SOCIAL SUSTAINABILITY IN DANGER. THE EFFECTS OF PUBLIC EXPENSES REDUCTION ON HEALTH IN THE ECONOMIC CRISIS CONTEXT

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Abstract

Society wellbeing is one the main goals of economic development. During the XX century, societies succeeded increasing their standard of living and the general welfare. But, in 2008, barely begun the XXI century, the strongest economic crisis ever known, destroyed much of the social achievements. Although the European Union had to deal with this situation by designing common policies, the member states have handled this crisis in many different ways. Their restrictive budgets affected a lot of social policies and its effects were mainly suffered for the most disadvantaged people. In this paper we deal with a structural equations model for assessing the population acceptation of those restrictions in health expenses. Spain has one of the best public health system all over the world, and that is the reason for choosing this country to conduct our survey. Our results point out the general disagreement with the cuts in health expenses.

Key words: economic crisis, social sustainability, health policy, inequality, poverty, structural equations model

1. Introduction: economic crisis and restrictive policies

The creation of the Euro-Zone has meant a major change for the member states of the European Union who decided to join it. In particular, it has supposed to major changes in how to manage economic policies [1]. We must note that these countries are unable to use a monetary policy mechanism to address any possible situation, because they belong to a currency area.

In the previous period to 2008, the favorable economic environment in Spain, with an increasing labor demand, became an attractive gateway, which promoted the

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entrance of a quite important number of migrant people, who came due to the strong attraction pole, arisen from the takeoff of the Spanish economy [2]. Despite this complementarity between receipt of migratory flows and economic growth, it should be noted that Spain has never been positioned itself a strong power in terms of GDP in the European environment and the installation of foreigners is more related to the persistence of an irregular labor market, which quickly favored integration of people, even those who were in irregular administrative situations [3]. Furthermore, the Spanish social protection system, with a free universal health care, a public education quality, attending students up to 16 years, supposed the strengthening of such attraction, started by the prosperity of economic environment. Then, the incoming labor force was mainly composed by unskilled workers, and it was quickly absorbed by the construction [4] sector and home care. Some of this workers were in an irregular administrative status in Spain, for their lack of legal permission for working in the country.

When the crisis began things did change [5]. The economic boom and the vigor in the sectors related to construction soon were translated into rises generalized wage far above the productivity gains, triggering a significant rise of unit labor costs, clearly superior to that experienced in most of the Eurozone countries, and the Spanish economy competitiveness was radically decreasing. The economic environment is unfavorable, no labor force is required, the unemployment rates are very high and many immigrants have lost their jobs.

Spain's financial system was suffering from indebtedness and a lack of competiveness. The Spanish government has to take serious measures, but it lacks the mechanism of monetary policy, so decide act upon two main areas: increasing competitiveness and seek fiscal consolidation, and to achieve this, it is accurate to reduce expenses. When this fickle financial system saw the housing bubble burst in conjunction with its many job losses, it resulted in radical measures for increasing competitiveness and for achieving fiscal consolidation [6] (Spanish Government. Royal Decree-Law 8/2010, May, 20, to undertake extraordinary measures for reducing public deficit, 2010) [7].

These measures for fiscal consolidation are broken into three core reforms: labor, healthcare polices, and education policies. While favoring competitiveness and economic sustainability, these measures adversely affected social terms and social sustainability [8], yielding the greatest effects to the most disadvantaged citizens. In our paper we deal with the effects of restriction on free access to the National Health System [9]. The interest of this work goes beyond the simply Spanish concern, as it is an analysis in the context of an economic crisis in a currency area, where we study the possibilities of action of the states involved in it. Specifically, we analyze new Spanish health policy, which resulted in the expulsion of some groups from the public health system (universal and free in Spain until 2012) (Spanish Government. Law 16/2003, May, 28, on cohesion and quality of national

health system, 2003) [10]. Even all this policies were meaning a diminishing of social protection and a weakness of workers' rights, the policy makers take care of named them with a sort of "explanation" of the reasons for boosting those kind of policies (i.e. "urgent measures for labor market reform", educational reform "to improve educational quality", "urgent measures to ensure the sustainability of the National Health System and improve the quality and safety of its services", and so on), maybe we should think about the Nilson et al (2006) [11] state about that the support of public policies is related with the given argument associated to them, which make more favorable the evaluation and, as a consequence, the acceptability of the policy intervention increases.

