ESPN Thematic Report on Inequalities in access to healthcare

Spain

2018

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European Social Policy Network (ESPN)

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The ESPN brings together into a single network the work that used to be carried out by the European Network of Independent Experts on Social Inclusion, the Network for the Analytical Support on the Socio-Economic Impact of Social Protection Reforms (ASISP) and the MISSOC (Mutual Information Systems on Social Protection) secretariat.

The ESPN is managed by the Luxembourg Institute of Socio-Economic Research (LISER) and APPLICA, together with the European Social Observatory (OSE).

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Summary / Highlights

Spain's universalistic, taxation-financed, decentralised national health system (SNS), was profoundly transformed with the reintroduction of an insurance logic to determine eligibility in 2012. Historically financed through social insurance contributions linked to labour market participation, the public healthcare system became fully funded from general taxation in 2000, losing all financial links with the social security system. The reintroduction of the concepts of 'insured' and 'beneficiary' significantly altered the universalistic character of healthcare access in Spain as it had been designed since the establishment of the SNS in 1986.

The Spanish healthcare system traditionally obtained positive results on a whole range of indicators when compared with other OECD countries. The introduction of strict cost-containment measures (reduction of healthcare expenditure by 13% between 2010 and 2014) significantly altered basic features of the system. Those cuts resulted in a 5% reduction in the number of functioning hospital beds (more than 5,000), a 3% reduction in the number of health professionals employed by the system (more than 20,000), and a deterioration in working conditions for those professionals, as well as a significant reduction in funding for healthcare centres. According to the 2017-2020 stability plan, the Spanish government expects the impact of fiscal consolidation on public healthcare expenditure to continue during that period, reducing the capacity of the SNS to respond to the growing and changing nature of healthcare demand. Recent studies have analysed the consequences of the exclusion of undocumented immigrants from access to the public healthcare system, estimating that it increased by 15% the mortality rate among this group.

The decentralised nature of the Spanish SNS facilitated the emergence/strengthening of inequalities in access to healthcare between the different regions, a trend reinforced by the crisis. Significant variations across regions persist in the performance of their healthcare systems, as the significant increase in waiting lists clearly shows (e.g. while the average waiting time for non-urgent surgical interventions in Madrid was 46 days in June 2017, patients in the Canary Islands had to wait 169 days). Other cases such as Andalucía (66 days), Valencia (83 days) or Catalonia (163 days) show significant variation regarding the waiting times necessary to access medical care. Strengthening resource-allocation mechanisms, and linking national and sub-national health budgets to objective measures of the health needs of the population, appear to be the way to solve the underfunding of regional healthcare systems (SRS).

The effects of the economic crisis contributed to a higher prevalence of chronic illnesses, and to an increasing presence of risk factors among the most vulnerable groups of the population (Urbanos Garrido et al., 2014). Traditionally poorly developed areas of the public healthcare system (such as mental health services), proved incapable of responding to these developments (Pérez et al., 2014).

The increasing number of people buying private health insurance (from 8.8 million in 2013 to 10 million in 2017), notably among the wealthier segments of the population, appears to be linked to a deterioration in citizens' perception of the functioning of the system (satisfaction with the SNS decreased from 73.9% in 2010 to 62.7% in 2014).

The introduction of co-payments for pharmaceuticals for pensioners, and the increased share of costs assumed by patients of working age, contributed to reducing the pharmaceutical bill. Nevertheless, those co-payments are at the origin of new inequalities in access to healthcare, particularly for patients with chronic illnesses, or for low-income segments of the population. The use of moderate co-payments is expected to increase patients' individual responsibility to contain healthcare costs, and to displace consumption towards drugs with a better cost-effectiveness profile through the application of differential rates of cost-sharing: but negative impacts on drug consumption for chronic conditions affecting essential treatments must be closely monitored.

1. Description of the functioning of the country's healthcare system for access

The Spanish national health system (SNS) was established by a series of incremental legislative changes initiated in 1986 by the 14/1986 General Health Law[1]. This key piece of legislation was aimed at transforming the various existing social security healthcare schemes into a universalist healthcare system modelled on the British national health service. Over time, its coverage was gradually extended to include all persons residing in the country, regardless of either their relation with the social security system (1088/89 Royal Decree for the incorporation of the charitable healthcare schemes under the SNS[2]), their level of income/wealth (33/2011 Public Health Law[3]), or their legal/administrative status (4/2000 Immigration Law[4]). In this process, the SNS experienced a gradual but systematic disconnection from the social security contributory schemes, and since the early 2000s it has been fully financed through general taxation[5].

