Healthcare Reform in Italy and Spain

Do these tax-financed, decentralised systems facilitate better reform implementation than in the NHS?

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Contents

Introduction

Since the Lansley reforms of 2012 the NHS in England has been subject to increased scrutiny and criticism. Due to the financial crisis and demographic challenges, the NHS is indeed under added unprecedented strain. However, when looking for a solution, critics, politicians and researchers are often quick to compare the NHS with 'Bismarckian' social insurance healthcare systems, like those of France and Germany, rather than other 'Beveridgean' tax-financed systems like our own. Both the Italian and Spanish healthcare systems are also tax-financed and Italy has a similar population to the UK, with Spain not too far behind. When looking at how other healthcare systems have responded to the financial crisis and demographic pressures it seems appropriate to look at those that operate similarly to the NHS.

All three countries have experienced great fiscal challenges, which have impacted on their healthcare systems. Moreover, the demographic situation in recent years has deteriorated. All three countries are also victims of their own healthcare successes, which have caused many more people to live longer. Interestingly, this report has found that despite particularly severe economic hardships in Italy and Spain and the subsequent harsh austerity measures, their healthcare systems appear to be operating more efficiently. This report particularly investigates the effects of each country's post-crisis healthcare reforms on primary care, the ability to maintain core values and its healthcare outcomes.

Crucially, Italy and Spain operate heavily devolved and decentralised political systems amongst their 20 and 17 autonomous regions, respectively. Healthcare in both of these countries is one of the most devolved competencies. With devolution and decentralisation playing an increasing role in the NHS and in political rhetoric, this report also analyses the efficiency of decentralisation in Italian and Spanish healthcare and how it could impact the NHS.

Financial response to the crisis

Italy

Since 2007 co-payments have existed in Italian healthcare. The financial crisis, however, led to an introduction of further co-payments. For example, a co-payment of €25 was introduced for uses of the emergency services deemed inappropriate[1]

and additional €10 co-payments per prescription were also implemented.[2] The controversy surrounding the co-payments will be addressed later in the report.

The regions were also to take further responsibility regarding their finances. From July 2014 between €109bn and €115bn was to be distributed to the regions annually until 2016, in accordance with the 2014 Pact for Health, in exchange for increased efficiency, such as: reduced hospitalisations, integrated primary care, revised hospital and specialist fees in line with inflation and improved electronic heath records.[3] Regions were also to be assessed according to their financial performance and austerity measures were implemented faster in regions identified as less economically efficient, who also had to sign recovery plans or *Piani di Rientro* with the central government to ensure more frugal spending.[4] Large cuts imposed by the central government were also made to SSN spending. General SSN cuts of between €900m and €2.1bn per year from 2012 to 2015 were implemented.[5]

The main impact of the financial crisis was to hasten already ongoing reforms. These included the improved accountability of the regions and targets such as the reduction of hospital beds to 4 per 1000 from 4.5.[6]

The reforms to the SSN have achieved their efficiency aims. Regional deficits now appear to be under control[7] and reductions in healthcare spending were at a rate of -3 per cent in 2013.[8] Moreover, since 2009 pharmaceutical spending has fallen every year, most likely due to co-payments.[9] However, secondary care costs have actually increased and are above the OECD average.[10] In 2013, Italy's percentage of GDP spent on the SSN was 9.1 per cent, which is below the OECD average of 9.3 per cent and further below their spending of 9.4 per cent in 2009, indicating it had achieved its aims to reduce spending.[11]

Spain

The reaction of Spain's healthcare system, the *Sistema Nacional de Salud* (SNS), to the crisis, was not dissimilar from Italy's. Co-payments were expanded, regions were given fiscal targets and cuts were made. These were all enacted by the Royal Decree Law (RDL) of April 2012: 'Urgent measures to guarantee the sustainability of the National Health System and improve the quality and safety of services'.[12] Under the RDL co-payments were introduced on services such as prosthetics, dietary products and non-urgent ambulance trips (similar to Italy).[13] Regions were now pressured to rationalise their spending. This led to better use of medicines, a focus on promotion of public health and an increase in primary care resources.[14]