Since the population consensus is one of the keys to the success of public policies [12], this work has focused on the study of the acceptance of health policy by the Spanish population. To do this, we have relied on a survey conducted in 2015 and we have analyzed the data using a structural equation model, which has established certain causal relationships between the acceptance of the new health policy and the perception of abuse of the system. So, this paper analyzes the acceptance of the population of the new sanitary policies arose as a consequence of the restriction due to economic crisis, and the people perceptions of overuse of the healthcare system.

2. Free access to healthcare and overuse of medical services

To increase competitiveness relies on the process of internal devaluation, mainly propelled by the labor reform ("urgent measures for labor market reform") of 2012 [6]. To reduce spending several measures are taken, the main of which they are educational reform ("to improve educational quality") [13] and health reform ("urgent measures to ensure the sustainability of the National Health System and improve the quality and safety of its services") [14] (onwards RDL 16/1012). In this paper we have focused on this measure.

At the time of the entry into force of RDL 16/2012, the Spanish health system was public, and free and universal access. Its quality was recognized worldwide. For this reason, in the years before the beginning of the economic crisis, has emerged in Spain the phenomena known as "sanitary tourism" to refer to people under the pretext of spending their holidays in the country, in fact, what they wanted was to solve their health problems, free of charge and with health guarantees. In an unfavorable economic environment, the costs generated by this activity could not be assumed by a country immersed fully in the economic crisis. Moreover, this situation generated controversy among the Spanish population, due to the different perceptions regarding the overuse or abuse of the public health system. Then, it could generate different positions for supporting of the new legal framework [15,16] and it could affect to the effectivity and success of those policy [17].

Both the extent of educational reform as healthcare, have been highly responded by the population, and social protection achieved so far, has been greatly weakened. As literature states, the attitudes are a key factor for succeeding in launching any social or economic policy [18]. That's why some authors suggest tailoring information with regard to people's values for promoting positive attitudes towards policy measures [11].

The main restrictions imposed by the new health regulations, affected the financing of prescription drugs and restricting access to public health services for some groups. This mainly affected immigrants in irregular administrative status. In the opinion of medical professionals. This is a potential public health concern in the future, largely because immigrants suffer from different diseases to those national [19]. If so, it could generate a significant deferred expense substantially greater than the present savings [20], in addition to the suffering of the population.

The economic crisis that began in 2008, and the measures adopted for alleviating its effects, strongly damaged welfare of many countries and many people. In addition, poverty and inequality substantially increased, so much that it has become a threat to system's social sustainability. Specifically, the situation was became most severe in Greece, Italy, Portugal and Spain. Health care is one of the first steps for guaranteeing the human rights. The Spanish constitution establishes the right to health protection and health care for all citizens. The former coverage of Spanish health system included "all Spanish citizens and all foreign residents of Spain". The economic crisis began in 2008 bit harder to Spanish economy and forced to the Government to restrict public expenditure, then, the National Health System became affected, and the new regulation on public health coverage grants access to care only to "those citizens who hold the status of being insured", so it restricts access to the public health sector only to Spanish citizens and foreigners registered as residents in Spain [21]. Then, undocumented migrants and people aged 26 years and over who have not entered the labor force are not entitled to receiving public health care. Access is guaranteed for those below 18 years of age, pregnant women, people who need emergency care, international protection seekers and victims of human trafficking. This is an important transformation which has strongly discussed by society. Some studies have shown the negative impact of economic crisis on inequality and healthcare [22, 23], and some underlined the effects on the weakest social groups [24] as unemployed, chronically ill people, ethnic minorities, etc.

We verified that immigrants in an administrative irregular situation, lost their free access to public health system (Spanish Government Royal Decree-Law 16/2012, April 20, of urgent measures for granting the sustainability of national health system and improve the quality and security of its services, 2012) [14], which was restricted to certain groups such as children under 18, and women in situations of pregnancy, childbirth and postpartum; however, universal support is provided in

cases of emergency (Spanish Government: Royal Decree 1192/2012, August 3, for regulating the condition of insured status and beneficiary for the effects in health care in Spain, from public funds, through the national health system, 2012) [25].

