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EDITORIAL

The difficult resilience of the Spanish national health system in the XXI century: decentralization, austerity, and pandemics

La difícil resiliencia del sistema nacional de salud español en el siglo XXI: descentralización, austeridad y pandemias

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The Spanish National Health System (NHS) has suffered in this century a series of shocks, while experiencing a process of weakening and loss of momentum to carry out reforms. It may be useful to review the evolution of the Spanish health system in the last two decades, to understand its its response to the COVID-19 pandemic in the past two years.

The Spanish health system has undergone important changes in the twenty-first century.

The current configuration of the NHS is very recent. In 2002, healthcare centres and competencies were completely decentralized to the 17 Autonomous Communities (AACC), and central earmarked financing for health disappeared, so that each region had its tax capacity and its freedom to prioritize expenses.[1]

Only three years later, in 2005, the Spanish government had to carry out a refinancing operation of the accumulated debt attributed to health care, because the AACC had incurred deficits that were difficult to assume regionally.

Part of the problem of initial financial insufficiency is attributable to the fact that the central government underbudgeted the cost of the services it transferred to the AACC; in the negotiations of devolution, central government took advantage of the asymmetry in information and power to save some hidden costs in the bargaining process.

However, between 2002 and 2009 there was a great growth in health spending promoted by the AACC, fuelled by the extraordinary economic growth of those years; the credit and housing bubble that promoted the Great Recession also provided extraordinary financing to regional and local governments.

In contrast to the technocratic frugality of the old Social Security health administration (*Instituto Nacional de la Salud* –INSALUD-), the new political authorities of the Autonomous Communities assumed a more expansive management model, with not few examples of technical naivety and local clientelism.

There were also improvements attributable to the regional management of health, for its proximity and its adjustment to local needs and preferences. However, the NHS, as a whole, loses density and capacity for cooperation.

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The dysfunctions of the decentralization process.

A new balance was quickly created, based on the power-sharing of the ''State of Autonomies in health'', in which the lack of effective mechanisms of collaboration, and the weakening of the leadership role of the central authority, led to a loss of cohesion. Moreover, this situation favoured the emergence of opportunistic behaviours and the increasing politization of any proposal or problem in the health system.

The late attempt to regulate and enhance cohesion and coordination was of little value: the genius of decentralization had escaped from the lamp and no longer wanted to return; and, in addition, even the central government found the new balance more convenient and rewarding, because it had detached itself from inflationary and conflictive sectors such as health, education and social services. However, as the economic and public health crises would later show, the problems related to the health of the population ended up returning to the Spanish central government.

Nevertheless, with the motto ''*healthcare is devolved*'' the government of Spain after 2002 passed the problems to the AACC, while reducing the personnel and downsizing the Ministry of Health and its national institutions and agencies. The AACC exercised their power without allowing interference from the national level but taking advantage of the fact that the debts accumulated in suppliers put pressure on the central government to implement new financial rescue operations.

In this ambiguous scheme, which fostered opportunism, the ''*comfortable state of unrest*'' was consolidated: all institutions and agents could endorse the blame to a third party and avoid their own responsibility.

End of the expansionary cycle and beginning of the sufficiency problems

In 2008 the Great Recession began, whose effect on the health sector was noticeable from 2009. Here the most serious problems for the NHS begin. Although its effect did not have significant consequences on morbidity and mortality, it clearly affected the healthcare structure and NHS services.[2]

This great economic and fiscal crisis from 2008 to 2014 that Spain suffered, promoted a recentralization that imposed austerity at the regional and local level, regulated some limitations on health coverage, and expanded co-payments in medicines.[3]

Budget cuts particularly affected staff and investment; public employees were reduced; wages were frozen and weekly working hours increased. The deterioration particularly affected primary care, where the quality of employment and working conditions worsened rapidly.

There was a growing disaffection of young doctors and nurses; some migrated to other European countries, and many others lost the intensity of the commitment that had been had by the pioneering cohorts of professionals who had led the reforms of the 1980s, within the transition to democracy. The massive staff retirement that is announced in the next two decades, raises with greater urgency the worries for this generational relief.

Between 2014 and 2019, the recovery in public health spending was lower than economic growth. The Spanish NHS, uncoordinated, impoverished, and demoralized, faced in worse conditions the great shaking of the COVID-19 pandemic.

The pandemic arrives in Spain

The pandemic erupted brutally in March 2000, creating an unthinkable situation of morbidity and mortality, the collapse of much of the health network and damage to health professionals who had to care for patients without the necessary means of protection against infection.

