The financial crisis and health care systems in Europe: universal care under threat? Trends in health sector reforms in Germany, the United Kingdom, and Spain

Crise financeira europeia e sistemas de saúde: universalidade ameaçada? Tendências das reformas de saúde na Alemanha, Reino Unido e Espanha

Crisis financiera y sistemas de salud europeos: ¿universalidad amenazada? Tendencias de las reformas de salud en Alemania, Reino Unido y España

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Abstract

The paper analyzes trends in contemporary health sector reforms in three European countries with Bismarckian and Beveridgean models of national health systems within the context of strong financial pressure resulting from the economic crisis (2008-date), and proceeds to discuss the implications for universal care. The authors examine recent health system reforms in Spain, Germany, and the United Kingdom. Health systems are described using a matrix to compare state intervention in financing, regulation, organization, and services delivery. The reforms' impacts on universal care are examined in three dimensions: breadth of population coverage, depth of the services package, and height of coverage by public financing. Models of health protection, institutionality, stakeholder constellations, and differing positions in the European economy are factors that condition the repercussions of restrictive policies that have undermined universality to different degrees in the three dimensions specified above and have extended policies for regulated competition as well as commercialization in health care systems.

Universal Access to Health Care Services; Health Care Reform; Health Policy

Resumo

O artigo analisa tendências de reformas de saúde contemporâneas, em contexto de forte pressão financeira, resultante da crise econômica iniciada em 2008, em países europeus com sistemas nacionais de saúde (modelos bismarckiano e beveridgiano) e discute suas consequências para a universalidade. São analisadas reformas recentes na Espanha, Alemanha e Inglaterra. Para descrição dos sistemas de saúde, utiliza-se matriz comparativa da intervenção estatal no financiamento, regulação, organização e prestação de serviços. O exame das repercussões das reformas sobre a universalidade é realizado com base em três dimensões: amplitude da cobertura populacional; abrangência da cesta de serviços; nível de cobertura por financiamento público. Modelos de proteção em saúde, institucionalidade, constelação de atores e posição na economia europeia diferenciados condicionaram as repercussões das políticas restritivas. Elas afetaram a universalidade nas três dimensões, com distinta intensidade nos países, e aprofundaram políticas prévias de competição regulada e comercialização.

Acesso Universal a Serviços de Saúde; Reforma dos Serviços de Saúde; Política de Saúde

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Immersed in their worst economic crisis since World War II (comparable to that of the 1930s) [1,2], European Union member countries are suffering major financial pressures on their universal health systems. Following the international banking crisis of 2008 triggered in the United States (and resulting from deregulation of the financial market in recent decades), the financial crisis sparked a widespread recession in 2009. Since then, Europe has suffered a crisis with heavy indebtedness and public deficits resulting from government takeover of private bank debts, rising and spreading interest rates in the different European states, and fiscal austerity measures [2,3]. European governments used public funds to bail out their financial systems, transferring private bank debts to the public debt, even while the economic recession (with rising unemployment) caused a drop in government revenues [2,4]. This process led to deficits in public budgets and the so-called "public debt crisis".

With the aim of stabilizing the European financial system, a fiscal pact and financial stabilization fund were negotiated to support the countries in crisis. Under the fiscal austerity pact, European Union member countries committed to a sustained reduction in their deficits and greater budget discipline to "consolidate" their public budgets [1,2]. Drawing loans from the stabilization fund, the countries submitted to an austerity and adjustment program that included measures to restructure the labor market and their financial, fiscal, social security, and health systems, along with unprecedented budget cuts in various social programs [3,5]. During this process, international agencies have intervened directly in national health policies [6].

The current article aims to analyze trends in the contemporary health system reforms in a context of heavy financial pressures stemming from the economic crisis (2008-date) in European countries with universal health systems (Bismarckian and Beveridgean models) and to discuss their immediate and potential consequences for universal coverage. We analyze the recent reforms and principal characteristics of the health systems in Spain, Germany, and England.

The crisis affects the European countries to different degrees and in different ways, depending on each country's capitalist development model and corresponding welfare state regime, with distinct interactions between growth policies, labor market institutions, and social sectors [2], the correlation of political forces, and countries' differential insertion in the single European market. However, by taking excessive public indebtedness resulting from the banking crisis as the cause of the crisis, the single recipe of the European agencies is a fiscal austerity program that affects social policies and impacts health reforms [5].

European health systems are already showing repercussions from the economic crisis and fiscal austerity policies. In 2010, in various European countries, real per capita health expenditures decreased, reversing a persistently upward trend (4.6% per year in the previous decade) [7,8]. The economic crisis also impacts access to health services and the population's health status, with an increase in suicides, homicides, mental disorders, and drug abuse in the most heavily affected countries [9,10,11].

Methodology

Comparative analysis of countries is a traditional approach in political science that has been widely used for some time to study regimes and institutions. In the social policy field, it allowed identifying welfare state regimes, as in the classical studies by Titmuss [12] and Esping-Andersen [13]. In public policies, it is common to compare structures and institutions for operational purposes and (more recently) to identify performance determinants [14].

In health, comparative policy analysis has evolved in recent decades, moving away from simple performance classifications and ranking of health systems between countries, viewed with increasing skepticism [15], towards studies aimed at a more in-depth understanding of the conditions under which given changes occur: what works, where, and why [16].

Case studies are still the cornerstone of comparative research, and the trend among comparative scholars is intensive analysis of a few cases, since it allows a comprehensive understanding of the theme under study and the multiple interrelations between the observed phenomena [14,17]. In health policies, the best comparative studies analyze a few cases and examine a specific theme based on a common structure or matrix, and/or a main theoretical question [18].

For the current study, three cases were selected that exemplify European countries with universal health systems: Germany, Spain, and the United Kingdom. These countries differ in their welfare systems and in the organization of their health care systems, and are subject to different financial pressures from the European crisis. During the pre-crisis period, they were similar in their high economic and social development with an expanded social protection system, universal health coverage with public financing, and

public financing exceeding 75% of total health expenditures. The three countries share excellent health indicators and an analogous epidemiological situation and face similar demographic pressures and prevalence rates for chronic diseases (Table 1).

The selected cases allow comparing reforms in the face of the crisis and trends in countries with distinct modalities of health protection and health system organization. The study assumes that differences in health sector institutionality and the countries' positions in the European financial crisis condition the impacts on their respective health systems [18].