Since its inception, the SNS evolved as a profoundly decentralised system, made up of 17 regional healthcare systems (SRS) run by each of the autonomous regions, plus the healthcare systems of the two city-enclaves of Ceuta and Melilla (directly run by the ministry of health). The central government is responsible for the basic legislation on healthcare and pharmaceutical products, while regional health authorities are in charge of the deployment of that basic legislation within their own territories, with a very large degree of autonomy in the way they structure their respective SRS. The ministry of health is supposed to play a role in facilitating the coordinated functioning of the whole SNS, by gathering and analysing the information on the different components of the system, promoting the development of learning processes on best practices across regions, and leading the decision-making process on healthcare policy through the Interterritorial Council of the Spanish Healthcare System (Consejo Interterritorial del Sistema Nacional de Salud, CISNS), the equivalent of a federal health commission on which central government and regional health authorities sit.

The decentralised nature of the system is also visible in the financial functioning of the SNS. While most taxes are raised by the central government (with the exception of the Basque Country and Navarre, which enjoy a special taxation system), and then transferred to the regions, it is in the power of the regions to decide on the use of those funds. In this way, healthcare costs are included in the calculation of the financial resources received by regions (within a complex formula including population, dispersion, age structure, insularity, etc.) from the central government, but it is then up to the regional governments to decide on the relative priority attached to healthcare within the general list of policies they are responsible for (education, social services, culture, certain infrastructures, etc.). While the debts accumulated by the SRS are the responsibility of regional governments, there have been instances (notably in 2005-2006, and from 2012 onwards) when additional funds were transferred to the regions with the objective of wiping out some of those debts.

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[1] 14/1986 General Health Law, http://goo.gl/qd0BBi.

[2] 1088/89 Royal Decree extending access to the SNS to people without resources, https://goo.gl/Riroct.

[3] 33/2011 General Public Health Law, http://goo.gl/FTynNs.

[4] 4/2000 Foreigners Law, http://goo.gl/rCluQ0.

[5] Civil servants in central government and their dependants (1,476,000 people in 2016) have their own specific social insurance scheme (MUFACE), which allows them to choose between healthcare provided by the SNS (290,000 chose this option in 2016), or by private healthcare providers (the choice of 1,185,000 people) (MUFACE, 2017). A similar situation applies to members of the armed forces and their dependants (606,000 people), most of whom had opted for private healthcare insurers (553,000), with the rest being directly provided for by the SNS (ISFAS, 2017); as well as member of the judiciary (around 92,600 people), with most of them opting for private insurance (75,300), and the rest receiving healthcare through the SNS (MUGEJU, 2017). Civil servants hired after January 2011 could not join MUFACE, and have been directly linked to the general social security system, https://goo.gl/nDCVfM.

Autonomous communities' governments are responsible for the organisation of their SRS, including the articulation of the role played by private healthcare providers within their regional public healthcare systems. This implies a great deal of variation in the resources devoted by the different SRS to contracting out healthcare to private providers (ranging in 2016 from nearly 25% in Catalonia to 4% in Aragón, with Madrid occupying an intermediary position with 11%) (FEADSP, 2017).

In the wake of the long economic crisis starting in 2008, reforms and funding cuts profoundly altered the functioning of the SNS. The fiscal consolidation measures adopted implied that the financial resources devoted to healthcare decreased by 13% between 2010 and 2014. Although public healthcare expenditure increased by €3.5 billion in 2015, and by some additional €600 million in 2016, the process of fiscal consolidation in the healthcare sector seems to be far from over. According to the Spanish government's 2017-2020 stability plan, public healthcare expenditure, which represented 6.78% of GDP in 2009, fell to 5.89% in 2017, and should be further reduced to 5.57% in 2020[6]. This reduction is framed within a general logic of retrenchment in public expenditure, which should be reduced from 44.3% of GDP in 2013 to 38.7% in 2020.

In addition to the cuts in funding, the Spanish healthcare system experienced a very significant transformation in recent years, changing its very philosophical foundation from a universalist system, back to the insurance logic of its origins.

