HANDBOOK ON THE POLITICAL ECONOMY OF HEALTH SYSTEMS

21. Political economy of health system reform: evidence from Spain

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1. INTRODUCTION

The Covid-19 pandemic has been a major disruptor of health care systems and has had both conjunctural and structural effects, but it also provides new opportunities to learn from an unexpected shock to the health system. Pandemics are not an unusual feature in modern health care systems, but health systems face a series of complex challenges, including the need to constantly update their coverage and access gaps, and address concerns about a rapidly changing quality of care and workforce shortages, as well as the duty to provide integration and continuity of care, including the epidemiological shift in needs that involve multiple chronic diseases alongside emerging viral threats.

Health systems struggle with growing health costs and the social demands to find ways to bend the cost curve while designing sustainable financing schemes. Technology is increasing the demand for more and better person-centered care, challenging established approaches to service delivery, alongside quality regulation and governance. All of these goals and challenges are conditioned by an aging population and a commitment to universal health coverage. New public health problems call for refocusing public financing of health systems, and rebalancing the State's role in providing health care.

This chapter discusses the political barriers encountered in mainstream health systems that are socially financed, such as national health service (NHS)-type systems. We draw on some of the evidence of the Spanish health care sector as a case study. The Spanish case is especially interesting given the degree of decentralization to cater to territorial diversity in needs and preferences, the nature of government institutions and the frequent confusion in political narratives between public provision and public production of health care services. Furthermore, the human resources of the system are grounded on the civil servant status of its employees, yet it allows physicians to work in both public and private practices (López-Casasnovas & Pifarré i Arolas 2021). This chapter argues that reforming such a system entails overcoming political barriers driven by its unique institutional features.

This chapter follows Hart and Moore (2005) and Roberts et al. (2003) in describing the various issues at stake in health system reform from a unique perspective. We follow an institutionalist political economy approach. That is, we rely on the assumption that an analysis of health care reform requires a careful understanding of the institutional and political constraints that reformers face. We specifically inquire about which reforms are likely to succeed, and what actions can be taken to mitigate potential reform barriers which we describe below.

The chapter puts forward the argument that health care reforms are the result of context-specific institutional advantages resulting from the way political markets operate, which in equilibrium give rise to a certain degree of path dependency. That is, reforms encompass first and foremost the identification of political opportunities considering the political

demand and supply for health policies (Costa-Font et al., 2020). Such political opportunities include the role of constraints or the social barriers to reform, including overcoming ideological, distributional concerns and addressing wider social determinants of health. Political decentralization, both functional and territorial, plays a central role in the Spanish case in steering experimentation and policy innovation and transfer (Costa-Font & Rico, 2006). The Spanish experience suggests that health care reforms in public health care systems need to overcome constraints beyond their broader macroeconomic environment (e.g., economic growth, technological research and development, and industrial activity), along the lines of narratives of inequality and social cohesion. The final part of this chapter discusses the specific factors that may act as health reform deterrents, and some proposals to change the dynamics of how health care systems operate, mainly a stronger attention to outcomes and evaluation.[1]

The rest of the chapter is organized as follows. Next, we outline the main types of health systems. Section 3 discusses the political factors in the public provision of health care, and Section 4 reports on the main drivers and constraints to health care system reforms in Spain.

2. GENETICS OF HEALTH SYSTEMS: MORPHISMS AND POLYMORPHISMS

Public intervention and financing of health systems has given rise to two types of models, namely an NHS or a social health insurance system (SHIS). In an NHS model, health is pursued by "services" managed by an administrative organization with a "national" scope that aims to be cohesive. In contrast, an SHIS model is structured based on a network of diverse suppliers. These health system designs are defined by the following features: they are "systems" in a web of cogs that accommodates this diversity of suppliers and the heterogeneity of the individual affiliations; they play the role of an insurer as they cover a limited range of limited health contingencies; and they are "social," because they need to serve all of society (they do not serve just individuals, they are not actuarially based, they are not adjusted to risk premiums). Both structures, NHS and SHIS, are legitimized through political processes, even when policy proposals are often not met by evidence. For instance, the desired intersectorality of the NHS is often a myth, and the same is true for the elimination of any sign of adverse selection or risks in the SHIS.

