Austerity measures on fiscal policy: an attempt to dismantle the Spanish National Health System and citizen resistance[1]

Políticas de austeridade fiscal: tentativa de desmantelamento do Sistema Nacional de Salud da Espanha e resistência cidadã

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Abstract

This theoretical essay analyzes the fiscal measures adopted in Spain as a response to the economic crisis of 2008, its implications to the Spanish National Health System (SNS) and the social response. We performed a case study having as primary source of information the narrative of a social actor who participated in the Spanish reform. We also used secondary sources to gather socioeconomic data and performed a literature review of 20 articles published in the 2014 Sespas Report. SNS was implemented by a progressive growth of healthcare coverage, complete funding by taxes and Primary Health Care-based organization. Austerity measures imposed cuts on the health care budget, reduced the roll of services delivered, introduced co-payments, and moved the universal coverage back to meritocracy. Critical political economy pointed out that the purpose of the measures on fiscal policy is to regressively redistribute income and wealth. The *Mareas Ciudadanas* constituted themselves as a citizen response with success in many social struggles against austerity. The alternative of resistance and overcoming through a political path is strongly present in Spain and is resisting the dismantling of SNS.

Keywords: Social Welfare; Health Systems; Public Policies; Health Economics; Spain.

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Resumo

Este ensaio de natureza teórica analisa os ajustes fiscais colocados em marcha na Espanha como resposta à crise financeira de 2008, suas implicações para o Sistema Nacional de Salud (SNS) e a consequente resistência cidadã. Elaboramos um estudo de caso tendo como fonte primária a narrativa de um ator social que participou da reforma espanhola. Utilizamos também fontes secundárias para coleta de dados socioeconômicos e a análise de 20 artigos publicados pelo Relatório Sespas 2014. O SNS formou-se por aumento progressivo da cobertura populacional, financiamento total por impostos e organização da rede por meio da Atenção Primária em Saúde (APS). As medidas de austeridade fiscal impuseram limitações de ordem orçamentária, reduziram a provisão de serviços, introduziram copagamentos e retrocederam o direito à saúde à meritocracia. A corrente crítica da economia política sinaliza que o propósito dos ajustes econômicos é a transferência regressiva de renda e riqueza. As *Mareas Ciudadanas* constituíram-se numa resposta cidadã com êxito em muitas lutas sociais contra a austeridade fiscal. A alternativa de resistência e superação pela via política se fez presente com vigor na Espanha e tem resistido ao desmantelamento do SNS.

Palavras-chave: Seguridade Social; Sistemas de Saúde; Políticas Públicas; Economia da Saúde; Espanha.

Introduction

The consequences of the global financial crisis of 2008 showed themselves with particular harshness in the countries of southern Europe. In Spain, a serious economic crisis began, largely due to problems in the real state area. The government responded with public policies developed to reduce the deficit of public finances, putting other possible objectives – such as the economic growth or social protection policies – in the background. Paradoxically, the anti-crisis policies produced more unemployment and negative growth, as well as a significant increase of public debt (Benedicto, 2014).

Among the options for reducing the deficit, both conservative and socialist governments opted for cuts in the public budgets, combined with an increase in taxes on consumption (in Europe, the added value tax) and, to a lesser extent, on income. Thus, the cuts in public services became the great protagonists of the politic responses to the crisis in Spain, especially in health public services, where they were expressed with great virulence.

Despite the decreases in virtually all determinants after 2008, the welfare state[2] constructed in Spain has been very resilient, playing an essential role in maintaining social cohesion. The country has a decentralized State, with three levels of government: central, regional, and local. Being a monarchy, the Spanish State is remarkable for the high degree of political and financial autonomy of its 17 autonomous communities (regional level of government). In the Constitution of 1978, the right to health was ensured to all Spanish citizens by the creation of an universal public system, with a regional-level organizational landmark, called Sistema Nacional de Salud (SNS) (García Armesto et al., 2011; Lopez; López Fernández; Mendoza Garcia, 2014).

2 We refer here to the welfare state anchored in the Keynesian concept of capitalist intervention in the social area. It is in this idea that the European Beveridgian health systems are based on. We agree with Mendes et al. (2017), from his reading of Boschetti (2016), which differentiated the welfare state from the social state, of Marxist episteme, through which it is sought "to capture the economic and social adjustment through social policies, giving to the capitalist State objective determinations, indicating that the incorporation of these policies does not extract from it its essentially capitalist characteristic".

