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1 Executive Summary

There seem to be signs of improvement in the economic situation in Spain, for the first time since the beginning of the crisis in 2007. The crisis of sovereign debt seems to be over and the threat of a state collapse ended up in a bank bail-out. The effects of this measure on restoring the financial activity is not clear yet. Although the job destruction seems to have slow down, the unemployment rate is still above 26%. Both the government and the IMF predict some positive growth for 2014 (0.7 and 0.2 respectively). The IMF also predicts that the 2014 deficit target will be reached even though it did not happen in 2013. In May 2013 the moratorium conditions were adjusted to reach the required 3% of deficit to GDP gradually until 2016. The deficit target of 4.5% was raised to 6.5% of GDP in 2013, 5.8% in 2014, 4.2% in 2015 and 2.8% in 2016. These prospects could give some relief to the Spanish government, if population ageing were not to hit Spanish economy in the next decade. In this sense, there is common challenge in the field of pensions, health care and long-term care. Being all affected by the future increase in the old dependency rate, there is an embedded contradiction between offering adequate benefits and keeping the system sustainable. Hence, efficiency of the political process is essential. Indeed the reform of the public administration – including a transparent and efficient financing interregional system– is the task that should finished in order to avoid arbitrary cuts in expenditure that would end up harming the social protection system and social cohesion. Coordination between the different government levels is crutial in the long-term care and health care systems where expenditure and management is completely devolved. Since the political transition in 1975, financing has always been a problematic aspect, favouring opportunistic behaviour of both the Central Government and the Autonomous Communities.

The economic crisis has probably fostered the necessary reform measures, especially in the field of pensions by deteriorating the otherwise good situation of the pension system having still the baby boomers as contributors. In 2012 for the first time since the Toledo Agreement, a pensions indexation below the consumer price index has been approved. Furthermore, the completion of the general reform undertaken by the last government in 2011 - the first with expected sizable effects on sustainability- has been indertaken. Nevertheless, this reform lacks coherence with respect to the preceding reforms and to the balance between sustainability and adequacy. While there was still room for further adjustmens to foster the link between contributions and benefits, which is expected to have an indirect positive effect on sustainability through reduced pension benefits, this reform path was not undertaken. Instead, the sustainability factor mentioned in the 2011 law has been designed by two different elements. First, the annual updating factor defining the growth rate of all pensions has been introduced in order to ensure sustainability. Nevertheless, the fact that pension cuts are limited by a minimum 0.25% reduces the balancing effects of the sustainability factor. Second, the main reform undertaken in 2011, consisting of a gradual increase in normal retirement age of two years, has not been complemented by linking retirement age to life expectancy as other countries do. Instead an intergenerational equity sustainability factor adjusts pensions according to life expectancy. By this, an increase in the retirement age is not ensured. The new restrictions on partial and early retirement might compensate for this but only to some extent. An increase in retirement age - which improves both the revenue and the expenditure side of the system- is far from being ensured.

The health system faces the main challenge of introducing thorough reforms that foster the efficiency of the system to reach sustainability without losing the high quality standards reached. The economic crisis has triggered substantial cuts in this field. The health and social services budget was reduced by 13.65% in 2012, with disproportionately high cuts to

professional training (75%) and public health and quality programmes (45%). Those cuts coincided with increased demands on the health system, in part reflecting the main economic problems such as high unemployment and increased poverty, but also because of a very substantial cut in the dependency fund which supports elderly people and people with disabilities. Further adjustments were announced for 2013. The Spanish National Reform Programme contained a further €3134m cut in the health sector for 2013, including an additional €1108m to be taken from the dependency fund for elderly people and people with disabilities, of which €571m will come from the regions.

The budgetary adjustments were accompanied by structural changes. The changes related to the access to public health coverage, which led to the exclusion of undocumented immigrants; increasing co-payments and privatisation of services are the three most important changes. Despite the adjustments, the Spanish health system is still viewed positively by the public. Moreover, research has shown that it still performs better than in some neighbouring countries. Among the aspects that still need to be tackled - most of these were issues even before the crisis – are: dissatisfaction among health professionals (attributed to low salaries), procurement problems, limited access to certain specialized treatments, management efficiency (clinical management, process management, continuous assessment and addressing chronic patients) and human resources, equality in health and equity in access to health care, pharmaceutical expenditures, the need to adopt a "Health in All Policies" approach when aiming to improve population health and equity, etc.

The situation of the Spanish long-term care system is quite different. Being introduced in 2007, with a considerable delay with respect to other EU countries, the austerity measures caused by the deep economic crisis interrupted its full implementation (Royal Decree 20/2012). The central government reduced its contribution to the application of the SAAD, and this is causing financial problems to the Autonomous Communities, which are in charge of managing the system and financing the benefits. Interestingly, the more efficient were regions in recognising benefits to dependants, the more harmed they are now by the changes in the state financing.

Public expenditure for long-term care is far below the EU average. According to the 2012 Ageing Report it represented a 0.8% of the GDP in 2010. Spain has one of the highest proportions of population providing informal care across the OECD. Hence, it seems crucial to find strategies to formalise the informal care and to improve the quality of the service without expelling it from the system. This, together with the need to coordinate the different government levels, seem to be the main challenges for the LTC system.

2 Pensions

2.1 System description

2.1.1 Major reforms that shaped the current system

The origin of the Spanish pension system dates back to the beginning of the XX century. In 1919 the first mandatory pension plan named *Retiro Obrero* (Retired Laborer) was established for all employees, co-financed by employees themselves (25%) and their employers (75%). It was a capitalisation system, but in 1939 it was transformed in a pay-as-you-go (PAYG) system and renamed as *Seguro de Vejez* (Old-age Insurance). In the next years, special schemes for specific occupations inside this system were introduced. At the same time, complementary pension plans were created for public workers. Therefore the system reached a high degree of complexity, with important problems of coordination.

In 1967 the main structure of the modern social security system was established with the entry into force of the General Law of Social Security. It established a universal pay-as-you-go system, with a general scheme for all employees, although several special schemes for specific occupations were maintained (self employed and employees from the agricultural, coal mining, homework and fishing sector). Initially it offered only retirement and disability pensions, but from 1972 unemployment was also incorporated into the system.

Due to the political situation in Spain – with a dictatorship between 1939 and 1975 – the welfare system in general and the pension system in particular were much underdeveloped compared to most European countries. Hence, when Europe started to think of the need of adjusting the welfare state to the new demographic scenarios, Spanish public pension expenditure was still relatively low.

Since 1967 many reforms of the social security have been undertaken, changing different aspects but maintaining its basic structure. It is worth mentioning the creation of the *Pacto de Toledo* (Toledo Agreement) in 1995 - a parliamentary agreement approved with the consens of all political parties and social agents devoted mainly to recommend reforms in order to foster the contributory nature of the social security system, which was at that moment combined with redistributive elements. The subsequent reforms of the system have been always discussed within the Toledo Agreement framework and its recommendations, which were renewed in 2003.

The most important changes in retirement pensions took place in: the minimum contribution period, the initial benefit calculation and the retirement age. First, the minimum contribution period has increased from 10 to 15 years in 1985 (Law 26/1985) remaining unchanged from then on. Second, the formula to calculate intial benefit has been modified several times. In general, initial benefit is calculated as a percentage – depending on the number of contributing years – of a "base pension" – obtained as an average of past earnings. Initially, the base pension was obtained with only the last 2 years of contributions paid prior to retirement. Subsequent reforms have increased this period to 8 years in 1985 (Law 26/1985), 15 in 1997 (Law 24/1997) and finally to 25 in the last reform approved in 2011 (Law 27/2011) – to be applied progressively from 2013 to 2027.

Regarding the percentage applied to the base pension, it is related to the number of years of contribution. In particular, except for the establishment of a minimum contribution period, it gives more weight to the first years. Several adjustments have been made in subsequent reforms to make it more linear. Initially, the first 10 years of contribution gave a 50%, impliying 5 percentage points per year, while the 25 years left would give 2 percentage

points. In the 26/1985 Act, the minimum contibution period was increased to 15, leaving the weights unchanged. The 24/1997 Act changed the weigths: the first 15 years of contribution entitle to 50% (3.3 percentage points per year) of the base pension; from then on, each additional complete year entitle 3% more until the 25th contribution year, and 2% more for each additional year from the 26 th to the 35 th contribution year. So, the maximum benefit was achieved with 35 or more years of contribution. With the 2011 reform, from 2027 on, the proportionality between the contribution period and benefits will increase for those with more than 15 minimum years of contribution, measuring the intervals in months instead of years. The maximum benefit will be reached with 37 or more years of contribution.

Third, the retirement age has also been modified in the past, but only slightly.[1] The most important reform in this sense was approved in 2011. On the one hand, a general increase of two years in the legal retirement age has been established from 65 to 67 – also with a progressive application from 2013 to 2027. Nevertheless, retirement with a full base pension at the age of 65 will be possible for individuals with 38.5 or more years of contribution. On the other hand, new requirements for early and delayed retirement have been also approved, in order to rise the effective retirement age. Being still high for EU standards according to OECD data, the effective retirement age in Spain has decreased sharply from 66.8 years for men (72.4 for women) in 1970-75, to 61.8 for men (63.4 for women) in 2004-2009. Interestingly a new pathway to early retirement is available from employment from age 63, while before the reform was only possible for the unemployed from age 61 and for workers in old mutualities from age 60. Additionally, the share of the pension base received as a pension has been modified to foster delayed retirement. On the one hand, the weight given to contribution years has been adjusted to a maximum of 37 years (instead of 35). On the other hand, the incentives to stay in the labour market beyond statutory retirement age have been increased. The premium to continue working beyond the statutory retirement age has been increased from 2% per year – or 3% with more than 40 years of contribution– to a scale of 2% to 4% depending on the number of contribution years. Although it is not yet actuarially fair it is a substantial increase and it can contribute to a higher participation rate of elderly workers on the labour market.

Parallel to the social security system, in 1990 a non-contributory means-tested system has been introduced in Spain for those individuals not eligible for the contributory one. This system is *Beveridgean*, financed through general public revenues and provides flat benefits, without any relation to previous contributions. At present it covers around 5% of total pensioners, mostly women, and it is mainly managed by regional governments.