3. Research question and hypothesis

Our major research question is determinate the agreement and acceptance of the general population of the Spanish Sanitary Reform, launched as a consequence of the economic crisis in Spain, which was reflected on RDL16/2012 elaborated by Spanish Government (*RQ1*). One second query is related to the perceived overuse of medical care services (*RQ2*). Our third issue deals with whether the personal opinion of the free and universal or restricted access to the Public Healthcare System influences the opinion about the overuse perception. Our last objective is to explore if it is there a casual relation between perceived overusing and the acceptance of the new restricted health system access, specified by the new legal framework, as well as with the personal opinion about free and universal or restricted access to the Healthcare Public System (*RQ3*). Our research questions and their related hypothesis are stated in Table 1.

Table 1. Research questions and hypothesis

RQ1: Do Spanish people agree on new legal framework for cutting Public Health Spending as consequence of economic crisis?
• H1: Spanish people agree on new legal framework for cutting Public Health expenses as consequence of economic crisis • H2: Women have the same level of agreement with the new health policy than men • H3: People of different ages have the same level of agreement with the new health policy
RQ2: Do Perceive Spanish people overusing the Public Health System?
• H4: Spanish people don't perceive overuse of Public Healthcare System • H5: Women have the same perception about overuse of Public Healthcare System than men • H6: People of different ages have the same perception about overuse of Public Healthcare System
RQ3: Is there a relationship between the perception of overusing of health services and the personal opinion about the free and universal access to Public Healthcare System?
• H7: Perceiving an overusing of the Healthcare System has no influence on personal opinion about free and universal access to Public Healthcare System • H8: Perceiving an overusing of the Healthcare System has no influence on personal opinion restrictive access to Public Healthcare System • H9: Perceiving an overusing of the Healthcare System has no influence on accordance with restricted health policy

4. Method

In our analysis we deal with observable variables (the ones at the Table 2) and with latent variables, which cannot be measured directly, so the observable variables are

used as indicators for create the unobserved variable, which is the construct or latent variable. The whole set of variables at our analysis are shown at Table 3. The latent variables in our model are constructed by three observable variable, as [26] recommended for samples around 150 observations, nevertheless, the latent variable According with the Health Policy is formed by only two indicators, due to the difficulty of getting so different shades for responding to the same question, but it is not a problem if the size of the sample is 240, as is our case [27].

Table 2. Descriptive statistics for the whole group and for women and men

		The whole group (N=240)		Men (N=104)		Women (N=136)	
Item	**Code**	**Mean**	**SD**	**Mean**	**SD**	**Mean**	**SD**
I think everybody in Spain should have access to free health services	FUA1	4.690	2.244	4.029	2.329	5.199	2.043
I think all resident in Spain should have full access to free health services	FUA2	4.370	2.188	3.856	2.231	4.757	2.078
I think all immigrants should have access to free public health services	FUA3	4.750	2.020	4.413	2.041	5.007	1.972
I think immigrants at irregular administrative status should have free access to the public health system, only in case of medical emergencies	RA1	2.700	1.828	2.923	1.959	2.522	1.708
I think women and children in an irregular administrative situation should have free access to the public health system, regardless of their administrative status	RA2	3.000	2.077	3.240	2.188	2.809	1.976
I think the national health system should be universal and free, only for Spanish people, and workers at regular administrative status	RA3	2.880	2.229	3.250	2.306	2.596	2.134
I think there is a lot of "sanitary tourism" in Spain	PO1	3.050	2.079	3.394	2.170	2.787	1.975
I think immigrants overuse the emergency medical services more than national	PO2	2.680	1.776	3.087	1.931	2.375	1.587
I think some people overuse the health emergency services	PO3	2.580	1.835	3.010	1.998	2.243	1.631
Sounds good to me the Decree-Law 16/2012 of urgent measures to ensure the sustainability of the National Health System, for reasons of economic crisis	RDL1	3.410	1.866	3.769	1.818	3.140	1.863
I believe with the Law Decree 16/2012 will save a lot of money	RDL2	2.890	1.759	3.288	1.688	2.588	1.757