1.1 Healthcare coverage

The passing of the April 20th. 16/2012 Royal Decree on 'urgent measures to ensure the sustainability of the SNS'[7] meant a radical change in the ethos of the SNS, eliminating its universalistic nature (up to then healthcare access was based purely on residence in the territory), and reintroducing an insurance logic in the definition of entitlements (despite the fact that financing continues to be fully tax-based). This regulation established the categories of 'insured persons' (workers, pensioners, and unemployed persons receiving benefits, as well as job-seekers), and 'beneficiaries' (spouses, and siblings younger than 26, of 'insured' persons), as the groups entitled to receive the whole package of healthcare services granted by the SNS [8].

Following this regulation, Spaniards with income higher than €100,000 per year, and not contributing to the social security system (who had been included in the SNS only in January 2012, through the 33/2011 Public Health Law) were not considered 'insured' and were therefore excluded from the system. In July 2016, the constitutional court issued a ruling cancelling this limitation (STC 139/2016)[9], and therefore granting access to the SNS again to every Spanish and EU citizen legally residing in Spain. A similar development took place with regards to jobless people older than 26 without benefits, and unemployed workers without benefits who leave the country for more than 90 days. Both of these groups were initially excluded from the SNS by the RD 16/2012, only to be readmitted to the system soon afterwards on condition of proving lack of financial resources. Migrants in an irregular situation (with the exception of minors and pregnant women) were the other group officially left out of the SNS by this regulation, entitled to care only in the case of emergency or infectious disease[10]. Non-resident EU citizens were treated according to EU cross-

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[6] Update of the Stability Programme of the Kingdom of Spain, 2017-2020, https://goo.gl/saV4JU.

[7] 16/2012 Royal Decree on urgent measures to ensure the sustainability of the SNS, http://goo.gl/ILEV6r.

[8] Those who were not considered 'insured' could not open entitlements as 'beneficiaries' to their dependent relatives, so these too were excluded from the SNS. The total number of people affected by this restriction was estimated by the ministry of health to be around 47,000 (https://goo.gl/9cCgxS).

[9] Available at https://goo.gl/EmP7SG.

[10] The government justified the need to go back to a logic of insurance in the public healthcare system by referring to the problem of charging non-resident foreigners (many of whom are, in fact, EU citizens

border healthcare regulations; in order to receive treatment in the SNS they had to produce a European health insurance card for unforeseen medical treatment, have the authorisation of their country of origin's health authority in the case of planned treatment, or show a certification of lack of healthcare entitlement in the country of origin and lack of financial resources[11].

Given the decentralised nature of the public healthcare system, the implementation of the new SNS eligibility mechanisms introduced in 2012 was met with an extremely heterogeneous response from regional health authorities[12]. This resulted in an increase of administrative discretion, a reinforcement of inequalities in access to healthcare for vulnerable groups, and growing conflicts between the central and regional governments over the delimitation of competences to define healthcare entitlements[13].

1.2 Availability of care

Waiting lists constitute one of the main limitations on the availability of care, and they appear strongly related to the budget cuts implemented in recent years in the SNS. While the average waiting time for a hospital non-urgent surgical intervention was 74 days in December 2007 (with 376,000 patients on the lists), this had risen to 89 days by the same month of 2015 (550,000 patients), and to 115 days by December 2016 (614,000 patients). By the end of 2017 it had decreased to 104 days (604,000). Certain procedures show significant increases in the waiting times to receive care. As an example, patients waiting for a neurosurgical intervention had to wait an average of 91 days in 2007, and this figure had increased to 161 days by 2017. In the case of traumatology patients, the waiting time went from 86 to 130 days over the same period; and for paediatric surgery treatments it increased from 79 to 118 days[14]. Nevertheless, 2017 showed a relative improvement in waiting times for most procedures in the majority of autonomous communities compared with the previous year.

Table 1. Waiting lists for selected procedures (2007-2017)

	2007	2009	2011	2013	2015	2017
Non-urgent surgical intervention	71	65	71	95	84	104
Neurosurgical intervention	91	81	90	160	160	161
Traumatology	86	75	83	129	112	130
Paediatric surgery	79	76	84	113	105	118

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spending part of the year in Spain) for the medical treatment received from the SNS. As the Tribunal de Cuentas (2012) suggested, that problem could be solved by improving bilateral compensation mechanisms with other EU countries, without having to distort the universalist philosophical foundation of the SNS.