In Spain, despite heavy decentralisation, most of the cuts were enforced at a national level, with less discrepancy given to the regions than in Italy. Nationally, a salary reduction of 7.1 per cent was enforced and working hours for GPs and nurses in primary care was increased from 35 hours per week to 37.5.[15] In 2012, the health and social services budget was also cut by 13.65 per cent, impacting heavily on the elderly and the unemployed.[16]

Like Italy, it appears that Spain has been effective in expenditure reduction. In 2009 the total percentage of GDP spent on the SNS in Spain was 9.6 per cent, which was reduced to 8.9 per cent by 2013.[17] In particular, reduction in pharmaceutical expenditure has been effective, which in 2011 fell by over 6 per cent in real terms, again most likely attributable to co-payments.[18] The central government also successfully achieved its aim of SNS budget reduction as in 2012 it decreased by 13.7 per cent and 22.6 per cent in 2013.[19]

How does England compare?

The Lansley reforms, considered 'so big that you can see them from space' by the then Chief Executive of the NHS, David Nicholson, aimed to change the way the NHS was commissioned.[20] 211 Clinical Commissioning Groups (CCGs),[21] comprising nurses, GPs, hospital doctors and managers were now in charge of the NHS commissioning for their local areas, replacing 151 Primary Care Trusts.[22] From 2013 to 2014, CCGs controlled around half of the total NHS budget.[23]

Unlike Italy and Spain, no co-payments were introduced; however the long-standing prescription charges remain. Moreover, no overt cuts to NHS spending were announced, instead the government pledged to 'ring-fence' NHS spending. However, in reality whilst Spain openly reduced salaries, the pay of NHS workers has largely been frozen, which of course in real terms means a reduction in wages. The implementation of the reforms also led to the redundancies of 10,000 NHS staff by March 2013; another cut taken place under the guise of reform.[24]

Furthermore, the top-down reorganisation of the NHS appears to have stifled efficiency aims. In the NHS Five Year Forward View, it is claimed that £30bn a year by 2020/2021 needs to be invested in order for efficiency to reach its 3 per cent target.[25] Yet from 1980 to 2012/13 annual growth productivity has only increased from 0.7 per cent to 1.2 per cent.[26]

It is possible that this lack of efficiency is due to economic waste which has resulted from the Lansley reforms.[27] Inappropriate care such as misuse, overuse or underuse is identified by the King's Fund as a possible contributor to waste.[28] In

the last year or so higher spending has also been attributed to inefficiently hiring agency nurses.

Inefficient spending in the NHS is also evident from its deficit. In 2014-2015 the NHS budget deficit reached £822m from £115m the previous year.[29] It is also estimated by Chris Hopson the Chief Executive of NHS Providers that this year the NHS deficit could hit £2.5bn.[30] The SSN's deficit has more than halved since 2009 to €1.043bn (about £755m) in 2012, whereas the NHS's is increasing.[31] Further evidence that the NHS is less economically efficient than the SSN and the SNS is the expenditure per capita on health (PPP): Italy- 2439USD, Spain- 2004USD and the UK- 2733USD.[32] However, the percentage of GDP spent on healthcare has also reduced from 9.7 per cent in 2009 to 9.1 per cent in 2013, an even bigger reduction than in Italy.

The King's Fund dispel accusations of increased privatisation, pointing to the fact that only £10bn of the total £113bn budget is spent on care from non-NHS providers.[33] Instead, they accuse these claims of being distracting and believe that the real cause of the NHS's problems has been the reforms that 'took scarce time and expertise away from efforts to address the pressures of the financial and demographic challenges.'[34]

Comparing primary healthcare systems

Italy

Primary healthcare in Italy is delivered by Local Health Units (LHUs), who pay self-employed GPs on a capitation basis. Every three years the government consults with GP trade unions and an agreement is signed regarding their payment levels, duties and responsibilities.[35]

The Italians operate an impressive out-of-hours primary care service called the *Guardia Medica*. It is a free telephone service operating at night and on weekends. Unlike NHS 111 it is a doctor providing the medical advice and home visits when necessary.