As a tool for comparison and analytical description of the health systems, a matrix was developed that contemplates the dimensions of state intervention in health as suggested by Immergut [19] and the corresponding categories: financing (share of different sources of financing, trends in public financing, copayment, modalities of resource allocation); regulation (insurance, services package and incorporation of medical technologies, relations between financers and providers, payment systems); and health services organization and delivery, grouping ownership of services and health employment (supply and organization of primary outpatient and specialized care, hospital care, share and role of public and private providers, management modalities, employment modalities, changes in public-private relations in the delivery of services).

The analysis of how health system reforms impacted universal coverage was based on the model proposed by the World Health Organization (WHO) [20], including three dimensions of universal coverage: (i) breadth of population coverage by social health protection (variations in the insured population and rules for inclusion); (ii) depth of the package of services (changes in the package, rationing measures, variation in supply); and (iii) height of coverage by public financing (proportion of health spending covered publicly, trends in public expenditures, and changes in copayment).

The sources of information and techniques included: document analysis of reforms and legislative bills (2008-2012), secondary data from the Organization for Economic Cooperation and Development (OECD) Health Data, and statistics from the European Union and individual countries' information systems. A review of the recent literature was performed to monitor the current reform processes, including the gray literature and press articles, since they examine processes under way, without the delay involved in publishing analytical articles in scientific journals. They provide valuable additional sources of information for analyzing contemporary political processes [21].

National health systems from a comparative perspective

Germany, England, and Spain have different welfare regimes [13,22], and in health they represent two main modalities of state intervention: Bismarckian social insurance and Beveridgean national health service models (Table 1).

In Germany, social health protection is guaranteed by compulsory Social Health Insurance, depending on participation in the labor market and solidarity contributions by workers and employers in proportion to wages [23] and currently covering 89% of the population. In the United Kingdom, the National Health Service (NHS), created in 1948, with universal access based on citizenship and tax-based financing, guarantees free coverage to the entire population, using a traditionally single and centralized structure. However, the NHS-UK was decentralized in 2004 to the four countries of the United Kingdom, and the current NHS of England, Scotland, Wales, and Northern Ireland display some distinct characteristics [24]. Therefore, the case analyzed in this article is NHS-England. In Spain, after a prolonged dictatorship, the 1978 Constitution provided the universal right to health care, and 1986 witnessed the creation of the Sistema Nacional de Salud, or National Health System (SNS), with tax-based financing and universal access, decentralized to the 17 Autonomous Communities (State level) [25,26,27].

Financing

Financing is predominantly public, with distinct sources and characteristics in the three countries, summarized in Table 2. Resource allocation displays different dynamics. In Germany, a Health Fund of the Gesetzliche Krankenversicherung (GKV), created in 2009, combines all the contributions collected by the Sickness Funds and redistributes them on a risk-adjusted per capita basis using age, gender, and presence of 80 diseases among the insured population in each Fund [28]. Allocation between sectors results from negotiations between Sickness Funds and organizations representing providers according to sector of care.

In Spain, the responsibility for health care has been fully transferred to the Autonomous Communities (CCAA) since 2002, and health care financing has been integrated into general

Table 1

General characteristics of selected case countries: Germany, Spain, and United Kingdom.

Countries	Germany	Spain	United Kingdom
Capitalist model	Coordinated market economy or "social market economy".	Coordinated market economy, in transition to liberal model.	Liberal market economy.
Welfare state regime [22]	Corporatist conservative/merit-based regime. Less de-commodification and greater family participation than in the Social-Democratic model. Based on social insurance with right to access conditioned on participation in the labor market, previous contribution, and equivalence between contributions and benefits with maintenance of differential statuses.	Post-dictatorial regime. Recent tradition of government intervention in social services, fragmentation, strong family influence, lower social benefits in comparison to other European countries, participation by private sector, Catholic tradition, and permanence of patrimonialist relations.	Residual liberal regime. Low de-commodification, reduced income redistribution, focus on poverty relief, and access to benefits by means tests. Exception: NHS, with universal access.
Social health protection model	Statutory health insurance financed with mandatory social contributions proportional to wages with no relationship to risk. Established in 1883.	National health service with universal access and tax-based financing. Established in 1986.	National health service with universal access and tax-based financing. Established in 1948 [24].
Year of entry into the European Union	1951	1986	1973
Parties/coalition in power in 2000s	1998-2005: Social-Democrat/Green. 2005-2009: grand coalition (Christian Democratic-Social Democratic). 2009: Conservative/Liberal.	1996-2004: Conservative (PP). 2004-2011: Social Democratic (PSOE). 2011: Conservative (PP).	1997-2010: Social Democratic/New Labor 2010: Conservative Liberal.
Per capita GDP in ppp US$ (2010) *	37,567	32,076	35,917
Population in millions (2010) *	82.805	45.289	64.757
Percentage of population ≥ 65 years *	20.4	17.0	16.0
Life expectancy at birth (2010) *	80.5	82.2	80.6
Men	78.0	79.1	78.6
Women	83.0	85.3	81.1
Infant mortality (2010) *	3.4	3.2	6.1
Maternal mortality/100,000 live births (2010) **	5.5	4.1	5.0
Three leading causes of death % (2009)	1st: cardiovascular diseases (41.7%) 2nd: cancer (26.0%) 3rd: respiratory diseases (7.4%)	1st: cardiovascular diseases (31.7%) 2nd: cancer (26.9%) 3rd: respiratory diseases (11.4%)	1st: cardiovascular diseases (32.5%) 2nd: cancer (28.0%) 3rd: respiratory diseases (13.8%)
Stroke mortality in men/100,000 (2010) [8]	38	38	43
Breast cancer mortality in women/100,000 (2010) [8]	24.0	17.7	24.5

* Organisation for Economic Co-operation and Development. Country statistical profiles 2012. http://www.oecd-ilibrary.org/economics/country-statistical-profiles-key-tables-from-oecd_20752288 (accessed on 04/Feb/2013);
** Organisation for Economic Co-operation and Development. StatExtract: 2013. http://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT# (accessed on 04/Feb/2013).

Table 2

Financing of national health systems in Germany, Spain, and England.