[11] In September 2012, some 873,000 healthcare cards belonging to foreigners were cancelled.

[12] While certain regions removed their health cards from this group from September 2012 (Castile-La Mancha), as dictated by the central government, others did so with exceptions (Madrid, Baleares, Castile-Leon, Murcia, and Rioja), a third group explicitly refused to adopt the measure (Andalusia, Asturias), and a last group established alternative schemes to maintain provision for this population (Aragon, Basque Country, Canary Islands, Cantabria, Catalonia, Extremadura, Galicia, Navarra, and Valencia) (MDM, 2014). Eventually, most regions (with the exception of Castile-Leon, Rioja, and the autonomous cities of Ceuta and Melilla – whose healthcare systems are directly run by the central government) developed specific regulations to incorporate undocumented migrants within their healthcare systems (Reder, 2017).

[13] In November 2017, the constitutional court issued a ruling favourable to the central government in the case of the extension of health coverage to migrants in an irregular situation in the Basque Country (https://goo.gl/cALAK5). A month later it did the same with regards to the case of the Valencian Community (https://goo.gl/9QUqg3). In both cases, the court argued that these autonomous regions had exceeded their powers when trying to define eligibility criteria to access their SRS, something that remains the exclusive competence of the central government.

[14] Updated waiting lists information available at: https://goo.gl/ftu8je.

Total	74	67	73	98	89	106
Data source: SNS waiting lists information system, https://goo.gl/ftu8je.						

The significant increase in waiting lists reflected the relative containment of human and material resources for the public healthcare system. Thus, while certain resource indicators showed a relative improvement between 2008 and 2015 (the number of specialty doctors per 100,000 inhabitants increased from 1.76 to 1.86; that of specialised nurses went from 3 to 3.2; and CT scan devices increased from 1.43 to 1.66), some stagnated (the number of primary care doctors per 1,000 patients remained unchanged at 0.75), and others deteriorated in the same period (hospital beds per 1,000 inhabitants decreased from 3.22 to 2.98)[15].

Healthcare expenditure varies quite considerably across regions, due to a number of reasons ranging from the different composition of healthcare demand (linked to the socio-demographic characteristics of the population), to the political decisions taken by regional governments on how to allocate the financial resources they manage (obtained through transfers received from the central government, as well as from the taxes they levy directly). The fiscal consolidation measures introduced after 2010 reinforced these differences. In 2008, the region with the highest per capita healthcare expenditure (Basque Country, with €1,596) spent 32% more than the region with the lowest per capita expenditure (Valencia, with €1,211). That difference had increased to 60% by 2013 (ranging from €1,552 in the Basque Country to €965 in Valencia). In 2016, this overall spread was still around 50%, ranging from €1,110 in Andalucía to €1,669 in the Basque Country (with average national per capita healthcare expenditure of €1,332) (MSSSI, 2018).

This gradient translates into a significant variation in the human resources available: on average there were 1.86 specialty doctors per 100,000 inhabitants in 2015 in Spain, but the regional dispersion was from 2.33 in Navarre to 1.25 in Melilla. In the case of primary care nurses, the national average of 0.64 hides a dispersion from 0.89 in Castile-León to 0.51 in Ceuta. A similar pattern could be observed with regards to material resources: the national average number of hospital beds in 2015 (2.98 per 1,000 inhabitants) hid a dispersion from 3.83 in Catalonia to 1.94 in Melilla. Similarly, the availability of CAT scans per 100,000 inhabitants ranged from 2.04 in Navarre to 1.18 in Ceuta and Melilla, with a national average of 1.66. These differences in resources among the different SRS are reflected in variations in the actual availability of care for patients, depending on their region of residence.

1.3 Affordability of care

Together with other cost-cutting measures considered necessary to reduce the high pharmaceutical bill, the Royal Decree 16/2012 introduced co-payments on medication for pensioners[16], increasing them for users with annual income above €18,000 as well[17]. Pharmaceutical costs were nearly 16% lower in 2014 compared with 2011[18], with savings of €6,621 million between July 2012 and December 2016 as a consequence of the implementation of those initiatives, which included increasing co-payments, together with increasing use of generics, removal of products from the basket provided by the SNS, and price reductions imposed on providers[19]. The public

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[15] SNS Key Indicators, available at https://goo.gl/YBd1vj.