2.1.2 System characteristics

As explained above, at present the Spanish public pension system is organised in two main schemes, both of them unfunded, i.e., financed on a PAYG basis. The most important one – the contributory system– is a defined-benefit system. It covers retirement, disability, maternity and survivors risks. In parallel, the non-contributory system covers only old-age and disability. One of the recommendations of the Toledo Agreement was separating both systems and devoting contributions only to contributory benefits. This process started after the 24/1997 Law was enacted.[2] Quite interestingly, the contributory system has still some redistributive elements, which consist of maximum and minimum contribution and pensions thresholds. In 2012 more than 25% of pensions were below the minimum. Non-linearities in

[1] The normal retirement age in Spain has always been 65. It is worth mentioning that, according to Spanish legislation, it is not compulsory to retire at age 65, although in practice many collective wage settlements do oblige it.

[2] Minimum pensions were still financed with contributions until 2013.

the relation between contributions and benefits could also be considered as redistributive elements, although in some cases they act in the opposite directions, as it happens with the minimum contribution period.

The contributory system is mandatory for all employees and also for self-employed. Social security manages more than 93% of the contributory system. The rest corresponds to different public workers groups (civil servants, military personnel and judicial personnel) managed by different administrations. In September 2013, the number of social security pensions was 9.1 milion (8.9 in December 2012), of which 60.2% are retirement pensions, 25.7% widowhood, 10.3% permanent disability, 3.4% orphanhood and 0.4% other relative pensions. The number of contributors to the system in September 2013 was 16.3 million, that means 0.5 million contributors less than one year before. The continuous increase in the number of pensioners together with the dramatic reduction in the number of contributors – due to the deep economic crisis and an unemployment rate over 26% – have caused first financial deficits in the Spanish social security system. In 2011 this deficit was 0.06% of GDP, in 2012 it grew to 0.96 of GDP and for 2013 a deficit of 1.4% of GDP is projected, although it will be probably even higher. No significant improvements are to be expected in the next years. The Government decided to use the Reserve Fund to pay the deficit, a Fund that initially was planned to be used from the 2020 decade onwards.

Regarding the non-contributory system, it provides two types of benefits, i.e. old-age and disability. In September 2013 there were 250.381 pensioners receiving old-age benefits and 195.468 with a disability pension.

2.1.3 Details on recent reforms

Since 2008 Spain is experiencing a deep economic crisis which has exacerbated the debate about the need of reforming the social security system. Since the nineties, long-term projections of public pension expenditure showed the big impact that population ageing would have in the system after 2020, when the baby-boom generation would start to retire. Nevertheless, the present crisis has advanced the financial problems, mainly due to the high unemployment rates, which have dramatically reduced the system revenues, while the expenditure continues to grow. The last reforms have been designed mainly aiming at reducing the expenditure of the system, both in the short and in the long-term.

The first substantial reform of the modern social security system took place in 2011 (in the middle of the crisis), and it was enacted by the socialist government. As explained above, among the main measures, the 27/2011 Act introduced more proportionality between contribution and benefits in the entry pension formula. It also established a general increase in retirement age– from 65 to 67– and, more importantly, it for the first time introduced an explicit sustainability factor. In particular, it stated that from 2027 on, the main parameters of the system will be revised on a five year basis, taking into account the changes in life expectancy at the age 67 along this period. Nevertheless, the exact formula for that revision was not specified.

At the end of 2012, for the first time after the Toledo Agreement in 1995, pensions were not updated with the consumer price index for the next year (2013), according to the Royal Decree 28/2012. Instead, the 17/2012 Act stated an increase of 1% for pensions above €1,000 per month and a 2% for pensions below this threshold. Moreover, the compensation for the deviation in the updating of 2012 pension amounts was not payed either – pensions were increased by 1% for 2012, but the consumption price index was 2.9%.

In 2013, the age to access early and partial retirement was modified taking into account the change in normal retirement age. In 2013 the transitory period for the increase of the general

retirement age from 65 to 67 started. As a result of this adjustment individuals can enter early retirement four years before the legal general age of retirement – before 61 – if they are unemployed because of economic reasons, or two years before the legal age if they are employed – before 63. Moreover, the minimum period of contribution for early retirement is now 35 years instead of 33, and new penalties to the entry pension are introduced. Regarding partial retirement, the minimum period of contribution is now 33 years instead of 30, and the age to access this kind of retirement will be delayed from 61 to 65 as of 2027 when the transitory period ends. Only individuals with 36.5 years of contribution or more would access partial retirement from age 63. Moreover, the contributions of the partial retirees increase from 30% to 50% in 2013, and they will increase by additional 5% each year until reaching the 100%.

Second, regarding the sustainability factor included in the Law 27/2011, an independent expert commitee was created by the government at the beginning of 2013 with the objective of designing the specific formula to apply it. This commitee produced a report in June 2013 in which its members proposed a sustainability factor consisting of two different adjustments. On the one hand the so-called *Intergenerational Equity Sustainability Factor*, affecting only the new retirement pensions. With this factor new pensions would be calculated as before, but finally corrected by an adjustment measuring the change in life expectancy. On the other hand, the *Annual Updating Factor*, affecting all pensions. In this case, all pensions would be adjusted every year using a growth rate which takes into account the evolution of expenditures, the number of pensions, the substitution effect – relation between the level of pensions for the entries and the withdrawals– and the balance of the system – relation between revenues and expenditures.

In October 2013, the Project of Law to introduce the sustainability factor in the retirement pension system was approved by the Government and send to the Parlament for discussion and approval, projected for the end of this year. This project reproduces almost identically the report of the experts committee. The only noticeable change is the establishment of minimum and maximum thresholds for the annual updating factor – pensions can not increase annually less than by 0.25% neither more than by the consumption price index of previous year increased in 0.25%. Note that this measure might limit the balancing effect of this sustainability factor that would otherwise imply sustainability per se. The *annual updating factor* is to be applied from 2014, while the intergenerational equity sustainability factor would be introduced from 2019 – eight years before the initial planned date in the 2011 reform. Due to the hard economic situation of the country in general and the projected deficits for the social security system, the Government proposed the updating of pensions with the minimum factor (0.25%) for 2014, although this measure is still not approved. It is worth mentioning that this Project of Law is being hotly contested by the rest of political parties, unions and other social institutions such as CES (Consejo Económico y Social - Economic and Social Council). Probably, much of the social discontent stems from the hard economic context and the way the government is going ahead with social reforms – not only pensions but also education and health – which are being adopted unilaterally by the government using the absolute majority they held in the parliament without the agreement of social agents and the rest of political forces. In fact the 2011 reform has not been discussed in the framework of the Toledo Agreemnt and this has been also a reason for criticism.

2.2 Assessment of strengths and weaknesses

2.2.1 Adequacy

Pension adequacy in Spain seems to be high, at the moment, for EU standards. The aggregate replacement ratio, which has been improving fast in the past, is at the present similar to the EU27 average. The theoretical replacement rate is one of the highest in the EU27, following the Netherlands and Luxembourg. This is probably due to the final phase of the maturing process of the pension system on the one hand, and to the delay in the reform of the pension system on the other hand, corresponding to the delay of the Spanish baby boom related to the rest of Europe. Another reason might be that the Spanish pension system is not highly redistributive for EU standards.

The percentage of people at risk of poverty or social exclusion in Spain is higher than the EU average. Interestingly, the gap decreased in 2005 and 2006, but it started to increase again since 2007, probably due to the stronger impact of the economic crisis in Spain than in other countries. In Spain, the poverty index is mainly driven by the population aged under 65, while the elderly show the opposite trend. Clearly, this could be an effect of the continuation of social protection along the crisis, which has protected pensioners while active age people have suffered the most hard negative effects. Nevertheless, last reforms could change this picture to some extent. It is obvious that a general reduction in pension rights is taking place in the medium term, especially when the sustainability factors start to operate. Still, the elderly could become more protected against the business cycle, but their relative income could decrease significatively, threatening the adequacy of the system. In any case it should not be forgotten that the sustainability factor reduces the amount of pension, but due to the longer life expectancy, the pension is perceived during a longer period.

2.2.2 Sustainability

Spain is facing one of the deepest ageing processes in Europe. Dependency ratio (population over 65 related to population aged 20-64) is expecting to reach 61.8% in 2060, compared to 57.7% for the EU27. As a consequence, the sustainability of the public pension system is one of the main concerns in the political debate, probably because the current economic crisis has exacerbated the problem, as it advanced it many years. Projections showed first financial problems of the social security system after 2020, when the baby boom generations will start to enter retirement. Nevertheless, the dramatical reduction of revenues, mainly due to the huge unemployment rates, have advanced the deficits of the system to 2011.

Reforms undertaken in the last years in the Spanish public pension system should have a significant impact on improving its sustainability. First, the movement towards proportionality in 2011 reform has been sizeable, and it would also clarify the role of distribution in the system, now somehow mixed up. Second, the delay of retirement age should reduce the expenditure at the same time that it should increase the revenues of the system, and it is quite acceptable taking into account the big increases in life expectancy during the last decades.[3] Finally, the introduction of an explicit sustainability factor as the one

[3] The Spanish government estimated that the 2011 reform would reduce the share of expenditure to GDP gradually up to 3.5 percentage points. The effect of the current crisis was not yet taken into account. Several academic studies find similar effects (Conde-Ruiz and González, 2012 and Banco de España, 2011, IESE, 2013). Those studies are based on aggregate accounting models or overlapping generations models with limited degree of heterogeneity and hence not suitable to measure future pension adequacy. A thorough analysis should be carried out to make sure that the cut in pensions does not worsen adequacy to a great extent. Cohort and micro simulation analysis would be convenient in order to clarify the inter and intra generational effects of the reforms.

proposed in the Project of Law now being debated in the Parlament would significantly reduce the financial pressure on the system.

It is worth mentioning that since 2012 the Reserve Fund of public pensions is being used to cover partially system deficits. This Reserve Fund was created after the renewal of Toledo Agreement in 2003 in prevision of the financial difficulties arriving with the ageing process beyond 2020, and had accumulated a maximum of €66,815 million in 2011. In 2012 the governmet used €7,003 million to pay pensions, in 2013 it is projected to spend €11,648 million and in 2014 another 11,029. That means that in three years a 44% of the Reserve Fund will be spent.