In Brazil, although the Brazilian Unified Health System (SUS) was based in the tradition of universal public systems, the contradictions of an American private model prevail (Campos, 2007), and on an economic and social framework different from the European at a time of universalization of health (Mendes et al., 2017). Spain, on its turn, managed the transition from the Bismarckian model to the Beveridgian model, both by the universalization of access and the political and administrative decentralization, which we could define as integrated and coordinated.

In this article, we seek to contribute to the analysis of the situation of universal public systems in times of hegemony of the neoliberal thinking and social policies counter-reforms (Mendes et al., 2017; Santos, 2000; Siqueira; Castro; Araújo, 2003; Paim, 2013). This is an essay of theoretical nature, an analytical narrative of events related to economic policies implemented since 2008, reverberating in the SNS with budget cuts; without forgetting, in our analysis, the social response to the measures implemented by the Spanish government since 2011.

We analyzed 20 articles published in the 2014 *Relatório Sociedad Española de Salud Pública y Administración Sanitaria* [Spanish Society Report of Public Health and Sanitary Management] (Sespas), dealing specifically with the effects of the crisis on health and on the SNS. We employed two categories for the systematization of the information which shall be presented in Chart 1: (1) one horizontal, on measures produced by the crisis; and (2) three vertical, on political consequences in social determinants and health.

What motivated us to develop this essay was the promulgation of Royal Decree-Law No. 16, of April 20, 2012, which imposed conditions of eligibility for access to health care by the SNS, impacting mostly on immigrants and young adults who are not inserted in the social insurance system. The concept of health as a right of citizenship was reduced to the question of meritocracy (López Fernández et al., 2012), showing that, in fact, achievements can suffer set backs.

The welfare state in the way of the financial system

Why dismantle the SNS?

For this analysis, we shall revisit Marshall (1967) and his observations on the English welfare state, consolidated in the 1940s. For him, it is only possible to establish this social system when

> an exceptionally well integrated mechanism is combined with an exceptionally strong consensus regarding key points, in a historical context that favors the development of a collective self-awareness or – to use the term that appears repeatedly in French history – solidarity. (Marshall, 1967, p. 187)

In England, the National Health System (NHS) produced in society the sense of social well-being for being a service for all, in most cases for free, and funded almost entirely by taxes, as something that the community as a whole offers itself, as defended by Beveridge in his principle of universal coverage, later leading to the fragmentation of the Law of the Poor in 1929, embodying the antithesis of assistencialism (1967).

However, during the 1980s, in England, the neoliberal answer was very harsh. Margaret Thatcher's conservative reform failed to dismantle the NHS, though it paved the way for the privatization of its structure, undertaken years later by Tony Blair's labor government (Leys; Player, 2011). In the Iberian Peninsula, neoliberal reforms undertaken in the 1990s followed the same track, with variation between the autonomous communities according to how conservative was their character.

Since then, the neoliberal capitalism has interjected itself to the conquest and maintenance of democracy and citizenship. Harvey (2013a) calls "accumulation by dispossession" the accumulation categories regarded by Marx, in the period of the rise of capitalism, as "primitive" or "original". These categories include the privatization of land,

the conversion of collective goods in exclusive properties, neocolonial and imperialist processes of private appropriation of assets, and use of the credit system as a means of radical accumulation by dispossession (Harvey, 2013a).

Harvey (2013b) associates to these mechanisms the reduction or elimination of various forms of common law, such as social security benefits, paid holidays, and access to education and health. According to the author, accumulation by dispossession is characterized by the **privatization and marketification** (e.g. all kinds of public utility and social benefits); by the financialization (e.g. the promotion of debt, which reduced entire populations, even in advanced capitalist countries, to credit slavery); and by the **management and handling of crises** (e.g. orchestrated crisis, managed and controlled to rationalize the system and redistribute assets). It is estimated that, since 1980, over 4.6 trillion were sent from poor to rich countries. Currently, **regressive redistributions happen via State**, by means of privatization schemes and public spending cuts combined with regressive tax policies, which transfer income from the poor to the rich.

Thus, the violence that the neoliberal State imposes to people happens at the **regressive transfer of income and wealth**, i.e., through accumulation by dispossession. In this type of State, resources are transferred from the base to the top of the pyramid by tax codes that include the prioritization of investment returns at the expense of income and wages, the taxation of consumption, taxes for the use of natural resources, and subsidies and tax exemptions to legal entities.