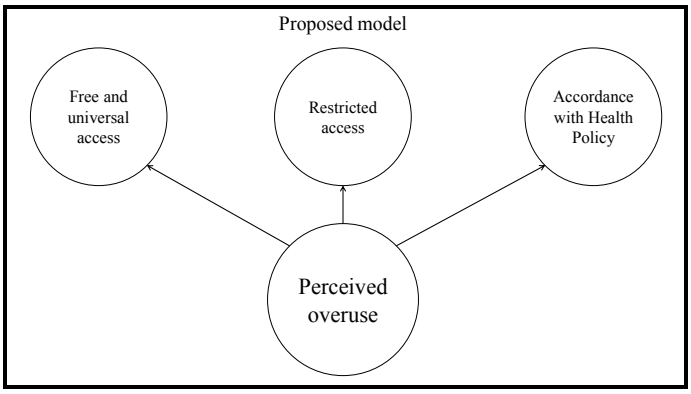
For solving our research questions, we have utilized mean comparison analysis and ANOVA (RQ1 and RQ2), and a structural equation model (RQ3). The structural equation modeling analysis is a tool well suited for working with observables and unobservable simultaneously, especially when we also expect the existence of causal relationships. This procedure combines the confirmatory factor analysis and analysis of causal relationships, which makes it very useful in the field of social sciences [28]. We used the statistical package IBM SPSS statistics 21 and AMOS 21.

The questionnaire was elaborate in basis to the opinion of experts on healthcare (doctors, nurses and administrative team at hospital and primary attention centers), and on the academic works of Björngren Cuadra (2012)[29]; Blanco Moreno & Hernández Pascual (2009)[30]; Cortès-Franch & González López-Valcárcel (2014)[21]; Esteva et al. (2006)[2]; McDonald & Kennedy (2004)[31]; Pérez et al. (2014)[32]; Rodríguez Álvarez et al. (2008)[33); Sánchez & Junyent (2006)[34] and Urbanos Garrido & Puig-Junoy (2014)[35]. The sample was collected between March and June, 2015 in the Autonomous Community of Galicia (NW Spain). A classic Likert-type 1-7 scale was used.

Table 3. Latent variables, observable variables and their relation

Item	Item	Latent Variable
FUA1	I think everybody in Spain should have access to free health services	Free and universal access
FUA2	I think all resident in Spain should have full access to free health services	
FUA3	I think all immigrants should have access to free public health services	
RA1	I think immigrants at irregular administrative status should have free access to the public health system, only in case of medical emergencies	Restricted access
RA2	I think women and children in an irregular administrative situation should have free access to the public health system, regardless of their administrative status	
RA3	I think the national health system should be universal and free, only for Spanish people, and workers at regular administrative status	
PO1	I think there is a lot of "sanitary tourism" in Spain	Perceived overuse
PO2	I think immigrants overuse the emergency medical services more than national	
PO3	I think some people overuse the health emergency services	
RDL1	Sounds good to me the Decree-Law 16/2012 of urgent measures to ensure the sustainability of the National Health System, for reasons of economic crisis	According to health policy
RDL2	I believe with the Law Decree 16/2012 will save a lot of money	

Figure 1. The proposed model



For testing hypothesis H7, H8, and H9, we have rely on the proposed structural equation model on Figure 1.

5. Results and discussion

For testing H1, we analyzed the values of mean and standard deviation for the items RD1 and RD2. As the scale goes from 1 to 7, both the mean and median are 4. All the means analyzed are <4, for the two items involved in this issue and for the whole group (3.410 for item RDL1 and 2.890 for item RDL2), as well as for women (3.140 for item RDL1 and 2.588 for item RDL2) and men (3.764 for item RDL1 and 3.288 for item RDL2), attending this results and the scores for standard deviation H1 should be rejected.

A mean difference analysis was undertaken for testing H2. A t Student test was carried out for different samples. We have previously performed the Levene test to test for equality of variances of the groups. Results shown in Table 4 indicate that there are significant differences ($p<0.01$) in means for the two items. The means of men are a little higher, so men agree more than women with new healthcare policy. Then, H2 must be supported.

