Asociación para la Defensa de la Sanidad Pública de Salamanca

Constelación de los Comunes

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Website
www.fadsp.es/

Who are you, where are we, and what is your relationship with the Federación de Asociaciones para la Defensa de la Sanidad Pública (FADSP)?

Aurelio: We'll introduce ourselves individually in a moment. We are three members of the Asociación por la Defensa de la Sanidad Pública de Salamanca. Salamanca is a province located in the Autonomous Community of Castilla y León, in Spain. The Asociación por la Defensa de la Sanidad Pública is federated. It is part of the Federación de Asociaciones para la Defensa de la Sanidad Pública. We are a non-profit association that supports a model of universal public healthcare that benefits everyone and that is accessible to everyone. We also believe that this system should be efficient, of high quality, and free when it needs to be utilized. To accomplish this, there needs to be sufficient funding, which comes from the national budget. I am an internist – I'm now retired because I am quite old – but I was an internist at the Hospital Clínico de Salamanca for 42 years and a few months. My name is Aurelio Fuertes Martín.

Emilio: Hello. My name is Emilio Ramos Delgado. I'm a family doctor. I trained through the MIR system, and one of the mentors who aided me in my training was Dr. Aurelio Fuertes. That professional relationship ended up becoming a friendly one, and at some point in between I became part of the Asociación por la Defensa de la Sanidad Pública. I've been with them ever since. At the moment, it's my turn to be the President of the Association. In our Association the positions are representative, and rotating through these positions improves the functioning of the Association. I also live in Salamanca and have worked as a doctor in two different places. I had a small rural practice as a town doctor, which I would have been happy to continue for the rest of my life. But, then I did my residency, which was a very valuable experience for me and for all of us here as family doctors. I then practiced for a few years in the city of Mérida in the Autonomous Community of Extremadura, which borders Castilla y León. Later on, I returned to Salamanca for personal and family reasons. It was also a good place to raise our children.

I would also like to introduce Dr. Luz Mari Martínez, who couldn't be here because of her occupation and needing to care for a third party. Dr. Luz Mari Martínez specialized in internal medicine at the same time as us and later practiced in Asturias as a family doctor. She has spent the rest of her career as a family doctor. She is currently working at the Alamedilla Health Center (I would like to take this opportunity to say that that is where I also worked in Salamanca over the years, until I retired two years ago). She is still practicing and is a very intelligent person. It's a shame that today, for reasons beyond her control, she could not be here.

Generoso: My name is Generoso Gómez Cruz. I'm going to start a little further back. I graduated from medical school the same year as Emilio, and I am a little jealous because he managed to do the MIR and I didn't. So, my background is strictly rural. When I finished my degree, I passed the public exam for certification in Asistencia Pública Domiciliaria (APD), which allowed me to become a "medical officer" that could make house calls to patients. As medical officers, we started working as soon as we finished our degrees – that is, without any practical experience – but with great peace of mind because we had a job for life. I started working in a rural area, with only the knowledge I had acquired during my degree. Hence my envy of those who trained further. I worked alongside a handful of colleagues in the towns next to mine, which belonged to what later became the Fuentesaúco Health Center, which is in Zamora, north of Salamanca. In those days, we each lived in our own house, we were doctors 24 hours a day, we lived in houses set aside for the town doctors, and we attended to our patients in such a way that when you wanted to go to Salamanca, for example, to the hairdresser, you had to put a note on the door saying "I have gone to Salamanca."

Starting from scratch helped me to recognize my weaknesses, which were really in all areas, and to recognize that I had to improve. Together with my colleagues we did our own retraining with the medical specialists at the Hospital de Zamora, and we gradually retrained, including in emergency medicine, which helped us fill our knowledge gaps. At the same time, the Real Decreto de Estructuras Básicas de Salud (Royal Decree on Basic Structures of Health) was implemented – which we will talk about later – and the health centers began to appear. We lived in a rural area (Emilio in an urban area), and it was great to start working in an organized way in primary care.

I spent 26 years working in the rural environment, in that same town as well as another town that was added to my list. Therefore, I also know a lot about starting one's medical career in a very small town, which leaves you at a disadvantage because you have no experience, you have very few patients and it's hard to do it all by yourself. At one point they offered me a job in another town. It was good for me. It was more work, but I was more active. So, ultimately that allowed me to end up managing more illnesses and that was very nice.

The rural environment left its mark on me. In fact, when people ask me, I say that I have a rural medical background, an APD background. Later on, there came a time when I moved to Salamanca, which is where I spent the last 12 years of my career, in an urban health center. That's where I joined the Association. In Zamora, I belonged to the Asociación por la Defensa de la Sanidad Pública de Zamora, which in those years was losing steam because Zamora is smaller and our functions were very local. In fact, during my last years in Zamora we didn't do anything anymore. But, when I came to Salamanca I joined the powerful Salamanca Asociación por la Defensa de la Sanidad Pública. I had been following the Association, but I hadn't joined it yet. When I came here I joined the ADSP of Salamanca and here I am. These have been very good years for me because I have learned a lot of things from the Association.

You mentioned that some of you trained through the MIR route. What does this refer to?

Emilio: The "MIR" pathway refers to the Médico Interno Residente (a Resident Intern Doctor). It is the training method in Spain for obtaining specialization, or postgraduate studies. In Spain you do six years of undergraduate studies in medicine. And then, medical students voluntarily take an exam to enter the MIR. The same exam is taken on the same day, at the same time, with the same questions throughout the Spanish state. From Girona, which is a city on the border with France, to the Canary Islands, which are at a much more southerly latitude. The exam is set by a team that is kept secret and that makes it very standardized. Each student receives a score and based on that score the Spanish Ministry of Health begins the process of assigning medical students one by one to programs based on the specialties that each person wants to pursue, whether it is family medicine, internal medicine, surgery, etc. And, then there is a training period of between four and six years, depending on the specialty.

On your website it says that "The FADSP is a federation of associations of healthcare professionals (doctors, nurses, assistants, administrators, psychologists, social workers, managers, economists, etc.) interested in the defense and improvement of the public healthcare system." Where, when and how was this initiative born?

Aurelio: The Federation was born at a meeting in Madrid in 1982. The Asociación por la Defensa de la Sanidad Pública de Madrid had been founded about a year prior, and this meeting was attended by people from all over Spain. Ultimately, they decided to form a federation of associations, which were organized either by Autonomous Communities or by provinces. That was in December 1982. It was an important moment, and it is especially interesting because this was a moment during which the Spanish transition from Francoism, which ended in 1975, was taking place. At that time, things were still very uncertain, and there was widespread chaos in healthcare at all levels, in both out-patient primary care and in-patient hospital care. This led to a confrontation between these sectors, which had to work together to design a new healthcare system. There was one sector, represented by the Consejo General de Colegios de Médicos (General Council of Medical Assosiation), which was committed to a more free-market oriented health system, like social security. And there was another sector that was committed to a National Health Service-type health system, modeled on the English one. The Consejo General de Colegios de Médicos in combination with the most reactionary sectors of healthcare in Spain made a very strong push to pursue that first approach. The Asociación por la Defensa de la Sanidad Pública de Madrid emerged as a reponse to that push. And then the Federation emerged to continue that fight. The Federation was initially conceived as a federation of doctors that would strengthen the fight against the Consejo General de Colegios de Médicos. But then, very soon, it became clear that it didn't have much of a raison d'être. We were advocating for there to be societal representation and for society to have a say in all aspects of healthcare. So, the Federation was opened up to all health professionals and, although it is not very regulated, to the entire population.

Who were the promoters of this Federation?