Despite the neoliberal tax violence, the passage of liberal rights of common property - obtained over hard class struggles - to the private domain has been one of the most important policies of dispossession (Harvey, 2013a). The dismantling of the welfare state is carried out by the neoliberal capitalism due to its antithesis to the regressive distribution of income. Piketty (2014) states that:

> Modern redistribution and, especially, the social state, established in rich countries throughout the 20th century, were built around a set of fundamental social rights: the right to education, health, and retirement. Whatever the limitations and challenges that these collection and expenditure systems face today, they represent an immense historic progress [...] a great consensus was formed around such social systems, especially in Europe, where a very strong attachment to what is perceived as a "European social model" prevails. (Piketty, 2014, p. 468)

Structural adjustments: the austerity of Latin America to Spain

In Portuguese, the word "austeridade" [austerity] is synonymous with temperance, restraint, modesty, sobriety (Azevedo, 2010). The term became an axiom in economics, hindering formulations that did not fit to an orthodox model of political economy. For Benedicto (2014), the word "austerity" was expropriated from its original sense, which, for the author, means to live without the superfluous. To understand this process of signification, we shall briefly revisit the production conditions of fiscal austerity speeches.

With the policies adopted by the United States after the ultra-conservative reform of president Ronald Reagan (1981-1989) - carried out by the Treasury Secretary James Baker -, dealing with the debts of third world countries, it became clear that the proposals for controlling the public deficit were a

> legitimation and a way to boost a productive recession, the greater unemployment and regressive redistribution of income as a way to allow - without excessive inflation - the payment of the basic services of the foreign debt and the reduction of the spaces and functions designated to the State for the benefit of the oligopolic private, and especially transnational, accumulation. (Lichtensztejn; Baer, 1986, p. 10)

Public spending austerity is selectively directed to social spending and, indeed, does not aim at the debt, whether its is licit or fraudulent. In this scenario, the austerity axiom is euphemistically mobilized by the orthodox economic current, with selective focus on fiscal policy.

The theoretical foundations of the International Monetary Fund (IMF), bastion of austerity, are based on the fight against inflation and against payments balance deficit. The tools used in Latin America since the 1970s/1980s for the "structural adjustments" established ceilings for credit expansion, especially for the public sector, and the increase in interest rates to limit private demand (Lichtensztejn; Baer, 1986).

Thus, austerity focuses on the monetary policy to control inflation, in an approach known as "monetarist". However, the measures are almost exclusively for cutting public spending, on the one hand, and increasing taxes, on the other, for not being possible, in the orthodox vision, for the capital to be taxed - which would prevent, according to liberals, progress and employment generation. This is the controversial liberal ideology that claims that the tide of prosperity lifts all boats, of both the rich and the poor.

The countries of the Iberian Peninsula, Italy, and Greece were submitted to these economic policies imposed on Latin America (high interest rates, overvalued exchange rate, and financing with external savings and short-term capital) to ensure the management of the international trade. As an example: Spain spends five times more with debt service (5% of the gross domestic product - GDP) than with education (1% of GDP) (Piketty, 2015).

The recession in the country began in 2008, after a cycle of growth in jobs from 2000 to 2007, due mainly to the increase in the economically active population generated by the influx of immigrants and the greater participation of women in the labor market. The first impacts were felt in the lower salaries strata (e.g. civil construction workers), and then in the higher salaries strata. This process was accompanied by an apparent increase in productivity after the cycle of discharges and decreased income. The average cost of labor decreased 6.7%, compared to 2000 (Lopez; López Fernández; Mendoza Garcia, 2014).

The development of the current crisis, which has not yet come to an end, can endanger the welfare state, by both the volume and the quality of employment, which determine the social contributions that finance public services. The situation is also aggravated by the regressive exemptions of the financial capital, putting greater weight to the popular strata. The economic crisis deeply affected Spain, especially regarding destruction of employment and increased socio-economic inequities (Lopez; López Fernández; Mendoza Garcia, 2014).

The effects of the crisis on the health systems are produced in a dual process at various stages. On the one hand, it increases unemployment and poverty, affecting the health of the population and, consequently, impacting the healthcare system. On the other hand, the effects of the crisis depend on policy responses from governments to meet (or not) the population on their health needs. However, in both cases, the crisis affects the public budgets, causing losses for the services to which the population is entitled (Lopez; López Fernández; Mendoza Garcia, 2014).