Reforms in public health systems should account for the political or bureaucratic processes which are country-specific, the system's capability to manage capital, access to contingency funds and a certain autonomy to anticipate cycles, how data is interpreted and managed, and how health care coordinates with other health services of interest. That said, the distinction between the two systems is not merely semantic; it also has a logic that allows the assignment of the different basic functions of the agents involved for an effective system operation.[2] Two basic parameters also distinguish these functions: the implicit weight assigned to the political and technical components in each of the systems and the management logic that feeds their rationality.[3] The systems could also be distinguished in terms of the balance (between costs and benefits) of priorities. In making policy choices, one should disentangle the tendency to fall prey to political demands which follow an electoral logic, and the management logic grounded on relative needs which tends to reject new policy proposals ("learning to say no").

All the above is a testimony to the difficulty of making health systems comparisons even when one accounts for the idiosyncrasies of their citizens. Benchmarking here seems to be

impossible. In public systems, the debate encompasses the classic Bismarck and Beveridge characterizations of health systems according to their features, and the models that have emerged from them: (i) financing based on direct payment, taxes, social insurance and private insurance; and (ii) the preponderance of the financing criteria with regard to service access and eligibility for use. Thus, regarding what must be understood as the public opportunity for health system reform, one needs to bear in mind the concept of the fiscal burden against the private social cost resulting from public regulation. In general, the genetics of the different systems can be known from verifying how they have arranged the key functions of any health organization in terms of financing and service provision and production. While by no means an exhaustive explanation, what follows is illustrative of a system's "polymers" (networks), "base molecules" (care functions), "cells" (centers) and "proteins" (incentives), enabling us to distinguish between systems that correspond to different trajectories, cultures and ideologies so as to avoid the consideration that the extremes of some are clearly "superior" to those of the rest. For this, the analysis of health systems can give rise to a few basic drivers: (i) those based on regulation, which confer responsibilities on third parties and, subsidiarily, only maintain public social security networks for the poor and the elderly, as in the case of the United States; (ii) those based on public provision and production that are structured in the form of national health services, as already spoken about, and treat health services as simply another administrative service; and (iii) those that opt for the social insurance form of health care, the so-called public provision and private production systems, frequently found in Continental European models.

Considering the above, it is remarkable that, regardless of the historical paths of each health system, health service organizations in the majority of Western countries are undergoing some significant reform, which calls for an understanding of the drivers and barriers to reform.

3. CONSTRAINTS TO THE REFORM OF PUBLIC HEALTH SYSTEMS

3.1 The Goals and Limits of Public Health Care Systems

Implicit in public provision of health care is the idea that health care is both a public responsibility and a financing obligation that must be addressed by the political decision-making process. A more extreme version refers to public production models (care delivery from civil servants), referring to the full integration of the health care value chain, namely when the public sector takes responsibility for every aspect, from planning to production of services as well as the definition and purchasing of the package of health care services and its allocation across the territory. The effectiveness of both public provision and production systems is tied to the possibility of integrating health care with no other obstacles than self-established policy directives and specific regulations and memos driving its implementation. The main advantage of such health systems lies in the role of collective purchasing of health care, which enables keeping costs down, and the pursuit of some uniformity in the provision of health care, even though this entails limited choice, common basic coverage of health care and an exclusive system for monitoring compliance. The latter are the common limitations of such systems.

3.2 The Misalignment of Incentives, Responsibilities and Surveillance

Health systems that rely on the public provision and production of health care have to confront the problems of a widespread misalignment of incentives, responsibilities and the factual management of the system. This feature is the result of the political incentives in place. The political processes produce a unique prioritization of health services, where the definition of specific services and the planning of the different needs (including the specific needs of the most fragile groups) are misaligned. Such unique prioritization results even though political attitudes in society do not show evidence of major disagreement in the needs to be addressed.

The origins of such misalignment can be tracked back to the fact that the political demand for health care is muddled by major institutional constraints such as the separation of health care responsibilities into the remit of different departments (e.g., the department of health, the treasury, the department of social care). Another set of constraints includes features that are more technical in nature, such as the inability of some health systems to define budgets that are specific to each health care program. Similarly, as described in Chapter 14 of this volume by Counts and Ilakkuvan, the demand for certain health programs is heavily influenced by lobbies and interest groups (e.g., the pharmaceutical industry, colleges of physicians), which explains why more efficient health care reforms do not always end up being implemented, or when they do, the implementation might be significantly influenced by the priorities of different interest groups rather than follow the wider public interest.

