-defines service portfolios. A first portfolio of services is labelled as "common" and applies to the whole country. This common portfolio of services is subdivided into three packages: basic, supplementary and ancillary – that is, non-essential services and products. The basic package refers to all products and services available to people who are insured and their beneficiaries. The supplementary package refers to all those other services and products that imply some cost sharing by the population, mainly drugs, orthoprosthetic and dietetic products. The third package refers to other services and products largely coadjuvant, for which a cost sharing is still to be defined. In the future,

specific drugs and services such as non-emergency ambulance services, certain hospital-administered drugs, wheel chairs, prosthesis, or hearing aids might be excluded from public finance. A second portfolio of services is labelled as "complementary" and refers to those services and products defined by the regions and thus to be covered with the regions' funds, such as fertility treatments, sex change and other.

But. . .what is really new about all this? First, we have seen that a number of services and products originally free at the point of use are no longer available free of charge since they have been included in either the supplementary or ancillary packages. Both packages imply user copayments of some sort. This is a major change in the volume of publicly financed health care.

Second, the RDL – and further legislation – re-defines who is entitled to health care and who is not [9,15]. Before the RDL was passed by parliament all residents in the Spanish territory were entitled to public health care – universal coverage – irrespective of their origin and legal status. The RDL explicitly links entitlement to contribution to the system, and two new categories replace "residency", namely the insured – i.e. those who pay or have paid some social security contribution to the system – and their beneficiaries – i.e. spouse and children under 26. Young people over 26 who have never entered the job market and illegal immigrants are excluded by this law from receiving health care. In addition, the RDL contained measures to prevent the abuse by foreign visitors of free medical care in Spain [9].

This we understand is a major reform in the health care system model as it links receiving a public service to contributing directly to its financing – paying social contributions largely through employment – which is rather more in the line of Bismarckian models than Beveridgean models [16,17]. There is an important corollary to this measure, though. The Spanish health care system is financed largely through taxation. This has a number of implications one of which is that the system is excluding a number of groups, illegal immigrants being the most numerous, who are actually contributing to the public purse but not getting any services in return. Indeed, illegal immigrants may have residency, and they pay indirect taxes through consumption but are denied health care by the RDL. The law makes some exceptions to this in the cases of accident, serious illness, pregnancy, delivery, and being under eighteen, but these were benefits already included in a specific law for immigrant populations dated 2000 [18].

2.3. Policies intended to affect the costs of publicly financed health care

One of the major policies for reducing public health expenditure has been the reduction in salaries and labour conditions of health sector workers. In this respect, measures have been taken at both regional and national levels. At national level, among the most important actions has been a 7.1% salary reduction – equivalent to one month's pay – a reduction in Union representation hours and holidays, and an increase in the number of working hours from 35 to 37.5 h per week for GPs and nurses in primary care [9,13,19]. At the regional level, Catalonia – largely in the public provider Catalan Institute of Health-CIH – has restricted salary supplements such as exclusivity, teaching, fulltime dedication, substitutions, reinforcements, afternoon activity and overtime. In addition to this, physicians and nursing staff experienced a delay in the payment of professional development benefits, and their incentive schemes linked to performance were cut to half [20]. Other providers in the Catalan system – i.e. other than the CIH, not ruled by the regional government – are not applying all of these changes.

Other measures in the RDL 16/2012 aim at increasing efficiency within the system, including centralisation of purchasing of supplies, energy saving, adequacy in drugs packaging, and price freezes for certain drugs. The first centralised purchase of drugs, approved in December 2012, is expected to save 80€ million [21]. Other efficiency-related actions are still to be developed. For example, the RDL explicitly mentions that cost-effectiveness is to be considered in determining programmes and services covered by public funds. This appears to be a step forward in the use of explicit rationalisation criteria but to date little has been done in this respect.

In addition to legislative measures a number of *de facto* measures have been taken by public financing bodies as a consequence of treasury shortage, particularly delaying the payment of providers.

Some regions have traditionally relied on a public–private mix in the provision of health care although keeping public finance. This has largely been the case in Catalonia and has escalated in Valencia and Madrid, particularly. In December 2012, the Madrid regional parliament agreed to favour the private management of six additional hospitals built in 2008 under a PFI initiative (similar to the Private Funding Initiative in the UK) as well as 27 primary care centres in the region covering some 1.5 million people [22]. This has been argued to bring down costs while keeping equity and quality standards. However, there is a surprising absence of good quality evidence on the merit of these initiatives, whereas experiences published relating to the Valencia region report no evidence of cost savings and doubts about cost-control, value for money and performance monitoring [23].