Aurelio: The first secretary general of the Federation was Gerardo Hernández Les and the president was Pedro Zarco. Pedro Zarco was a highly renowned cardiologist. Hernández was a dynamic person, and he ended up going into politics later. Marciano Sánchez Baile was also there, and he has ended up being the most important person, I think, in the entire history of the Federation. He has been there from the beginning, and he is a person who has never stopped moving and doing things. He has been an inspiration for the Federation. There were also women. The thing is that maybe they weren't in the front row at first, but yes, from the beginning there were female doctors and then, later, female professionals from other sectors.

How did the Asociación por la Defensa de la Sanidad Pública de Salamanca come about?

Aurelio: The Salamanca association came about the same way as the Madrid association and others because it was clear that the political moment demanded a counterbalance to the power of the Consejo General de Colegios de Médicos, to see to it that the healthcare system in Spain was going in the right direction. At that time, the Socialist Party had just won the elections in Salamance, and the moment was very significant. There was a meeting of doctors from all sectors. There were many doctors at the meeting because not only were primary care physicians divided on this issue, but so were hospitalists because not all of them were in the hospital, since some of them existed outside that hierarchy. And that's how it came about. There was a founding assembly in November 1982, shortly before the Federation was created. We joined in December, and from there it grew. A board of directors was formed and from then on we started our work.

And you are a founder?

Aurelio: I wasn't a founder. I wasn't there at the beginning. I was there, but I didn't join at the beginning, and I didn't join for one reason and that was because the Federation at that time wasn't open to everyone. Not everyone could join. And, there was a section, an article in the statutes, which I can't remember right now, which said that it was to be made up of only doctors. From the outset, I was in favor of the Federation including all types of healthcare professionals and being open to the general population, and that's why I didn't join at first. In 1983, a year later, at another conference in Cádiz, the Federation was opened to everyone, and I became a member. And since then I've been there in the second row, in the front row, and now in the back row.

How is this Federation governed?

Aurelio: The Federation has a national Board of Directors, with a number of members: a president, a vice-president, a secretary, etc., who are from different federations. Then, there is a Federation Assembly which is held every year, coinciding with a Congress which deals with some of the most pressing issues at that time. That's how it is organized. Every two years, I think, the management positions are changed by election.

How is the Federation sustained financially speaking?

Aurelio: The Federation is sustained by the members of the Federation. Fees are paid and half of these fees go to the Federation as a whole, and the other half stays with each association. In other words, I pay an amount of money, half of which stays in Salamanca and half of which goes to where the Federation is based, which is Madrid, which obviously has a lot of expenses.

Let's talk a little about history. Can you explain what kind of healthcare system existed in Spain during the Franco regime and up until the arrival of the public healthcare system that we have today?

Aurelio: It was quite chaotic. I don't think any particular model was being promoted; it was something that emerged more or less spontaneously, or that was based on previous legislation. There was already some previous legislation in place, but more related to public health than the healthcare system. And, in terms of healthcare there were tenured doctors, including rural doctors who were also tenured.

Generoso: APD, the medical officials. The exam I took was based on a law called the Ley de Bases de 1944 (the 1944 Framework Law). It was the law that had supported the system up to that point.

Emilio: At that time, rural doctors depended enormously on the mayors of each town council, to the point that they decided on how much vacation, leave, etc. the doctors would get.

Generoso: The local health officer was the mayor. He delegated to the doctor. Therefore, my boss, as we understand it today, was the mayor. We, the doctors of APD, were doctors who worked for the Ministry of Health, and in fact the Ministry of Health was the one that paid us our basic salary. What happened was that later, in 1978, Insalud appeared (I started working in 1983). So, as a doctor for Asistencia Pública Domiciliaria, for the Health Service, you were based in and worked in the town, and you attended to Insalud patients, and Insalud paid you for the medical cards of the people you attended to. We had two salaries, one from the Ministry of Health and another from the National Health Institute (Insalud). We are talking about a time when the autonomous communities did not yet exist. When I started working, Francoism had just ended, and we were starting to return to democracy. At that time there was no new legislation yet, and we were going back and forth.

Emilio: Can you correct me? But at that time, and we're talking about before '86, just so we're clear. That thing we were talking about the record book...

Aurelio: We're talking about before, in '82.

Emilio: '84.

Generoso: '84. Exactly.

Emilio: You're right. Well, essentially, each worker was assigned a document called a "card", which listed the people who were dependent on him. And each doctor was assigned a number of cards. And, I believe the card was given to a person based on their employment status because universal insurance, which would appear later, had not yet appeared.

Generoso: Of course, indeed. It went further. A person earned the right to healthcare by working and contributing to the system.

Aurelio: To try to summarize what healthcare was like in Franco's time and at the beginning of the Transition, as Generoso said: There were a number of people who had medical insurance, who were employed by someone else, or some other types of mutual insurance companies, such as agricultural ones, for example. There was also a large part of the population that had nothing, that when they had a medical problem they had to go to the private sector or pay a "share", as it was called, to a doctor in the towns or in the city.

At the specialized level there were charity hospitals, which is where a large part of the population went. These were very poorly equipped hospitals. These were also other hospitals that started being built in the 1960s, which were called “Health Residences”. And it’s funny, because Health Residences is a strange name for a hospital. It was given that name to make them sound better. They started to be called “residences” because the name hospital didn’t sit well with people. The hospital was the place where you went to die. They were called residences to change that perception. The residences started to become something interesting. But where did that lead? Well, surely to a social security type system paid for by insurance, as exists in Germany or France. That was the approach of the Consejo General de Colegios de Médicos. Our approach was the opposite: a system that was universal for everyone and that was paid for not because people were working, but because it was paid for from the General State Budget.

In Spain today we have a public healthcare system; can you explain how it came about and what this system means?

Generoso: We almost have to start at the beginning, connecting it to what Aurelio was saying. From my point of view in the rural environment, the first thing that appeared was not the Ley General de Sanidad (General Health Law) but a Royal Decree called the Real Decreto de Estructuras Básicas de Salud, in 1984.

It was a Royal Decree that attempted to start organizing primary care. It was a very important change because it centralized the individual work of each primary care physician into collective work that was organized around Health Centers. It was an important change but also something that the population did not understand. That’s because when Health Centers were created, the primary care doctor stopped working 24 hours a day and started working eight hours a day. And, they started doing on-call shifts, so the doctor stopped living in the town and that was an important change. The population had seen the doctor as someone who lived in the town and belonged to the town. Suddenly, the doctor stopped doing so and went to live in the capital. For them, at that time, having the doctor 15 kilometers away was complicated. As physicians, we didn’t know what that Health Center could offer either, but we did know that we were going to be able to work together and that we were going to be able to keep track of the patients we had and ask each other for help.

At the time, it was a very important change. We also knew that the equipment wasn’t going to be very good, but at least we were going to have some diagnostic tools that we didn’t have before, like an electrocardiograph (ECG), for example. We had to explain it in to the residents of the towns. They didn’t agree with the change, even though the doctor explained it to them and they eventually came to understand its importance. There were conflicts, but in the end we succeeded. That was the beginning. The time then came, politically speaking, to establish the Ley General de Sanidad. It was passed on April 25, 1986. It was an important change because it included three basic principles. First was the principle of universality. That is, up to that moment people had their cards which they received because they were workers. Other people who were self-employed had to look for insurance, and in the towns they had to make an agreement with the doctor, and suddenly that disappeared. The self-employed were initially left out, and then they were included later. But, then the principle of universality was established. In other words, everyone has the right, by virtue of being a person, by virtue of living in the country, to medical care, to health care, and that was an important point.