3.3 Limited Attention to Outcomes

An important limit to health care reforms comes from the relatively weak political influence of departments of health compared to other departments that make up different cabinets. Indeed, the political demand for health care reform often needs to confront the mismatch between health care reform narratives which are grounded on public interest and a population's health objectives, alongside the operational narratives of health care bureaucrats which are very much grounded on health care activity goals. Typically, information systems play very limited attention to how health care reform proposals impact a population's health. That is, the opacity of health care systems based on activity becomes an important limit to the capacity of patient citizens to judge the efficiency of health care reforms, which instead are grounded on improving health outcomes (Costa-Font et al., 2020). Public systems typically face significant barriers in monitoring that guarantees effective access to basic health care to which people are entitled. While traditionally control systems focus on the cost of health care inputs, the logics of health care financing reforms are instead defined incrementally when outcomes are evaluated by each health program.

3.4 Equity in Access as a Barrier to Reform

Another important feature of publicly funded and produced systems is the emphasis placed on their distributional effects. Indeed, "equity" in public health system provision is frequently the ultimate political argument underpinning NHS reforms, even when such equity is frequently inadequately defined, let alone measured or evaluated. However, even when policy proposals are budget-neutral (e.g., the introduction of small and capped co-payments), equity concerns can put a halt to them. Instead, political debates label them as attempts to privatize health care

systems. Prejudices, economic interests, ideological biases and mediocre analysts plague such privatization concerns. Hence, health reforms must take into account the narratives, ideologies and prejudices of each country's policy reform environment (see Theilen, Chapter 13 in this volume; Costa-Font et al., 2021).

The prevalence of equity concerns is pervasive, even though the pursuit of health system equity differs from equality in access or provision of health care because fairness is a principle guiding policy rather than the result of the implementation of a mathematical algorithm. So far, we know too little about whether policy should be based on "equity of access" (not to be confused with equity in health care financing) or equity of outcomes. This distinction is significant because what is accessible is not always consumed, and what is consumed does not always result in the same outcome. The latter can be explained by differences in information access, particularly how rationing by waiting list works alongside a number of non-monetary barriers that are frequently overlooked. Indeed, what is effective in theory is frequently ineffective in individual and actual terms due to other unaccounted constraints (habitat, social support, loneliness, unemployment).

In contrast to egalitarianism in access to care, full egalitarianism in outcomes might not be desirable in a democratic society insofar as it requires a degree of interference in individual decision-making, privileging collective goals above legitimate personal ones, hence restricting individuals' liberties and civic rights. So, often, health policy in NHS systems is content to erect barriers and allow access by "get in line for what is available in the kitchen as many times as you are in the queue."

To understand how "equity" works in health care reform, one must look beyond the role of health care systems in providing financial protection against the catastrophic consequences of health care use. Although the distribution of private health expenditure (resulting from out-of-pocket spending, insurance premiums and co-payments) is easily observable by the patient citizen, it seldom serves as evidence to judge the distributional effects of health system reforms. Private spending analysis is only a proxy inequity if all observed differences in private spending are deemed "inequitable" or as resulting from otherwise "unmet needs." However, this would only hold true if spending does not result from individuals' choice, nor amenities or "wasteful utilization" which do not necessarily reflect an unequal use of the public health system. However, if the health system package of services is the result of a careful financial assessment and prioritization, the private health care expenditure on treatments outside such a catalogue reflects health care of lower value to individuals, and hence likely not to give rise to unfair inequalities.

3.5 Cost-Sharing and Private Practice as a Barrier to Health System Reform

One of the barriers of health system reform lies in the use of co-payments. This is a highly political matter, though as I will argue below, it is based on ambiguous arguments. Certainly, one should distinguish between cost-sharing and the use of user changes. Among the first we find the use of co-payments, for example, on effective treatments where the health system passes its costs down to its users, as is common with regard to new dental or mental health treatments in most public health systems. However, a co-payment exerts a similar effect to a tax deduction on private health insurance to increase the perceived quality of care (see Lucarelli & Pauly, Chapter 19 in this volume), and both refer to public choices regarding what is a "merit good," and whether the patient citizen should pay the full cost of care or get

compensated for services offered at a lower quality of care. However, cost-sharing might well depend on the value of health care to a health system, and hence if a treatment is effective but at a high cost, the system may indeed abolish cost-sharing and regulating health care might be welfare-improving to ensure access by lower-income users.[4] A similar phenomena on the supply side refers to the extent to which physicians should be able to work simultaneously in their private and public practices. The risk with the latter is creating a two-tier system where some individuals have better access to health care by going private.

4. CONSTRAINTS TO HEALTH SYSTEMS REFORMS IN SPAIN

The nature and evolution of the health system in Spain has been characterized by the expansive universalist coverage. Universal coverage is recognized in the 1986 General Health Act, although it existed long before. That said, the economic crisis has occasionally questioned its foundations (the last unsuccessful reform in 2008 tried to limit the amount of coverage given to illegal immigrants). However, for a quality evaluation of the changes undergone by the health system in Spain, one must not get bogged down in conjunctural details. Considering the influence of the abovementioned political and institutional constraints on health system reform, the most outstanding institutional constraints to understand Spanish health system reform include the following.