[16] 10% of the cost of medication with a cap of €8/month for pensioners with an income below €18,000/year; €18/month for pensioners with an income between €18,000 and €100,000/year; and €60/month for those with income above €100,000/year.

[17] From 40% to 50% for those with income between €18,000 and €100,000/year, and to 60% for those above €100,000/year. Co-payments for unemployed workers who have lost their benefits, as well as for people on income support, were removed (they had to cover 40% of the prescription expenses before).

[18] Update of the Stability Programme of the Kingdom of Spain, 2015-2018, http://goo.gl/0OUhaH.

[19] Ministry of Health, Social Services and Equality, https://goo.gl/xCvq2E.

share of the pharmaceutical bill declined from 75.7% in 2009 to 71.5% in 2013 (MSSSI, 2016).

On January 1st. 2014, regional health authorities were also supposed to start implementing co-payments on certain drugs dispensed in hospitals. Only Ceuta and Melilla did so, with the rest of the regional health authorities blocking this measure (arguing technical difficulties, or expressing opposition to this policy) (Cantero, 2014).

Public spending covered 75.1% of healthcare expenses in 2010. After the introduction of the previously stated reforms this percentage was down to 69.8% in 2014, and it was back up to 71% in 2016 (MSSSI, 2016), reflecting an increase of private expenditure on healthcare, notably in the form of out-of-pocket payments, co-payments, and subscriptions to private health insurance. In this respect, annual per capita spending on pharmaceuticals increased by 15.6% between 2007 and 2015 (from €147.5 to €170.6) again with significant variations between regions (while household spending in this area increased by nearly 60% in Ceuta, 55% in Castile-León, and 48% in Galicia, it decreased by 14.6% in the Balearic Islands, and 11.5% in Valencia) (Pérez Huertas, 2016). According to the household income survey, families devoted an increasing amount of resources to healthcare, up from 3.2% of their disposable income in 2010 to 3.5% in 2014[20].

Satisfaction with the functioning of the SNS has fallen since 2010, going from 73.9% in that year to a low point of 62.7% in 2014, before increasing to 66.8% by 2017[21]. This facilitated the expansion of private healthcare insurance, which increased from 8.8 million insured people in 2013 to 10 million in 2017, notably among the wealthiest sectors of society. The social gradient in purchasing private healthcare insurance is quite clear according to the 2014 European health interview survey (EHIS): while 35% of those in the wealthiest 'social class 1' declared private healthcare insurance, this figure was 23% for class 2, 21% for class 3, 11% for class 4, 7% for class 5, and 5% for class 6 (quoted in Simó, 2016). The regional variation was also very visible, ranging from 34% of the population in Madrid to 5% in Cantabria (IDIS, 2018; Pérez Durán, 2016). The available empirical evidence shows that the dual insurance enjoyed by those purchasing private healthcare insurance has a clear effect on the waiting times to receive treatment: waiting times to be seen by a specialist doctor ranged from 30 days in the private insurance sector to 54 in the SNS in 2012; waiting periods for hospitalisation went from 1.4 months with private insurance to 5.8 through the SNS (Urbanos Garrido, 2016).

1.4 Depth of coverage

In the context of enforcing strict measures of fiscal consolidation, and with the objective of granting a minimum standard level of healthcare coverage across regions, the RD 16/2012 pushed in the direction of defining a common benefits package for all SRS, based on cost-effectiveness evaluations supported by scientific evidence. Thus, the regulations SSI/1329/2014 of July 22nd[22], and SSI/2065/2014 of October 31st. 2014[23], defined the basic common benefits package fully covered by the SNS (including prevention, diagnostics, treatment, rehabilitation and urgent medical transportation fully covered by public financing), as well as a complementary benefits package subject to co-payments (pharmaceutical products, orthopaedic and prosthetic devices, dietary treatments, and non-urgent medical transportation). These regulations also defined those healthcare services considered to be non-essential for

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[20] Annual reports on the household income survey available at: https://goo.gl/9NR43R.