SNS: democratic consensus and attempt of neoliberal deconstruction

In the following paragraphs, we describe the construction of the SNS with a narrative by the authors on the health care reform in Spain since the end of the Francoist dictatorship. Then, we analyze critically the attempt to dismantle the SNS. Finally, we discuss the forces dynamics between the market and citizenship regarding the SNS. To argue about the (des)construction of the Spanish health system by the fiscal austerity policies, we base ourselves on the critical reading of the 2014 Sespas Report. Such austerity policies are synthesized by Chart 1, in the column "Policies produced by the fiscal adjustment", and its effects were summarized in the column "Consequences". The second column was categorized into three axis: (1) political-institutional; (2) social determinants; (3) health.

Chart 1 – Summary of the main impacts of the crisis in Spain as raised by the *Relatório Sociedad Española de Salud Pública y Admnistración Sanitaria* 2014

Category	Policies produced by the fiscal adjustment	Consequences
Political/ Institutional	– Cuts on the public budget. – Deterioration of public finances. – Fiscal commitment of the Spanish government with the European Commission to reduce health spending by over seven billion euros between 2012 and 2015. – Labor market reforms. – Reduction of active/passive spending on policies to combat unemployment. – Decreased industrial activity. – Increased unemployment. – Policies of access restriction to social security benefits. – Proposals for changes in the law that legalizes abortion in Spain. – Reduction of new retirement pensions. – Reduction of spending with caregivers. – Privatization of social institutions. – Cuts on health spending (prevention programs and primary care). – Increased poverty. – 15% reduction in the percentage of the GDP invested in education in the period from 2013 to 2016. – Barriers in the access to health.	Political and cultural "catching" of the formulation of public policies; loss of autonomy of the institutions of public regulation; fall of 6% of the GDP (2008-2012); increase by over 200% of public debt after 2008; fall of the public budget for housing policies; introduction of privatizing elements to the SNS; placement of the privatization of the SNS services as a loss for the sustainability of the health system does not possess empirical subsidies in national and international literature, diverting attention to necessary reforms that are recurrently postponed; there are no systematic studies in Spain about management and independent models that point out to results on efficiency and effectiveness; decreased industrial activity; transformation of the right to health based on citizenship for a right founded on social security contributions; policies introduced for budget cuts and privatizations respond to ideological criteria, without concrete evidence.
Social determinants		Worst unemployment registered in the European Union 15; precariousness of work; increased participation of women in the labor market; increased by three percentage points in the number of young people aged less than 16 years at risk of poverty after the crisis; increase of the salary difference between a Spanish citizen and an immigrant from 25.5% to 31.4% in disfavor of the latter; increase in evictions of citizens who failed to pay rent and/or financing; reduction of public homes (privatization) and subsidies for social rent; strongest decrease of the levels of nitrogen dioxide (NO_2) and suspended particles in the atmosphere; changes in the life standards that can be beneficial to health; social vulnerability growth verified by a greater number of people cared for in official and non-official programs; fall in the volume of average consumption of food per family since 2009; increased consumption of vegetables as well as of sweet processed food; reduction in the average income of families; inequality measured by the Gini Index rose from 0.31, in 2006, to 0.35, in 2012; worsening of social determinants of health; deprivation of approximately 873,000 people residing in Spain to access health care.

continues...

Chart 1 – Continuation

Category	Policies produced by the fiscal adjustment	Consequences
Health	– Cuts on the public budget. – Deterioration of public finances. – Fiscal commitment of the Spanish government with the European Commission to reduce health spending by over seven billion euros between 2012 and 2015. – Labor market reforms. – Reduction of active/passive spending on policies to combat unemployment. – Decreased industrial activity. – Increased unemployment. – Policies of access restriction to social security benefits. – Proposals for changes in the law that legalizes abortion in Spain. – Reduction of new retirement pensions. – Reduction of spending with caregivers. – Privatization of social institutions. – Cuts on health spending (prevention programs and primary care). – Increased poverty. – 15% reduction in the percentage of the GDP invested in education in the period from 2013 to 2016. – Barriers in the access to health.	Reduction of general mortality rate, but at a slower pace of decline than before the crisis; setbacks in advancements achieved regarding reproductive rights; barrier of access to undocumented immigrant women to health services; increase in cases of syphilis and gonorrhea, while new infections by acquired human immunodeficiency virus (HIV) decreased; drop in fertility rates; discreet increase in cases of abortion; increased spending by direct disbursement in health by older adults; slowing of the decrease in the death rate among older adults; increased mortality among older adults during the winter; no significant changes were observed in the incidence of infectious diseases due to the financial crisis; growth of in-hospital mortality by infectious morbidities; airway respiratory infections and influenza became more frequent in the group aged between 30 and 55 years; variations in incidence of diseases and worsening of vaccination coverage were not attributed to the crisis; anxiety disorders, depression, anguish, and alcohol consumption (dependency and abuse) increased significantly during the crisis (2006-2010); until 2011, there was no variation in suicide cases; 10% growth in the consumption of antidepressants and sedatives; empirical evidence shows that the experience of childhood poverty has an impact on health and socioeconomic status in adulthood, which can hardly be compensated; loss of the right to health care by the undocumented immigrant population; spending reduction (2009-2011)of the SNS in pharmaceuticals (42.5%), capital (38.7%), primary care (5.7%) and health surveillance (35.2%); notable increase in the waiting list for SNS attention; introduction of co-payments to drugs; end of the financing of a set of 400 drugs for minor aggravations; co-payment produced a huge drop in revenue in the dispensing of prescriptions by pharmacies; increased waiting time for surgical interventions; increase of people with private health insurance; introduction of a list of services not covered by the SNS; the waiting list for elective surgeries grew 43%, with an increase of 21% in the days of waiting (2009-2012); decrease in continuous alcohol consumption, with the exception of intensive consumption and consumption of illicit drugs; small increase of overweight/obesity; 2% increase in the rate of people who do not exercise.