The Spanish health system is defined by the decentralized nature of its health care organization and a uniform expenditure per capita, which requires self-sufficiency in health care provision irrespective of the size of the autonomous region (even though populations range from 250,000 to 8 million people). The significance of the local demand for health care explains why most regional-level jurisdictions are eager to make their own spending decisions irrespective of their fiscal responsibility (not having to contribute from their own revenues) (see López-Casasnovas, Costa-Font & Planas-Miret, 2005).

Despite its decentralized nature, the health system's autonomy is severely limited by political restrictions and framework legislation regulating the appointment of high-ranking officials, publicly setting caps to professional salaries, and heavy administrative intervention in expenditure processes that is not efficiency-driven. Although the health system is tax-based and follows the steps of an NHS-type system, it is still heavily rooted in a former social security model, whereby health care provision is paid for by affiliated employees, but that since the inception of democracy in the late 1970s offers a universal right to health care.

Regional inequalities are persistent and refer to key dimensions of the service provision across regions (such as access, time and quality). However, such disparities become a double-edged sword, and although politically are presented as a rupture in the social cohesion goals, such narratives ignore the fact that at the same time they are an opportunity for policy innovation compared to a monolithic and unfirm provision of health care (see López-Casasnovas & Rico Gomez, 2000).[5]

Some regional health systems in Spain are rooted in historical pathways and culture, and have been structured alongside service providers other than strictly administrative bodies (such as health foundations, public–private consortiums and some social companies), led by civil society movements. In Catalonia, 60 percent of hospital beds are publicly financed and privately (out of the public system) owned. This is also the case but to a lesser degree in the Balearic Islands, the Basque Country and Navarra. However, empirical estimates suggest

that devolution has not increased regional inequalities, unlike in other health systems such as the UK's (Costa-Font & Pedkins, 2019). Indeed, in Spain one can observe evidence of policy interdependence fostering both collaboration and political differentiation between the central and regional governments.[6] That said, some political discourses in Spain have been designed to report territorial differences in access to services, waiting lists and quality of care. However, they do tend to turn a blind eye to such things existing within regional disparities (López-Casasnovas et al., 2005).

Spanish health care reform is "trapped" in its status quo, which is commonly defined as path-dependent. Consistently with political market behavior, health system reforms have traditionally been defined by interest groups, generally professional corporations, trade unions and a number of key vested interests (industry, academy, policymakers, groups of patients). The final reform of the health system has resulted generally from negotiation and exchange between governments of the same and different levels with specific vested interests. Among them, health professionals are central to the system. Physicians are civil servants who receive salaries that are meagre in comparison with their counterparts in neighboring countries, though in line with median Spanish standards of living.[7] These private–public dual employment arrangements are especially widespread in cities. In the public sector, professionals receive greater recognition from citizens and in some cases benefit from "diverting" the flow of patients towards private practices. Regarding their economic behavior, professionals in the public sector make their decisions while receiving a salary as an employee, thus assuming no financial risk from them. Some jurisdictions have experimented, albeit tentatively, with empowering general practitioners under capitated financing.

The current consensus among all stakeholders is that the Spanish health system is heavily underfunded. However, there is limited consensus on how to attract extra finance to the system, either from taxes, complementary premiums, co-payments or direct prices. Typically, the financing conundrum is solved by raising taxes, as tax payments are perceived as more equitable, while co-payments are classified as regressive financial instruments. All the above is at the root of the difficulty in implementing financial reforms, leaving the system in a situation where the new is thwarted from being born and the old refuses to die (Congreso de Diputados, 2022).

The latter explains why path dependency prevails, and reforms need to confront wider power competition that is grounded on a status quo (Rico & Costa-Font, 2005). This explains the difficulty in making changes (Artells 2014) and calls for balancing out the need of financial sustainability and the joint public and private responsibility. One way to address the latter is by pre-empting the effects of political health care markets, as we discuss in the following section.

5. THE POLITICIZATION OF THE HEALTH SYSTEM

One of the features of the Spanish health system is its extreme politicization right from the outset. Health care managers are usually appointed based on their political affiliation rather than their technical competence, and often lack sufficient standing to drive or redirect actions (López-Casasnovas et al., 2005).

