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Letter to the Editor

Reforming Spanish health care: A matter of survival

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Gallo and Gené-Badia report on the most important changes in the Spanish healthcare system as a result of the financial crisis and the preliminary impact of these changes on the health of the population. The authors rightly state that cost reduction has been the chief driving force and that the unpopular measures undertaken so far have not counted with the support of the main actors involved in their implementation, including healthcare professionals and some regional health authorities [1]. Some specific, evidence-based interventions may help readdress the worrying situation of the Spanish healthcare system.

The current situation of the Spanish National Health Service (SNS) may be unsustainable. Spain cannot continue to accumulate deficits while making cuts that may affect the quality of healthcare and health outcomes. In addition to economic woes, the system is imperiled by other elements, including total structural debts, growing chronic illnesses, an aging society, expensive, inadequately evaluated, new technologies, and disproportionate medicalization [2]. With a few exceptions, Spain has not used the crisis as a chance to increase quality and efficiency, reorganize and rationalize health services and recover public confidence and credibility. Therefore, reform is necessary. One way of introducing reform would be to mimic the paradigm of evidence-based medicine: fund what works and cut back what does not. When evidence is robust, act. When it is incomplete, look for better awareness to inform decision-making.

1. Implementing cost-sharing?

In Spain, free access has caused overuse and abuse, with a system responding to patient demands instead of needs [3,4]. One way of generating additional resources while eluding widespread restructuring would be to implement user charges, as is otherwise usual in numerous European Union (EU) countries [5]. The issue of cost-sharing and copayment is, and will be, controversial. Indeed, it may result in worse outcomes for frequent diseases, with patients deferring healthcare because of troubles in fulfilling cost-sharing duties, even in the wealthier EU nations [5–7]. Yet studies suggest that it can work in some situations. For instance, Japan, similar to Spain, delivers widespread outpatient and hospital care through public health insurance. By 2007, 82% of overall health costs were publicly funded by social health insurance and tax transferences. Two cost-sharing charges have been running as of 2001: 10% (formerly 30%) for moderately low-income citizens aged 70 years or older and 30% for people aged less than 70 years. Of note, the reduction from 30% to 10% was associated with physical health improvements, substantial reductions in out-of-pocket expenses, and significant mental health improvements [8].

In USA, mounting health spending led to debating whether cost-sharing tariffs for the Children's Health Insurance Program and Medicaid should be increased. While reports had indicated that low-income families would face high and raising health spending loads if even smallest cost-sharing was incorporated for publicly insured children, a study revealed that unfavorable consequences could be prevented by introducing income-based caps in family spending, which would not affect the estimated health budget savings [9].

Cost-sharing schemes can also encourage the use of good-value healthcare services. Thus, US healthcare insurers commonly reduce cost-sharing tariffs if providers offering better healthcare quality or cost-effective prescription treatments are chosen [10].

However, cost-sharing approaches, if ultimately implemented in Spain, should rely on income, health status, and age, and preferably applied to some unreasonably free healthcare services and therapeutic procedures included in national and/or regional portfolios such as surgical treatment of palmar hyperhidrosis, bariatric surgery and surgical sex reassignment for transgender individuals [11]. In fact, some specific services are no longer financed in a number of European countries (*e.g.* physiotherapy and *in vitro* fertilization in the Netherlands) [12]. People with significant disabilities, chronic patients, low-income groups, pregnant women and children should also be exempted from charges, as occurs in Portugal [13]. Unlike

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Portugal, however, because of the high rate of public health coverage in Spain, citizens should not be charged for the use of services such as emergency department visits, primary healthcare appointments or ambulatory specialist appointments. Furthermore, important public health services such as vaccination programs and family planning should also be provided free of charge.

2. Disinvestment strategies

Because of the potentially negative effects (and unpopularity) of cost-sharing, an accurate appraisal of health interventions' value with decided agreements on resource distribution should be given priority consideration. Funding for interventions with no or small added significance should be withdrawn while allotting the funds to cost-effective, safe interventions. Although the sanctioning components allowing for a disinvestment strategy have been at hand in the SNS for several years, it remains missing from the political pipeline, as it was recently reported by García-Armesto et al. [14] in their analysis of the required tools and the difficulties in implementing a value-for-money scheme in the SNS. As the authors stated, based on international data indicating that 30–40% of patients do not receive treatments of demonstrated effectiveness and that 20–25% receive potentially risky or unneeded treatments, the choices for lessening suboptimal healthcare and ineffective distribution of otherwise insufficient health resources in Spain are high [14].