[21] Information on satisfaction with the SNS, extracted from the Barómetro Sanitario, is available at: https://goo.gl/Ms5VpV, and https://goo.gl/LQ1qCE.

[22] SSI/1329/2014 Order establishing public financing caps for SNS procedures, http://goo.gl/G3JWSC.

[23] SSI/2065/2014 Order establishing SNS benefit packages, http://goo.gl/Bu8745.

the treatment of chronic conditions (e.g. cosmetic products for patients affected by rare diseases), also subject to co-payments. After guaranteeing the provision of the common minimum healthcare services, regions may choose to include treatments under the different categories of benefits, thus providing them free of charge or with a partial or total co-payment.

2 Analysis of the challenges in inequalities in access to healthcare in the country and the way they are tackled

The Spanish SNS traditionally obtained good health outcomes in comparison with the healthcare systems of other advanced societies[24], particularly when taking into consideration its cost-effectiveness. Although the healthcare system maintained its basic functions during the reforms and budgetary constraints experienced after the crisis, and was relatively successful in fulfilling its responsibilities to provide healthcare services to the population (Coduras Martínez et al., 2017), it experienced a deterioration in the quality of care provided due to the closure of wards and hospital beds (particularly in the summer season[25]), a reduction in the ratio of health professionals to patients, increased waiting lists, the exclusion of vulnerable groups, and the general underfunding of healthcare centres (Petmesidou et al., 2014; Urbanos Garrido et al., 2014). In this respect, self-reported unmet healthcare need experienced a slight increase between 2010 (when it was at a low of 0.3%) and 2013 (when it peaked at 0.8%), going down gradually again till reaching 0.5% in 2016 according to EU-SILC data. Of the three main components of this indicator (financial cost of care, distance to healthcare centre and waiting lists) the financial burden of healthcare was the one that experienced the most significant increase (from 0.2% to 0.6%), with not-employed and unemployed groups as those most affected by these difficulties in accessing healthcare.

2.1 Social inequalities and the SNS

Recent empirical evidence points to a deterioration in health among those groups of the Spanish population most negatively affected by the crisis (Díaz, 2016; Borrell et al., 2017; Pérez et al., 2014). Some health indicators, strongly associated with lifestyle aspects and not corrected by social or healthcare programmes (alcohol and tobacco consumption, morbidity linked to asthma, labour-related accidents, or frequency of hospitalisation), show a negative trend in recent years (Rajmil et al., 2013; Benach et al., 2014).

Social determinants of inequalities in health can only be partly mitigated through healthcare interventions. Nevertheless, traditionally poorly developed areas of the Spanish public healthcare system, such as mental health services, proved incapable of responding to the deterioration in the health status of adult men affected by long-term unemployment (Bartoll et al., 2013; Urbanos Garrido et al., 2014), or of the most vulnerable groups of the population suffering from other negative side-effects of the crisis, such as foreclosures (Vásquez-Vera et al., 2016[26]). These mental health services were also unable to prevent the considerable increase in self-harm and

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[24] 66 deaths from stroke for men per 100,000 population compared with 96 in EU28, 105 for ischemic heart disease compared with 176 in EU28, and 10% fewer deaths for all kinds of cancer among men than in EU28 (average 2011-2013) (OECD, 2016).

[25] Following a trend that started in 2012, around 10% of hospital beds were closed down during the summer of 2016 due to human resources shortages. The total number of healthcare professionals decreased from 505,000 in 2012 to around 480,000 in 2016, https://goo.gl/6bVRbG.

[26] 9 out of 10 persons experiencing problems paying their mortgage in the city of Barcelona suffered mental health problems, compared with 12% of the general population of that city.

suicide rates[27] experienced by certain segments of the Spanish population since 2011 (López Bernal et al., 2013; Gili et al., 2013; Fundación Salud Mental España, 2016).

The economic crisis may also be contributing to a higher prevalence of chronic illnesses, and to an increasing presence of risk factors such as obesity among the most vulnerable groups of the population (Díaz Martínez, 2016), as well as to a pro-rich bias in preventive screening programmes (Carrieri et al., 2013).