The territorial decentralization is part of the political market for health care. Each regional government tries to place its health managers to serve the purpose of eroding its political adversaries. Coordination among them, and hence with the central government, is harder,

and when it takes place is commonly determined by the political leanings of each regional government. As a result, a coherent health system reform entails large transaction costs and improvisation; not only in determining what actions should be pursued, but also in quantifying its effects and impact.

An extensive decentralization took place after 2001 as a political strategy to water down the differences between territories that since 1981 had been responsible for their regional health care. Indeed, the move was an attempt to implement a more uniform decentralization despite the fact that this would limit policy innovation and best practice diffusion that typically take place when regions engage in "learning by doing." Rather than evaluating the effects of decentralization, regional autonomy and potential inequalities have been placed at the core of the political competition among mainstream parties, irrespective of the existing evidence in place. Hence, health system reform seems to result from proposals of political manifestos, with political narratives according to hidden different interest groups as opposed to being driven by evidence of the impact of decentralization on efficiency or equity. That is, health system reform is limited by the politicization of the system itself.

6. LESSONS LEARNED SO FAR

Although there is wide consensus among policy academics in favor of the need for evaluation, prioritization and cost effectiveness of different reforms, political decision makers tend to prefer the opacity of a limited evidence-based policy, a system based on a "fourth hurdle" where policies are systematically evaluated by health technology agencies. Indeed, they are afraid of facing up to the results of the evaluation, and the analysis of prioritization, possibly judging it as negative discrimination against those who were "non-priority." Similarly, the management of the health systems and specifically the appointment of staff is still subject to several legal barriers which make reform very inflexible. Legality and bureaucratization of the health system prevails over efficiency considerations.

The value assigned to primary health care and public health and the importance of the quality of hospital care entails an improvement of the financing of the health sector. Among the obstacles to this development of health system reforms are the dangers of traditional political responses such as study committees, reports, consultation committees, national observatories, administrative secretaries and national centers of experts (civil servants). Public bodies typically fail to integrate health and social care as well as public health policy goals. A set-up that dilutes more than it concentrates, that passes the ball around rather than taking a shot at goal, which ends up with representatives of the status quo sitting alongside legitimate experts as a result of the age-old need to ensure "that everyone is represented," seeking a consensus that due to the heterogeneity only accepts euphemistic proposals and those involving an increment in resources. The process is at odds with a naïve reliance on commission groups, namely a well-identified group of experts who, with prudential powers (and recommendations of "Do it, or explain why you are not doing it"), make a ruling once the costs and results have been evaluated. For this, a draft of supposed consensuses based on ambiguities is typically not required. Often policy wishes are confused with realities and aspirations acknowledged as being highly unlikely to be satisfied, despite commanding wide support bases.

The Commission for Social and Economic Reconstruction of the Spanish State's upper house of parliament has been gathering recommendations to provide a response to the current

and future challenges of Covid-19 and its innumerable consequences. The initial worry of "it must not happen again" dissipates and the temptation of the economic and political status quo converges in short-termism. The Covid-19 pandemic has made it harder for health system reforms to rely on co-payments and has turned a blind eye to the growing weight of private health insurance and potential inequalities in access to health care. In contrast, cost-sharing arrangements are not "politically" affordable given existing political narratives. Health system reform needs to be redirected, and reform calls for changing narratives and reaching broader consensus where concepts such as "better governance," or "effective management," are not just administrative reforms, but policy goals that are commonly not attained given the reform barriers in place.

NOTES

1. For more extensive detail, see López-Casasnovas and Pifarré i Arolas (2021, 2022).
2. Clearly, we are referring to who must be responsible for (i) health planning, (ii) financing, (iii) insurance coverage and (iv) the purchase and supply of services.
3. In general, a gradient of political and technical content can be established for each function, ranging from planning and financing (much more political) to service provision.
4. At any rate, in a public health system the ultimate responsibility always rests in the hands of political decision makers rather than private insurers. The latter are profit-driven and make a business of improving and complementing the package of care and quality that public health insurance schemes provide, even though private providers might influence the support for the public health systems (Costa-Font & Jofre-Bonet, 2008).
5. That said, Costa-Font and Ferrer-i-Carbonell (2021) show that the decentralization of the public health care system does indeed reduce the use of private health care and insurance, and generally strengthens the use of public health care, and can potentially reduce regional inequalities.
6. Some variants of the public–private collaboration have been adopted in some regions, most notably in the communities of Madrid, Valencia and Galicia.
7. Although with high variance, they are reasonable when adjusted regarding full- or part-time commitment, productivity and moonlighting in private health care.

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