2.2.3 Private pensions

The private pension system in Spain is of a small size. Since 1988, when the system started, there has been a steady and moderate increase, but the financial crisis has affected it negatively. The majority of plans (around 60%) are employers' plans, but the partipation is low and also the accumulated funds. According to OECD data, by December 2010 the pension fund assets in relation to national economy was 7.9% of GDP in Spain, very far from the average of 71.6% for OECD countries. The accumulated funds were €83.8 million, still bellow the pre-crisis level (86.4 in 2007), and the number of participants is around 8 millions. The average annual contribution to a private pension fund in Spain is around €1,000, but 75% of participants contribute less than €300. Before the crisis, 80% of participants made annual contributions to their plans, but after the crisis only 50% maintained annual contributions.

The reasons of the underdeveloped private pension system in Spain are basically twofold. On the one hand, the high coverage and generosity of the public system which probably discourage people to save money specifically for their retirement. On the other hand, traditional savings in Spain were mainly directed to buy real state. According to INVERCO[4] it is estimated that around 80% of domestic savings are inverted in buying houses, while 20% is shared among other products i.e. deposits, share options, investment funds and pension funds.

2.2.4 Summary

The Spanish contributory pension system is a defined benefit system financed on a PAYG basis. Pensioners receive a pension after a minimum of 15 years of contribution, which depends to a greate extent on their contribution base and on the number of years contributed. Those individuals not elegible for contributory system can apply for non-contributory scheme, means-tested.

The strong ageing process projected for Spain in the next decades will be an important challenge: the financial balance of the system is severely threatened by the worsening system dependency ratio. The present economic crisis has advanced the financial problems of the social security system by more than 10 years. The first deficits were expected beyond 2020, when baby boom generations start to retire, but due to the high unemployment rates and the dramatical decrease of revenues, the system is in deficit since 2011, and the Reserve Fund is being used to cover it. In only three years, 2012-2014, if the deficit projections are met, 44% of the accumulated fund will be spent.

[4] INVERCO (Spanish Assotiation of Collective Investment Institutions and Pension Funds). http://www.inverco.es/documentos/publicaciones/documentos/0007_INFORME%20ANUAL%20IIC%20y%20FONDOS%20DE%20PENSIONES/C92_AHORRO%20FINANCIERO%20DE%20LAS%20FAMILIAS-IICs%20y%20FP-2012.pdf

Last reforms approved or planned in the short term for Spanish public pension system will help facing population ageing, improving sustainability but probably affecting pension adequacy at the same time. For the moment, there are no studies on the impact of the sustainability factor, apart from the government estimations, which do not analise the impact on adequacy. A thorough consideration of both short-term and long-term sustainability and adequacy would require a micro simulation exercise with adequate macro scenarios.

2.3 Reform debates

The debate about public pensions in Spain follows to a great extent the reconmmendations proposed by the Toledo Agreement in 1995, containing a set of recommendations and compromises for its periodical implementation. The first reforms enacted after the Toledo Agreement were indeed timid and did not fulfil the expressed proposals. Nevertheless, the strong effects of the current economic crisis in Spain, as well as the recommendations of the European Council had led to deep reforms in the last two years. Those reforms have been contested by public opinion and by unions, as usual, but, probably given the pressure the government is experiencing nowadays, the Law 27/2011 has been a deeper reform in line of the Toledo Agreement recommendations. And, as explained above, it has also introduced an increase of the retirement age and a sustainability factor for the first time. Nevertheless, the long transition period was established and no effects were noticed.

A new reform aiming at balancing expenditures and revenues was unavoidable. This means that expenditures should be reduced, or revenues increased, or both at the same time. Regarding the first, the reform is on the verge to be adopted, and it consists in advancing the application of the sustainability factor proposed in Law 27/2011, which will reduce expenditure by about €33.000 million in the next nine years, according to the projections of the government. In the case of revenues, an increase of 5% of the maximum contribution basis is proposed in the 2014 General State Budgets project, also pendent of approval. In spite of this, a reduction of contribution revenues is expected in 2014.

Other specific actions are possible while trying to face population ageing and ensure the sustainability of the system. First of all, the Spanish unemployment rate is the highest in Europe (over 26%), and it represents a big handicap in keeping the necessary ratio between workers and beneficiaries. Spain urgently needs appropriate changes in the labour market in order to stop and reverse the present job destruction trend, and the labour reform approved in 2012 did not bring the desired effects. On the contrary, job destruction continued and wage reductions caused an important decrease in Social Security contributions. Secondly, some specific groups such as young workers, older workers and women can represent a good resource to help improve the ratio between contributors and beneficiaries.

On evaluating the possible future reforms of the contributory public pension system in Spain one should bear in mind a non-trivial contradiction embedded in the nature of the system. As many other pension systems in OECD countries, two different objectives are mixed together with the complexities of the PAYG financing: redistribution and the need to motivate individuals to save for retirement. The latter should in principle be linked to some degree of capitalitzation. Given that this is not the case, fostering the bismarckian nature of the system – full proportionality between contributions and benefits seems advisable.

In fact the recommendations given by the Toledo Agreement went in this direction and so did the reforms implemented so far. But this process is not yet completed, which seems advisable before introducing new elements into the system as the sustainability factor. Even more, if we consider that some of those reforms have the indirect effect of cutting pensions rights and

would, hence, reduce the extent of the adjustment needed.[5] Note that the adjustments introduced by sustainability factors are related to the economic situation and not to individuals contribution and might, hence, introduce arbitrary redistributive effects. This applies especially to the factor that will be soon introduced, the annual updating factor. On the contrary, the other factor has been designed to foster inter-generational equity – as its name suggests - while it could have taken another role. In other countries this factor is designed to directly link the retirement age to life expectancy. The way it has been designed in Spain it links it indirectly and hence its effect is mainly a pension reduction – provided that individuals do not decide and can retire early - instead of an effective delay in retirement age.

3 Health care

3.1 System description

3.1.1 Major reforms that shaped the current system

Historically, in Spain legislations on public health and on the rights to health care are clearly differentiated, and they finally converged as a result of the approval of the Constitution in 1978 and the General Law of Health in 1986. In the field of public health, the first legislation is based on the Royal Decree of January 12, 1904 and the Basic Law of National Health in 1944. Regarding health care, the Occupational Accidents Act in January 1900 created the *Seguro Obligatorio de Enfermedad* (compulsory sickness insurance). Later, the Basic Law of Social Security in 1963 constituted the provision of health care within the social security system.

The Spanish constitution establishes the right to health protection and health care for citizens, clearly distinguishing it from social security benefits regulated in Article 41. The motivation of the legislator to anchor the right to health care on Article 41 of the constitution (that is, linked to social security) rather than on Article 43 (right to protection of health) seems to stem from the idea of centralization of decisions in the field of health, taking away budget allocation responsibilities from regional parliaments even at the expense of the contradiction that may be represented by the maintenance of a non-contributory and universal benefit within the social security system (Cabasés, 2002). There are four main regulations related to the right to health protection.

The General Law of Health (1986) seeks to guarantee the right to health protection and sets the competences to be conferred to the Autonomous Communities in health. It creates the *Servicio Nacional de Salud* (National Health Service, SNS) as an universal public service, integral (it covers benefits from prevention to rehabilitation), integrated (set by all agencies and institutions), with clear goals of equity and solidarity. Later, until the nineties, health competence has been gradually transferred to Autonomous Communities.. The SNS regulates the coordination, cooperation and communication among regional health services.

As a result of the decentralisation process, the Law of Cohesion and Quality of the SNS (2003) is intended to prevent disparities within the system, establishing coordination and cooperation mechanisms which aim to ensure equity, quality and social involvement in the SNS. The Act defines health benefits, allocates competences between the central state and the

[5] For example, a further increase in the number of past years used to compute the "base pension" from 25 to the whole working career would cut pensions for most people and would still reflect past contributions. Quite interestingly this measure tends to have a redistributive effect as long as high income workers have steeper earnings profiles along there life cycle.

regional governments, health professionals, quality plans and citizen participation. Besides, it creates a cohesion fund to ensure equal access to health care.

The Law of Warranties and Rational Use of Medication (2006) aims to ensure quality of health care provision across the SNS in a decentralized framework, promoting rational drug use in terms of effectiveness and safety.

Finally, the Public Health Law (2001) aims to protect and promote the health of population, both in the individual and collective sphere. It establishes the basis for policies, programs, services and other actions developed by public authorities and other institutions as businesses and civic organisations in order to promote health and prevent diseases.

3.1.2 System characteristics

The first serious attempt to reform the SNS, as a result of the economic crisis of the early 90s, was entrusted to a committee chaired by Abril Martorell (1991), which prepared the so-called Abril Martorell Report. The need for a reform stemmed the tensions which existed in the system: ageing, increasing demand, limited resources, etc. The report contained 64 recommendations, which although they have never been formally adopted, became the basis for many measures adopted by the Autonomous Communities later on.

In 1997 the Parliamentary Subcommittee for the Consolidation and Modernisation of the SNS approved the Romay Report. Among their main conclusions was the need of increaseing the system funding and the waiver to co-payment and to specific taxes.

Although equity (understood as equality of treatment in equal need, and equal access regardless of the cultural, economic and geographic precedence of the patient) is the fundamental principle of the Spanish health system, the inequalities in resources, expenses, debt and benefits among regional health services frequently violate this principle. The existing evidence reveals that access to (and utilisation of) primary health care is consistent with the principle of horizontal equity (equal access for equal need). Nevertheless, specialised and non-emergency hospital care show inequity favouring the better-off. This situation is faced with the Law of Cohesion and Quality of SNS (2003), as already noted, intended to prevent the disintegration of the system and to promote coordination and cooperation in order to ensure equity, quality and social involvement.

The last reform of the system is performed by Royal Decree-Law 16/2012 on urgent measures to ensure the sustainability of the SNS. It aims to improve the quality and safety of services and represents an important turning point in the field of Spanish health management, as it addresses significant changes in the areas of acquisition of insured status to qualify for health care, to define the portfolio of services common to all the Autonomous Communities and to rationalize expenditure in the fields of pharmacy and medicine purchasing and human resources policies.

3.1.3 Details on recent reforms

The present economic crisis has highlighted some of the weaknesses of the health care system which Spain is forced to address, as the excessive share of administrative costs for health care in GDP increasesand the productivity in the health system decreases[6]

[6] There are no official data about health system productivity, but a report of Antares Consulting provides some useful indicators which give an idea about the low productivity in Spain http://www.consorci.org/accessos-directes/patronal/documents-i-publicacions/articles-i-publicacions-d2019interes/informe antares sostenibilidad.