Italian primary healthcare has undergone transformation in recent years. There is now widespread encouragement for larger, integrated or multispecialty practices. Particularly in the northern regions legislation has introduced integrated care ranging from basic GP coordination and performance assessment to shared

records and provision of care beyond their catchment areas.[36] The aim is for GPs, specialist doctors and nurses to work together to avoid unnecessary use of secondary care and emergency departments. In 2010, around 67 per cent of GPs and 60 per cent of paediatricians were working in a team practice.[37]

The competencies of GPs, specialists and nurses have been combined to provide care in the community. As of July 2014 all regions signed a pact to establish primary care complex units to replace the already progressive general practice networks;[38] in the region of Emilia-Romagna there are currently 62 of these operating, providing multispecialty care.[39] In order to incentivise multispecialty and integrated primary care additional payments are made to GPs or paediatricians.[40]

Spain

It is considered that 'the Spanish primary health system in itself is an excellent testing ground and this could be of great value when implementing formulas at a European level'.[41] Since 1986 Spanish healthcare has become increasingly reliant on primary care as the principal way of preventing illness and thus the need for secondary and tertiary healthcare. In 2010 primary healthcare centres were responsible for 70 per cent of healthcare visits in the country.[42]

Spain's primary healthcare is successful due to its accessibility and its focus on multispecialty clinics. In 1978 it was intended that there would be a primary health centre within a 15 minute radius of every home, by 2010 this had nearly been achieved.[43] Use of electronic medical records, shared between practices and specialists have also improved accessibility, with over 97 per cent of practices in Spain operating electronic record systems.[44]

Multispecialty healthcare centres with the aim of preventing serious conditions by promoting healthcare play a crucial integrating role. The functions of primary healthcare have been set out by the government, including: 24-hour availability, minor surgery, family planning, obstetric care, pharmaceutical prescriptions, home visits, ambulance services, nursing and palliative care, healthcare promotion and services for the mentally ill.[45] Moreover, many primary health centres also include dentists, midwives and physiotherapists.[46] It is this use of multispecialty clinics that has reduced the pressure on secondary healthcare.

Primary health was briefly affected by the financial crisis when the Prime Minister Mariano Rajoy removed free healthcare from illegal immigrants in 2012. Yet no major increase in ambulatory care or hospital admissions indicates primary health's retention in efficiency throughout the crisis.[47]

However, of the 13.65 per cent of cuts made to the health and social services budget in 2012, 45 per cent of those were to public health and quality programmes.[48] Paradoxically, on the 2014 health barometer carried out by the Spanish government, primary health receives excellent feedback, including; receiving 7.82/10 for confidence in their doctors; 7.4/10 for home visits; and 7.22/10 for ability to receive an appointment.[49]

How does primary healthcare in England compare?

Unlike in Italy and Spain, integrated and multispecialty care in England appears to have taken a backseat. There was cause for optimism in 2013 when under the influence of Norman Lamb the Better Care Fund was established, which was to pool £4bn to dedicate to integrated care.[50] Although the number of GP practices with 10 or more GPs increased in 2013 by 76 per cent, it is still suggested by Nuffield Trust that multispecialty practices 'could make a major contribution to higher productivity and standards across the entire health service.'[51]

It is clear looking at the SNS in particular that there is truth in this assessment by the Nuffield Trust. It seems obvious that further investment in primary care, in the form of larger integrated and multispecialty practices will keep people out of secondary care. Yet this has fallen into the background of the debate surrounding the NHS. Dr Mark Porter, of the British Medical Association (BMA), argues the government has actually hindered integrated care, saying that regarding the 2012 Lansley reforms: 'A BMA survey of doctors found that three-quarters believed it has made the delivery of joined-up care more difficult.'[52]

The number of GPs has also declined between 2010 and 2013 and in 2012 GPs reported the lowest job satisfaction for over 10 years.[53] Most concerning is the fact that in 2014 more than one in 10 slots for new GP training was left empty.[54]

Spending on GP services has fallen in 2012/13 by £290m, which undoubtedly contributes to the aforementioned strain on GPs.[55] GP services are repeatedly criticised for a lack of accessibility as patients struggle to get through to them, let alone receive 24-hour care, like the *Guardia Medica* in Italy.