There are several paradigmatic examples of disinvestment approaches concerning clinical services and public health interventions in different countries such as the UK [15], Australia [16], and Canada [17], which could be used as a useful guide. In the UK, for instance, the National Institute for Clinical Excellence (NICE) has signaled over 800 clinical interventions for potential disinvestment that could indeed result in increased efficiency and quality [15].

3. Strengthening primary care and supporting alternatives to hospitalization

It is also the time to balance the largely acute-based system of care advocating for a clear improvement in the management of chronic diseases, increasing such management in the primary care setting and, at the same time, boosting the use of alternatives to conventional hospitalization. While health expenses are largely relying on growingly prevalent chronic illnesses, whose management is quickly becoming a EU priority [18], hospitalizations are a foremost component of healthcare costs in numerous countries, including the USA [19–21]. Based on the severe restrictions on public healthcare imposed by the Spanish government (and other governments) as a result of the economic crisis [22], preventing needless hospitalizations should be a main concern. As a matter of example, data show that hospitalizations due to chronic obstructive pulmonary disease, asthma and uncontrolled diabetes may be significantly reduced through proper, enhanced management in primary care [18,19,23]. Furthermore, because of the high rates of unanticipated hospitalizations as a consequence of acute decompensations of chronic diseases, especially in elderly patients, which otherwise result in increased health costs and impaired quality of life, cost-effective alternatives to hospitalization, which either replace hospitalizations or shorten lengths of stays, should be actively boosted. Current alternatives to conventional hospitalization for treatment, diagnosis, and follow-up or monitoring of medical disorders (*i.e.* other than palliative care, surgery, and psychiatry) include day centers, hospitals at home, quick diagnosis units, and telemonitoring [19].

4. The role of preventive healthcare

Martin-Moreno et al. [24] in 2010 analyzed the existing literature for clues on how the present crisis may negatively (and positively) affect cancer preventive strategies. Implementation of the human papilomavirus (HPV) vaccination was highlighted by the authors as one illustrative instance of how prevention policies may be restricted by austerity policies. Thus, when the economic recession began, universal HPV vaccination for girls had been officially approved or was in the process of approval in numerous developed countries. Yet budgetary restrictions led some countries such as Ireland to halt vaccination programs, while others sought negotiations for lower prices [24].

Another reported example of disruption of preventive healthcare strategies can be found in Greece, where low provision of preventive services with failures of needle exchange programs since 2008 led to increased HIV transmission rates among injecting drug users in 2011 and 2012 [7]. Moreover, a Spanish study revealed that uptake of the conjugate pneumococcal vaccine, which is only financed for immunocompromised or high-risk children, dropped between 2007 and 2011 in Catalonia, after a quick expansion in former years, most likely as a result of its high cost [25].

Nonetheless, hard financial times such as the current one can be positively and proactively used in the arena of primary prevention and health promotion. Thus, similar to other countries, Spain should tax sugar and trans fats (in addition to increasing tobacco and alcohol taxes) to modify consumer habits and set aside the returns obtained to job-generating disease prevention and public welfare plans [4,18,24]. A perfect combination of motivations – rising of revenue, job generation and health promotion – is often behind these approaches in several countries [7]. As Martin-Moreno et al. argued, "[there] are encouraging indications that prevention efforts hold added value in times of financial crisis. . .[as] individuals give up or reduce certain unhealthy lifestyle habits owing to cost, they may be especially receptive to new and healthier choices. . . [as] governments take steps to repair and rebuild the economic infrastructure, they may be encouraged to examine the long-term sustainability of the health system and the advisability of particular programmes" [24].

5. Shared leadership: the answer?

In their report, Gallo and Gené-Badia rightly assert that it is essential to examine the future of the healthcare system with the active participation of health professionals and citizens [1]. Regrettably, public health authorities