(characterised by a high rate of absenteeism, a low number of hours spent on direct care activities and the poor performance of working hours).

The new regulation on insurance[7] consolidates universal insurance for Spanish citizens living in Spain and foreigners registered as residents in Spain, and defines assistance to immigrants from other countries residing in Spain who cannot access the public system. Access is guaranteed for those under 18 years, pregnant women, in emergency situations, international protection seekers and victims of human trafficking. By this, previous regulations related to access to public health coverage were amended. The provisions represent a significant shift from the previous model. Public health coverage is no longer a universal right acknowledged to "all Spanish citizens and all foreign residents of Spain but only to "those citizens who hold the status of being insured".

Two types of publicly insured are defined, which grant different conditions to health care access. The first groups of insured ("insured persons") includes workers affiliated to the social security system, pensioners, individuals perceiving social benefits, and unemployed not entitled to unemployment benefits. The second group covered includes other Spanish nationals, nationals of a Member State of the EU, the European Economic Area (EEA) or Switzerland who are registered in the Central Registry of Foreigners and, finally, stateless persons and those having a residence permit in Spain upon application additionally fulfilling the following two conditions: the annual income is under €100,000 and not having any other mandatory health coverage.

The Royal Decree-Law 16/2012 unified services provided by the SNS, distinguishing a core package and a supplementary package. The core benefit package, completely public funded, consists of prevention, diagnosis, treatment and rehabilitation carried out in the health centers, and geriatric and emergency medical transportation. The complementary package includes pharmaceutical benefits, orthoprosthetic, dietetic and non-emergency medical transportation and other ancillary services. These complementary services are only partially public funded and subject to co-payments by the users.

The prescription of pharmaceuticals has also been reformed with the Royal Decree Law 16/2012. It stipulates that it is the Ministry who updates the list of drugs that are excluded from prescription, while the Autonomous Regions cannot unilaterally provide any specific change regarding prescripcion, drug dispensing and finance.

A significant change introduced by the Royal Decree-Law 16/2012 refers to the reference pricing system. The law determined the maximum amount that will be publicly financed for those medicines or medical products prescribed by public doctors. Each reference group must include at least one biosimilar or generic product already financed by the SNS, unless the medical product or its main active ingredient had been commercialized for a minimum of ten years in an EU member state. That is, the existence of a generic product is no longer essential to establish a reference group. The Law 10/2013 of 24 July, further modified Article 93, loosening the above mentioned requirement and establishing that it is sufficient that the medical product or its main active ingredient has been authorized (not marketed) for a minimum of ten years in any EU member state.

The Royal Decree 1506/2012, of 2 November, defines in a greater detail the package of supplementary orthopaedic care and products and establishes co-paymentsfor these products

[7] Established in Royal Decree-Law 16/2012 and Royal Decree 1192/2012. The specific criteria and mechanisms regulating the status of insured person and beneficiary for the purpose of public health care in Spain are further developed in Royal Decree 1192/2012, of 3 August, more recently modified by RD 576/2013, of 26 July.

and services. New co-payments for both orthoprosthetic provision and ambulatory drug delivery proportional to the income are fixed (60% for those with an income equal or exceeding €100,000, 50% for income between €18,000 and €100,000, 40% for the insured that are not included in the above sections, 10% for pensioners who do not meet the first criteria and their beneficiaries, and 10% for special products). In order to ensure continuity of chronic treatments and avoid inequality for people who need long-term treatments, overall rates are subject to co-payment ceilings. The caps for these co-payments applying to pensioners are the following: pensioners whose income is below the annual €18,000 should be reimbursed for any monthly expenditure beyond €8.14; those with income between €18,000 and €100,000 are entitled to reimbursements of all expenditures over €18.32 per month; and, those exceeding the annual €100,000 are entitled to reimbursement of costs exceeding €61.08. Civil servants participation in the cost of orthopaedic products and prosthesis is set to 30%. People affected by toxic syndrome, those on special social subsidies, people receiving tax-exempt pensions, unemployed not entitled to benefits, or those who have had work-related accidents are exempted from co-payments.

As far as the pharmaceutical co-payment is concerned, the regional health authorities of Catalonia (in 2012) and Madrid (in 2013) introduced a flat €1 per prescription tax (with some exceptions similar to those described in RDL 16/2012). This measure encountered public opposition leading to allegations before the Constitutional Court which has ruled a cautionary suspension of the measure, while the legal process follows its course.

The impact of those recent cost sharing reforms on pharmaceutical prescriptions has been evaluated by Puig-Junoy et al (2013). The main findings pointed to a dramatic drop in the number of dispensed prescriptions in the months following the reforms. Another notable contribution of the analysis is that it provides evidence of the high sensitivity of the demand for prescription of medicines to prices and to the fact that a small linear co-payment (1€ per prescription) has a large impact on medicine‘s use. The results exploiting regional differences in co-payment policies are also consistent with the hypothesis that the first Euro of cost sharing has a large impact on drug use. The authors claim that the results raise several new questions relevant for policies. It is necessary and urgent to know which groups of patients and therapeutic groups have been most affected, in order to evaluate the potential reduction in the abuse (moral hazard) attributable to free medicines and the equity issues which rose from the co-payment.

In the field of management efficiency, the centralized purchasing of medicines and health products and the application of new technologies to the health system have been introduced by the new legislation (individual and professional health card, electronic medical records, electronic prescription, online appointment and telemedicine). Regarding personnel, it establishes a uniform catalog of professional categories and their equivalents.

With all these measures, the Government aims to reduce the overall spending by €7,000 m, an amount that is disaggregated as follows: removal of assistance to 676,000 citizens (€917 m), basic portfolio management (€700M), fight against drug wastage (1,000 M €), pharmaceutical copayment (€500 m), new gazetteer (defunding of drugs) (€500 m), generic drugs promotion (€1,550 m), centralized purchasing platform (€1,000 m) and human resources management (€500 m).

Yet another cost-cutting measure was adopted by the Spanish Government in September 2013 and introduced a 10% co-payment on hospital drugs, dispensed through hospital pharmacies, for out-patients. The maximum monthly co-payment the patients will bear is limited to €4.2. All Autonomous Regions are bound to enforce the regulation from 1 October, but many

regional health authorities (e.g. Navarre, the Basque Country, Asturias, Catalonia, etc.) strongly oppose to the measure.

3.2 Assessment of strengths and weaknesses

Since the democratic transition, the Spanish health system evolved quite quickly from a social health insurance for workers and their families to a national health system, universal, decentralised to the regional Governments and consisting of a broad network of both primary and hospital care. The primary care reform from the General Health Law of 1986 and the contribution of professionals incorporating scientific quality, dedication and commitment, represented a huge improvement that allowed a strong health system orientation towards population health. The first level technological equipment and highly skilled professionals, who access the system through the speciality training of resident physicians, allowed achieving a significant clinical and technical excellence in hospitals.

Progress has been made, also, in improving the management of the centres with the implementation of program contracts between funding agencies and providers defining funding and commitments of activity, quality and results, while exploring new forms of management. Among the weaknesses of the system one can cite the problems of coordination between different regional health services, and between them and the central Government. In this sense, results achieved with the creation of the Inter-Territorial Council are not as satisfactory as expected. Financing has always been a problematic issue, which for years has favoured opportunistic behaviour of both the Central Government and the Autonomous Communities. On the other hand, since the transfer process ended, the central Government failed to address its new role in a decentralised SNS (Repullo, 2007). Finally the economic crisis revealed the sector's difficulties to manage the decline of financial resources by the social and political resistance to lessen inefficient services, and clearly show problems as the delays in payments to suppliers, and the increasing tensions between central and regional Governments, and among the latter themselves. Moreover, some conflicts have arisen among the regional Governments and both the medical and nursing professionals and the patients.

3.2.1 Coverage and access to services

Two areas of reform have caused negative effects on coverage and access to services. The first relates to access to health care for illegal immigrants, and all people - Spanish or foreigners – aged over 26 who do not meet any of the four criteria certifying the status of insured (see section 3.1.3 above). The second is the gradual progressive increase observed in waiting lists. In 2012 there were 11.82 patients waiting for non-emergency surgeries per 1,000 inhabitants (10.59 in 2003 and 9.11 in 2009) with an average waiting time of 76 days (81 in 2003 and 69.7 in 2009). In the same year there were 35.94 patients waiting for consultation in hospitals per 1,000 inhabitants (35.41 in 2006 and 33.0 in 2010) with an average waiting time of 53 days (54.37 in 2006 and 53.18 in 2010). These delays in the delivery of services vary between different Autonomous Communities, although data are not in the SNS statistical portal.[8]

Spain has a population of over 46 million people, including 5.7 million foreigners, being the second country in the EU-27 with a larg group of foreign residents after Germany. The life expectancy is one of the highest in Europe. The health system offers primary care covering the entire national territory, with health centers in each municipality and a large hospital network quite well equipped. In 2011, there are 3.2 beds per 1,000 inhabitants (slightly lower than the OECD average); 9.1 operating rooms, 1.57 computerized axial tomography apparatus

[8] http://www.msssi.gob.es/estadEstudios/estadisticas/sisInfSanSNS/

and 1.14 magnetic resonance imaging apparatus per 100,000 inhabitants, figures in line with the OECD average. The number of doctors per 1,000 inhabitants was 4.1 (3.2 for OECD average), and 5.5 nurses (8.7 for OECD average). The frequency of primary health care use is on average 5.51 times a year per person. Regarding hospital care, 1,904 hospital consultations, 113.09 hospital admissions and 102.62 surgical interventions per 1,000 inhabitants took place in 2011.

Social inequalities in health are the result of the unequal opportunities to access health services for the following reasons: social class, gender, nationality or ethnicity. Health inequalities are unfair and avoidable with adequate social public policies. In Spain, socioeconomic status, gender, ethnicity and recently nationality, are axes of inequality with a substantial impact on the health of the population. In this regard a difference of three years in life expectancy among the richest regions (such as Navarra and Madrid) and one of the poorest (Andalusia) can be mentioned. There are also important differences by gender and social classes, i.e. 55% of unskilled women declare a good state of health, while this share is 85% for highly skilled men. Moreover, inequalities in some diseases or risk factors are increasing, as is the case for obesity. There are also inequalities by gender and social class in health-related behaviours such as physical activity.