The next important point was that the National Health System, which was created by law, was public and would be financed through State taxes. Through these taxes, the State financed the National Health Service and provided services to the population, so that the financing was based on how much a person paid in income tax. It was therefore proportional to the income of any given person. It was a proportional contribution. However, the services offered by the National Health System were proportional to the needs of the patients. Therefore, we come to another third point, which is basic, which is that of solidarity. So, people with greater purchasing power contribute more and once they have contributed, more will be given to those who need it most. That is the principle of solidarity. These three basic principles of solidarity, universality, and equity were the three principles on which the National Health System was based. From there, the services provided to the population and the primary care Health Centers were developed.

Is it an efficient system?

Emilio: It is a very efficient system, although I will start by saying that it has some problems. But those problems mean that we, as an Association, are active with so many things, although hopefully that would not be necessary. But it is very efficient. If I had to give figures, I would mention one that has surprised me even now as I consider it: 29% of men consulted the National Health System in the last four months and the figure for women is more or less the same. That is to say, every four months a quarter of the population of Spain has depended on some part of the health system. Someone will say to me: “yes, but the sickest use it more.” In that case, I would return to the principle of solidarity. As long as I have remained healthy it must not have mattered to me, and that is a message that we continually send out. I shouldn’t have cared about financing the public system because someone at some point is going to use it. If someone calls this do-goodery or something else, I would reply that it has clearly redistributed wealth but that it has also been a tremendous success for the Spanish population. We are talking about the 40 years that the National Health System has existed, since 1986. If there is any problem it may be that it’s been a victim of its own success. We can debate whether all these visits are justified, etc. We also know, from other data, that in Spain, on average, we consult the doctor six times a year. That’s called “frequentation.” So, we make use of the health system six times a year and every four months a quarter of us have had to use it. That generates a degree of satisfaction, as you can see in the surveys, and people seem to be happy. There are two other very interesting facts. Only three out of ten people asked would change anything in the Spanish National Health System, and only one in ten thinks it should be replaced and redesigned. So it must be doing ok, right? I would even say it’s going well.

Generoso: If I may, speaking in economic terms, we should compare ourselves with the rest of the countries in the European Union. Public spending on healthcare in Spain right now is at 7.8% [of the GDP]. Private spending is at 3.1%. If we compare ourselves with the rest of the countries in the European Union, it turns out that Germany, France, the United Kingdom, Portugal even, the Netherlands, consume more than Spain in both public and private spending. France, off the top of my head, is at around 11% of GDP in public spending and around 9% in private spending. These are important figures to remember because what Emilio is talking about is also being done at a lower cost.

Who has access to the public health system?

Emilio: Everyone.

Generoso: Yes, everyone.

Emilio: Fortunately, today, again, everyone. We can clarify how it used to be.

Aurelio: There was a time when people who did not have a justified reason for working as well as others who had a high income from other sources did not have access to public healthcare. Right now, I don't know if that has been corrected because there have been ups and downs. There was also a very serious problem, which has been more or less resolved, with undocumented migrants. At that time, due to a regulation that came into force in 2012, I believe that these people only had access to the health system in urgent cases as well as for pregnant women.

Emilio: Pregnant women and children under two months old.

Aurelio: I think that has been largely corrected, although I don't know if it's been completely corrected. That was a very significant problem that arose because it was unfair and quite absurd, as well as problematic, to leave people without healthcare. For them and for the whole community.

Are all medical specialties accessible through this system?

Emilio: No. We have access to all of them, but there are exceptions. We're looking at each other because, to give an example, going to the dentist – for children it is included, but not for adults, except for tooth extraction. It is not included in dental treatments for adults. The financing of glasses is not included either.

Generous: Cosmetic surgery as well as, I think, physical therapy and podiatry are not included. Well, physical therapy is included, but podiatry is not. Podiatry, cosmetic surgery and plastic surgery with nuances. Plastic surgery is for those occasions when it is considered medically necessary, but plastic surgery as a whole is not included in all cases.

Which would you say is the best equipped specialty, economically speaking?

Aurelio: The funding depends on the technological equipment they have. Logically, there are specialties that are better funded precisely for that reason, but perhaps it is because they need it. I don't know if this is of major importance. What is best funded for professionals is the transplant system. It is something special in Spain. It works extraordinarily well. I think it's the world leader in transplants, but it does have special provisions for those people who work in the system, which is a lot of people. That doesn't happen in other specialties. These people, let's say at the end of the month or the year, have higher earnings.

How does the Spanish public healthcare sector differ from the private system?

Emilio: The public system aims to provide a service to the community. The private system aims to get rich. Full stop.

Generoso: It's a clear issue. As a consequence of this, the private system treats all those illnesses that are profitable. Therefore, it does not attend to those that are not profitable. Patient care in the private sector is based on a contract, and the care provided is specified in that contract. This means that quality is offered to those who want to pay for it, who can afford it, I'm sorry to say. However, the public system offers quality to the entire population. That is the big difference: People in Spain, who are already over 40 and who were born into this system, are very at ease, even if they sometimes complain, because they know that they will always have medical care and that it will be of high quality.

Emilio: We are talking about the public and private systems. There are work situations in which the worker is forced, more directly or indirectly, to turn to the private sector. One example would be through a mechanism that applies, for example, to teachers, but also to local council workers and civil servants. The classic example is this: When a person is young, and therefore they have fewer health conditions, they remain in the private system, but when they get older and begin to develop a long list of illnesses, suddenly they switch from the private system to the public system. But this flow can be altered over time. If, unfortunately, a serious illness appears, the citizen who was in the private system will automatically switch to the public system that takes them in and looks after them.

Aurelio: This is a very important part. I think that, first of all, the public health system looks after the health of the population, when they are healthy and when they are sick. The private system only looks after you when you are sick. I wouldn't be as radical as Emilio. The private services aim to make a profit, but they also provide a treatment, let's say, for illnesses that people turn to because they can. But, fundamentally, the problem is that these services, in addition to not attending to preventive aspects, are not universal, of course. Not everyone can access them, only people who can pay for them. And, that is a very important point. It is not fair at all, because it does not attend according to needs, but according to the economic possibilities they have. That is the big difference. In Spain, the private health system is seen as something complementary to the public system and as something complementary it has its raison d'être. The problem is when the private system wants to take over part of what belongs to the public system and wants to take over what the public system is providing. That is the problem we are facing, and I think we have been facing it for some time now.

In this neoliberal capitalist moment we are experiencing increased privatization of public services; is this happening in the healthcare sector?

Emilio: This is not only happening in the United States. Right now, it is happening in Spain, and in some autonomous communities, even more so. The case of Madrid is a clear example, as you can see. I am much more radical than Dr. Fuertes. Madrid has abandoned preventive and curative care for many of its citizens. Primary care is closed, emergency rooms are closed. So, of course, people who can are moving to the private system as much as possible.

The description of the Federation says that it was created for the "defense and improvement" of the public healthcare system in Spain. Can you explain exactly what this system needs to be defended from?

Aurelio: We support the public healthcare system as it is established. A National Health Service type of health system, with all that that implies. And we believe that this system maintains a necessary assurance of quality. We fight for it to continue to be equitable. We support something that is very important right now, which is that it has, shall we say, normal accessibility. Right now, for example, a current problem is waitlists. If the waitlists are not logical, if they do not make sense, then the system

is not accessible to everyone. And, it is causing problems, which may cause patients or citizens to go elsewhere to have their health problem or illness resolved better.

The issue is how to defend the public healthcare system from this and to defend it fundamentally at an ideological level from everything that has come from neoliberalism over the years, which advocates that everyone should fend for themselves as best they can. Individuality versus the collective. And to defend it on a more practical level, to defend it from being absorbed by the private system, which many economic sectors that live simply off finance are promoting. And also political sectors that seek to give more power to the private health system. I think that's basically what we're defending it from.