Source: Antentas and Vivas, 2014; Ballester et al., 2014; Benedicto, 2014; Benmarhnia et al., 2014; Bernal-Delgado, Campillo-Artero and García-Armesto, 2014; Escribà-Agüir and Fons-Martinez, 2014; Flores, García-Gómez and Zunzunegui, 2014; García-Altés and Vicente Ortún, 2014; García Armesto et al., 2011; Gili, Campayo and Roca, 2014; Hernández Aguado and Lumbreras Lacarra, 2014; Larrañaga, Martín and Bacigalupe, 2014; Llácer, Fernández-Cuenca and Martínez-Navarro, 2014; Márquez-Calderón et al., 2014; Novo et al., 2014; Pérez et al., 2014; Rivadeneyra-Sicilia et al., 2014; Ruiz-Ramos et al., 2014; Sánchez-Martínez; Abellán-Perpiñána and Oliva-Moreno, 2014; Urbanos Garrido and Puig-Junoy, 2014; Vázquez, Vargas and Aller, 2014

The gradual increase of population coverage

A gradual incorporation of the population to social security and aggregation by the public administration happened in Spain. The coverage of health services extended to all Spanish citizens, theoretically. In reality, there was a service for poor people that depended on the State and municipalities and a health care coverage by social security for employed workers and their families. The scarce middle class used a small private system, fundamentally with their trusted physicians and some experts, as well as a rudimentary network of private health. In the larger capitals, the private system was better structured; in the countryside, the poor assured themselves by their own means, through an "agreement" with the public home assistance physicians, who worked for the State.

Some services to specific problems – such as mental health and tuberculosis – had infrastructure and human resources. There was also coverage for some problems and populations given by the cities and *diputaciones* – province's councils that make up an autonomous community, formed by an election among the representatives of the municipal Legislature of each city of the province. The *diputaciones* have specific responsibilities (i.e. environment, rural activity), being a heritage of 19th-century Spanish political organization that remained after the Constitution of 1978 – clinical hospitals, military hospitals, and others.

From the 1960s, a rapid and progressive increase happened in the social security coverage, due to the successive enlargement of the number of benefitted workers and the growth of employment in Spain. When the dictator Franco died, social security covered 80% of the Spanish population. In the 1990s, practically 100% of the population was already protected by the SNS.

Progressive fusion of the provision network of public services

The different networks of public service began to fuse, mostly because of the General Health Law no. 14/1986 (España, 1986). Initially, the Instituto Nacional de la Salud [National Institute of Health] (Insalud) was created, which gathered the social security resources devoted to health. Later, the process of transfer to the autonomous communities was developed for 20 years (1982-2002). In this process, the Insalud resources corresponding to each of the autonomous communities were transferred to the regional administrations. Seventeen Servicios Regionales de Salud [Regional Health Services] were created, one for each community. In each autonomous community, the transferred Insalud resources were grouped with other public resources – which were already in the communities – from the Administración Institucional de la Sanidad Nacional [Institutional Administration of National Health] (Aisna) and other public services of the cities (*diputaciones*), in a very complex legal process.

Currently, the SNS is formed by Servicios Regionales de Salud with different denominations, originated from scattered networks of previous public administrations. The SNS owns an important network of its own resources, with buildings and technology. Professionals, including physicians, are public servants.