Policies to reduce inequalities in health are a priority for many countries and meet the objective number 2 of the Health Strategy for the 21st Century of World Health Organization noting "by 2020, the differences in health among socioeconomic groups in each country must be reduced by substantially improving the level of health of disadvantaged groups". In Spain, policies to reduce health inequality have hardly entered the political agenda, except some actions directed to reduce gender inequalities.

3.2.2 Quality and performance indicators

Quality Plans for the SNS were created in the Cohesion and Quality Act (2003). During the early years, efforts have been concentrated in the areas of health promotion, equity, clinical excellence, medical records and information systems. Its elaboration has involved experts, Autonomous Communities, scientific societies as well as patient and social organisations, seeking agreement and involvement of all parties.

The Quality Plan for the SNS 2010 associates quality with attributes as health promotion and disease prevention, health care provision in appropriate time, adequate information to patients to facilitate their participation in decisions related to their health, clinical excellence, the evidence-based medicine, patient safety as well as the concept of equity and the efficient use of resources. The 2010 Quality Plan has 6 areas and 12 strategies: protection, health promotion and prevention (health and lifestyle and protect health), promoting equity (promote health policies based on best practices, health policy analysis and propose actions to reduce inequities in health with emphasis on gender inequalities), support planning and human resource development (matching resources to needs), promotion of clinical excellence (evaluate technologies and clinical procedures, accrediting and auditing centers and services and improve safety and patient care and clinical practice) and use of technology to improve care and transparency (consolidate a reliable, timely and accessible system).

The Spanish health care system is comparable to other European countries in what refers to the quality of service delivery. The crude death rate[9] (year 2011) is 828.5 per 100,000 inhabitants; infant mortality is low, only 3 of 1,000 die in the first year of life and prenatal

[9] According to the National Statistics Institute, http://www.ine.es

mortality is around 4 deaths per 1,000. Hospital mortality rate[10] (year 2011) is 4.29% overall; 1.69% of patients undergoing surgery; 8% of patients treated for stroke; 5.58% of patients treated for bleeding intestinal or 11.57% of patients treated for pneumonia.

Regarding citizen satisfaction with the health system, according to the National Service System data, in 2011 87.5% of the population expressed its satisfaction with the primary health care, 83.5% in case of hospital visits, 86.7% for hospital care and 79.4% for emergency services.

3.2.3 Sustainability

According to the OECD[11], Spain is slightly below the OECD average in terms of per capita total health expenditure, with average spending of $3,072 in 2011 (adjusted for purchasing power parity), compared with an average of OECD $3,339. Health expenditure per capita in Spain was €1,923.21 in 2011 (€1,404.54 in 2003 and €1,990.51 in 2009), being per capita public spending in those years of €1434.39 (€1005.61 and €1,508.25). In 2011, 13.83% of total expenditures was dedicated to primary care, 53.11% to hospital care, 19.2% to pharmaceutical spending, and the rest to the other various benefits.

Regarding the total health expenditure as a percentage of GDP, according to World Bank data, Spains expenditure grew from 7.5% in 1996 to 9.4% in 2011. These figures show that, despite slight cuts Spain continues to be below the EU average in 2011. On the other hand, according to OECD, health expenditures between 2000 and 2009 increased by 5.6% on average per year compared to the average 4.8% in all OECD countries, but it fell 0.5% in 2010 and 2.8% in 2011.

The per capita pharmaceutical expenditure is similar to the European average in the period 1980-1990. Thereafter, the Spanish public pharmaceutical spending increased sharply so that in 2007 it was 40% above the European average. Public pharmaceutical spending as part of public health expenditure has always been above the European average, even between 1980 and 1990 when the public pharmaceutical expenditure per capita was at the European average or below it. Regarding private pharmaceutical expenditure in Spain it has been always below the European average.

Many factors have caused the observed upward trend in health spending in Spain (Arenas Díaz, 2011). First, the population has been increasing, and at the same time is ageing, although this factor does not seem to be the most important. Second, an increasing incidence of chronic health problems (cancer) has been observed. Third, regarding technology, providers push for the introduction of new and more expensive technologies and motivate patients to its maximum use. Fourth, during economic crisis periods the demand for health care provided by the public system has increased. And finally, there have been significant increases in personnel expenditure and investments in infrastructure in recent years. Regarding human resources, it is worth mentioning that in the last years, and mainly due to the crisis, an important number of Spanish doctors and nurses are emigrating to other countries. There are no official figures on this phenomenon, but it doesn't seem that it could generate a problem of lack of professionals in the next future. In fact, in the last years the number of students accepted in Spanish Schools of Medicine has increased by around 50%, and a similar trend has been observed in nursing.

[10] According to the National Service System data: http://www.msssi.gob.es/estadEstudios/estadisticas/sisInfSanSNS/inclasSNSDB. htm

[11] http://www.oecd.org/els/health-systems/Briefing-Note-ESPANA-2013-in-Spanish.pdf

According to the 2012 Ageing Report, absolute public expenditure on health in Spain will increase by 19% between 2010 and 2060, which is above the European average (16% for EU27 and 15% for EU15). Although health expenditure would increase from 6.5% to 7.8% of GDP it still would remain below the EU average (8.3% of GDP in 2060 for EU27, and 8.4% for EU15). Recent reforms have introduced various measures to ensure the sustainability of the Spanish health system, such as increasing the co-payment of system users (pharmacy and orthoprosthetic provision) and potential savings that could involve centralised purchasing.

3.2.4 Summary

The Spanish health care system is a system of universal coverage decentralised to the Autonomous Communities. It consists of a broad network of health centers, with a strong focus on population health in the primary care sector. The system is well equipped, with first class technological equipment in hospitals, highly skilled professionals that achieve a significant clinical and technical excellence and significant improvements in the center management with the implementation of program contracts.

Some weaknesses of the system include coordination problems not solved in a system which is fully decentralised; from the expenditure side, are the stresses on financing and the inability of the Ministry of Health to address its new role in a decentralised system that legitimised it in an area with little competences.

But undoubtedly, the main challenge of the system was that in the period 1999-2009, real public health spending per person grew by 50%. Prescriptions per person increased by 30% during the decade, the number of people working in hospitals – adjusted for protected people – increased by 20% and their real wage increased by more than 21%. The good performance of the economy and the high public revenues allowed to deal with this situation, but the economic crisis and the subsequent drastic reduction of consolidated revenues have raised the problem in all its harshness.

The crisis exacerbated the weaknesses which were not faced during the economic boom. The austerity measures implemented in order to content expenditure are having negative consequences on access to services in general and for certain groups, i.e. undocumented immigrants. Besides, the co-payment introduced in some services could also generate financial problems for the less favoured classes.

Moreover, clinical and technical excellence designed to acute treatments is neither adequate nor efficient to care for patients with chronic and multiple diseases. Chronic diseases should be treated in the community by primary care services which need to be better coordinated with hospital specialists, to avoid blocking the hospital care.

In summary, the most important causes of the observed increase in health expenditure in Spain in the last decades are the decentralisation of health management to the CCAA, the increase in pharmaceutical expenditure, inefficient procurement systems and the growth of human resource spending in a country with a growing attendance to public health, an increasingly ageing population and a significant increase in chronic health problems. Sustainability of the health system depends on the joint commitment of professionals, managers and citizens.

3.3 Reform debates

The need for structural reforms of the National Health System and, by extension, of its organisation and management, cannot be attributed to the current economic recession. The economic downturn has just acted as a catalyst for reforms. The Spanish health system faces

many difficulties and inefficiencies, which urges the debate on the design of relevant health policies aiming at buffering the impact of the crisis on the health of the population (CGCOM, 2012). In this context, the following works can be mentioned: the document elaborated by the Spanish Health Economic Association that will be released in October 2013, the Libro Blanco del Sistema Sanitario Español (White Paper on health system in Spain by Rubia Vila, 2011), the Informe sobre Desarrollo Autonómico, Competitividad y Cohesión in 2010 (Report on Autonomous Development, Competitiveness and Cohesion, CES 2010) or the most recent report elaborated by Price Waterhouse Coopers (PWC, 2013). The main issues raised in the debate are issues of sustainability and territorial cohesion, efficiency in management (clinical management, process management, continuous assessment and addressing chronic patients) and human resources, equality in health and equity in access to health care, the pharmaceutical expenditure, the need to adopt a "Health in All Policies" approach when aiming to improve population health and equity, etc..

Can we waste (scarce) public resources in the design and implementation of health policies that do not work? (Vera, 2011). The rule of introduction and evaluation of interventions, programmes, strategies and policies in the Spanish system is very inefficient. Spain should follow the example of countries such as USA, the UK, the Netherlands, Colombia or Mexico, where decision-making is based on evidence from policy evaluations, and promote the generation of high-quality health information. The Strategic Impact Evaluation Fund can be used as an example for an independent institution that carries out and supports research in evaluating the impact of policies and programmes to alleviate poverty. The Fund uses rigorous methodologies and mechanisms to fill key knowledge gaps in strategic areas, providing evidence for designing more effective policies and programs to improve people's lives.

Work remains to be done in the elimination of those health services that are not worth what they cost, requiring distinguishing between three main types of health services: those which are clearly effective, sensitive to supply and sensitive to patient preferences. Following Chandra and Skinner (2011), in the group of poor or no cost-effectiveness one would include many imaging diagnostic tests, specialist visits, stays in intensive care and most of the decisions regarding chronic patients.

Regarding the reform enacted in April 2012, one of its most important measures, the regulation of health services packages, still hangs in the air. The trouble is reaching the necessary consensus among the Autonomous Communities which have difficulties in its policy development. As an example, patients are not yet co-paying for non-emergency medical transportation because it is under discussing when they should pay and who should do it. The co-payment for prostheses, wheelchairs or hearing aids began more than a year after the reform April 2012.