However, by and large most criticisms of primary care in England stem from structural problems such as a lack of integrated care or funding. The Nuffield Trust acknowledges a culture of criticism and confrontation when it comes to GPs rather than helping and supporting them.[56] However, 88 per cent of people polled said that their doctor was good at listening to them and 83 per cent said they were treated with due care and concern.[57] Some improvements have also taken place in

terms of electronic booking, repeat prescription requests and shared records but it is still incomparable to Italy and Spain.

It is important to take on board the Nuffield Trust's recognition of how GPs are treated and focus policy on the structure of primary care and look towards Italy and Spain for improved efficiency. A lack of available data on GP productivity not only means a lack of accountability, but it also makes it harder to assess the efficiency of primary care in order to improve it.

Contrasting human and medical resources, clinical outcomes and satisfaction

Resources- human and medical

Resources	**Italy**	**Spain**	**UK**
Hospital beds (per 1000 people) (2011) [58]	3	3	3
MRI units available per 1,000,000 inhabitants(2013)[59]	N/A	15.3	6.1
CT scanners, total, per 1,000,000 population (2012)[60]	33.3	17.2	7.7
Doctors (per 1000 people) (2013) [61]	4.2	3.8	2.8
Nurses (per 1000 people) (2013) [62]	6.1	5.1	8.2

MRI units data was not available for Italy, but a recent WHO report gives credit to the SSN for having one of the highest amount per capita in the EU.[63] We can see that Spain has over double the units than the UK.[64] And the UK performs even worse in terms of CT scanners.[65] Given frequent complaints of waiting times for diagnostics in the UK, this seems like an area to improve.

Both Spain and Italy in particular have more doctors available per 1000 people than the UK.[66] Yet the UK has significantly more nurses.[67] Availability of doctors and nurses is crucial to efficiency and quality of treatment. A lack of doctors makes appointments harder to attain and therefore delays medical care.

Therefore in terms of approving efficiency, waiting times and diagnosis rates it appears that MRI units and the number doctors available would be a key area for improvement for the NHS when comparing to its Italian and Spanish counterparts.

Clinical outcomes

	Italy	Spain	UK
Estimated maternal mortality per 100,000 live births (2013) [68]	4	4	8
Mortality rate, under 5s (per 1,000 live births)[69]	4	4	4
Life expectancy at birth (years)[70] (2013)	82	82	81
Postoperative pulmonary embolism or deep vein thrombosis. (per 100,000 discharges)[71]	536	285	812
Foreign body left in during procedure (per 100,000 discharges)(2009)[72]	3.3	5.6	5.7
Mammography Screening, percentage of women aged 50-69 screened, 2000-2009.[73]	60	71.8	74
Deaths from cancer per 100,000 (2012)[74]	205.4	194.1	226
Average length of stay, All causes, Days (2013)[75]	7.7	6.6	7

The UK comparative lack of equipment and personnel could prove crucial when analysing why it lags behind some fundamental clinical outcomes. In particular, the UK's estimated maternal mortality, [76] postoperative pulmonary embolism or deep vein thrombosis,[77] foreign body left in during procedure[78] or deaths from cancer[79] rates are unacceptable when compared to countries operating similar healthcare systems with significantly lower GDPs (Italy- USD 2.144 trillion, Spain- USD 1.404 trillion, UK- USD 2.942 trillion).[80] Medical resources could be responsible, but the difference in primary healthcare systems is vital.

Italy is above the OECD average of 7.3 for average length of stay for all causes.[81] Whilst this is to their credit as it shows they are not rushing patients out, it could also indicate a lack of efficiency. Due to hospital superbugs, recuperating at home is often

preferable. Conversely Spain and the UK are both below the OECD average for this, which again could either indicate efficiency or a lack of resources.