Table 4. t test for means differences (RDL - gender)

	Levene test		**t test**			
	F	**Sig.**	**t**	**fd**	**Sig. (two tailed)**	**Mean difference**
RDL1[(a)]	0,608	0,436	2,622	238	0,009	0,630
RDL2[(a)]	0,226	0,635	3,112	238	0,002	0,700

(a) Equal variances were assumed

For testing H3, we distributed the respondents on 4 groups of age (< 23, from 23 to 35, from 36 to 50 and > 50) and conducted an ANOVA for items RDL1 and RDL2. Results in Table 5 indicate that there are differences. As the Levene test indicate

that unequal variances should be assumed for both items ($p < 0.02$), we performed a Games-Howell T3-Tuckey and T3 de Dunnett post hoc analysis, the results have shown differences between only for the item RDL1 and only for the group of the younger people (< 23) and the older one (> 50) with a significance $p < 0.05$ for the Games-Howell test and none differences for the T3-Tuckey (Table 6) H3 must be supported.

Table 5. ANOVA (RDL-age groups)

		Sum of squares	fd	Root mean squared	F	Sig.
RDL1	Inter-groups	23.355	1	23.355	6.873	0.009
	Intra-groups	808.807	238	3.398		
	Total	832.163	239			
RDL2	Inter-groups	28.896	1	28.896	9.682	0.002
	Intra-groups	710.287	238	2.984		
	Total	739.183	239			

Table 6. Post hoc tests (age groups)

Item RDL1			Means difference (I-J)	Standard error	Sig.
Games-Howell	< 23	> 50	0.751*	0.286	0.047
T3 - Dunnett	< 23	> 50	0.751	0.286	0.057

Given that H1 was rejected and H2 and H3 were supported, the answer to our first research question is clearly negative: the Spaniards disagree with the new health policy, no differences are appreciated due to age or sex. Therefore, there is a widespread rejection of cuts in healthcare as a result of the economic crisis.

The perception of overusing of healthcare system was tested through H4, H5 and H6. For testing H4, we based on the same procedure than for H1, applied to the items PO1, PO2 and PO3, and attending the data shown in Table 2, we should reject H4, because all means values, are lower than 4.

H5 vas contrasted in basis to a t-test analysis. Results in Table 7 indicate that there are differences between genders. Although means scores for both sexes are lower than 4 (which indicates low perception of overuse), there are significant means differences for all items involved in this latent variable ($p < 0.03$) and men have more perception of overuse than women. H5 is rejected.

Table 7. t-test for means differences (Perceived overuse - gender)

	Levene test		t test			
	F	Sig.	t	fd	Sig. (two tailed)	Mean difference
PO1[(a)]	2.561	0.111	2.262	238	0.025	0.607
PO2[(b)]	7.699	0.006	3.051	196.765	0.003	0.712
PO3[(b)]	10.933	0.001	3.187	195.913	0.002	0.767

(a) Equal variances were assumed (b) Equal variances vere no assumed

Hypothesis H6 should be supported, because, seen Table 8, the ANOVA conducted for age groups has not shown differences between ages.

Table 8. ANOVA (RDL-age groups)

		Sum of squares	fd	Root mean squared	F	Sig.
PO1	Inter-groups	17.663	3	5.888	1.368	0.253
	Intra-groups	1015.737	236	4.304		
	Total	1033.400	239			
PO2	Inter-groups	2.984	3	0.995	0.313	0.816
	Intra-groups	750.949	236	3.182		
	Total	753.933	239			
PO3	Inter-groups	6.828	3	2.276	0.673	0.569
	Intra-groups	797.822	236	3.381		
	Total	804.650	239			

Research question 2 (RQ2) should be answered negatively (H4), and it must be pointed out that we have no found differences in age basis, but men are more aware of overusing, than women, nevertheless none of genders have not the perception of overusing the healthcare services.

For testing H7, H8, H9 and H10 a structural equation model was conducted, in basis to the proposed model in Figure 1. According Anderson and Gerbing (1988) [27], we have followed the two-step approach, distinguishing between the measurement and the structural models. The maximum likelihood was the estimation method, which has been the predominant estimation since de middle 1960s [36-38] and it provides consistent, efficient and unbiased with sufficient sample sizes, and it is able of facilitating the convergence of parameter estimates even in the absence of normal estimates. A structural equation model, consists of two main parts (the measurement and the structural models). The measurement model analyzes how each latent variable, and if it is correctly measured through their observable indicators, moreover, it studies the errors affecting the measurements (different from the prediction errors), whilst the structural relationships model encloses the effects and relationships between latent variables. It is similar to a regression model, but can it also contain concatenated effects and loops between variables. The first step of our analysis was testing the factor structure of our model, conducting a confirmatory factor analysis, in order to check the reliability and validity of the measurement scale, previously it has been found that the factor loadings of all items exceed the required minimum thresholds,, which are usually accepted for < 0.5, since all the results exceed these values, then the convergent validity of the scale is expected [39](see Table 9).