In the pharmaceutical area, the urgent need to cut expenditure and to obtain results as quickly as possible explains that measures which are easier to implement and to produce immediate savings are a priority. As a consequence, almost all spending cuts had affected the citizens, the pharmaceutical industry and pharmacies, with co-payments from patients, reductions in prices for providers and the exclusion of some treatments.
Based on the information from the Health Barometer 2002-2012 published by the Ministry of Health, Social Services and Equality, the general degree of satisfaction with the SNS has been relatively high and increasing over the decade between 2000 and 2011 and has only slightly declined in 2012. When asked to evaluate the SNS's performance, people rated it at 5.94 in a scale of 1 to 10 in the year 2002 and at 6.57 out of 10 in 2012 (compared to 6.59 in 2011), but representing an overall significant increase in satisfaction in the past decade. The second most cited indicator, the percentage of users who valued the functioning of the system as good or

very good, also experienced improvements between 2000 (66.8%) and 2010, when it reached its maximum (73.9%). The last two years a negative trend has been observed. In 2012 70.6% of the patients consider the system's functioning to be good or very good. The results are not homogeneous across Autonomous Regions, but there has been convergence over the years.

The figures regarding some specific activity indicators (the attitude of healthcare personnel, the availability of medical technology and equipment, the waiting lists, the consultation times, etc.) do not allow clear inference. In the case of primary health care, users report a degree of satisfaction similar to that recorded in 2000. On the contrary, patients consider that medical equipment has worsened over the last decade. Users generally believe that the health services are not working towards shortening waiting lists and more people thought that this problem was worsening with time instead of improving. In short, it seems that it is time to face the inevitable changes and to correct the weaknesses of the health system. In the debate on new reforms new aspects emerge which had been poorly addressed in the past: searching territorial balance of funding, assuming that efficiency is an ethical imperative, adjusting the structure of the health sector, encouraging efficient clinical practice, accepting that in the field of professionals quality of the service should be prioritized with respect to stability in the work place, working on the standardisation of personnel based on the population covered, encouraging formation on cost-efficiency and cost-benefit of treatments, continuing to push the centralised purchasing, unifying the portfolio of services in all the regions, reducing bureaucracy, defining a homogeneous catalogue of professional categories, improving the coordination between health and social services, pushing on health technology assessment, deepening the field of e-health and considering alternatives to traditional hospitalisation.

4 Long-term care

4.1 System description

4.1.1 Major reforms that shaped the current system

It can be said that a long-term care system as a such in Spain started in 2007, after the approval of the Law 39/2006 Ley de Promoción de la Autonomía Personal y Atención a las Personas en situación de Dependencia (Law of Promotion of the Autonomy and Care of People in a Dependent Situation, LAPAD), which established the so-called System for Autonomy and Care for Dependency (SAAD). Before 2007, dependency seemed to be mainly a private problem and had to be resolved within the family. This meant that dependency was attended mainly through informal carers and the costs basically assumed by dependants themselves and their families.

It is estimated that in 2000 only around 12% of elderly dependants received some kind of publicly financed help. The role of the public sector was absolutely subsidiary, limited to cases where family help was not possible or insufficient and taking into account the economic capacity of the dependant. In any case, competences in social services were decentralised to regional and local Governments, so important differences existed among the different territories.

During the first years of this century an intense debate about the need to incorporate long-term care to the welfare system in Spain was developed. This debate culminated with the above mentioned LAPAD which was approved during the first mandate of Rodríguez Zapatero of the socialist party (PSOE), and the creation of the SAAD. Nevertheless, no financing was assigned to the new system which was supposed be financed through general taxes.

4.1.2 System characteristics

According to the LAPAD, the SAAD was created in 2007 with the objective of promoting personal autonomy and ensuring the necessary attention and protection of all dependants in Spain, through the collaboration of all public administration levels. A progressive calendar of application to incorporate all dependants was established initially finishing in 2015, although it was delayed later.

Benefits of the SAAD can be both in kind and in cash, and are financed and provided jointly by the central state and the Autonomous Regions, with certain co-payment from the beneficiaries in most cases. The above mentioned LAPAD at state-level only ensures the provision of a minimum level of protection and/or financial aid for dependency situations. Within their territorial boundaries, each regional Government (Autonomous Regions) may then establish a wider set of benefits. Finally, municipalities can also complement the basket of benefits within their constituencies. Autonomous Communities are also responsible for managing the register of providers, inspection and evaluation.

Three different degrees of dependency are defined: Degree I – moderate; Degree II – severe; and Degree III – high dependence. Initially, each degree was in turn divided into two levels, where level 1 referred to less severe and level 2 to more severe. A progressive calendar, from 2007 to 2015, was established in order to incorporate all dependants in the system. Only Degree III could apply during the first year (2007), then Degree II level 2 in 2008, Degree II level 1 in 2009-2010 and finally moderate dependants (Degree I) in 2011-2012 (level 2) and 2013-2014 (level 1) were to follow. Hence, the process was expected to be achieved in 2015, although as explained below (see subsection 4.1.3), this calendar was delayed later.

Regarding the benefits, they include different services and cash benefits. Chapter 15 of the LAPAD lists a wide range of services available to be carried out through a public network of social services, controlled by the Autonomous Communities through public centers or private centers and subsidized by the public sector. These services include teleassistance, home care, personal care help, residential care and day/night residential services. The network of public institutions belonging to regional Governments, local organisations, state reference centers and duly accredited private providers deliver these services. Regarding cash benefits, which are granted according to the person's degree of dependency and economic status, the LAPAD considers a monetary benefit for home care (accompanied by the payment of the social contributions for the carer by the SAAD) and a monetary provision for personal assistance.

4.1.3 Details on recent reforms in the past 2-3 years

The LAPAD started without a clear accounting of the necessary resources. Moreover, the economic crisis in 2008 forced reforms before the system was fully implemented, altering both the planned schedule of application and the benefits initially considered. First, in 2011 the Royal Decree 20/2011 of December 30th established that moderate dependants (Degree I) that were not yet incorporated in the system should wait until 2013 (level 2) and 2014 (level 1). A new delay arrived barely seven months later, with the Royal Decree 20/2012 of July 20th. First of all, it eliminated the two levels within each degree, so after that date dependants are evaluated only in the three degrees, without distinction by levels. Second, all moderate dependants (Grade I) not incorporated in the system in that time, need to wait until July 2015. Regarding benefits, a cut in the number of hours for home assistance was implemented but, the most significant change affected the economic aid for home care (more than 50% of beneficiaries receive this benefit). On the one hand, the benefit was reduced by 15% not only for new carers but also for the existing ones. On the other hand, the SAAD discontinued the payment of social contributions for home carers – about 160€ a month.

4.2 Assessment of strengths and weaknesses

4.2.1 Coverage and access to services

The management of the SAAD is a competence of the regional Governments, and as a consequence, many differences can be observed among the different Autonomous Communities. As an example, overall 2.0% of population is recognized as dependent in Spain. Nevertheless, this ratio is 2.7% in Andalucía and Cantabria, while it is only 1.1% in Canarias, 1.3% in Comunitat Valenciana and Baleares and 1.4 in Navarra.

According to the SAAD data in August 2013 in Spain there were 1.228.207 people with some degree of dependency. In particular, 370.479 people were recognized as high dependents (30%), 444.218 as severe dependents (36,2%) and the rest (413.510, 34%) as moderate dependents. In the last case, and due to the successive delays in the fully application of the LAPAD, only 126.756 people were entitled to receive some benefits, while there might be a great number of people who has not been able to apply yet. Hence, at the moment 941.453 people have been incorporated to the SAAD as potential beneficiaries, although only 739.724 are receiving benefits, while the other 201.729 (21%) are on the waiting list. Regarding this waiting list, it should be noted that it has been reduced by 35% during 2013, as at the beginning of the year there were 305.941 people on it.

Regarding the benefits, each beneficiary receives 1.26 different benefits on average, although again this figure varies among the Autonomous Communities. Clearly, the most important benefit is the cash benefit for home care. According to the SAAD data in August 2013 403.284 people (54.5% of the total dependants receiving benefits) are receiving it. The incidence of in-kind benefits is lower: 17.5% of beneficiaries were receiving residential care, 16.4% had help assistance in their homes, 16.2% were in a program of home teleassistance and 9% received services in day/night centers.

4.2.2 Quality and performance indicators

The Spanish law stipulates the need for accreditation, professionalisation and inspection as well as the use of quality standards for all dependency benefits and services. Autonomous Communities retain an important role as regulatory powers and quality assurance. There are guidelines for the latter, mainly on structural and process standards, set by territorial councils. Some regions have already taken the initiative to establish their own standards. The SAAD Inter-territorial Council (CISAAD) establishes a common quality assurance framework for the accreditation of centers and quality programs, as well as quality and safety criteria, quality indicators for continuous improvement and benchmarking, best practices models and the development of quality standards. For instance, the CISAAD's 2008 Agreement (Ministerio de Educación Política Social y Deporte, 2008) established cross-regional minimums in quality standards that should be met by the nursing home sector in such categories as staff qualifications and material resources, equipment and documentation. And the CISAAD's 2009 Agreement (Ministerio de Sanidad y Política Social, 2009) established further minimums regarding the accreditation of informal caregivers' expertise and knowledge.

It is estimated that in 2010 only 10.5% of disabled people in Spain aged 15 and more had access to institutional care, and another 16.5% to some kind of home care. The other 73% were receiving informal or no care. By 2060 it is expected that institutional care will cover 13.4% and home care 21.5%. Dependants receiving institutional care are clearly fewer than those receiving other types of attention, but the higher costs of the former explain their importance in terms of expenditure. Particularly it is estimated that unit cost institutional care represents 81% of the Spanish per capita GDP in 2010, while formal care at home is only

25%. In both cases, figures are below the averages for EU27 –106% and 36% of the per capita GDP respectively[12.]

According to OECD (2011a) Spain has one of the highest proportions of informal carers together with one of the biggest care intensities. Non-professional carers are mostly women who dedicate 20 or more hours per week to caregiving. It is worth noting that intensive carers are generally older, less educated and poorer, and they have more probability of leaving the formal labour market and a higher poverty risk (ibid).

4.2.3 Sustainability

Sustainability is clearly the main concern in designing and developing the LTC system in Spain. In this sense, last reforms aimed to delay the full application of the LAPAD and to limit its benefits trying to limit the expenditure and face the medium-term budgetary constraints that the Stability Program has forced.

Spains long-term care public expenditure is far below the EU average. According to the 2012 Ageing Report it represented 0.8% of the GDP in 2010 out of which 0.46% was aimed to institutional care, 0.22% to home care and 0.14% to cash benefits, while the average in the EU27 amounted to 1.8%. Projections do not show an improvement in this sense, as it is expected to grow to 1.6% of GDP by 2060 for Spain, while it would reach 3.6% on EU27 average.