However, there are anomalies that do suggest the NHS does perform well comparatively especially given the UK's mortality rate of under 5s [82] and percentage of mammography screenings.[83] Moreover, it is significant that given the perceived quality of life in Italy and Spain is so high due to lifestyle and diet that the UK's life expectancy is only one year behind (yet since the financial crisis this may no longer be applicable).[84]

Public satisfaction

Indicators- satisfaction	Italy	Spain	UK
Percentage of participants 'fairly satisfied' or 'very satisfied' with their healthcare. (2008)[85]	57	74	85

Unfortunately, there is a lack of WHO data available for public satisfaction of healthcare systems for our three countries since the financial crisis and subsequent reforms. Therefore it is interesting to note the measures the countries are taking to improve their patient satisfaction rates. For example, in Italy national legislation requires all public healthcare providers to have a 'health service chart', which contains information on performance, waiting times, quality assurance strategies and protocol for patient complaints.[86] Similarly in 2009, the Care Quality Commission (CQC) was established in England to monitor performances based on nationally set standards. The CQC's findings are then published on NHS choices. There has even been talk of the CQC carrying out inspections and playing a role 'akin to Ofsted's role in education'.[87]

Similar to the data above, in 2011 a national survey reported that 73.1 per cent of individuals believed the SNS was working fairly well to well.[88] Yet nearly 87 per cent supported increased spending on primary healthcare, rejecting the cuts.[89]

Have these systems maintained their core values?

The NHS defines its core values as follows: that it meet the needs of everyone, that it be free at the point of delivery and that it be based on clinical need, not ability to pay.[90] If these are adhered to by the Beveridgian systems then they will also be following Article 25 of the UN Declaration of Human Rights that states

'Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including … medical care and necessary social services, and the right to security in the event … sickness, disability … in circumstances beyond his control.'[91] Therefore, they are to be universal and free at the point of delivery. It is interesting to assess whether or not our three countries despite the troubles of recent years have managed to abide by these principles.

Italy

In a survey carried out in 2011, only 33 per cent of Italians considered the SSN to be maintaining these core values.[92] The main threat to universality in Italian healthcare is the large discrepancies between regions. Particularly, Italy has a huge divide between the northern/central regions and the southern regions; healthcare funding varies from 10.2 per cent below the national average to 17.7 per cent above.[93] This is mainly because the southern regions are less economically developed and as LHUs are able to raise additional funding from local taxation, revenue in the south is lower. As regions can choose to self-finance services that are not included in those the government deem 'essential', more affluent regions have access to a wider variety of treatments.

Varied resources have also meant a lack of universality in access to previously mentioned multispecialty and integrated GP services; advanced medical equipment; and hospital beds available.[94]

However, in recent years in particular there has been an effort to reduce these inequalities in the form of the Interregional Equalisation Fund and the directing of EU resources toward healthcare in the less affluent south since 2007.[95] Universality in healthcare also extends to all immigrants in Italy.

Italy's ability to provide healthcare free at the point of delivery has been hindered since the expansion of co-payments following the financial crisis. These included co-payments on pharmaceuticals and outpatient care, as already mentioned, as well as a €10 co-payment for specialist visits.[96] Not only do co-payments hinder the principle of free at the point of delivery, but the central government also allowed regional discretion in their implementation leading to further inequality. Yet exemptions from co-payments are applied to the following: those under the age of 6 and over 65, household with a gross income of below €36,000, severely disabled people, prisoners, those with chronic or rare diseases, pregnant women and those who are HIV-positive.[97] Moreover, those with out-of-pocket payments of above €129 per year are also eligible to receive tax credits.[98]

The core values of Italy's SSN are also threatened by corruption. 40 per cent of people when asked believed that bribes and abuse of power were widespread in the SSN, compared to the EU average of 30 per cent.[99] Moreover, the ECJ estimates that every year malpractice and corruption in healthcare costs Europe €56bn and that Italy is responsible for €20bn of that.[100]

Spain

As in the case of Italy, regional differences in Spanish healthcare exist and were exacerbated by the controversial RDL. The decree prohibited (although this has very recently been reversed) undocumented migrants from receiving healthcare, despite many arguing that they too contribute to the economy through taxes such as VAT.[101] The implementation of this has been varied across the Autonomous Communities (ACs), with some such as Catalonia, Andalusia and Asturias refusing to realise it.[102] Evidently this means uneven care available across the country as well as a lack of universality for immigrants.