Table 9. Reliability and internal consistence of the latent variables

Latent Variable	Item	λ	Alpha Cronbach	CR	AVE
Free and universal access	FUA1	0.843	0.874	0.878	0.706
	FUA2	0.918			
	FUA3	0.752			
Restricted access	RA1	0.899	0.850	0.857	0.669
	RA2	0.837			
	RA3	0.706			
Perceived overuse	PO1	0.787	0.923	0.926	0.808
	PO2	0.935			
	PO3	0.965			
According Health Policy	RDL1	0.722	0.640	0.641	0.537
	RDL2	0.651			

To check the reliability and internal consistency of the model, we calculated Cronbach's alpha, rates of composite reliability and variance extracted values. Alpha ≥ 0.7 [27, 40], composite reliability (CR) should take scores ≥ 0.5 [41] for confirming the internal consistency of constructs; about discriminant validity, for measuring the accuracy with which the analysis instrument represents the variables, the average variance extracted (AVE) values exceed 0.5 score [40]. Each latent variable's AVE was larger than the squared correlation between each pair of latent variables, thus demonstrating the good discriminant validity of the scale [39].

Table 10. Correlation matrix of constructs

	Free and universal access	Restricted access	Perceived overuse	According Health Policy
Free and universal access	1			
Restricted access	-0.493	1		
Perceived overuse	-0.239	0.330	1	
According Health Policy	-0.133	0.238	0.480	1

The model fit indexes, and its reference scores are shown in Table 11. Our model has a good or acceptable fitting, according all indexes.

Table 11. Goodness of model fitting

Fit index	Score	Reference scores	
		Good	Acceptable
$\chi 2$/df	2.815	$0 \leq \chi 2/df \leq 2$	$2 \leq \chi 2/df \leq 3$
CFI (Comparative fit index)	0.952	$0.97 \leq NFI \leq 1.00$	$0.95 \leq NFI \leq 0.97$
TLI (The Tucker-Lewis coefficient)	0.936	As close as possible to 1	
NFI (Normed fit index)	0.929	$0.95 \leq NFI \leq 1.00$	$0.90 \leq NFI \leq 0.95$
RMSEA (Root mean square error of approximation)	0.087	$0 \leq RMSEA \leq 0.05$	$0.05 \leq RMSEA \leq 0.10$

The reference values indicates that χ^2 values $1 \leq \chi 2 \leq 2df$ are compatible with an acceptable fitting [42]. In our model, the interval is $1 \leq \chi^2/df \leq 82$, and $2df \leq \chi 2 \leq 3df$ ($82 \leq \chi 2 \leq 123$). For the comparative fit index, is considered a good adjustment when $0.95 \leq CF \leq 1.00$, and acceptable for $0.94 \leq CF \leq 1.00$. The typical range for TLI lies between zero and one, but it is not limited to that range [43, 44]. TLI values close to 1 indicate an acceptable fit. The normed fit index (NFI) indicates a good fitting when $0.95 \leq NFI \leq 1.00$ and acceptable when $0.90 \leq NFI \leq 0.95$[43, 44], this is the case of this model. The good and acceptable values for the Root mean square error of approximation (RMSEA) are $0.00 \leq RMSEA \leq 0.05$ and $0.05 \leq RMSEA \leq 0.10$, respectively [45,46]. So, we can conclude that, in general terms, our model is suitable for analyzing. Nevertheless, the scale of the fit indices is not always easy to interpret [43].

To evaluate the fit of the structural model incumbent first for analyzing the significance attained by the estimated coefficients, because a no significant parameter indicates that the proposed relationship between analyzed variables has no substantial effect, so it should be removed and then reformulate the model. Thus, any estimated parameter should be statistically different from zero, or what is the same, considering a significance level equal to 0.05. In our model all parameters are significant ($p < 0.05$).