The first wave of COVID-19 was contained thanks to the harsh confinement measures of the population, the vigorous care response of the NHS and its professionals, and the commitment of caregivers of institutionalized old people.

Citizens expressed their gratitude for the huge effort and sacrifice of health personnel; they placed a great example of commitment and self-organized responsiveness. The health system, despite its weaknesses, was very resilient to the onslaught of the pandemic (it bent but didn't break).

No one anticipated the long duration of the pandemic, but at the end of this first wave (mid-2020) there was a broad consensus that health was a precondition for the economy. For this reason, the Spanish Parliament created a Commission for Social and Economic Reconstruction that in July 2020 approved by a large majority a package of reforms to revitalize the NHS and address the main dysfunctions that had been evidenced.[4]

Successive waves are weakening the resilience of the NHS

The following waves of COVID-19 were stress tests of increasing hardness: the physical exhaustion of health personnel was combined with lower social involvement: there was a ''pandemic fatigue'' of the population and political leaders, which highlights the loneliness of health workers in the face of cyclical increases in the use of services.[5]

Although the collapse of the first wave was not reproduced, the delays were accumulated in non-COVID patients. Private healthcare began to grow in the face of increasing waiting times, and the difficulty for getting medical appointments.

The year 2021 lived around vaccination as a tool for everyone to return to dear old normality. Political life became more tense, and conflicts arose between administrations of different policy options on vaccination policies and on decisions on limiting social interaction and mobility.

The central government tried to recover the initiative and assumed a new leadership before the authorities of the AACC, under the new term of ''co-governance''. But there was a great mutual distrust at the prospect of deconcentrating difficult and unpopular decisions. The legal battle over the government's ability to limit citizens' freedom implied that many Public Health measures must be previously submitted for approval of the of the Courts of Law to be implemented.

The sixth wave due to the omicron variant of the COVID-19 virus brought a collective frustration: its transmissibility

broke the illusion of a herd effect through vaccination and disease, and its ability to mutate led to mistrust that the sixth was to be the last wave.

The short-sighted of developed world, and its unsupportive abandonment of global immunization, creates reservoirs and opportunities for new variants to be incubated in large areas of the underdeveloped world.

Divergent visions in the twilight of the sixth wave

The vision of the society and the health system begins to diverge; public opinion seems to get used to paying a price of illness and death and accepts well the story that omicron is milder and that it could be considered as a flu (the so-called ''*flu-reshaping*'' of the pandemic).

In health services, particularly in primary care, emergencies and critical care, situations of overflow and collapse are reproduced, and a strong demoralization is spreading due to the lack of awareness in society and in institutions of the seriousness of the problem; many health professionals consider they are getting alone in the face of COVID.

In 2022 it is not clear that the resilience shown by the National Health System will be maintained; some things that had been bent have begun to break:

Firstly, the primary care crisis is the most visible, and possibly the most serious, expression.

Secondly, the growth of private health is also very worrying because it is driven, and is a symptom of the saturation, deterioration, and misgovernment of public health.

And thirdly, the lack of reformist spirit in politics to promote an agenda of changes that overcome problems and dysfunctions is possibly the most troubling dimension that can put at risk the sustainability and solvency of the NHS.

From the perspective of medical professionalism, we must contribute to restore the deep wounds inflicted on the NHS by the economic and public health crisis, as well as to resolve the dysfunctions that those crises have shown. And we should do it from knowledge and persuasion. In the midst of the hopelessness and confusion of many, and the opportunism and greed of not a few, health workers must continue to preach by the example and the voice the enduring values that animate our life in society, and that are the same that give strength to the millenary Hippocratic commitment to the patients, to the society and to the good science.

The space for a reformist agenda in the NHS

Despite the above, there are some important levers that can be used to open room for reforms, and that have been generated in the last two years of the pandemic. The awareness that a good health system protects the economy and well-being of society; the widespread awareness that there are serious but solvable dysfunctionalities in the existing organizational model; and the already mentioned document approved by the Spanish Parliament for social and economic reconstruction, which marks a series of lines of strategic change with a broad political, institutional, social, and professional consensus.

From here on, more than a crisis of ideas, we are facing a crisis of implementation. The NHS must remain high on the public and political agenda. The war in Ukraine and the slowing of the economic recovery do not help to deepen this reformist agenda. That is the reason why it is necessary to launch a dedicated and lasting advocacy from civil society and professional organizations to promote and sustain the lines of reform.

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