Characteristics	Germany Gesetzliche Krankenversicherung (GKV) Statutory Health Insurance	Spain Sistema Nacional de Salud (SNS)	United Kingdom/England * National Health Service (NHS)
Public spending on health (% GDP) **, ***			
2005	8.0	5.6	6.7
2008	7.9	6.3	7.3
2010	8.6	6.9	8.0
2011	8.4	6.6	7.8
Public spending on health (% of total expenditure) **			
2000	79.5	71.6	79.1
2005	76.6	71.0	80.9
2010	76.7	74.2	83.5
2011	76.5	73.0	82.8
Per capita public spending on health in ppp US$ **			
2000	2,130	1,101	1,446
2005	2,577	1,614	2,206
2008	3,037	2,169	2,593
2009	3,250	2,314	2,819
2010	3,331	2,267	2,857
Total health spending (% GDP) **, ***			
2000	10.4	7.2	7.0
2005	10.8	8.3	8.3
2010	11.6	9.6	9.6
Financing model	Social contributions, proportional to wages (15.5%) unrelated to risk: 8.2% workers; 7.3% employers.	Fiscal resources decentralized to CCAA (progressive taxation).	Fiscal resources (progressive taxation).
Principal sources/agents (2010) [24,28] **			
Fiscal resources	6.7	69.2	67.9
Social security contributions	70.5	4.6	15.3
Private insurance	9.6	5.7	2.9
Out-of-pocket	12.4	20.2	11.1
Copayment in public system/ social insurance	10 Euros per day for hospitalization, maximum 28 days; medicines, health transportation, and other means from 5 to 10 Euros; maximum burden 2% of family income and 1% for chronic patients; partial subsidies for dental prostheses; Exempt: children up to 18 years and pregnant women.	Until 2012: medicines 40% of sales price and 10% for some chronic conditions, exemption > 65 years.	Medicines, treatments, and dental prostheses. 50% of population exempt: > 60 years, children, pregnant women, low income.

(continues)

Table 2 (continued)

Characteristics	Germany Gesetzliche Krankenversicherung (GKV) Statutory Health Insurance	Spain Sistema Nacional de Salud (SNS)	United Kingdom/England * National Health Service (NHS)
Financial transfers/ Resource allocation	A Social Health Insurance Fund combines the levied social contributions and redistributes them among the GKV Sickness Funds on a per capita member basis, weighted by age, gender, and illness (80 health conditions). Allocation between sectors: annual negotiations between corporate stakeholders by sector of care.	Health resources part of overall transfers to CCAA, non-binding, structured in Essential Public Services Guarantee Fund and Global Sufficiency Fund.	Transfer to CCGs, previously PCTs, by weighted capitation: per capita adjusted by demographic, epidemiological, socioeconomic, and health inequality factors.

CCAA: Autonomous Communities; CCGs: clinical commissioning groups; PCTs: primary care trust; GDP: Gross Domestic Product.
* Numerical data refer to the United Kingdom and to the specifications of NHS-England;
** Organisation for Economic Co-operation and Development. Country statistical profiles 2012. http://www.oecd-ilibrary.org/economics/country-statistical-profiles-key-tables-from-oecd_20752288 (accessed on 04/Feb/2013);
*** Organisation for Economic Co-operation and Development. StatExtract: 2013. http://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT# (accessed on 04/Feb/2013).

non-binding Federal transfers, calculated on the basis of demographic criteria and public services to be covered [29].

In England, transfers to the decentralized agencies of the NHS responsible for hiring services (health authorities, subsequently "primary care trusts" or PCTs, and since 2013 the "clinical commissioning groups" or CCGs), are based on a "weighted capitation" formula for equitable resource allocation: per capita allocation adjusted by demographic, epidemiological, socioeconomic, and health inequality factors (Table 2) [24].

Regulation

Market-oriented health reforms in recent decades have posed new challenges for state regulation and have been accompanied by the creation of specific agencies for the task [30]. Regulation of health protection and the health system in the three countries occurs in different ways, in addition to the respective national legislative processes. In Germany, the decision-making process is shared among corporate organizations with public functions, the Federal government, and the 16 States. Health sector regulation is traditionally of the meso-corporatist type, according to which the government delegates regulation of a given sector of society to the stakeholders immediately involved in that activity. Federal legislation defines the structural conditions, while the competencies for their materialization are delegated to the stakeholders, namely representative organizations of the Sickness Funds, and providers, especially the Associations of Accredited Phisicians (KVen) and the Joint Federal Commission of Sickness Funds, Physicians, and Hospitals (G-BA) [31].

In England, the NHS was traditionally regulated by the Department of Health, which both financed the system and regulated resource allocation and delivery. Beginning with the establishment of the internal market in the 1990s, a series of independent agencies with specific regulatory functions were created and successively restructured, featuring the National Institute for Health and Care Excellence (NICE), Monitor, and Care Quality Commission (CQC) (Table 3) [21,30,32].

Regulation of Spain's SNS occurs mainly through national and State legislation and government agencies: Ministry of Health, Inter-Territorial Council of the SNS, and the Consejerias or Boards of Health and Health Services of the 17 Autonomous Communities or CCAA (States). The Federal government, through the Ministry of Health, is responsible for setting basic standards and requirements for the functioning and coordination of the SNS and for guaranteeing equity. The 17 Regional Health Systems organized by the CCAA are autonomous and report to their local parliaments [27].

In the three countries, the guarantees for entitlement and population coverage are regulated

Table 3

Regulatory characteristics of the national health systems in Germany, Spain, and England *.