Generoso: In fact, there have been several institutional attacks on the system. You see, as early as 1991 a report appeared, called the Abril Report, which already opened up the possibility of privatizing all situations that public healthcare did not cover. But it seems to me that the greatest risk was taken with the Royal Decree Law of April 1982, which was called the Sostenibilidad del Sistema Nacional de Salud (Sustainability of the National Health System), but which curiously did the opposite. It was intended to destroy the safety net that is the National Health System by trying to reintroduce insurance. At that moment, it was a serious threat because it left many people out. For example, those over 14 years of age were excluded.

So, it had to be reorganized and the Salamanca ADSP actively mobilized. We studied the Royal Decree Law. As we normally do, we tried to make it accessible and we set up working groups. So, we went around to neighborhood associations, both urban and rural, to inform them of the situation and what was really happening because nobody was talking about it.

They only talked about another part of this Royal Decree Law which was the pharmaceutical co-payment for retirees. Until that date, workers paid a percentage of the cost of medicines, but retirees had free medicine. And what this Royal Decree Law included was the pharmaceutical co-payment for retirees, which was not done in a linear way but depended on what was called the Individual Health Card. At that time there were payment percentages; still, some people were unable to buy. As this co-payment was public knowledge, part of the information remained at a public level, but what the Association really cared about was the other thing because it completely undermined one of the basic principles, which was that of universality. And, that is why we were forced to defend it by giving direct information to the population.

Aurelio: One important thing, to be able to answer your question, is to remember that when the Ley General de Sanidad was passed in Spain, which is where everything we are talking about starts, it was 1986. That was when the PSOE came to power in Spain. The Transition was beginning to stabilize and Margaret Thatcher and Reagan had already been in government. At that time, when Spain was starting to have a welfare state, everyone else was cutting back. And then, of course, four or five years after the Ley General de Sanidad, a commission was set up under the Abril Report to annihilate the progressive aspects of the Ley General de Sanidad. From that point on, everything starts to make sense. We have always been opposed to these changes.

There is also talk in the Association of wanting to improve the system; what needs to be improved in this system?

Generoso: Accessibility. The health system has weaknesses. It also depends on how it is managed. One of our basic requests is for increased funding. In Castilla y León we know how important this funding is because it is one of the autonomous regions with the best funding for primary care, although it is still far from what we're asking for.

In Castilla y León right now, discounting expenditure on pharmaceuticals, primary care accounts for around 16-17% of the health expenditure of Castilla y León. We are asking for 25% because we think that is a minimum level of funding. But it is not all about funding. The government of Castilla y León defends itself by saying that they provide the most funding in Spain. But funding per se is not enough. We need good management because if we mismanage this money we are going to misuse it, and that is the key point for us: proper management. And, to do that more power has to be allocated further down in the healthcare system. Those who legislate have to direct the management, but the management has to be reallocated further down. And that management, even at the level of the department, we consider to be very lacking. Therefore, we find ourselves with overworked professionals and we find that there is no time to attend to patients even though these professionals have quality of care in their DNA. The consequence: waitlists and overworking are leading to this. Controlled waitlists are a form of self-regulation of the public system, but they are regulated. The problem is when waitlists get out of control, and the problem is when the administration starts to hide data. Because when the waitlists get out of control (and I'm talking about what causes the most problems, which is when we in primary care refer patients to hospital specialist consultations) it is very important for us to know how long it will take to see the patient because we have already reached the limit and we are referring. But it turns out that when we refer we assume that the patient will be given an appointment, but this is not the case. That patient goes to what they call the inbox, and we call limbo: they are put on a list to get an appointment and we don't know when they are going to be given one. What's more, in some services they don't even know how many referrals they have pending. This is a very serious issue, and it is an issue that we are obviously against. Solutions have to be found for this issue. And, they have been found.

Aurelio: There is a problem with how the system distributes funding because as of now the funding goes mainly to the hospital. And, we have been arguing, for some time now, that 25% of the health budget should go to primary care, which serves as the foundation of the system. There is a problem with technical management and we have been asking for years that technical managers do MIR-type training and that they are not appointed simply because they follow the political line of the party in power at the time. And, we want this management to be efficient and for this financing to be as it should be. That is, there has to be a firm political commitment to the public healthcare system. This commitment is not clearly seen at the state level and at the regional level it mostly does not exist because a large majority of the regions are governed by the political right that clearly does not support this model. I believe that the financing-management problem is the key issue and it has a solution. But we have to want to give it to them.

Emilio: One piece of information to add to what my colleagues are saying. At the moment, in Spain, 47,600,000 inhabitants are served by the public health system. We said before that each patient goes about six times a year. Well, in primary care there are 225 million consultations a year, about 30 a day per professional. Hospitals attend to around 4 million patients, and that is around 84 million consultations a year. That's to give you a sense of the workload. But then also, as I always say, the analysis has to

go further. Each of those consultations has a weight, it requires time and a resolution. But, I would also draw attention to this: a professional who works with a theoretical initial load of 30 consultations a day has to make very important decisions together with the patient. In other words, they also have to listen to them, it is not enough to say you do this, you do that, no; they have to empathize, they have to agree and they have to make decisions, and they have to do that 30 times a day. And, this is at a time when there is a complete absence of staff replacement policies.I emphasize that complete absence of policies because nobody did anything when everyone knew that we would need them. 30 or 40 years ago we were 20 and we all entered the system around 1986 when a lot of staff joined and we were all very young. We were all 20 years old then. And, 20 years later we started to realize: “Hey, in another 20 years, maybe some of us won’t be here and others of us will have to leave.”
The time has come, but there is no replacement. The MIR system is still in place and the number of spots has been increased, but, of course, training a doctor or training another health professional like a nurse, takes a lot of years. We can’t solve this issue overnight. There is an inefficiency in how the system is managed that frightens us because we see it becoming more and more established. Inefficiencies are already taking root, and sometimes they are even being praised. Some might think that it is actually something that is intended to happen, so then the system is not fixed.
They talk about putting more money into the system, but then they trick you. They may put more money in, but then there is no rational use of the money. And, yet the population has not only increased in number, but also increased in problems. I was talking earlier about the increase in illnesses. We have more and more chronic health conditions because we are living longer. Nobody over the years has paid attention to these particularities or to making the changes that the healthcare model has needed, especially the primary care model (and also the hospital care model, of course) to provide the support and solutions needed for the requirements of the population.

Do you think that the public is aware of the importance of having a public healthcare system?

Aurelio: I think that a minority of people are aware of its importance. Because the younger sector of the population is fundamentally made up of healthy people who have no contact with the system and do not see the system as necessary as it is. This means that there is a large sector of the population that is left out and could be the one with the most strength to make demands. There is also a sector, let’s say, economic, of the population that has the possibility of having either public healthcare or private health care. So, by the time they need it, they obviously don’t see the need either. But, there is a sector, which is fundamentally made up of people who have problems, older people who see the problems they or those around them are experiencing, who are becoming aware that this cannot go on like this and that it has to be improved. And, above all, there are problems, such as waitlists, that do mobilize the population. In recent years, the White Tide has emerged, which has been very successful in mobilizing a large part of the population and in reclaiming their rights. That, perhaps, is still not enough, and part of our efforts should go in that direction, to make the population aware of their rights and to defend them.

Who makes up the body of professionals in the public health system?