Political decentralization of the management to the autonomous communities, from 1982 to 2002

Most of the political responsibilities related to health are in the hands of the autonomous communities that administer health services fully. Under the responsibility of the Ministry of Health in Madrid are health competences with other countries, representation in international bodies, some themes related to general coordination, approval of drugs, and the training of specialists, among other functions. Other ministries have responsibilities, in general terms, related to the management of public workers and employees and the training of professionals. The European Union regulates environmental standards and public health themes. The municipalities are responsible for water supply, the collection and treatment of waste, and other public services. However, most of the demand in health care and health surveillance services is under the responsibility of the autonomous communities, which designate to the area a third of their budgets.

Total financing by taxes from 1999

The SNS is financed by taxes since 1999. Public funding represents 74% of the total health spending.

Annually, an average of US$3,371 are invested per person,[3] with significative differences among the autonomous communities. Initially, the funding came from the shares of businessmen and workers aimed at the social insurance and complemented by a transfer of State for assistance to the insured. The amount coming from the social insurance was gradually reduced and, from 1999, the health services began to be funded by the State's general taxes. With transfers to the regional managements, spending began to match the budgets approved by the autonomous communities.

Creation of a new network of health centers with primary health care criteria

Regarding primary health care (PHC), the SNS services model is based on a scheme with elements partly inherited of the social security system and partly of the old system of State-dependent professionals, bringing new elements as well, arising at the time of creation of the system and influenced by the prospect of the Declaration of Alma-Ata. The new PHC model was indeed created in the years of political transition, from 1978 onwards, on the basis of a new specialist, the family and community physician (at this time, over 25 thousand professionals), trained in the system of medical residences and working with a group under their responsibility, enabling the continuation of assistance to persons and families through teamwork combined with other professionals - especially nurses, responsible for collective attention - and an organizational environment favorable to coordinated work. The PHC reform began formally in 1984, although earlier pioneering experiences existed. Today, despite the problems of imbalance at the hospital level, the PHC model is strong and prestigious.

Reform and modernization of hospitals and other specialized services

From the 1970s, the SNS significantly improved the quality of its greater complexity services. The new hospitals and new generations of expert physicians, beautifully trained by the system of medical residences, created high-quality services, with high technology, which implies large consumption of financial resources. From the 1990s, smaller, regional hospitals, start to improve and intermediate services, situated between high technology and good PHC, began to develop. Thus, some system components, such as blood donations and transplants, began to become global references. Since the political transition, pioneering initiatives can be observed in mental health, innovative efforts in management, modern mobile emergency services etc. Services that complement a system with major deficits, but basically with good results and high social acceptance.

Next, we describe the attempt of dismantling the SNS, mainly by the effects produced by the Royal Decree-Law no. 16/2012.

The attempt to dismantle the SNS

The effort to increase coverage, which we previously discussed, starts to decrease with a gradual dismantling of the existing coverage and replacement of the efficient SNS by a model based on competition between insurers. However, the central government and autonomous communities, mainly governed by conservative parties, are not simply creating business opportunities for insurers, but also striving to strengthen the market of health services providers. With various mechanisms.

Since 2012, with the austerity measures now in motion, it is possible to witness an unprecedented attack to the six axes that defined the last 30 years of building of a public health system. Earlier, in Catalonia, at the State level - in a generic way, to all public services -, significant cuts had already occurred, mainly in the salaries of public servants.

In April 2012, the biggest hit occurred, specifically aimed at health systems, with the proposal of the Royal Decree-Law (a way to legislate supposedly reserved for very urgent matters) no. 16/2012, validated soon after in a short parliamentary debate thanks to the absolute majority of the conservative

3 Public and private spending. Source: https://data.oecd.org/spain.htm#profile-health

party. Even if their excuse was to carry out budget cuts, the most substantial change was legislative, with the amendment of articles to shift the right to health from the context of citizenship to the context of "insurance", a measure which, despite not having any budgetary consequence, modifies a right - won with much struggle - and reinforces the marketing conception of health, with the introduction of insurances.

According to the decree-law, immigrants who do not a regularized residence in Spain are not entitled to the coverage. They represent a numerically significant group in a country where 12.7% of the population was not born in Spain (the European country with the largest proportion of immigrant population after Estonia, which has an important proportion of Russians). This has generated a serious problem to this population, held accountable for the crisis in some speeches. The inattention to immigrants by the standardized assistance is a serious justice problem that has mobilized the population, converting thousands of Spanish physicians into consciousness objectors.