Regulation	Germany Gesetzliche Krankenversicherung (GKV) or Statutory Health Insurance	Spain Sistema Nacional de Salud (SNS)	United Kingdom/England * National Health Service (NHS)
Predominant form of regulation	National legislation and meso-corporatist regulation through organizations with public functions, representing sickness funds and providers.	National and State legislation, and by government agencies: Ministry of Health, Inter-Territorial Council, Consejerias de Salud e Servicios de Salud of the 17 Autonomous Communities.	National legislation and independent specialized agencies: National Institute for Health and Care Excellence (NICE), Monitor, Care Quality Commission (CQC).
Population entitlement and coverage [64]	Compulsory social insurance linked to participation in the labor market. GKV 146 sickness funds in 2012. Covers 89% of the population (2011).	Universal access for citizens and residents. Coverage of 99% of the population (2011). SNS with 17 Community Health Services (State).	Universal access for citizens and habitual residents. NHS 100% of the population.
Private insurance coverage	11% substitutive (4.4% public employees).	13% – additive/duplicate (5% substitutive for public employees)	13% – additive
Package covered	Deep at all levels of care. Includes nearly all available diagnostic and therapeutic measures; sickness compensation; uniform coverage between sickness funds; no predefined package.	Deep at all levels of care; a portfolio of common services is defined, to be guaranteed in all the CCAA; limited dental care; variations between CCAA.	Deep at all levels of care; guaranteed comprehensive care, no predefined package.
Regulation of package of services and incorporation of technologies	Joint Federal Commission of the GKV: corporatist, consisting of representatives of the sickness funds, physicians, and hospitals; supported by the Institute for Quality and Efficiency of the Health System (Institut für Qualität und Wirtschaftlichkeit im Gesundheitswesen-IQWiG)	Ministry of Health supported by the Inter-Territorial Council of the SNS consisting of the 17 Health Council Members of the CCAA, and prior assessment by the Agency for Health Technology Assessment of the "Carlos III" Institute of Health and the Spanish Network for Health Technology Assessment.	NICE recommends clinical guidelines and defines whether new procedures/ treatments should be made available by the NHS based on cost-effectiveness analyses. Develops guidelines for the use of technologies; clinical practice guidelines for appropriate treatment of specific diseases; health promotion guidelines.
Regulation of the relationship between financers and providers	Collective (and selective) contracts between sickness funds and corporate organizations of providers in each sector of care: Associations of Accredited Physicians, Associations of Accredited Dentists, associations of hospitals, pharmacies, midwives, pharmaceutical industry, etc.	Relationship between the Consejería de Salud (financer) and the Regional Health Service (provider) regulated by a program contract (goals-based management system), reproduced at the various management levels: between the Regional Service and the Area Management Bodies, and between these and their health centers and hospitals.	Service commissioning contracts between PCT/CCG and providers. CQC: sets standards and monitors safety and quality of services. Monitor: regulates Foundations Trusts, licenses providers, regulates competition between NHS providers (any qualified provider) and sets prices.

CCAA: Autonomous Communities; CCGs: clinical commissioning groups; PCTs: primary care trusts.
* Numerical data refer to the United Kingdom and to the specifications of NHS-England.

by national legislation, and services coverage is comprehensive at all levels of care. The incorporation of new services and technologies tends to be regulated by specific agencies (Table 3).

Relations between financers and providers are regulated by different mechanisms in the three countries. In Germany, relations are regulated corporately by collective bargaining (with some selective contracts) between Sickness Funds and providers, organized representatively in Associations in each of the health care sectors: accredited physicians, accredited dentists, pharmacies, midwives, as well as directly with the pharmaceutical industry.

In England, with the creation of the internal market and separation of roles between financing and delivery in the NHS, primary care organizations took over the planning, commissioning, and service procurement roles and began to establish contracts with providers of specialized care. Such primary care organizations have assumed different formats over time: in the 1990s, some GP-Fundholders; from 2003 to 2012, the PCTs grouped all the GPs (general practitioners) in a given area, and since 2013 the CCGs were created. Relations between CCGs and other providers are currently regulated by the new health authority, NHS-England, which authorizes, hires, and monitors the clinical commissioning groups (CCGs), transfers resources, and commissions primary care services and part of the higher-complexity specialized care, replacing the previous strategic health authorities. CQCs set standards and monitor safety and quality of services. The Monitor licenses providers, sets prices, and regulates competition between NHS providers [24,33].

In Spain, the health authority in each CCAA is the Consejeria de Salud, responsible for individual and collective health policy by establishing, regulating, and planning the Autonomous/Regional Health Service, which adopts different management formats in the various CCAA. Its attributions include health services delivery and management and coordination of networks. The relationship between the Consejeria de Salud (financer) and the Autonomous/Regional Health Service (provider) and between the latter and each health area management tier is regulated by a program contract: a goals-oriented management system that defines the budget, an assessment model, and incentives to strengthen strategic lines of action [26].

Organization and delivery of services

The state's social protection models and territorial arrangements in each country condition the organization of their health care systems. Germany's Social Health Insurance does not deliver services directly, but contracts them out to public or private providers organized in corporate entities, without regionalization or territorial organization of the network. In the national health services in England (unitary) and Spain (decentralized to the States), the predominant format is the system's own providers with a tradition of regionalized and hierarchical territorial organization of services networks, strong primary care, and general practitioners in the gatekeeper role. Table 4 summarizes the main characteristics of the system's organization and outpatient and hospital care in the three countries.

The three country cases differ as to characteristics of the hospital sector. In Germany, the Sickness Funds establish contracts with each hospital and pay for their users' hospitalizations based on a system of prospective, diagnosis-related payment (adapted DRG). Nearly all of the hospitals in Germany are hired by the all Sickness Funds, with the supply distributed between public (49%), charity (35%), and private providers (17%) [28].

In the English hospital sector, the establishments are predominantly public (95%), although they have gradually assumed greater management autonomy (trusts), and the physicians are salaried employees of the NHS [24].

In Spain, 84% of the general hospital beds are public and 81% of hospitalizations are financed by the SNS, of which 92% provided by public hospitals [34]. Each health area, with a population of 200 to 250 thousand inhabitants, has at least one general hospital in charge of admissions, specialized outpatient care, and emergency services. Most hospitals are still under direct public administration with a program management contract with the CCAA Regional Health Service [26].

Financial crisis and health reforms

In recent decades, facing economic, demographic, epidemiological, and political pressures, health systems in European countries have undergone repeated reforms. Particularly in the 1990s, accompanying neoliberal economic policies, widespread reforms were implemented, introducing market mechanisms to increase competition in public health systems, with different results between countries, conditioned by the institutional legacy, traditions of state interven-

Table 4

Organization and provision of services in the national health systems of Germany, Spain, and England.