Emilio: First, there is the administrative staff in all the centers, who are fundamental. Aides, clinic assistants, nursing staff, midwives, primary care doctors, primary care nurses, hospital doctors, hospital nurses. And then physical therapists, psychologists. I’m sure I’m leaving others out...

Aurelio: There are far too few psychologists, unfortunately.

Emilio: We’ve been talking about physical therapists and psychologists without emphasizing the important work they do and how under-represented they are in the public healthcare system. Social workers are another group that is clearly understaffed.

Generoso: We have too few of them. Social workers are mainly dedicated to managing the subsidies that people request, which means they are not allowed to do as much of their real job, which is to go to the patients’ homes, see what their needs are, talk to them, try to solve what is not solved in most cases with subsidies, which is what they are dedicated to. But that’s not something against social workers; it’s an issue within the system. Because the social workers, the few that there are, are so overworked that they can’t manage to provide the information and the help that their profession is really being asked to provide.

Emilio: In fact, when you’re in practice, when you’re working, when you’re in the exam room every day, the tools that you really miss the most, among others, are the accessibility, agility, and efficiency of social workers. The same goes for physical therapists and psychologists. Because in healthcare, which we have already said has an enormous workload, we are not really going to be able to say what is purely a healthcare issue or due to illness. That’s because in many cases other personal issues are present and need to be dealt with, which is important. But, they require different solutions. And, unfortunately, the solutions that are offered don’t usually include a prescription for a social worker.

If we could do physical therapy, how many fewer anti-inflammatories and painkillers would have to be prescribed? Side effects and expenses would decrease. And in terms of mental health, how much would wellbeing be improved? And, rather than the understanding being “this person has a problem, I’ll pass it on to someone else,” it would instead be “this person has a problem and I, as the family doctor, ask the psychologist for an opinion, I ask the physical therapist for an opinion, sometimes the social worker”, and with that I go about solving the patient’s problems. I think that not having that perspective is a major flaw in our health system.

Taking into account the problems you have mentioned, would you say that there is a certain degree of dissatisfaction among people who work within the health system?

Aurelio: There is dissatisfaction, not because of the work itself, because until now, at least as far as I have seen, there is job satisfaction in practically all sectors of the health profession. There is a feeling of dissatisfaction because there is often job insecurity, because salaries are often inadequate and because, as we have said, there is a shameful lack of staff in some specialties (psychologists or physical therapists, for example, or social workers). I think that’s where the dissatisfaction comes from. There is dissatisfaction, of course, but fundamentally it is because perhaps the public administration is not treating them as it should.

Emilio: Again, it's a problem with the managers. Not enough managers and bad management is creating a work situation, a work scenario, which leads to people being... I've been thinking about which adjective to use because I don't want to use the term "burnout." I'm going to put it another way. Healthcare professionals are very much committed to the concept of caring and we like to do it well and we can't do it well because we lack the means. And, sometimes the main thing we lack is time. Because if it's just me, as I explained before, I can't do it alone. You don't have the time and you can't solve everything.

Generoso: And there is another important factor, which is having the Public Administration recognize the work you are doing. The Administration tends to equalize in all aspects. Equal work, in theory, equal pay, let's say. But, I'm not just referring to what you are paid at the end of the month. I'm referring to the recognition of the workers themselves.

And, here, we lack incentives from the Administration to reward professionals who contribute more to the system, including a lack of any attempts to create those kinds of incentives. Because it doesn't exist. So, in the end the professional who contributes more, as Aurelio was saying, because of their way of being and their way of thinking, well, they contribute much more than others who don't dedicate that care. The Administration would have to offer clear incentives to some professionals and would have to go a little further, such as instituting a series of objectives, such as evaluating the actual activity of each of the professionals.

Do you think that feeling of dissatisfaction intensified with the COVID pandemic?

Emilio: The pandemic took its toll on everyone, but as we are talking about Spain and the public healthcare system, I am going to talk about that specifically. For a number of months, without really knowing what was going on or what was going to happen, a lot of professionals put on their biohazard suits every morning because they had to work in one.
Human beings have to drink, excrete and communicate and in a biohazard suit all of that is very difficult. And they also have to go home and be with their children and their families. That was the situation. At that moment we were applauded from the balconies in Spain but afterwards, once it happened, there was no awareness of the situation, no evaluation or analysis of it or of the daily exercise.

The other day we were in a meeting with a management team from Castilla y León, and I repeatedly asked them if they would be able to tell me what a professional in that area of healthcare would do if I asked them. They didn't know. They don't know what we are doing. So the fact that nobody supervises your work and that working in this system is voluntary also contributes to frustration. And the third thing, lastly, is that it generates a very dangerous dynamic that creates a perverse incentive. And that is that the one who works gets all the work. Because if I have to get in touch with my colleague, who is so approachable, so friendly, so intelligent, so well-read, who studies at the hospital to ask him about an internal medicine problem, and I don't look at anyone else... then I'm always going to call Generoso, I'm going to call Luz María and I'm going to call Emilio... and the work is going to fall on just one person. It's not one, nor is it three, we understand that there are many people. Nor should we think that the public healthcare system is full of slackers and crooks. Quite the opposite. It is full of very strong-willed people and that is why the public health system continues to function well,because those who work in it, from aides to doctors, put everything they have into their work every morning. Through thick and thin.

How could the flow of the health system be improved to prevent it from collapsing?

Generoso: We have to adapt to the currents of change. Aurelio pointed it out, and it's true. As I was talking about it, I was remembering that he led certain things that helped me a lot. When the National Health System was created, it mainly dealt with acute illnesses. But, the population has aged, and now the population that is being treated is dealing with chronic illnesses, and the system was not very prepared for that. And that is one of the reasons why it has become saturated. At a certain point, when I was already working in Salamanca, Aurelio led what was called the UCA, the Unidad de Continuidad Asistencial (Healthcare Continuity Unit). We organized ourselves to attend to patients with multimorbidity, which is a patient who has, if I remember the definition correctly, two or more chronic illnesses. So, we also have to organize ourselves to attend to that population. If we do nothing, we become overwhelmed. If we do nothing, we overwhelm the emergency department, which is why the emergency department is now the real gateway to the system.

The problem with the current structure of public healthcare is that the natural gateway to the system is primary care and the health centers. And, it works well for what it was designed for. But, due to the problems of accessibility and of saturation the patient has to go somewhere. And, where they continue to be attended to, even if it means a six-hour wait, is in the emergency room. That is the problem. The problem is that the gateway to the system now is the emergency room, and that is why everything is changing. What happens is that we have to organize and we have to evolve. Curiously, I don't know where the idea of the UCA came from – I imagine at an institutional level – but you were the one who put it into practice, Aurelio.

Aurelio: What we were trying to do with the UCA, fundamentally, was to have much more direct contact with primary care and that contact meant that we could solve two types of problems that were not being solved within the time that they needed to be solved. And they were: problems that primary care saw as urgent to diagnose and treat, such as suspected tumors, for example. And on the other hand, there was the patient with multiple health conditions, who was a patient who consulted all medical specialties and who was often not given a solution. It was a way of dealing with this, but I think that the main thing, what they were fundamentally trying to do, was to establish a more fluid relationship with primary care; that the hospital was not something isolated and primary care something isolated, but that there was a continuous flow that meant that the things that were needed were not delayed and were dealt with as quickly as possible. I think that is another one of the problems with the system.

Emilio: One issue that is important from the outset is that primary healthcare is solving around 95% of the problems it tackles, which don't even need to go to the hospital level. But, that other percentage, which is a very significant percentage, needs a rapid hand-off, and that is what was achieved. And, that is what we lack now.