Spain has also compromised the concept of free at the point of delivery with the aforementioned co-payments. However, Spain took what was considered to be a progressive stance, linking them to income. For example, pensioners on higher incomes pay a flat rate of 10 per cent of the cost of drugs, whereas others pay between €8 and €60 monthly, depending on their pension revenue (amounting to less than the flat rate).[103] Moreover the RDL redefined what services were 'commonly' available for the whole country and introduced supplementary packages, those services now subject to co-payments and complementary ones, which were to be defined on a region by region basis.[104]

Whilst corruption in the SNS does not appear to be as prevalent as in the SSN, it is ranked second, behind unemployment, as issues of highest concern amongst Spaniards; undoubtedly undermining confidence in the public sector including healthcare.[105] When asked the same question, 23 per cent of those polled in Spain believed bribery and abuse of power were widespread in public healthcare.[106] 'Informal payments in the medical service' have been found to be 'common practice.'[107]

How does England compare?

The common criticism that the NHS faces is the issue of the 'postcode lottery'. Whilst healthcare in England is not subject to the discrepancies of local taxation, a recent report by NHS England and Public Health England highlights the huge variations in healthcare across the NHS.[108] For example, they show huge variation

in the rate of mortality from cancer in people aged under 75 years and in the percentage of people aged 15–99 years who survived one year after being diagnosed with any cancer.[109] Even within London rates vary greatly between CCGs.

This is also reflected in the significant variations in life expectancy across the UK with a difference of over 10 years between the shortest living regions and the longest living ones, much higher than Italy's 2.8 years.[110]

It is hard to ascertain for certain, unlike in Spain and Italy why some regions are better at managing, preventing and diagnosing some diseases whereas others are not. It is perhaps most likely due to management decisions in commissioning.

In comparison with the SSN and the SNS, the NHS has managed to maintain healthcare free at the point of delivery. The financial crisis has not led to any additional co-payments or cost sharing in England, aside from the pre-existing prescription charges. Instead, in 2013 90 per cent of all prescriptions in England were dispensed free of charge.[111]

Furthermore, from the latest data available (2012) only 9 per cent of total expenditure on healthcare in the UK was out-of-pocket. This is compared to 18 per cent in Italy in 2013 and 20.7 per cent in Spain in 2011.[112]

Similarly, the NHS performs well on the corruption front, with only 18 per cent of people believing that bribery and abuse of power are widespread.[113]

Would decentralised healthcare benefit England?

Italy

As addressed in section four of this report, it is clear that decentralisation has a negative impact on equitability in healthcare due to varied funding and therefore treatment available. However, there is a strong case for decentralisation improving efficiency, which is evident in Italy's clinical outcomes and level of primary care. This is because decentralisation allows for regions to apply treatments and procedures based on the peculiarities of that region. For example in Italy, regions can adopt their own 'organisational architectures' and if they prove to be effective on a smaller scale are often adopted on a larger scale by other regions.[114] Yet some argue that decentralisation has worsened the North-South divide in Italy.[115]

In 2009, 168,000 southern patients chose to be treated in the North, whereas only 31,000 remained in the South.[116]

Spain

Again, as is the case with Italy, decentralisation of healthcare in Spain allows for efficient allocation of services depending on peculiarities of the region. In Catalonia for example, more hospital beds were provided as data showed its ageing population required more long-term care.[117]

Many also believe that decentralisation makes it easier to implement reforms and analyse cost efficiency.[118] If one region is not meeting economic targets it is easier to implement reform locally before it becomes a national issue.

However, decentralisation in Spain often leads to conflicts between local and central government due to differing politics. This has been the case in the aforementioned implementation of the RDL; many local governments have opposed its measures, which in turn has meant reform implementation is stagnated. Moreover, in 2012, purchasing of supplies, drugs and matters such as energy saving all became centralised, which was estimated to have saved €80m.[119]

Would decentralisation of the NHS benefit England?