Reflecting on some of the most extreme consequences of the crisis, some authors have pointed to the death of patients due to an inadequate provision of healthcare in the SNS (Juanmarti Mestres et al., 2018; Legido-Quigley et al., 2013). Other authors claim that observed mortality seems to be decreasing at a slower rate than would have been expected in the absence of the crisis, while an increase in winter mortality among elderly people can be perceived as well (Benmarhnia et al., 2014).

2.2 Exclusion of undocumented migrants

The exclusion of undocumented migrants from accessing the SNS was one of the most direct (and contested) measures adopted in the heat of the financial crisis. Around 150,000 undocumented migrants were estimated to have lost access to the SNS following the RD 16/2012 (Moreno-Fuentes, 2015).

Combining the qualitative evidence produced by civil society organisations on the negative effects of excluding undocumented migrants from the SNS (MDM, 2014), recently published studies have analysed the consequences of that exclusion – which officially remains in place, although severely altered by the bypassing actions of the governments of the autonomous communities (Juanmarti Mestres et al., 2018). According to these authors, the mortality rate among undocumented immigrants increased by 15% after they were excluded from the SNS, showing how access to public healthcare has a very significant effect on the health status of vulnerable populations.

Several institutions, both national (Ombudsman[28], Tribunal de Cuentas[29], Constitutional Court[30]) and international (Council of Europe[31], UN Special Rapporteur on extreme poverty and human rights[32]) made clear statements criticising the expulsion of this vulnerable group from the public healthcare system, and pointing to the potential public health risks of not adequately treating patients within the normal channels of the public healthcare system. In 2015 the minister of health publicly and explicitly recognised the negative side-effects of expelling migrants in an irregular situation from the SNS, accepting that no savings in healthcare spending could be directly attributed to that measure. In July 2015 he presented the inter-territorial commission of the SNS with a proposal for a homogeneous coverage of the healthcare needs of undocumented migrants who had lived in a Spanish region for more than six months, but no decision was officially adopted in that forum to change the situation[33].

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[27] The average suicide rate was at a record low level of 6/100,000 in 2010 (10 for males), but peaked at 8.25 in 2014 (13.2 for males), before going down again to 7.46 in 2016 (11.84 for males). These aggregate figures hide a significant regional variation, with the highest average suicide rate of 11.08 in the region of Galicia in 2016, and the lowest rate in the autonomous city of Melilla, with 2.45 (Fundación Salud Mental España, 2016).

[28] 2012 Spanish Ombudsman Annual Report, http://goo.gl/MA6hWu.

[29] Audit report on the Management of Healthcare Benefits arising from the implementation of the EC Regulations and International Conventions on Social Security, Madrid, 2012, http://goo.gl/4rFhA9.

[30] 239/2012 Spanish constitutional court ruling, December 12th., 2012, http://goo.gl/cGLJ9z.

[31] Council of Europe, European Social Charter, http://goo.gl/d8V3vE.

[32] UN Human Rights, press release, http://goo.gl/zs0bLR.

[33] Source: Ministry of Health, Social Services and Equality, http://goo.gl/OtfJQl.

In September 2017, all opposition parties in Parliament (with the exception of *Ciudadanos*), joined a platform of civil society organisations and healthcare professional associations in calling for the re-establishment of a universal SNS when a majority in Parliament allows for it. The incoming government announced on June 15th. 2018 that in the following six weeks it planned to reverse the measures introduced by the RD 16/2012 that restricted undocumented migrants' access to the SNS.

2.3 The territorial dimension of access inequalities

One of the most relevant aspects related to inequalities in access to healthcare in Spain, and which is in need of further analysis, is the evolution of inequalities across regions. The lack of adequate data to delve into this dimension is a consequence of both: (a) the complexity of generating and sharing standardised data in a multi-level governance structure such as the SNS; and (b) the difficulty of establishing dynamics of trust and cooperation among the different healthcare administrations involved in the functioning of this system (often managed by political forces of different affiliations, and with a defensive attitude towards the potential political use of any data generated by information sharing). In this context, it is extremely difficult to systematically evaluate in a comparative manner the functioning of the different SRS, or the innovation in the organisation and management of the systems, as well as in the healthcare protocols and practices applied by health professionals. Despite these difficulties, several studies show how the profoundly decentralised nature of the Spanish SNS facilitated the emergence/strengthening of inequalities in access to healthcare in the different regions (Coduras Martínez et al., 2017; Comisión para Reducir las Desigualdades Sociales en Salud en España, 2015), a trend that the crisis has only reinforced.