Generoso: Of course. And, that's what I mean, that we have to evolve, that we have to keep adapting. For family doctors, communication between primary care and hospitals is key and has the greatest impact on the patient, who is the center of attention. So, it is crucial that solutions are found for uncontrolled waitlists that, on the

one hand – and this is the main point – attend to the patient in a timely manner, and on the other hand, keep the waitlist moving and desaturate the emergency room.

We have touched on an important issue, which is that nowadays it is essential that communication between primary care and hospitals is direct and real. So now the Administration seems to be moving towards extending the continuity of care to other hospital specialties, but so far there is nothing. It is something we are asking for from primary care, of course. The better the communication with hospitals, the better the benefit for the patient, without a doubt.

We will also avoid something else, which is that between the back and forth, on some occasions we end up treating the patient when it's already too late. And, then the illness begins to be more serious, and there are even more admissions. If we treat patients when they need to be treated, we are reducing the number of patients going to the ER, and, as a result, we are reducing the number of admissions. And, in the long run we are reducing mortality. We are not talking about patient satisfaction in being cared for and feeling comfortable. We are talking about mortality and that is very serious and depends on the Administration managing and recognizing the professionals, both health and non-health, who work for the National Health System.

People tend to think of the medical profession as being very highly compensated, seeing physicians as people who live above the average and who enjoy a whole series of benefits associated with the healthcare market. What is false in these perceptions?

Emilio: This is a question that Luz Mari had been talking to me about. As I said, Dr. Martínez couldn't make it, so those of us here will answer it. People think that doctors live outside of society: that they don't pay mortgages, that they don't have children at school, that they don't have mothers or fathers to look after, etc.... I'm talking about doctors, but it could also be extended to other professions. Not only is that not the case, but all work requires a salary, some form of compensation, right? You put in what you have, which is your labor, but you also need to pay your mortgage, for example. We all understand that. And compensation should be proportional to the level of responsibility and effort involved. And, we feel that this is not the case in Spain. We believe that this work is undervalued and underpaid. Aurelio gave the example of people who work in the transplant ward. The level of responsibility that I tried to explain before is very high; therefore, we believe that sometimes it is not well paid and that in other moments it is paid too much because that payment is not based on effort, work, responsibility or workload. That is to say, it does not depend on whether one deals with more complicated cases or less complicated ones. If the part of the salary that is linked to working in the emergency room were too high in primary care, that would be a different issue. But, that incentivizes professionals to legitimately put their work where they will be paid the most and that generates other problems, right? And besides, healthcare professionals do not have an adequate system of continuing education.

What we have is a basic system based on cooperation between doctors. Here, we learn through cooperation. Because Generoso teaches me, because Aurelio teaches me, because I can teach someone. Because if he knows something, he tells me. And that flow of information in primary care teams, in hospital services, is inherent to the system. Here, keeping information to oneself is not well regarded. At a certain point in my life, I was very struck by the fact that when I moved on to administrative tasks, instead of information flowing, information was hidden, when they weren't outright deceiving you. And when I went back to healthcare again, the information flowed. That part is essential. But the other part, being able to train, acquire a skill, acquire knowledge, go to another service, to a conference to present something... well, for that you have to have time. Generoso said it before, it is not only the payment in money; it is the payment in recognition and also in time. Time to be able to train ourselves, time to be able to say: "Of course, I have to present a project... I want to go and learn how to take ultrasounds of joints, and do it where they know how to do it very well, and I have found this person who will teach me at such and such place, and for that I need a month to explore this". At some point, I personally have had that time. But it is not very common. They are exceptions. And that makes us as healthcare professionals, and doctors in particular, feel underpaid.

Aurelio: It's a complicated question, but on a broader level I would answer it with a phrase that existed and still exists, although fortunately less so now, which was used in the media to refer to doctors: it was called the "medical class". There is not, nor has there ever been, a medical class, obviously. There are doctors who live very well and other doctors who live fairly well and some who do not live well. In fact, in terms of the myth of the super amazing doctor who makes a lot of money and who goes to all the conferences, that type of doctor exists but is absolutely in the minority.

The vast majority of doctors are professionals who work hard, who have an important responsibility, and who have to train continuously, largely at their own expense. And these doctors are probably not paid as much as they should be for what they do. But this is debatable because we would also have to see and compare ourselves with other professionals who have a similar education and a similar job. And, then there is also a myth that I think needs to be treated with caution, which is that doctors earn very little working in Spain and abroad they earn a lot. Well, that has to be adjusted for the standard of living in each place and then maybe it's not as shocking. I agree that the salaries of doctors working in the public health system are probably not adequate. What that means is that they shouldn't have to take other types of jobs in the private sector, or do excessive on-call duty, or extra work in the hospital or in primary care.

This should be adjusted to what is considered reasonable. And, at the moment this does not seem to be happening. Some things are changing, however, specifically in relation to on-call medical shifts.

What care do people with a terminal diagnosis receive within the public health system? Are they guaranteed palliative care?

Emilio: If a person comes to consult one of us with a situation that becomes terminal, as medical staff we sometimes offer our mobile phone to them during that stage of life. And they become what we used to call "VIP patients".

At the Alamedilla Health Center, even the administrative staff who answered the calls knew about them and knew that if one of those "VIP patients" called Luz Mari, Emilio, Elena, Luis or my colleagues, we would take that call. We looked after a specific group of people, we knew the people, we had direct contact with patients and with the nursing staff, let's not forget. If there is anything that we have tried to convey to the residents, it is that the patient cannot be left alone. We start with

that sense of responsibility. Patients must always be accompanied and in a terminal situation they cannot be left alone. They have to know that we are always there.

Having said that, in a province like Salamanca we only have so many family doctors here; there is one palliative care team for a city of 130,000 inhabitants and one palliative care team for the province which is scattered in towns 90 or 100 kilometers from the capital. The team is made up of a social worker, sometimes a psychologist, nursing staff and a doctor...

Generoso: The same thing happens in the hospital, it's understaffed, so they can't cover this. What Emilio was saying, that's one view of primary care, but there's another view of primary care. Since, sadly, a large part of the work depends on the will of each individual, I want to emphasize the other part of primary care: The primary care doctor who is overworked, who doesn't want to commit himself so much because he's up to his ears and because it's half past three and he's still working. He doesn't want to get involved when he's called for a palliative care patient, on the one hand, because he's overworked, but on the other hand, let's not forget, it's because it's been so long since he's seen palliative patients that he no longer knows how to handle it. This is difficult to say about a healthcare professional because it feels like we have to know everything, but it's like all professions. What you don't use you forget, if you learned it in the first place. So he only has one solution, which is to pick up the phone, call palliative care, and get angry if palliative care is not going to see the patient.

But on many occasions this depends on palliative care. And that is important because those patients, in the end, receive care too late. That is why we keep emphasizing this same point: you cannot treat all professionals equally. It can't be like that. That is the real cancer of the National Health System right now, that the administration is treating those who do what Emilio is saying and those who do what I am saying in the same way. And that has to be solved once and for all.

We are trying to solve it. We keep coming back to the same thing, with continuity of care, with direct communication, with palliative care. And here comes the best part, I'll skip to the good part. The best part is that when a primary care doctor, who hasn't seen palliative care patients for a long time, but who has to attend to them out of professional necessity, gets in touch with palliative care, the part that really has a satisfactory impact on the patient is that they are both attended to in a coordinated way. Then there comes a moment when palliative care lays itself bare and tells the primary care physician: "I'm sorry, I can only see this patient once every 15 days." And the primary care physician, who is up for the job, even though he has no training, says: "Okay, we'll make a deal. I'll see him for the remaining 14 days, I'll take care of him, and as soon as I have a problem I'll call you." What happens? The vicious circle becomes a virtuous circle. Suddenly, the doctor who wasn't involved in palliative care starts to take an interest, starts to manage it, starts to understand it, he starts to see professional satisfaction, and the patient has that positive impact that we all want. What I'm getting at is that our colleagues who pick up the phone and get angry because there aren't enough staff to attend to palliative patients can't just sit there. We can't just keep asking professionals to "put more palliative care doctors on". Yes, indeed, I agree one hundred percent with what Emilio says, but there are real mechanisms for a solution that need to be put in place. And that, I always say the same thing, ends up benefiting the patient, and in this case, the professional, too.