It is clear from looking at outcomes, primary healthcare and reforms that the NHS lags behind the SSN and SNS despite them all being tax-financed systems. This gives hope to the defenders of Beveridgian healthcare, but it does bring into question the centralised structure of the NHS.

The main limitation that comes to mind when people suggest a decentralised NHS is the issue of the postcode lottery. However, patients could have the option of choosing to use services in other health areas (as they do in Italy and Spain). Moreover, we have seen that the postcode lottery in the NHS is already substantial and if a system is implemented whereby there are standard treatments and services available by national legislation in each health area (as in Italy), this could even safeguard it.

The finances of NHS trusts are currently in turmoil. Given that local authorities ‘can claim a rather better record of fiscal self-discipline’, devolving NHS funding to them from the complex web of NHS organisations could cut out bureaucracy and prove more efficient.[120] Also, as demonstrated in Italy and Spain devolved healthcare could address regional healthcare or demographic trends.

It is strongly believed by many that devolved healthcare would lead to the 'holy grail of integrated care.'[121] It would allow public health, social services and health services to work under one auspice. This could improve outcomes as well as act as a preventative healthcare system to avoid many cases having to go beyond primary care. We have seen particularly in the case of Spain that devolution and integrated primary care seem to go hand in hand.

Some attempts have been made at decentralisation; influenced by the Liberal Democrats, an emphasis was also put on the role of local government. Public health was now devolved to local government along with Health and Wellbeing Boards. As the CCGs consult with Health and Wellbeing boards this introduced a link with local government.

Of course there are risks involved with what would be considered another huge structural reorganisation of the NHS. However, if the trial devolution of healthcare to Greater Manchester proves to be effective, then it would surely fix a system that has many severe flaws. Decentralisation could take place slowly and carefully as was done in Spain starting with devolved healthcare to Catalonia years before the other ACs. This report has found that the previous healthcare reforms of Andrew Lansley restructured the NHS without making it more efficient than its Beveridgian counterparts and as decentralisation of healthcare could be done gradually, it could be the perfect solution.

Conclusion

The main difference between how the UK reacted to the financial crisis and how the Italians and Spanish did, is that they reformed their healthcare services within their existing structures. The past cannot be changed, so whilst it is true that a top-down reorganisation in the middle of a financial crisis was detrimental, it is more useful to learn from other countries how to proceed. From the SSN and the SNS the NHS can learn two key lessons.

Firstly, this report has shown the primary healthcare in Italy and Spain operates more efficiently and often more equitably than in England. Integrated and multispecialty GP practices would reduce the constraints on secondary healthcare and therefore the ever growing budget deficit. It could also improve our clinical outcomes, many of which compare inadequately to Italy and Spain.

Secondly, the government must start to seriously consider devolution of healthcare. This report acknowledges that progress is being made with trials in Greater Manchester, but in order to implement it successfully it must follow a blueprint that has been successful, which Italy and Spain can provide.

Both of the above could remedy the NHS's financial efficiency, which can no longer be ignored. This is shown by the projected budget deficit and high spending per capita. Moreover, if cuts are going to be made, honesty is crucial in order to allow the health service to make future plans. As critics often accuse this inefficiency as being inherent to tax-financed healthcare systems, proving that the SSN and the SNS operate more fiscally efficiently shows that the NHS has a lot to learn from them as well as social insurance systems.

It must be recognised that the NHS, throughout the trials and tribulations of the financial crisis, has managed to continue to deliver healthcare free at the point of delivery. There is often criticism over waiting times, which do need improving, yet it is a testament to our healthcare that it remains free. This is where Italy and Spain have compromised their core values in order to achieve efficiency.

It is significant that Italy and Spain have such relatively successful healthcare systems given their financial situations. This indicates they are operating with a structural advantage. Of course they are flawed in many areas such as disparities and corruption. Yet we should look to learn from their systems as our closest relatives in the healthcare sector.

The NHS is something to be proud of and by learning from other Beveridgian systems and implementing reforms we can strengthen it further. The SSN and the SNS do outperform the NHS in crucial areas and so long as the NHS is to remain a tax-financed system it makes the most sense to compare it to other Beveridgian systems.

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