4.2.4 Summary

The LTC system in Spain is far from being established. It was introduced in 2007, with a considerable delay with respect to the EU countries. Nevertheless, the austerity measures caused by the deep economic crisis have interrupted its full implementation and modified the benefits. Initially it was planned that all dependants would be incorporated in the public system in 2014, but the majority of moderate dependants, after the last reform approved in the Royal Decree 20/2012 will have to wait until July 2015 before they can to apply. Regarding the benefits, the central Government has reduced its contribution to the application of the SAAD, and this is causing financial problems to the Autonomous Communities, which are responsible of managing the system and financing the benefits. Interestingly, the regions that were more efficient in recognizing and giving benefits to dependants are now the most negatively affected by the changes in state financing.

Spain will be hit by a drastic ageing process starting in the 2020 decade with the retirement of the baby boomers, so a careful design of the future development of the LTC is crucial. According to OECD (2011a) by 2060 it is expected that institutional care will cover 13.4% of dependants in Spain, and home care - 21.5%. That means that the rest 65% of dependants will receive informal or no care (75% in 2010). Spain has one of the highest proportions of population providing informal care across the OECD, and more than half of them provide more than 20 hours of care per week. Meanwhile, the long-term workforce remains one of the lowest compared to the number of care-needers, and it consists mainly of low-qualified workers. Given the relevance of informal care is Spain, it seems crucial to find strategies to formalise the informal care and to improve the quality of the service without expelling it from the system.

[12] Data on number of disabled people receiving care: Economic Policy Committee, Long-term care expenditure projections, ECFIN/C2 (2011). Data on unit costs: Comission services, DG ECFIN. Long-term care: need, use and expenditure in the EU-27.

4.3 Reform debates

The debate about the necessity of a public long-term care system is quite new in Spain. Until 2006, dependency was mainly considered a private problem to be solved inside the family, primarily through informal care. With the approval of the LAPAD in 2006, the need of socializing the costs of dependency, following the model of other European countries, was accepted. Nevertheless, reforms of the public LTC system arrived before its full implementation, mainly due to the severe economic crisis affecting the country, which has increased dramatically public deficits and forced adjustments in the public budget. In this sense, all public expenditure programs have been affected to some extent. In the case of LTC, last reforms were aimed mainly to reduce the expenditure, trying to improve efficiency while at the same time avoiding predictable negative effects on adequacy. Nevertheless, the simultaneous achievement of all these objectives is complicated.

The premature reforms in the Spanish public LTC have been very badly perceived. Different social stakeholders have rejected them, including the Social and Economic Council (CES) - an advisory body created by the Government with representatives of unions, employers and independent experts. It seems to be a generally agreed by the Spanish society that the necessity of developing public LTC system would socialise at least partly the cost of dependency. Nevertheless, the ageing process and its impact on public budget has to be also taken into account in order to ensure both the sustainability of the system and the adequacy of benefits.

Severe doubts about the funding of the SAAD existed since its inception, and these doubts have been exacerbated by the economic crisis. First, the initial projection of funding only contemplated the need of resources until 2015, overcoming the hard ageing process expected in Spain after 2020, which could jeopardize the economic sustainability of the system. Second, a triple funding of the LTC system was established involving the central Government, Autonomous Regions and beneficiaries themselves through some degree of co-payment. This triple funding made the system complex, and lead to the emergence of regional disparities. In this sense, coordination between the different Government levels is still a pending subject. The asymmetry of the Spanish regional financing system - most of the expenditures are devolved while revenues are mostly handled by the central Government - does not foster the responsibility and the efficiency of public and private provision. During the last years the central Government has reduced the extent of its co-founding to the SAAD, leaving regional Governments in a difficult financial situation (CES, 2012). Full coordination between central Government and Autonomous Regions is imperative in such aspects as the homogenisation of quality criteria and the functioning of the information system to improve the efficiency of the system.

5 References

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ARENAS DÍAZ, (2011) Sostenibilidad del Sistema Sanitario en España. Revista SEDISA Siglo XXI (Sociedad Española de Directivos de la Salud): Revista nº 23 [see section on key publications]

BANCO DE ESPAÑA (2011), Informe Anual 2010. BdE, Madrid.

CABASÉS HITA, (2002) La financiación del gasto sanitario en España. Valoración del sistema de financiación, medida de la necesidad relativa y equidad." Informes 2010 Economía y Sociedad. Bilbao: Fundación BBVA. [see section on key publications]

CARPIO, M. Y M. Y E. DOMINGO (1996), Presente y Futuro de las Pensiones en España, Ed. Encuentro, Madrid

CES (2010) (Consejo Económico y Social de España). Informe 01/2010. Desarrollo autonómico, competitividad y cohesión social en el sistema sanitario español. [see section on key publications]

CES (2012), La aplicación de la Ley de Dependencia en España, Informe del Consejo Económico y Social, Madrid.

CHANDRA AND SKINNER (2011) Technology growth and expenditure growth in health care, National Bureau of Economic Research, Working Paper n.o 16953, Cambridge, Massachusetts [see section on key publications]

CONDE, J. I., GONZÁLEZ, C. (2012), Reforma de las Pensiones 2011: Una Primera Valoración, FEDEA, Estudios Económicos 01-2012.

IMSERSO (2012), Datos estadísticos del Sistema para la Autonomia y Atención a la Dependencia, Instituto de Mayores y Servicios Sociales. www.dependencia.imserso.es/dependencia 01/index.htm (retrieved october 2013)

MINISTERIO DE EDUCACIÓN POLÍTICA SOCIAL Y DEPORTE 2008. - Resolución de 2 de Diciembre de 2008 Crieterios comunes de acreditación para garantizar la calidad de los centros y servicios del SAAD. [Resolution on common criteria for accreditation and quality assurance of SAAD's centres and services]. Boletin Oficial del Estado (BOE), 3.

MINISTERIO DE SANIDAD Y POLÍTICA SOCIAL 2009. Resolución 4 de Noviembre… sobre criterios comunes de acreditación en materia de formación e información de cuiadadores no profesionales [Resolution 4th November..on common criteria for information and teaching of non professional caregivers]. Boletin Oficial del Estado (BOE), 6.

OECD (2011a), Help Wanted? Providing and Paying for Long-Term care, Parisat www.oecd.org/health/longtermcare/helpwanted (retrieved september 2013)

OECD (2011b), "Pension Fund Assets Climb Back to the Pre-crisis Levels but Full Recovery Still Uncertain", *Pension Markets in Focus*, 8 http://www.oecd.org/daf/fin/private-pensions/48438405.pdf (retrieved october 2013)

PRICE WATERHOUSE COOPERS (PWC), (2013). Informe 15 temas candentes en la sanidad española. [see section on key publications]

PRICE WATERHOUSE COOPERS (PWC), (2011) . Informe 10 temas candentes en la sanidad española.

REPULLO, J. R. (2007): Los instrumentos extracompetenciales para el gobierno del SNS. Derecho y Salud 2007 (nº extraordinario); 15: 11-26

RUBIA VILA, FRANCISCO J. ET AL. (2011) Libro blanco sobre el sistema sanitario español. Academia europea de ciencias y Artes [see section on key publications]

VERA HERNÁNDEZ (2011) Evaluación de políticas públicas, In Bagües, M. et al. (Eds.), La ley de economía sostenible y las reformas estructurales: 25 propuestas. FEDEA, p. 12-18. [see section on key publications]

Annex – Key publications

[Pensions]

IESE (2013), El reparto y la capitalización en las pensiones españolas, Fundación Edad&Vida, June 2013, Barcelona, retrieved from: http://www.edad-vida.org/fitxers/publicacions/Estudio%20pensiones%20E&V_IESE_final.pdf

"Pay-as-you-go and capitalisation in the Spanish pensions"

The report discusses the situation of the Spanish pensions system in an international context. On the one hand it develops a comparative analysis of the main characteristics of the system in relation to those present in other countries. On the other hand it uses an overlapping generations model to simulate the effects of the reform. The model includes some intra generational heterogeneity apart from the consideration of intergenerational heterogeneity in this kind of models.

COMITÉ DE EXPERTOS (2013), Informe del Comité de Expertos sobre el factor de sostenibilidad del sistema público de pensiones Madrid, 7 de junio de 2013

http://www.lamoncloa.gob.es/NR/rdonlyres/BA253188-A40C-47C4-9FCC-06D04C65EC26/238803/informesostenibilidadpensiones.pdf

"Report of the experts committee on the sustainability factor of the public pension system"

This report has been elaborated by an experts committee appointed by the Government in order to develop a particular shape for the Sustainability factor mentioned in the 2011 reform. The experts propose a specific shape for the sustainability factor. In particular, first, an annual updating factor defining the growth rate of all pensions is proposed. It is derived from the equilibrium condition of the system, so that it ensures that the system es near sustainability along the period. In order to smooth the process, the formulas are applied taking into account the observed past and expected predicted value of some key variables during a period. Second, an intergenerational equity sustainability factor adjusts pensions reducing it according to the increase on life expectancy.

[Health care]

ABRILL MARTORELL, F. et al. (1991). Informe Abrill Martorell. Retrieved from:

http://www.consorci.org/accessos-directes/patronal/documents-i-publicacions/articles-i-publicacions-d2019interes/resumen%20informe%20abril.pdf

Report Abril Martorell, recommendations for opening the sector to market

This report revealed the challenges faced by the Spanish Health System and set out alternatives to improve its sustainability and efficiency.

ALTISENT, R. et al. (2012). Profesión médica y reforma sanitaria. Propuestas para una acción inmediata. Retrieved from:

https://www.cgcom.es/sites/default/files/profesion_medica_reforma_sanitaria.pdf

Medical Profession and the health care reform. Proposals for Immediate Action

ARENAS DÍAZ, CA. (2011). Sostenibilidad del Sistema Sanitario en España. Sedisa Siglo XXI (Sociedad Española de Directivos de la Salud): Revista nº 23. Retrieved from:

http://www.riberasalud.com/ftp/biblio/21032012132243sedisa.pdf

The sustainability of the Spanish Health Care System

The article discusses the sustainability of the Spanish Health Care System and sets out a list of recommendations for the future.

ASOCIACIÓN DE ECONOMÍA DE LA SALUD (2013). Sistema Nacional de Salud: diagnóstico y propuestas de avance. Barcelona, October, 2013.