Is the public health system prepared to deal with the requests that will come with the Euthanasia Law?

Generoso: To put it plainly, when a primary care doctor – if I'm wrong, please correct me – has a patient come to him asking to organise their dignified death, the doctor is either very prepared or his hair stands on end because, in theory, he has to deal with something for which he is not prepared. Of course, the medicine we are practicing now has nothing to do with the medicine of the 1980s, when we started practicing. We have learned many things and this is also something that has to be learned. But, this also involves another aspect, which is the aspect of whether we really want to care for patients in this way because ethically some people have problems with this approach. But we are caring for people who have a right and we have to give it to them.

And that is an obligation. That's a word that can be very difficult to say, but we have an obligation to these patients. Therefore, whoever wants to respect that obligation must learn.

I'll explain it from that same palliative care perspective we talked about earlier. It's not just a question of learning, we also have to provide a solution for that person. It is made worse when the administration backs the person who doesn't want to find that solution. Then, everything gets extremely complicated, and, as I was saying at the beginning of the interview, what ultimately happens is what nobody wants, which is that the patient commits suicide. That is the real problem. And that is what we have to avoid. So, to those people who find it so difficult, to that administration which, for whatever reasons, refuses to implement this law or delays doing so, we have to remind them that there are people who are finding their own solution, but the wrong one. And, we have to find a way out of that dilemma.

Aurelio: I don't know. It's complicated. I really am not sure. As we are discussing this topic, I can think of some very significant problems with palliative care and even more significant problems with how euthanasia is being implemented. That is clear. It is one thing when a person is reaching the end of their life and they are at home, or in the hospital. I think that in those circumstances, in general, I want to think that they die well.
I studied many years ago and obviously the subject of how to deal with death was not covered in medical schools. I doubt that it is now, or that it is covered in the way it should be.

Emilio: It is not.

Aurelio: Well, you would also have to look at different medical schools, but it is not done here. It is a problem, but people have learned. I remember my first years as a resident doctor, the anguish when you saw someone dying, having trouble breathing, essentially drowning, and you didn't know what to do. I think that now that subject has been resolved. Furthermore, it would be considered malpractice according to the ethics of the Colegio de Médicos – which is not exactly the most progressive organization in the country – not to attend to them with dignity in that moment. I think we should differentiate between palliative care, which tends to be for a period of time, and euthanasia, which raises serious problems of what death is when the time comes and everything is prepared in the hospital or at home. I think that is attended to correctly. In general.

Generoso: I would add one thing. There was a time when most people died in hospitals. That has been changing and now people, perhaps influenced a little also by professionals, which I think is essential, tend to die at home and that is where primary care comes in. And primary care has its part to play in ensuring that the person dies well.

Of course, sedation falls within this category. We have come a long way. When Aurelio was talking about the hospital, I was thinking about my town and, you know, things were so poorly managed that when you had a terminal patient for whom you no longer had the tools to care for, it was very difficult for you to go and see them. Very difficult. And people did die badly. All that has changed. Now not only do you not just feel bad about not going to see them, but you increase the frequency of visits to try to help them die peacefully, which is how it should be. And, that's essential for having a good death. But I think there is still a way to go in that area.

Can you give us a definition of "dignified death"?

Emilio: Leaving aside freely chosen death, I understand dignified death to be that which is reached with maximum psychological peace and minimum physical suffering. If possible, one is accompanied. In a recognizable environment, and, if possible, it happens where you have lived.

And that what you see around you are people who love you. And, if there are no people who love you, at least people who take care of you.

Aurelio: I think you said it very well.

Generoso: I totally agree.

In Spain, there is discussion about the two million people who cannot afford medication; there is even talk of a situation of pharmacological poverty. Can you explain what causes this situation?

Emilio: We were going to address this. In Spain, when you are given a prescription, it is written on a specific, special document or in a computer file that gives you access to the purchase of a medicine in a pharmacy.

Depending on your situation, you may have to pay for everything if it is not subsidized, or for part of it if it is subsidized by the health system. That part will depend on your income level, which Generoso explained earlier with the TSI, which means that those who have more pay more. Also, if you are a retiree. Although that has decreased because there was a time when retirees in Spain did not pay anything into the Social Security system. That has changed.

On the other hand, there is the price of medication. I have a theory that is not at all scientific, which is that the more useful a medicine is, the cheaper it is. So, basic medicines generally have a low cost, but medicines that are increasingly expensive are entering the pharmacopoeia. Therefore, the proportion that the patient has to pay is greater, and that means that there are people who cannot afford it. On the website of the Asociación por la Defensa de la Sanidad Pública, there is an easily accessible article, written by our colleague Maxi Diego, about a classic case, which always serves as an example, of the patient who bursts into tears in the doctor's office when he is asked if he has taken his medication. He hasn't taken it.

But that's what they told him. Many of us are not told. "I'm not taking it because I have to decide whether to buy food for the kids or to buy medication." We – I'm talking about the Asociación por la Defensa de la Sanidad Pública – consider it a co-payment and we are against that co-payment. If we have to pay, we should do the math and pay it with taxes. But at that point, maybe, we need to standardize much more. And, we have to pay for what is useful and what is needed and take the rest out of the medicine budget. Another issue is that more and more medicines are coming out that seem more efficient for the treatment of some diseases. I'm thinking of cardiovascular diseases. You get an injection once a month and your cholesterol goes down, if you have the money to pay for it.

But, then, tomorrow we are going to have to decide whether to pay for the medication for a 67-year-old or whether to pay for the treatment for a 14-year-old, for example. That's how it is. It can't be any other way. Or, it could end up like that. We are seeing how the cost of pharmaceuticals is increasing. The public health system costs 94 billion euros a year. Well, 13 billion are pharmaceutical costs.

Aurelio: So, about 20%.

Emilio: 20% is a lot and it's making up a greater and greater percentage.

Aurelio: The thing is that this spending on pharmaceuticals is mainly for medicines used in the hospital and for very few illnesses. They are illnesses that normally have no other treatment. At the beginning of the interview, we said that public healthcare in Spain was free when one needs to use it. This has never been true. In other words, there has always been a pharmaceutical co-payment, which could be significant, up to 40% or so of the cost of the medication. Then, later on, there was the issue of retirees, which gave rise to a fairly serious movement. Because among the retirees were the sickest patients, those on multiple medications who had to pay a lot at the pharmacy. That's when the problem of pharmaceutical poverty, which does indeed exist, began to be studied. How can this be solved? Well, it's clear, by eliminating co-payments.

If there has to be any co-payment, it has to be based on income, not on a "one size fits all" basis, for example. And then there is a big responsibility for the Administration when it comes to negotiating with the pharmaceutical industry, and for the pharmaceutical industry, which really puts costs on medicines that are not adjusted to what they have researched or to what they need, but rather absolutely crazy extra costs. I know a little about the subject through the drugs that were used for the treatment of hepatitis C, or before HIV, and what these costs were like. For example, a drug used for hepatitis C was about four times more expensive in Spain than in Egypt. In Egypt they had made it very cheap because there were many patients and it was the only way to introduce the drug, and here it was much more expensive. This caused a problem, which was that initially these treatments were only given to a certain group of people, those who were the worst off.