Characteristics	Germany Gesetzliche Krankenversicherung (GKV) Statutory Health Insurance	Spain Sistema Nacional de Salud (SNS)	United Kingdom/England * National Health Service (NHS)
Outpatient care			
Characteristics of primary care/type of provider	No definition of first level; self-employed professionals; private offices accredited with the GKV through the Associations of Accredited Physicians.	Territorial organization in health areas subdivided in basic zones with a population of 5 thousand to 25 thousand registered in public primary health care centers with full-timed salaried professionals.	GP clinics, self-employed professionals with exclusive contract with NHS; territorial organization in 211 CCGs including GPs from a region responsible for commissioning secondary services (since 2013).
Gatekeeper role	No (some selective contracts with voluntary adherence).	Yes: list of 1,300 to 1,800 users for GPs and 700 children up to 15 years for pediatricians.	Yes: average list of 1,432 patients per GP (2009) (compared to 1,999 in 1997).
Primary health care "team"	No primary care teams are established; care provided by the GP; some assistants delegated to perform home visits in rural areas; independent midwives.	Multi-professional teams: family and community physicians, pediatricians, nurses, support from social workers, physical therapists, midwives.	On average, clinic with 5 GPs, nurses, physical therapists, health care assistants, administrators.
Form of payment for primary care	Cases treated per quarter; limited by financial caps per office and specialty.	Salary plus per capita complement per user registered on the list, adjusted by age (15%).	Capitation adjusted by risk + performance.
Characteristics of specialized care (consultations and procedures)	Self-employed professionals; private offices accredited with the GKV through Associations of Accredited Physicians.	Access to specialized care, conditioned on referral by GP, provided in hospital outpatient clinics or specialty centers linked to the Area's public hospital by salaried specialists of the CCAA.	Access to specialized care, conditioned on referral by GP, provided in outpatient clinics of public hospitals (Trusts and Foundation Trusts) by salaried specialist physicians of the NHS.
Number of physicians/1,000 inhabitants (2010) **,***	3.7	3.8	2.4
Number of GP/1,000 inhabitants (2010) [24] #	0.7	0.8	0.7
Number of medical consultations/1,000 inhabitants (2010) [46] **,***	17.0	7.5	5.0
Form of payment for specialized dare	Cases treated per quarter, limited by financial caps per office and specialty.	Salary plus complement, differing between CCAA.	Salary plus complements for performance.
Hospital care			
Number of acute care beds/1,000 inhabitants (2010) **.***	5.7	2.5	2.4
Distribution of beds per provider (2010) [24.28.34] ##			
Public % (n)	48.6 (387)	83.9 (376)	94.2
Private non-profit % (n)	34.5 (229)	-	-
Private % (n)	16.9 (125)	16.1 (113)	5.8

(continues)

Table 4 (continued)

Characteristics	Germany Gesetzliche Krankenversicherung (GKV) Statutory Health Insurance	Spain Sistema Nacional de Salud (SNS)	United Kingdom/England * National Health Service (NHS)
Hospitalization rate/100 inhabitants (2010) **,***,###	24.0	10.2	13.6
Hospital payment system	Prospective diagnosis-related groups (adapted DRGs) since 2003.	Overall budget based on weighted care unit, partial DRG.	PbR, payment by results with national fees system per procedure, similar to DRGs.
Number of CT machines/1,000,000 inhabitants	17.7	15.0	8.9

CCAA: Autonomous Communities; CCG: clinical commissioning groups; DRG: diagnosis related groups; GP: general practitioner; CT; computerized tomography; PbR: payment by results.

* Numerical data refer to the United Kingdom and to the specifications of NHS-England;

** Organisation for Economic Co-operation and Development. OECD Health Statistics 2013. http://www.oecd.org/els/health-systems/oecdhealthdata.htm (accessed 15/Jan/2014).

*** Organisation for Economic Co-operation and Development. Country statistical profiles 2012. http://www.oecd-ilibrary.org/economics/country-statistical-profiles-key-tables-from-oecd_20752288 (accessed 04/Feb/2013);

World Health Organization Regional Office for Europe. European health for all database (HFA-DB). http://data.euro.who.int/hfadb/ (accessed 21/Mai/2013);

In parentheses, mean number of beds/hospital;

All-cause hospitalization admissions.

tion in health, stakeholder constellations, power distribution, and values [31,35,36,37].

In the context of the crisis, the three countries experience distinct financial pressures (Table 5) with different repercussions on the health systems. Spain, UK, and Germany entered a recession in 2009, but their different positions in the European economy conditioned both the ways they dealt with the crisis [38,39] and its consequences for the national health systems, as presented next, beginning with Spain.

Spain was one of the European countries most heavily affected by the 2008 financial crisis. With a production model characterized by low competitiveness, moderate deindustrialization after the country's entry into the European Union, growing economic dependence on the construction market and mortgages, and a real estate boom that led to progressive private indebtedness, the burst in the real estate bubble had disastrous effects: widespread default by indebted families, growing unemployment, and rising interest rates (European Central Bank. Statistical data warehouse 2013. http://sdw.ecb.europa.eu, accessed 13/Jan/2013) [40,41]. With the ongoing recession, the public deficit has remained above 10% since 2009 (Table 5).

In the face of the crisis, Spain submitted to fiscal austerity dictates by imposing major cuts in public expenditures [41]. In health, in 2012, a specific national act called the *Royal Decree Law 16/2012* [42] included drastic measures: seven billion Euros in cuts in the SNS, a change in entitlement, excluding undocumented immigrants, changes in the common package of services, expanded copayments, and changes in the regulation of pharmaceutical care. Table 6 summarizes the impacts of this reform on universal coverage.

Considered a counter-reform move against the guarantee of a universal public system [26,43,44], *RDL 16/2012* [42] imposed a legal change in entitlement and thereby broke with the principle of health as a right of citizenship and established Social Security membership as a condition, in opposition to the universal citizen's right and the spirit of the *General Health Law* of 1986 that created the SNS, in a break with previous consensuses and a return to its Bismarckian origins, according to various researchers that have criticized the reform [26,43,45].

The Conservative government has created a drastic scenario of cuts in the SNS that have already reduced the mean per capita budget in the SNS from 1,343 to 1,203 Euros between 2010 and 2012 [46,47,48]. The spending reduction was achieved mainly through cuts in staff (wage freezes and cuts, lack of employee replacement, increased workload) and in pharmaceutical care, given increases in copayment and new rules for rational use [47]. As an immediate consequence of

Table 5

Economic indicators, Germany, Spain, and United Kingdom, 2008-2012.