In brief, the most relevant changes to the system introduced during the last year are having an impact on who is insured, which benefits are covered, and what share of the cost of service provision is contributed by the population, while at the same time reducing salaries and working conditions in the sector.

3. Actors

3.1. Professionals

As a consequence of health care cuts, despite their initial resignation, a major protest movement has spread throughout the country led by healthcare professionals and followed by large sectors of the population. The Professional Medical Association (OMC), which represents all practicing doctors in the country, has warned that the changes introduced could result in a serious damage to the health of the population [24]. Over 1300 professionals

in the system have declared themselves "conscientious objectors" asserting that they will not exclude illegal immigrants from receiving public health care in their wards [25]. This strong professional protest movement has forced the government to consider offering these immigrants the possibility to obtain public insurance coverage through direct payment of a premium (710–1800€/year). However, this has not been implemented to date.

Further, it is well known that illegal migrants with tropical diseases and HIV seek care in the system far too late. It is argued that excluding them from regular care will worsen the situation and will ultimately have repercussions for the health of the entire population [25,27,28].

Moreover, the public announcement of privatisation of six additional hospitals and primary care centres in the Madrid region has unleashed a series of demonstrations and protests, and sizable number of primary care directors and hospital managers has resigned from their posts [29].

3.2. General population

The cuts in public expenditure and services have led to protests in the form of two general strikes in 2012 (12th May and 14th November) and literally thousands of smaller local demonstrations [30]. Citizens have begun to distance themselves from politicians. According to a government survey the general population believes that politicians themselves are the fourth major problem in the country after unemployment, the economic crisis, and corruption [31]. Health care itself is the population's fifth major cause of concern.

We have also seen the emergence of some "revolving door" phenomena, that is, numerous cases of public health managers and senior politicians turning private and working as senior managers in private companies under public contracts, and vice versa [32]. Overall, 95% of citizens think that political parties protect those accused of corruption [33]. Despite disaffection with the political class the population still appreciates public health care and embraces solidarity, and Spain continues to be the country leading blood and organs donation in Europe [34].

3.3. Central and regional administration

Despite this dramatic the situation, there is great disloyalty among public administration levels in implementing legislative changes, particularly between central and regional administrations. For example, the Canary Islands, Andalusia and the Basque Country health authorities unilaterally decided not to exclude immigrants from public health care as stated in the RDL, and Catalonia is only partially doing so. Similarly, the Basque Country, Navarra and Extremadura, as well as numerous public hospitals, have sought loopholes to avoid introducing pay-roll cuts contained in the RDL [35]. Some regions have appealed to the Constitutional Court questioning the legal bases of some parts in the RDL. The Court has already made its position clear, for example, by favouring provision of health care to illegal immigrants as demanded by the Basque government in its appeal, justifying it on a public health rather than on individual health basis [36]. Other regions have asked the Constitutional Court to rule on other matters in the RDL, the most recent appeals coming from governments in Catalonia the Basque Country and Canary Islands in February 2013 [37].

3.4. Providers

The constraints on public finances have led to a major delay in paying providers and in consequence have triggered protests. For the first time, pharmacist's office bosses went on strike in Catalonia and Valencia [38]. In turn, some pharmaceutical companies, a sector that is enduring even longer delays regarding payment, have threatened not to fulfil orders. In practice there has been no shortage of drug supplies. The delay in payments also affects subsidised health care providers, particularly in Catalonia. Some of these providers are treating patients below the production cost which will soon place them in a very difficult financial position [39].

Since public administration and providers cannot increase their level of debt, private companies are seeing this as an opportunity to increase their business scope. Surely this fact, rather than a strategy based on neoliberal political beliefs, explains the growing importance of these organisations in public health. The protests of citizens and professionals are only slowing down the reform process that politicians see as the only solution to resolve the situation in the short term.