The dismantling of the public system creates business opportunities in a market - reshaped and promising - for the private sector of health insurers. As Naomi Klein (2008) demonstrates in her book *The Shock Doctrine*: those who are against the welfare State never waste a good crisis.

In some autonomous communities, such as Madrid, Castela-Mancha and Valencia, an aggressive privatizing program advanced onto new hospitals, proposing administrative concessions or cooperatives, though these are much less profiled. In the Catalan community, the hiring of private service providers has increased. Across the country, the work of progressive fusion of public networks - which demanded several years of efforts and negotiations - are being dismantled apart a new fractionation of the system.

The central government and the autonomous communities have also configured a market space by decreasing the portfolio of some services that until now were free and public, such as non urgent health transport, prosthetics, inputs for diagnostic exams and other similar products. A broad list of drugs has also left the public coverage. These decisions facilitate the advancement of private providers - favoring the private sector to the detriment of the public sector - and establish quotas for the participation of patients as copayment, increasing health spending by direct disbursement on the part of Spanish citizens.

Other measures that are undermining the quality of public services are the massive cuts in the wages of physicians, nurses, and other workers, accompanied by increased workload and limited days off (equivalent to those of vacation). Naturally, the discontent is general, negatively affecting work places, both in primary care and hospitals. It is also important to consider that the remuneration of Spanish physicians is smaller than that of fellow European countries, generating the emigration of these professionals to other countries.

All the superficial changes and quality limitations imposed by budget cuts generated several business opportunities for insurers, providers of health care and general services. With the worsening of public services - with wrongly paid professionals - and the limitation of coverage, the number of potential insurance and private services clients increase.

Public services based on competition between insurers are more expensive than those based on the SNS model. In other words, in addition to not represent savings in the current budget, the measures implemented for the medium term will be much more expensive to taxpayers. The only ones who benefit are insurance companies or those that are willing to enter this business. The most serious problem of this passage of the right to citizenship or residence to the right to insurance is the absence of coverage for a great part of the population.

The greatest risk in this situation is the fractionation of the system, since the rich and the upper middle classes can access private services of quality, while the poor and the popular sectors will have to settle for increasingly deteriorated public services. As stated by Richard Titmuss (Alcock et al., 2001) in the early days of the welfare state, a service for poor people will always be a poor service.

Next, we shall discuss the SNS faced with the dynamics between the tension of the market by the concentration of income and social resistance.

The dismantling of the SNS for concentration of income and wealth

The orthodox policies of IMF were resumed soon after the Latin American crisis of 1982 by an alignment of its traditional approach to the neoliberal thought, aiming to reallocate the resources of peripheric economies, reducing them to exporters of primary products, with a funding attached to the guidelines dictated by the markets and by the international capital circulation (Lichtensztejn; Baer; 1987).

The imposition via public debt of the IMF policies to Latin America moved, given the crisis in the euro zone, to southern Europe, with structural adjustments of the IMF and the European Central Bank (ECB) under the supervision and oversight of Germany and France. The crisis in Spain has had direct consequences in this process, particularly regarding unemployment, increased poverty, and social exclusion. The economic inequities that are making the rich richer also endanger Spain's social cohesion (Lopez; López Fernández; Mendoza Garcia, 2014). Paradoxically, the "cult to austerity" caused the increase of public debt. The neoliberal economic adjustments have generated, since 2008, economic stagnation, unemployment, and poverty. These economic instruments disregard that there is no country in the history of capitalism that has evolved without a significant collaboration of the State (Fagnani, 2015).

As empirical evidence of the relationship between accumulation by dispossession and dismantling of the welfare State in Europe, we have increasing inequality in a context in which the return rate of the capital is greater than the growth of national income (Piketty, 2014). The historical data presented by Piketty shows that the concentration levels of income of the 21st century are close to those of the Belle Époque, in the early 20th century, which has experienced very high levels of inequality. The financialization of the economy since the 1970s, time landmark of the ultraconservative neoliberal revolution, has concentrated income among the richest 10% and, in particular, among the 1%, vis-à-vis the reduction of taxes to financial capital. The configuration of a new class, the super-executives, with multimillion-dollar salaries (determined by them) characterize our society divided between us (99%) and them (1%).