Economic indicators	Germany	Spain	United Kingdom
Annual growth rate (% GDP) *			
2008	1.1	0.9	-0.8
2009	-5.1	-3.8	-5.2
2010	4.0	-0.2	1.7
2011	3.3	0.1	1.1
2012	0.7	-1.6	0.3
Ten-year interest rate (%) **			
12.2008	3.05	3.86	3.36
12.2009	3.14	3.81	3.60
12.2010	2.91	5.38	3.34
12.2011	1.93	5.53	1.81
07.2012	1.24	6.79	1.47
12.2012	1.30	5.34	1.60
Public debt (% GDP) *			
2008	66.8	40.2	52.3
2009	74.5	53.9	67.8
2010	82.5	61.5	79.4
2011	80.5	69.3	85.0
2012	81.0	86.0	88.7
Increase in public debt from 2007 to 2011 (%)	23.5	90.9	92.3
Public deficit/surplus (% GDP) *			
2008	-0.1	-4.5	-5.1
2009	-3.1	-11.2	-11.5
2010	-4.1	-9.7	-10.2
2011	-0.8	-9.4	-7.8
2012	0.2	-10.6	-6.3
Increase in private debt from 2001 to 2007 (%) *	-8.0	62.6	30.8
Unemployment rate *.***			
2008	7.3	14.9	6.5
2009	7.6	19.2	7.7
2010	6.6	20.5	7.8
2011	5.6	23.2	8.3
2012	5.4	26.2	7.8

GDP: Gross Domestic Product.

* Data from the European Commission. (Eurostat: statistics. http://epp.eurostat.ec.europa.eu/portal/page/portal/statistics/search_database, accessed 22/Jan/2014);

** Data from the European Central Bank (Statistical data warehouse 2013. http://sdw.ecb.europa.eu, accessed 13/Jan/2013);

*** Refers to December each year.

the cuts, staff downsizing, and purchase of services, waiting times have increased for elective surgeries [34].

The CCAA are suffering growing pressure to enforce cuts, but the CCAA have responded differently, depending on their respective governments: five CCAA have filed appeals against RDL 16/2012 on grounds of unconstitutionality and continue to provide treatment to immigrants, with differential enforcement of the legislation [43].

In the United Kingdom, due to the great importance of the financial sector, the banking crisis of 2008 had serious consequences for the British economy. The UK suffered a recession with a drop in the GDP in 2009, slow growth in the following years, a strong increase in the public debt (92%), and a public deficit that reached -11.5% of GDP in 2009, despite persistently low interest rates (European Central Bank. Statistical data warehouse 2013. http://sdw.ecb.europa.eu, ac-

Table 6

Impacts of health reforms vis-à-vis the financial crisis (2008-2012) on dimensions of universal care in Germany, Spain, and England.

	Germany Gesetzliche Krankenversicherung (GKV) Statutory health Insurance	Spain Sistema Nacional de Salud (SNS)	United Kingdom/England National Health Service (NHS)
Breadth: variations in population coverage			
Changes in rules for inclusion	No	Changes entitlement to SNS card from citizenship to Social Security membership. For non-members, registration in special agreement via payment of quota.	No
Changes in the proportion of the insured population	No	Excludes undocumented immigrants (150 thousand persons); does not cover individuals > 26 years without prior participation in the labor market.	No
Depth: services covered			
Changes in package of services – explicit exclusion and cuts in services	No	Fragments common package of services in SNS: (i) basic: clinical services, without copayment; (ii) supplementary: medicines, orthoses/ prostheses, dietetic products, non-urgent health transportation, with copayments; (iii) accessories. Excludes 417 medicines for minor symptoms.	No CCGs may define which services they consider necessary to meet health needs. Some PCTs/CCGs set "priorities".
Measures for rationing and prioritization of services (formal and informal, implicit and explicit)	Implicit in payment systems.	Implicit in staff and investment cuts.	Due to budget cuts, CCGs will be forced to ration services; already practiced by PCTs, which have excluded services with low cost-effectiveness, and have regulated access.
Control of entry of new services in package	Reinforced action by Joint Federal Commission of the GKV in the definition of whether services will be incorporated into the package	Increased discretionary power by Ministry of Health in cutting services; expanded control over the entry of new services through creation of the Spanish Network for Health Technology Assessment of the SNS.	Expands the functions of the National Institute for Health and Care Excellence (NICE): includes social care – assesses whether the procedures are cost-effective and safe and develops guidelines for priorities.
Increased waiting times	No. There are no waiting lists for surgeries or delay in specialized consultations regulated: maximum time four weeks.	Increase in waiting lists for elective surgeries: number of patients on waiting line increased by 43% from June 2009 to June 2012, and the waiting time increased from 63 to 76 days (21%) [34].	Increase is expected in waiting times (data not available); decrease in user satisfaction.
Reduction in supply of health services (staff cuts, reduction in investments)	Merger of Sickness Funds	Closing of out-of-hours services and local medical offices in rural areas; closing of surgical centers; reduction of investments by 16.5% in 2011 and 35.3% in 2012 [26].	Reduction in management positions –30 thousand health care professionals displaced.

(continues)

Table 6 (continued)

	Germany Gesetzliche Krankenversicherung (GKV) Statutory health Insurance	Spain Sistema Nacional de Salud (SNS)	United Kingdom/England National Health Service (NHS)
Privatization of health services and new management formats for public establishments	Merger and sale of some local hospitals under budget pressure from national program for adjustment of public spending.	Plans for outsourcing management of public hospitals; public-private partnerships for concession of services (Madrid, Valencia, Castilla la Mancha) – strong opposition – suspension of privatization [59].	All hospitals transformed into Foundation Trusts; CCGs must hire "any qualified provider" (public or private); Commissioning support services to be outsourced.
Height: proportion of expenditures covered by public resources			
Proposals to reduce public expenditures in health	Control GKV contribution rates; end of parity: freeze employer's contribution rate.	Reduce public expenditures in health from 6.5% to 5.1% of GDP by 2015; per capita spending in SNS decreased from 1,343 to 1,203 Euros between 2010 and 2012 (-10.4%) [46].	Reduce 20 billion pounds from 2010 to 2015.
Public expenditures as share of total health spending (%)			
2007	76.4	71.9	80.2
2011	76.5	73.0	82.8
Annual variation in public expenditures in health (%) *			
2008-2009	4.6	6.0	8.3
2009-2010	2.3	-1.2	-0.7
2010-2011	0.7	-4.3	-1.2
Changes in copayment	In 2012, abolition of 10 Euros/quarter copayment for outpatient medical consultations.	Increase in rates and expansion of services subject to copayment for health transportation, ortheses/ prostheses, and dietetic products; copayment of medicines for pensioners.	Implicit: providers offer NHS patients the "option" of direct private payment (self-funding) of procedures not approved by PCTs or with long waiting times (in vitro fertilization, bone mineral densitometry) [58].