4. Consequences

It is probably too early to fully appraise the impact of these reforms on the health of the population. We can however compile some relevant consequences and only referring to Catalonia where data is available. First, there has been a reduction of the health care activity and waiting lists in Catalonia have increased as a consequence of declining health care supply (see Table 2). For now, it would appear that this situation is not seriously damaging the quality of health care provided. Primary care teams seem to maintain their resolution capacity, as we have observed neither a significant increase of persons admitted into hospital with "ambulatory care sensitive conditions", nor an increase in non-scheduled hospital admissions. We do, however, observe how hospitals are beginning to present financial difficulties. Overall, the system seems to be adjusting to cutbacks probably by looking internally for improvements in efficiency. We need further and detailed data to appraise the effect of reduced supply of services on the health of the people in the middle and longer terms.

Second, we observe an increase in patient satisfaction in Catalonia in the period 2009–2011. Although there is no data for 2012 yet, we observe a slightly higher end-user satisfaction with services in 2011 when compared to 2009. A plausible explanation could be a change in users' expectations. In a traditional consumer model, a higher level of satisfaction may be reflecting lower expectations over the services received [40]. In a context of economic crisis and public services cutbacks user expectations are lowered and hence more easily met.

Table 2
Selected performance indicators of Catalonia (2009–2011).

	2009	2010	2011
Millions of visits in primary care (% difference compared to previous year)	51.1	48.3 (−5.5%)	46.5 (−3.7%)
Hospital emergency visits/100.000 inhab. (% difference compared to previous year)	461.5	441.6 (−4.3%)	435.3 (−1.4%)
Waiting list for guaranteed procedures (days) (% difference compared to previous year)	50,705 (121)	56,670 (125) (+11.8%)	80,540 (139) (+42%)
Ratio of hospital admissions by ambulatory care sensitive conditions/100.000 inhabitants	990	981	972
% admissions to emergency wards	64.9	65	67
Income–costs/produced unit	−1.0€	−66.34€	
Patient's satisfaction (1–10)	8.07	8.26	8.19

Source: [39].

Third, the consumption of pharmaceuticals has fallen as a consequence of the implementation of cuts and copayments. The implementation of new copayments led to a 10% reduction in the volume of units sold in the following three months (2012). It must be noticed, however, that this reduction has not been homogeneous across drugs, being higher among medications for chronic illnesses than among those for acute pathologies [41]. We could therefore expect an increase in the use of hospital services in the future as chronic pathologies worsen over time due to individuals making inappropriate self-medication decisions.

Finally, one study has shown there has been an increase in the number of primary care visits for depression symptoms [42]. The authors point out that the economic recession has significantly increased the frequency of mental health disorders and alcohol abuse among primary care attendees, particularly among families experiencing unemployment and mortgage payment difficulties.

5. Conclusions

The measures recently introduced by the government aim at tackling public expenditure in health in three different ways. In the first place, the measures set limits on the number of people entitled to coverage by excluding illegal immigrants and others who do not contribute economically to the social security system. As we have indicated, this creates a paradoxical situation in which entitlement to public health care – largely financed by general taxation – comes now from individuals contributing to the social security system. Second, the government has increased cost sharing by setting new and higher copayments. Finally, these measures have meant the exclusion from public coverage of some services and products, including more than 400 drugs for the treatment of common diseases [43]. Cost reduction remains the major driving force. Although time is needed to fully appraise their impact on the health of the population, the measures undertaken so far are somewhat incrementalistic and with no analysis of their plausible consequences in terms of equity, quality and cost [44].

In addition, since changes have not counted with the support of the major actors involved in their implementation, or the complicity of regional authorities, those affected by these measures have eventually found ways around them, which have ultimately diminished their potential impact on cost reduction.

The initial attitude of resignation with health care cuts among professionals and patients has now turned into growing distrust of politicians and their policies. Our health care system must adapt to a new situation and that calls for greater consensus and debate. In the eighties, Spain made the transition from dictatorship to democracy. Social and political debate and consensus helped then to shape the health care model we have today. However, this model has its limitations. We should now discuss what kind of health care system we want in the future and how can we make it sustainable. Citizens and professionals should actively participate in this process. Without their complicity no reform could ever be effective.

The European Commission (EC) economic forecast for the coming years is less optimistic than the national government's predictions [5]. The EC estimates a 1.4% fall in the GDP in 2013, and only a slight increase for 2014 if major policies remain the same. This would most probably increase unemployment in 2013 to 27%, government deficit to 10.2%, and public debt to 95.8%. Thus, it is probably reasonable to expect the government to extend tax increases and cut public expenditure further.

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