Economic crisis and counter-reform of universal health care systems: Spanish case

Paulo Antônio de Carvalho Fortes,[I] Regina Ribeiro Parizi Carvalho,[II] and Marília Cristina Prado Louvison[III]

Abstract

The economic crisis that has been affecting Europe in the 21st century has modified social protection systems in the countries that adopted, in the 20th century, universal health care system models, such as Portugal, Italy, Greece, the United Kingdom, and Spain. 2

This communication, as part of a study conducted on economic crisis trends on health care policies and the national health care system in Spain, presents some recent transformations that were caused by changes in the legislation. These processes relate to the access to health care services, to financial contribution from users for health care services, and to pharmaceutical assistance. Having many points that may be closely related to Brazil's public health care system, despite the historical differences and the distinct political, social, and economic contexts of those countries, it seems to us that it is important to understand what has been happening with the Spanish health care system during this time of economic crisis.

In Spain, from 1978 to 1986, the health care system consisted of mandatory insurance, in the form of social security, and it was available to insured workers and their beneficiaries. As of Law 14/1986, which was called *Ley General de la Sanidad* (General Health Care Law), principles and guidelines were established, and allowed health care to become universal and accessible to all Spanish, regardless of their employment relationship statuses. 3

The system started to be financed by general taxes, rather than by mandatory contributions from workers and companies. A national health care system was implemented, along the lines of the Brazilian Unified Health System (SUS), joining old and fragmented regional and corporate service networks, regardless of their operation conditions.

A National Health Care System was created, considering the set of health care services from the central government and from the Autonomous Communities (CCAA), in a way that was similar to Brazilian state governments, but with increased autonomy, which were then responsible for planning and managing health care center and specific service networks.

The Interterritorial Council of the Spanish National Health Service was organized as a coordination instrument between the national scope and the CCAA, in an effort to reach consensus among involved parties, a task that, in Spain, is partly performed by the Tripartite Intermanagement Committee. Similar to SUS, it gathers representatives from federal, state, and municipal governments. However, in SUS social participation spaces have been organized in the decision-making agencies, such as the *Conselho Nacional de Saúde* and other state and municipal councils.

Based on constitutional regulations and on the Autonomy Statutes, all CCAA have progressively taken over responsibilities regarding public health care, in a decentralization process that differs from the one existing in Brazil, as two government levels exist in Spain – the national and the regional one – which do not establish local competences, rights, or duties such as SUS. 4

The Law from 1986, in article 1, aimed to protect the health of all Spanish people, including non-residents, and of all foreign citizens who resided in the national territory. The coverage of

the universal system went from 86.0% of insured people, in 1982, to 97.0% of the population in 1987. 1

The legal grounds, up to 2012, enabled the system to provide coverage of health care services to the whole Spanish population and to all foreigners, even the illegal ones. That situation has been changing after the *Real Decreto-ley* 16/2012, from April 20, 2012, was enacted. It deals with urgent measures in order to ensure the sustainability of the National Health Care System.

That regulation was created during a crucial period when the country was hit by the economic crisis. It contained measures that were considered urgent, on the need for economic and social adjustments, on the alleged claims that they would ensure sustainability in the National Health Care System, contain expenditures, and target improvements in quality and safety for the provision of services.

Some changes stand out in the Spanish health care system, as of 2012, when the legislation changed the health care model, which shifted from a health care system that was conceived under a model of universal rights, back to a social security model, with insured individuals and beneficiaries.

Out of the changes included in that law, article 3 of the *Real Decreto* stands out – "regarding the condition of the insured party" – where it is established that the Spanish health assistance, as provided by the publicly-funded National Health Care System, must be assured to individuals who fit the status of insured persons; that is, workers who are affiliated to the Social Security Program, pensioners in the system, and beneficiaries of periodic payments such as unemployment insurance.

Another change is the increased access restrictions to the system. Thus, the persons with Spanish nationality or who are citizens from other Member States of the European Union, from the European Economic Area, or from Switzerland were excluded, as they have never made contributions to the funding of the social security system. The same is true for individuals whose income exceeds one hundred thousand (100,000) euros a year.

Illegal foreigners, who are neither registered nor authorized as residents in the country, lose the right to health care, and it may be granted only in emergency situations – due to serious diseases or accidents, regardless of their causes – and during pregnancy, labor, and postpartum situations. However, all people under 18 years old should be granted health care in the same conditions as the Spanish people.

Other measures that extended restrictions were the increase in financial contributions at the time services are provided and the division of those services in three categories, named basic, supplementary and accessory. In supplementary and accessory modalities, insured people must make copayments when receiving care.

The common basic portfolio of health care services comprises all health care activities regarding prevention, diagnosis, treatment, and rehabilitation, which are performed in health centers or in social health centers, as well as emergency transportation, whose full cover is made possible by public funding.

The common supplementary portfolio includes all services whose provision is conducted in outpatient facilities, and cover the provision of pharmaceutical assistance, prosthetics, diet products, and non-emergency medical transportation. The portfolio of accessory services includes activities such as occupational therapy, services, and techniques that are not deemed essential, or are adjuvant in supporting the treatment of chronic pathologies.

In regards to outpatient pharmaceutical assistance, the *Real Decreto* outlined specific regulations and guidelines that restrict the free distribution of medications. The access to those products makes users subject to significant copayments, which are proportional to their income levels. These values are updated annually.

Each CCAA may incorporate techniques, technologies, and procedures in their portfolios which are not covered in the national regulations, with their own additional funds.

Those listed measures are inserted in the core of the discussion, and in political and judicial disputes, not only in Spain, but also in the whole European community. Thus, important protests are being conducted, involving the population, health care professionals, the Spanish judicial system, and some of the organizations that develop European agreements. Those protests criticize the change in the universal health care model. 1

Some of those debates question whether the adopted measures will be efficient and effective, with a significant financial impact, or if they will increase injustice and iniquity to individuals, thus hindering public health, and therefore, the country's economy. That scenario, it is important to remember, was the one which consolidated the creation of the first universal health care system in the United Kingdom, in 1948.

During crisis situations in countries whose social protection systems are greatly important, reforms that restrict rights may cause damage to the most underprivileged people, deepening inequalities and social exclusion.

In the European economic crisis, which has included several restrictive measures in social wellness policies in the region, the health care area has been submitted to the most expressive alterations, with questionable effects. Those measures show that the neoliberal project, despite being the economic model that is responsible for the crisis, is still the formula used to solve budget problems, above all when health care is not considered an essential responsibility of the State.

Go to:

REFERENCES

1. Abellán Perpiñan JM, Sánchez Martinez FI, Martinez Pérez JE, Méndez Martinez I. El sistema sanitario público en España y sus comunidades autónomas: sostenibilidad y reformas. Bilbao: Fundación BBVA; 2013.
2. Conill EM. Campos GWS, Minayo MCS, Akerman M, Drumond M, Júnior, Carvalho YM. Tratado de saúde coletiva. 2. Rio de Janeiro: Hucitec; Fiocruz; 2009. Sistemas comparados de saúde; pp. 563–613.
3. García-Armesto S, Abadía-Taira MB, Durán A, Hernández-Quevedo C, Bernal-Delgado E. Spain: health system review. Health Syst Transit. 2010;12(4):1–295. xix–xxx. [PubMed]
4. Sacardo DP, Fortes PAC, Tanaka OY. Novas perspectivas na gestão do sistema de saúde da Espanha. 10.1590/S0104-12902010000100014Saude Soc. 2010;19(1):170–179.