CCAA: Autonomous Communities; CCGs: clinical commissioning groups; PCTs: primary care trust.

* Organisation for Economic Co-operation and Development. OECD Health Statistics 2013. http://www.oecd.org/els/health-systems/oecdhealthdata.htm (accessed 15/Jan/2014).

Source: prepared by the authors, based on The National Archive [33]; Congreso de los Diputados [41]; and Reiners & Müller [65].

cessed 13/Jan/2013. European Commission. Eurostat: statistics. http://epp.eurostat.ec.europa.eu/portal/page/portal/statistics/search_database, accessed 22/Jan/2014) (Table 5). The economy's heavy dependency on the financial sector and the private indebtedness during the crisis forced the British government to deal with the dual challenge of dwindling revenues from the financial sector and the simultaneous need to inject public resources into this sector to avoid a collapse in the banking industry [11]. However, the British austerity program did not result from an imposition by the European Union. The United Kingdom did not introduce the Euro, and to defend its financial elites, it refused to participate in the fiscal pact of 2012, which included guidelines for regulating the financial system [39].

In England, with the new UK Conservative-Liberal coalition government, 2010 witnessed an important reform in the NHS, regulated in 2012 in the *Health and Social Care Act* 2012 [33], which established a budget cut policy in NHS-England (20 billion pounds in five years) and stepped up previous trends towards privatization of services and the introduction of greater competition within the NHS, with the reorganization

of relations between financing/purchasing and delivery and expanded roles for the regulatory agencies [32,49,50]. The CCGs were created as local organizations of GP clinics, replacing the PCTs since April 2013 in hiring specialized and hospital services for their enrolled patients (abandoning territorial accountability [51] and taking over management of 70% of NHS expenditures). To encourage competition, the CCGs are mandated to purchase services from "any qualified provider", which includes the public hospitals of the NHS (all of which to be turned into Foundation Trusts) and private providers. The CCGs are also expected to present referred patients with different options for providers [33], a measure intended to incentivize private supply, which still has a limited presence in the NHS. The CCGs are intended as small administrative structures and hiring Commissioning Support Services (CSS) for the commissioning tasks [52,53]. The aim is to cut administrative expenditures in the NHS by 45%, with an estimated 30 thousand displaced NHS employees [32] (Table 6).

The CCGs will have greater autonomy and will be regulated by NHS-England, an independent organization vis-à-vis the Department of Health, a move that has been interpreted as eliminating the responsibility of the Secretary of State for Health in guaranteeing care [54]. The CCGs should guarantee health care delivery but are not responsible for the population's health in a given geographic area, except for urgent and emergency care. According to Pollock & Price [55], government's duty to provide comprehensive care has been abolished, since according to the new law, government only has the duty to promote comprehensive care, not to guarantee it.

Germany, with a production model based on high-tech development, a highly skilled workforce, and high productivity, was benefited by the introduction of the Euro [2], which facilitated exportation within the region. In an advantageous positon due to growing German trade surpluses with the other European countries and extremely low interest rates, Germany resumed positive growth in 2010, reduced unemployment (Table 5), and received investments, and the social insurance schemes showed surpluses in 2012 due to rising employment [38].

In Germany, the financial crisis was not accompanied by new containment measures or a structural health reform, but the crisis did serve as the catalyst and legitimation for the intensification of social cuts and the commodification of health by the Conservative-Liberal coalition [5]. The country enacted a series of laws on financing, pharmaceutical care, and regulation and improvement of the services supply in rural areas [28].

The 2009 recession led to forecasts of deficits in the GKV, and initially to compensate for revenue losses resulting from the crisis, the country established an additional transfer of fiscal resources to the GKV Health Fund (created in 2007). In 2010, the contribution rate in the GKV was increased to 15.5% and the parity contribution was revoked: employers' contribution was fixed at 7.3% and workers' contribution was increased to 8.2% of wages. The limit was also abolished on charging an additional tax (a per capita amount bearing no relationship to wages and paid directly by members to the Sickness Fund in case the latter was unable to cover its expenses with the resources from the GKV Fund), thereby reducing solidarity in financing [56].

Germany also passed an important law in 2010 to restructure the pharmaceutical market, establishing a set of rules for price controls and cuts for medicines and rigorous standards for systematic evaluation of the benefits of new drugs by the GKV Joint Federal Commission, expanding its functions [28,56].

Immediate and potential repercussions for universal coverage

The reforms in the three countries impact the three dimensions of universal coverage to different degrees (Table 6). The first dimension, "breadth of population coverage by the public system" is affected in Spain by changes in the rules for inclusion, which will result in reductions in the proportion of the population insured in the short and long term, with the exclusion of undocumented immigrants and residents not enrolled in Social Security. However, no changes have been observed so far in the indicators for population coverage, since the number of undocumented immigrants is relatively small, and some Autonomous Communities and services have resisted enforcing the restrictions.

In the three countries, coverage by the public system has remained at the previous levels, and there has been no increase in coverage by private insurance. The proportion of the population with duplicate coverage in Spain and England has not changed, and in Germany the population covered by substitute private insurance has remained at the same level (Table 3) [29].

The dimension of universal coverage "depth of the services package" is under stress and is suffering various types of restrictions in the three countries. Spain is experiencing changes in the package of services, with the explicit exclusion of

certain services. In England, the CCGs will be able to define the services they consider necessary [54]. In the three countries, implicit rationing measures with prioritization of services tend to result from budget cuts. There has been stricter control on the inclusion of new services in the package, strengthening the regulatory bodies' role (Table 6). The increase in waiting times for elective surgeries is an immediate effect of the cuts in Spain and those planned in England. Spain is suffering a reduction in the supply of health services due to cuts in staff and investments.