The standardized regression weights for the observable variables and for constructs are shown in Table 12 and Table 13. These results (see also Figure 2) lead us to test H7, H8 and H9. As results indicate, the higher is the perceived overuse, the lower is the opinion of stablishing an universal and free Public Healthcare System, and the higher is the willingness to restrict access, so H7 and H8 should be rejected, because when perceived overuse increases in one unit, the opinion of free and universal access decreases in 0.24, and the opinion of establishing restrictions increases in 0.35 (significance p-value < 0.001). H9 should be rejected too, since it has been proved that there is a positive and statistically significant relationship ($p < 0.001$), which points out that when the perception of overuse in the health system increases, the agreement with the restrictive health policies in times of crisis also increased by 0.6. Considering the above, the answer to the RQ3 has to be yes without a doubt.

Table 12. Standardized regression weights. Observable variables

Item	Standardized regression weights	Significance	Latent Variable
FUA1	0.833	***	Free and universal access
FUA2	0.931	***	
FUA3	0.744	***	
RA1	0.924	***	Restricted access
RA2	0.820	***	
RA3	0.690	***	
PO1	0.787	***	Perceived overuse

PO2	0.934	***	
PO3	0.966	***	
RDL1	0.722	***	According to health policy
RDL2	0.651	***	

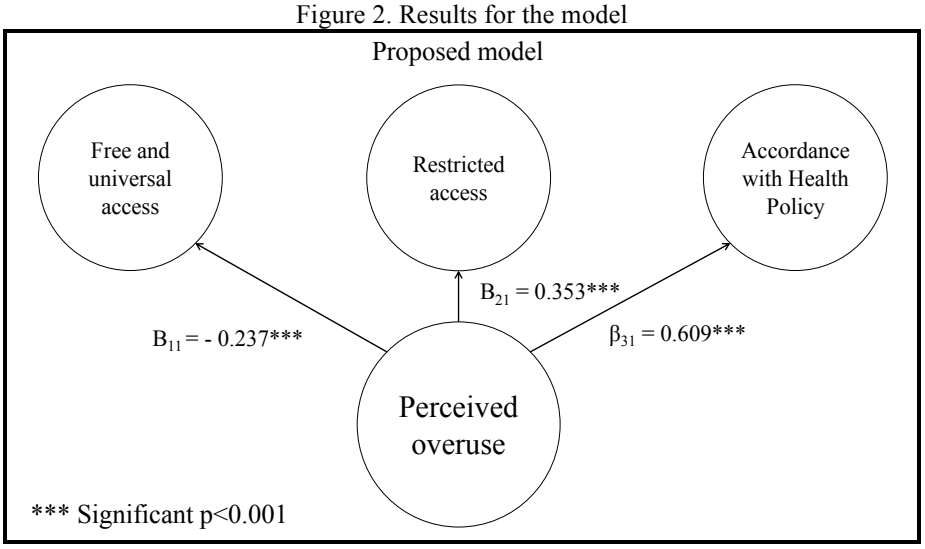
*** Significant p<0.001

Table 13. Standardized estimators for dependent variables

Latent variable	Regression weights	S.E.	C.R.	Standardized regression weights	Significance
Free and universal access	-0.201	0.059	-3.427	0.353	***
Restricted access	0.307	0.062	4.974	-0.237	***
Accordance with health policy	0.393	0.061	6.459	0.609	***

*** Significant p<0.001

Figure 2. Results for the model



6. Conclusions

The Spaniards disagree with the new health policy, no differences are appreciated due to age or sex. Therefore, there is a widespread rejection of cuts in healthcare as a result of the economic crisis. Moreover, they don't have the perception of a general overusing of health care system, nevertheless, men are more perceptive

than women, but none of genders have the perception of overusing the healthcare services.

We have probated that there is a relationship between the perception of overusing of health services and the personal opinion about the free and universal access to Public Healthcare System. We can ensure that, according to our sample, the greater the perceived overuse the public health system, the greater the support for cuts in health spending and restrictive policies. Moreover the opinions favorable to universal and free access will start diminishing, and the ones favorable to establishing restrictions will increase.

Summarizing, we can conclude stating that the question of public acceptance of cuttings in public healthcare is tightly related to the adequate use. Since we have found that if a free and universal access to the health services turns into an inadequate use, politicians would be supported for general population for establishing cuts in expenses and the expected effects on society welfare could be hard to predict.

7. References

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