The impact of the two world wars and of the depression of 1929 were responsible for greater income distribution during the Thirty Glorious Years, when there was a correction of directions, called "embedded liberalism" by Harvey (2013a). The fiscal State and the welfare State played a very important role in this short period of time, redistributing income to allow universal access to health, education, and retirement (Piketty, 2014). In summary:

> the fact that the concentration of capital appropriation at the beginning of the 21st century is substantially lower in European countries than in the Belle Époque is largely the result of a combination of accidental events (the shocks of 1914-1945) and specific institutions, in particular in the field of fiscal right to capital and its incomes. (Piketty, 2014, p. 367)

Social institutions (case of the SNS) are placed in danger when inequality exceeds a certain threshold and, consequently, political freedom tends to lose its value, with the representative government being representative only in appearance (Rawls, 1993; Piketty, 2014). This was recognized by the public, who no longer recognizes the political legitimacy of the two main Spanish political parties, the Popular Party (PP) and the Spanish Socialist Party (PSOE).

Democratic and popular resistance

With the publication of Decree-Law no. 16/2012, a strong popular movement against the processes attempting to dismantle the SNS began. In Madrid, where, in addition to the consequences of the Decree, a very aggressive process of privatization of services began, the popular manifestation was very active, forming various organizations that gathered health professionals and citizens. The confluence of these movements and their demonstrations in the streets was called *Marea Blanca* (because of the physicians' coats), with successive waves of protests from 2012 until early 2015. The movement

included street demonstrations, strikes, and citizens' actions in defense of public services, without failing to mention the role of the Justice system and the Parliament. Although they occurred throughout Spain, the *Mareas Blancas* were very energetic and significant in Madrid. Other *mareas* started to form: the *Marea Verde*, which defended the public educational system; the *Marea Amarilla*, which faced the laws that turned free justice into paid justice; the *Marea Roja*, of unemployed people; among others.

With great media repercussion, the *Mareas Blancas* demonstrated the advantages of an **universal** and **public** health system through conferences, articles, radio and television programs etc. The demonstrations also showed the appreciation of citizens and professionals to the SNS.

There were also protests to defend one of the portions of the population who would suffer the most with the loss of universality: undocumented immigrants. Family physicians rebelled through petitions in which they claimed themselves as insubmissive, refusing to fail to care for the immigrants, a form of civil disobedience enabled by the Spanish Society of Family and Community Medicine itself, resorting to the feelings of its affiliates.

The *Mareas de Colores* were part of a new kind of public manifestation, whose origin dates back to the mobilizations of the 15-M Movement (in reference to protests across Spain on May 15, 2011), in which thousands of Spanish citizens, especially young people, joined fights with values that differed from those of the traditional left, generating strong debates on social networks and making hundreds of Spanish cities manifest themselves. Finally, the demonstrations ended in campsites in squares of different cities, developing, for a week, new ideas and new ways of fighting based on social networks and the occupation of public spaces. These movements, apparently, thinned out, turning to social networks and the peripheric neighborhoods to reappear in 2012 at the *Mareas Ciudadanas* and other movements such as the *Plataformas de Afectados por la Hipoteca*, which fought against evictions for lack of payment of loans, very frequent in Spain after the crisis.

Among the participants of the movement of displaced people, 15 M, *Mareas de Colores*, and other actions, some people declared themselves apolitical, but others organized themselves in a party named *Podemos* [we can], which had great success in the European and general elections that followed, endangering the hegemony of PSOE and PP in Spain, the so-called "1978 parties". Breaking with the protests for direct democracy of the outraged 15 M, *Podemos* wants to be the heir to the "spirit of May", primarily by principles of participatory financing, transparency, and collective deliberations (Lambert, 2015).

Faced with the fear that emerging political forces could win over the 1978 parties, several proposals of Decree-Law no. 16/2012 were retreated, as well as the privatization initiatives in the health sector. The law that "dismantled" the system was not applied in good part, although the fundamental aspect, which assumes the changing to an insurance model, has been kept. However, in March 2015, the political parties (except for PP and Ciudadanos) signed a commitment for their government programs for the 2015 elections with the Asociaciones Ciudadanas – that composes the *Mareas Ciudadanas* – to promote the universalization of health.

Final considerations

In this essay, we maintain that the issue of fiscal austerity is a selective agenda to reduce public spending with cuts in social policies, resulting in regressive income transfer. We mobilized the critical literature in political economy to postulate that the structural reforms implemented in Latin America between the 1970s and 1990s, and in the peripheric countries of the European Union from 2011, undermine the welfare state, which is interposed to the neoliberal project of accumulation by dispossession. In Spain, popular movements gained some ground in defending the SNS through the *Mareas Ciudadanas*. And although the SNS has shown itself as resilient when faced with the neoliberal offensive, it is still threatened by more setbacks, such as the flexibilization of the right to health in 2012.

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Authors' contribution

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