New management formats in public establishments, public-private partnerships for investments, privatization, and outsourcing of hospital administration are trends in all three countries that can influence the availability of services, given their commercial orientation. In England, all public hospitals are to be turned into Foundation Trusts with greater autonomy and the possibility of raising private funds, and the CCGs will be required to hire any provider, thus pointing to greater private sector participation in health care delivery. Even so, in Spain, the Conservative government in Madrid gave up on its plan to privatize public hospitals due to the widespread social mobilization of the *marea blanca* movement in defense of public hospitals and the five-week health workers' strike [57].

The third dimension of universal coverage, "height of coverage by public financing" has been affected by budget cuts and increases in copayments, although no immediate impact has been seen in the proportion of health expenditures covered publicly, which were slightly higher in 2011 than in 2007 and maintained their share of GDP (Tables 2 and 6). The legislation set restrictions. Beginning in 2009, the trend was towards decreasing public expenditures in Spain and the UK and a slowdown in Germany, mirroring the overall trend in European countries towards reducing public health expenditures since the financial crisis [7,8].

Increases in copayments shift the responsibility for financing from the state to families. Following the trend in other European countries [6], copayments were expanded explicitly in Spain and implicitly in England, since public hospitals transformed into autonomous organizations have started offering NHS patients the "option" of direct private payment for certain services [58]. In Germany, on the contrary, given the GKV surplus, copayment was abolished from outpatient care due to pressure by physician specialists who were constituents of the Liberal Party, part of the Conservative government coalition [38].

Final remarks

The recent international financial crisis heightened the economic pressures on national health systems and was used as an opportunity by conservative governments to extend restrictive measures, expand market space and competition, and reduce state intervention [5,39].

Recent policies in the face of the financial crisis follow the previous strategies of "market-oriented reforms" and extend regulated competition, with separation of roles between financers/purchasers and providers of services in the national health systems, besides mechanisms to expand competition between insurance organizations in social insurance. There has been an expansion of management measures inspired by the "New Public Management", with new management models in public services and the relationship between providers and purchases regulated by contracts.

Responses to the crisis in the three cases had common objectives of containing public health expenditures and austerity policies to control the public deficit, however with different measures. Spain, the country of the three most heavily affected by the crisis, has suffered more drastic cuts with an emphasis on increases in copayment, exclusion from coverage, and cuts in staff expenditures. The English reform is the deepest, with extensive reorganization of the NHS and of the relations between financers and providers with a reduction in management roles and administrative personnel and opening of the "internal market" to private providers, with an increase in competition and commercialization in the NHS. Financing remains public, but with a trend towards privatization in various components of the NHS: encouragement for private use of hospital services, delivery of GP services by private companies, changes in the management and ownership models in NHS hospitals, and outsourcing of funds management with the creation of the CCGs. Decisions on allocation of the majority of NHS resources will be made by CSS outsourced, and no longer by NHS agencies as in the case of the PCTs. Germany, better positioned in the crisis, with low unemployment, showed a surplus in its Social Health Insurance and reinforced its policies to stabilize the contribution rates. The country froze the employers' contribution, shifting the responsibility for future increases to employees, allowing additional taxes stipulated by the Sickness Funds in case the latter fail to cover their expenditures with resources from the GKV Fund, forcing competition between Sickness Funds and a reduction in expenditures.

The degree of impact of restrictive measures differs between the three countries, due to their diverse health protection models, institutional frameworks, and health sector stakeholder constellations, besides their very different positions in the European financial crisis and economy. The "breadth" of the insured population has only been explicitly affected in Spain. The "depth" of the package of services covered by their health systems has been affected indirectly in the three countries, with greater control over the incorporation of new procedures and restrictions on delivery. Per capita public expenditures have decreased in Spain and England, affecting the "height" of universal coverage.

Nevertheless, these changes have only had a marginal effect on universal coverage thus far: public schemes cover the vast majority of the population, the package of services insured by the system remains deep, and in the three countries more than 74% of health expenditures remain public. In the face of the crisis, the European countries in general have not made important changes in the package of legally insured benefits, and reductions in population coverage have mostly been marginal [6]. However, there has been a stagnation or reduction in public health expenditures which, if it persists, could have harmful consequences for universal coverage in the medium term.

This is an open process. The financial crisis has placed serious pressures on the European welfare states and national health systems, but analyses of the repercussions of previous experiences with conservative reforms in the 1980s and 90s suggest non-linear processes with both backward and forward trends. Pro-market rhetoric has been more intense than its implementation in practice, and the principle of solidarity and the health systems' public nature have not been seriously shaken [35,37,59,60,61].

Meanwhile, crises can also engender positive consequences and new solutions. Economic crisis situations highlight the importance of social policies to mitigate their adverse effects, and citizens can rally to defend such policies [62]. The intensity of repercussions on universal coverage in the medium and long term will be conditioned by the action of social stakeholders and the nature of the crisis (whether situational or structural) as a crisis of democratic capitalism characterizing Western Europe in the latter half of the 20th century [1].

This study of selected national cases revealed a diversity of situations in the respective health systems in the face of the financial crisis, while contributing to the contemporary debate on universal coverage [63]. Nevertheless, this was a situational analysis limited to examining the recent literature and general data, which does not allow identifying the consequences for specific social groups or geographic and social inequalities. Unveiling the long-term trends requires further follow-up and new studies.

Resumen

El artículo analiza las tendencias de reformas de salud contemporáneas -dentro del contexto de la crisis económica (2008)- en países europeos con sistemas universales de salud (modelos bismarckiano y beveridgiano) y discute las implicaciones para la universalidad. Se analizan las reformas de salud en España, Alemania y Reino Unido. Para la descripción de los sistemas de salud se utiliza una matriz comparativa de la intervención del Estado en la financiación, regulación, organización y prestación de servicios. Se examinan los efectos de las reformas sobre la universalidad en base a tres dimensiones: amplitud de la cobertura a la población; composición de la cesta de servicios; y nivel de cobertura con fondos públicos. La diversidad de modelos de protección en salud, instituciones implicadas, constelaciones de actores y la posición de esos países en la economía europea han condicionado el impacto de las políticas restrictivas en cada uno de ellos. Estas últimas afectaron a la universalidad en sus tres dimensiones, con diferente intensidad, y profundizaron políticas anteriores de competencia regulada y comercialización.

Acceso Universal a Servicios de Salud; Reforma de la Atención de Salud; Política de Salud

Contributors

L. Giovanella and K. Stegmüller participated in the article's conceptualization, analysis and interpretation, and writing and critical revision of the manuscript.

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