The national Health Care System: analysis and proposals for the future

The book, to be released in October 2013, aims to analyze the performance of the Spanish Health Care System, evaluate the most recent changes in health policies and legislation and, provide a comprehensive list of proposals for health policy reforms.

BELTRÁN, A. et al. (2009). Impulsar un cambio posible en el sistema sanitario. Mackinsey&Company y Fundación de Estudios de Economía Aplicada (FEDEA). Retrieved from:

http://www.observatorioecro.com/index.php/biblioteca.html?task=download.file&fid=110.155&sid=80

Driving towards possible improvements in the health care system.

The Spanish care model has significantly evolved over the past 30 years and today National Health Care System is well positioned as compared to most developed countries. Nevertheless, the system will face important challenges in the coming years related to financial constraints, increased demand for care and, potential shortage of available resources. Urgent structural reforms are needed to ensure system's sustainability in the short and medium run. This report aims to encourage debate on future of the health care system.

CABASÉS HITA, JM et al. (2010). "La financiación del gasto sanitario en España. Valoración del sistema de financiación, medida de la necesidad relativa y equidad." Informes 2010 Economía y Sociedad. Bilbao: Fundación BBVA. Retrieved from:

http://www.fbbva.es/TLFU/dat/valoracion%20financiacion%20gasto%20sanitario_web.pdf

Financing the health care system in Spain. Evaluating financing structures, measuring needs and equities

This report aims to contribute to the debate on the regional healthcare financing system in its three major axes: estimates of public revenues and health spending, the measurement of relative need, and the impact on the equity of the system. The authors show that the

sustainability of the financing system could be threatened in the absence of vertical adjustments reflecting the changing needs of different levels of Government, especially at a time of severe fiscal constraints. Given that the main difficulties the financing system faces are shown to stem from the health spending side, there is need to increase the fiscal co-responsibility of the autonomous regions. Interestingly the authors conclude that health spending growth is determined by technological progress more than by the ageing of the population. The major issues of regional health financing, sufficiency, autonomy and equity, are claimed to be relevant to decide which criteria should be used to build the financing model.

CONSEJO ECONÓMICO Y SOCIAL DE ESPAÑA (2010). Informe 01/2010. Desarrollo autonómico, competitividad y cohesión social en el sistema sanitario. Madrid: Consejo Económico y Social. Retrieved from: http://www.ces.es/documents/10180/18510/Inf0110

Report 01/2010. Regional Development, competitiveness and social cohesion in the health care system. Economic and Social Counil (CES).

This report addresses the state and evolution of the Spanish Health System from the perspective of regional development, social cohesion and competitiveness. The strategic importance of the health sector is emphasized. The CES aims to promote social debate on the challenges that the system may face in the coming years.

GIL, V. ET AL. (2010). Sostenibilidad financiera del sistema sanitario: 10 medidas estructurales para afrontar las causas del crecimiento del gasto. Antares Consulting. Retrieved from:

http://www.antares-consulting.com/uploads/TPublicaciones/c6588ca870017ee857c1e86ac325f514a6fcf5b4.pdf

Financial sustainability of the health care system. 10 structural measures for addressing the causes of continuous expenditure growth.

This report proposes ten structural measures to address the causes of continuous health expenditures growth in Spain. Each measure is described in retail; its relevance is assessed; and, its potential impact is evaluated. The measures are: (i) strengthen the role of evaluation of health technologies; (ii) improve the performance of health professionals; (iii) increase drug co-payment; (iv) develop a model of chronic illness care; (v) create socio-sanitary alternatives to hospitalisations for acute patients; (vi) invest in health prevention and promotion; (vii) increase shared services supply; (viii) reorganize tertiary health care and hospital supplies; (ix) promote patient safety; and, (x) promote ICT health initiatives to accelerate return on investment.

ESPAÑA CORTES GENERALES CONGRESO COMISIÓN DE SANIDAD Y CONSUMO (1998). Consolidación y modernización del Sistema Nacional de Salud: (Acuerdo parlamentario de 18 de diciembre de 1997). Ministerio de Sanidad y Consumo, Centro de Publicaciones, 48 p.

Consolidation and modernisation of the National health care system.

A document containing legislative measures that aimed to promote the consolidation of the NHS.

ORTÚN, V. & CALLEJÓN, M. (2012). La reforma sanitaria. Papeles de Economía Española, 133: 128-139. Retrieved from:

http://www.econ.upf.edu/~ortun/publicacions/PapelesEconEsp2012.pdf

The health care reform. Spanish Economic Papers.

The paper gives clues for understanding the dynamics of technological innovation and expansion of health care spending. Crisis in Spain requires a credible reaction avoiding the chasm between those who can pay and those who cannot. Health care reforms that are needed to improve productivity and strengthen the welfare state are described. In the health reforms are equally important the questions "what" and "how", technical rationality and social legitimacy.

PEÍRO, M. & BARRUBÉS, J. (2012). "Nuevo contexto y viejos retos en el sistema sanitario". Revista Española de Cardiología, 65(7): 651-655.

New context and old challenges in the health care system.

The economic crisis cannot conceal the need for transformation of the National Health System. The financial difficulties of healthcare systems whose spending is growing at a faster rate than the economy have been well known for years. The development and diffusion of new technologies, increased use of health services, rising drug costs, inflation of prices, and the inefficiency of the system explain the new context. The challenges facing the healthcare system are not new: address the debt, improve funding, review the list of services, transform the governance of the system and provide the institutions with real management autonomy. The severity of the economic situation can be an opportunity to carry out the long-awaited changes.

Price Waterhouse Coopers (2013). Diez temas candentes para la Sanidad Española para 2013. Madrid: Price Waterhouse Coopers. Retrieved from:

http://www.pwc.es/es/publicaciones/sector-publico/assets/diez-temas-candentes-sanidad-2013.pdf

Ten burning issues for the Spanish Health Care for 2013

A summary of the annual meeting on the state of the health care sector in Spain and the challenges for the future.

PUIG-JUNOY, J. (2011). "¿Recortar o desinvertir?". Economía y Salud, 72: 2-5.

http://www.econ.upf.edu/~puig/publicacions/Any2011/AES2011.pdf

Cutting the spending or disinvesting in health care?

The article shows the most recent trends in the evolution of public health expenditures and revenues and questions the sustainability of the Health Care System. Two alternative types of reforms are considered – spending cuts versus disinvestment in health care – the advantages and deficiencies of each are discussed. Examples from other developed economies sharing similar health care system organisation as the Spanish one are given.

PUIG.JUNOY, J. et al. (2013). "Paying for formerly free medicines in Spain: Dramatic prescription drops, looking for unanswered questions". CRES working paper 2013/776. Retrieved from:

http://www.upf.edu/cres/_pdf/CRESWP20130776_JPJBGLV.pdf

The paper provides accurate estimates of the overall impact at the regional level of a cost sharing reform on pharmaceutical prescriptions with regional variants established in Spain since July 2012 in the framework of heavy austerity reforms on public financing. The authors estimate the reform's impact on the quantity of dispensed medicines during the first ten months after its establishment. The analyses reveal that the co-payment established in mid-2012 led to a dramatic reduction in the use of drugs whose effect on health is not known. A relevant policy message is that even though the new co-payment is modulated by income, a small percentage of patients support a large part of the expense.

RUBIA VILA, FJ (Coord.) (2011) Libro blanco sobre el sistema sanitario español. Madrid: Academia Europea de Ciencias y Artes. Retrieved from:

White Paper on the Spanish Health Care System

This document analyses the evolution of the Spanish Health Care System during the past century. It lists the main challenges that the system faces at present and contains a number of recommendations for the future.

VERA HERNÁNDEZ, M. (2011). "Evaluación de políticas públicas." In Bagües, M. et al. (Eds.), La ley de economía sostenible y las reformas estructurales: 25 propuestas. FEDEA, p. 12-18. Retrieved from:

http://www.ilo.org/public/libdoc/nonigo/2011/464909.pdf

Evaluation of public policies.

The author points out the under limited budgets and scarce resources, public policy requires evidence of what works, and what does not. Effective evaluation of public policies will inform policy makers and permit improvements in policies and programme implementation and can increase efficiency. The article compares experiences in public policies evaluation from the American continent to the Spanish ones. In addition, it develops a strategy to strengthen evaluation of public policies in Spain. Public policies implementation should start with a pilot phase, at a small scale, allowing assessment prior to the actual implementation at a national level. It is also An Evaluation Agency is should be created, as an independent institution, to participate in the design and supervise the assessment of public policies. The main objectives of such an institution are also described.

World Health Organisation (1999). Health21: the health for all policy framework for the WHO European Region. European Health for All Series No. 6. Denmark: WHO (Regional Office for Europe). Retrieved from:

http://www.euro.who.int/__data/assets/pdf_file/0010/98398/wa540ga199heeng.pdf

This Health for all policy document provides the framework for taking up the challenges of achieving better health by applying the best strategies that have emerged from the Region' s collective experience during the past 10–15 years. The arguments contained within this new policy for the European Region demonstrate the essential relationship between health, poverty

and social cohesion and show how health and health development efforts are now emerging as important factors in contributing to greater social cohesion between and within the populations of the Region. The Health21 policy aims to achieve full health potential for all through promoting and protecting peoples' health along the course of their lives and through reducing the incidence of and suffering from the main diseases and injuries. The documents contains four main strategies for action to ensure that scientific, economic, social and political sustainability drive the implementation of the Health21.

[Long-term care]

CONSEJO ECONOÓMICO Y SOCIAL (CES) (2012), La aplicación de la Ley de Dependencia en España, Informe del Consejo Económico y Social, Madrid. Retrieved from:

http://www.ces.es/documents/10180/106107/preminves_Ley_Dependencia.pdf

The application of the dependency Law in Spain. Report of the Economic and Social Council

The report analyses the application of the dependency Law in Spain since its adoption in 2007. Moreover, an assessment is made of the various reforms that have been undertaken in the system and their possible effects in the short and medium term care for dependants.

This publication is commissioned by the European Union Programme for Employment and Social Solidarity – PROGRESS (2007-2013)
This programme is implemented by the European Commission. It was established to financially support the implementation of the objectives of the European Union in the employment, social affairs and equal opportunities area, and thereby contribute to the achievement of the Europe2020 Strategy goals in these fields.

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