Fortunately, this was later resolved, but I think it's an open debate, a complicated debate, involving many institutions and many people. But, really the first thing would be to solve the problem of these people who are poor, and – in the same

way that special situations are addressed, such as energy poverty or poverty of another kind – we would also have to work specifically with that group of people who have this problem. Sometimes broad solutions for everyone are ideal, but sometimes you have to solve problems for small groups and then, from there, solve everything. Because otherwise that small group is going to have a very hard time.

Do you think that medical schools train future doctors in issues related to the organization and defense of the public healthcare system?

Aurelio: The training they are receiving, and what interests them at the moment, is receiving training in medical issues, diseases, or health problems. They see problems that have to do with the organization of the healthcare system as very distant. It's very difficult. What can we do? I think we should do studies on the subject and give our opinion on it. Normally we continue to give our opinion through the press, now digital press, or through some manifestos or something like that, and continue our advocacy activities with approaches that may or may not reach these students. I think it might be easier to reach young doctors now.

But the problem is also still sort of the same. I recently wrote a short article in the press and said that for us being a physician has been an inseparable aspect of our lives. In other words, being a doctor was everything. Everything else was very much on the sidelines. Leisure was on the sidelines, travel was on the sidelines, and often family was on the sidelines. I think that this is understood less and less among the younger sectors.
Right now what predominates in the younger sectors is to see medicine as a profession, and they try to do that profession as well as possible. But maybe they don't go any further. To go further is to go further in the community, not only in what you have in front of you, the patient or the Health Center, but to see the community a little and see what you can do with the whole community in terms of health and prevention, and so on. In that area, one would find the political or union struggle, or the associative struggle like ours. I think that the younger medical professionals, perhaps, neglect this last section a little.

Would it be necessary to restructure the curriculum taught in medical schools?

Aurelio: I don't think it would require restructuring so much as adapting things to what is a priority, and also to the times. Because these things are a priority now, although they were also a priority 40 years ago, so we have to adapt to the times. Now comes the issue of artificial intelligence, or things like that, which people will have to start moving into, because otherwise we'll arrive late again. I think that we have to adapt the curriculum to what is a priority now and to what is happening now, not to what was important, say, ten years ago. What's more, medical students are being trained for when they finish in six years' time. And we do spend a lot of time, for example, explaining the drugs that have to be given for hepatitis C, which we have now discussed. Maybe hepatitis C will no longer be a problem when they finish their degree, so they should also learn to look for information, to educate themselves, because we have talked about education and how important peer education is, but education, in principle, is everyone's responsibility. Each one of us. I am responsible for my education and if I understood that I had to receive that education from a colleague or an institution, I would feel more committed to defending that right. And that has to be learned from the first day at university. There are many things to do.

What keeps you energized and dedicated to this fight for public healthcare in a complex context of systemic crisis?

Generoso: First of all, we are convinced that this is the solution. We are convinced that the best way to provide quality medicine and healthcare to the entire population is through this system, the National Health System. We are convinced that it is also efficient, that it is the best way to provide the best quality care at a lower price, and that it is a way of ensuring that they are cared for. But we are also sure that it is feasible. Not only is it efficient, it is feasible.

It has been happening since '86. It is working, but it is starting to have defects. So we believe that someone has to draw attention to it, to sound the alarm, that this has a solution, and we are involved in that. We clearly think that this has a solution. So, we try to put those solutions in the hands of the administration, in the hands of the population, and that is what moves us to continue here. Of course, there are other things that move us too. When we are convinced that this is the solution, when we see that there is political interference, in many cases social too, because neoliberalism is ruthlessly attacking the system. Let's not forget that there is a significant amount of money at stake here that we are trying to stop because healthcare is very attractive economically. We know that we are absolutely rowing against the current and that is what drives us.

But the most important thing that moves me, and I'm speaking personally now, is that I can't do it on my own. So what really gives me strength are my colleagues.

Emilio: Well, that's how it is, I don't know why I'm going on. Aurelio said in his article that being a doctor for us has been a way of life. And being a doctor for us *is* a way of life. We have had to give up clinical activity, but in no case have we wanted to, want to, or can, give up intellectual activity related to the health system. It's because we think that the health system is good enough, as Generoso has already explained, to justify its defense, and because we believe that not doing so generates suffering.

Because at the end of the day what we are talking about, as when we talked about dignified death, is about making things just a bit easier for people. That is to say, we believe in the concept of the welfare state. I was thinking about it yesterday while I was walking. It's just that we don't care about being rich; rather, want everyone's needs to be met. As I was taught in another country and on another continent, having one's needs met sometimes means having a swimming pool, but it also means being healthy enough to get in it, or if you're not so healthy, having someone who cares for you or loves you to help you bathe. Well, that's our idea. We can't stop. I can't stop. And the strength I get from others is the cooperation, the constellation, the creation of that network. That you see that it's worth thinking about what you're seeing, reflecting on it and that you're going to be listened to by someone to receive some criticism, sometimes devastating, that doesn't hurt because it comes from people who think, and you change your idea.

Aurelio: I think everything I would say has been said already. I would reinforce what I said before about it being a way of life that it has been for us for many years, and that it continues to be, although now with fewer demands. I believe that being a health activist is part of the demands of being a doctor. This is also not talked about much, but it is important for a doctor to be aware of this. It is not enough to see the patient in front of you, or to solve their problem,

but also to see the problem of all the people behind the patient. I often say that it is not enough to see the patient and attend to them as best as possible (the patient in front of you), you also have to consider what is behind the chair where the patient is sitting, and behind that there is the whole community.

That's why you can't just focus on treating that person and solving their problem, which is essential, you have to go further and be an activist so that the rest of the community doesn't end up in that situation, or if they do, they can also come to you to solve it. And with that mindset of being a health activist, which is something that some of us are clear that we have to do when you are a doctor, well, that is what leads you to be here for many years, and to keep doing as much as you can.

At the Constellation of the Commons (CC) we are working on the production of a useful and proactive imaginary that encourages citizen participation in the transformation of the hegemonic system. Can you share any good news with us?

Emilio: Oh, yes, I think so. The first is that the National Health System is still here and will still be here tomorrow. What we are talking about is maintaining an efficient, supportive, and universal system. And that there are still very well-trained doctors and health professionals entering the system all the time. There will be fewer than are needed, but many are entering the National Health System. And that part of the population, at least some part of it, values it and knows what it is. That's the good news.

Generoso: There's another piece of good news, which is that the population has internalized the National Health System to such an extent that we must have a very good national health system because with all the attacks it has suffered over the last 35 years it is still here.

It must be very good. In fact, it must be great. And, the population knows it. I have my doubts about changing the system, despite the high percentage of people who also have private insurance. I am convinced that in the long run (of course, it's been 35 years!) the population has internalized the National Health System to such an extent that now a French, German or American system would disorient them, it would leave them totally disoriented. They wouldn't understand it.

This idea of going to the emergency room and being charged, or this idea of going in and being asked, "What type of card or what type of contract do you have?", doesn't enter the heads of the people of this country. And, that's an important point. Look, it's another point that motivates us, even if it's in the subconscious and we haven't made it conscious. For me, it's something important.

Aurelio: It's about the stability of the system and whether we can do something to contribute to it. If so, then we are going to continue doing it.

Emilio: I insist that there is good news. The good news is that when we were there, or right now, in the health system, there are a lot of people being listened to, being cared for, and getting involved. If you work in that system, how can we not continue to defend it?

Generoso: Exactly!