Some of the clearest indicators of the existence of differences in the availability of healthcare access regions are related to the waiting times to receive medical care, reflecting both the different impact reforms and budget cuts had on SRS, and the different policy priorities established by their respective governments (Sánchez-Bayle et al., 2018)[34]. While in Madrid patients had to wait 51 days on average for a hospital non-urgent surgical intervention in December 2017, patients in Catalonia had to wait 160 days. Other cases such as the Canary Islands (146 days), Andalucía (77 days), or Valencia (75 days) show significant variation regarding the waiting times necessary to access medical care for this kind of procedure. If we focus on waiting times for other critical medical procedures, such as neurosurgical interventions (321 days in the Canary Islands, 209 in Castile-La Mancha, 130 in Valencia, or 62 in Madrid), or traumatology operations (204 days in Castile-La Mancha, 164 in Catalonia, or 43 in Melilla), we can again observe wide variations, indicating the significantly different availability of healthcare in the different regions.

2.4 Inequalities in access generated/strengthened by the market

The tensions introduced in the system by the budget cuts, the reforms, and the change in logic of the healthcare model, resulted in a relative deterioration in the public perception of the functioning of the SNS[35], as well as in a relatively high visibility of this area of policy in the judicial sphere, in the media, and in the public and

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[34] Updated waiting lists information available at: https://goo.gl/ftu8je. A comparative assessment of the functioning of the different SRS, including a comparison of the evolution of waiting lists in the different regions, can be consulted at https://goo.gl/AQ727o.

[35] Between 2010 and 2014, the survey on health (*Barómetro Sanitario*) showed a steady decline in the number of respondents stating that the SNS worked well or reasonably well, from a peak of 73.88% to a low of 62.7%, before slightly recovering to 67.6% in 2017. Those stating that the system required substantial changes increased from 3.51% to 6.3% in the same period (MSSSI, 2017).

political arenas. In this context, those in the wealthiest sectors of society who could afford it increasingly 'partially exited' (Andreotti et al., 2015) the SNS, and acquired complementary private health insurance. According to Pérez Durán et al. (2016), 11% of the upper-class/upper-middle-class population had private health insurance coverage in 2009, and that figure had risen to 26% by 2014. By comparison, working-class buyers of private health insurance increased from 1.4% to 4.9% in that same period, thus reflecting the different price-elasticity across social groups with regards to this type of insurance.

This trend was clearer in those regions where budget cuts had been more severe (IDIS, 2018), thus reinforcing the evidence for a relation between the deterioration of the public healthcare service and the increasing use of private health insurance to avoid waiting times for access to specialised diagnosis and care. This trend increased the risk of the development of a dual healthcare system, with increased inequalities in access (private providers are used to bypass waiting lists for access to specialised care, diagnosis, and certain hospital treatments), and with wealthier segments of the population – who are paying for their own private health insurance – weakening their support for a tax-financed, universal public healthcare system (Benach et al., 2004).

2.5 Co-payments as a potential obstacle to access medication

An additional source of potential inequalities in access to healthcare derives from the increase in pharmaceutical co-payments, particularly for patients with chronic illnesses, or for low-income segments of the population (Urbanos Garrido et al., 2014).

The 2014 EHIS shows that people of lower social class in Spain have more problems accessing medication (4.5%) than wealthier groups (0.6%). People with chronic conditions are also more likely to express difficulties in affording their medication due to co-payments (3.2%, by comparison with 1% of the general population). The greatest differences can be observed among those at the intersection of different axes of potential inequality: 5.6% of people under 65 belonging to a lower social class have problems accessing medicines, by comparison with only 0.5% of people of the same age in the wealthiest groups (MSSSI, 2014).

The reduction in the intake of necessary medicines due to the introduction of co-payments has recently been studied in the Spanish case, showing how in the short term pensioners reduced adherence to some essential treatments for secondary prevention of cardio-vascular conditions as a consequence of increased co-payments, notably for the most expensive treatments (ACEI/ARB and statins), although not in the case of low-priced medication (antiplatelet agents and beta-blockers) (González López-Valcárcel et al., 2017). These trends were even more pronounced among the middle-to-high-income working population, which was subject to a higher increase in co-payments following the recent reforms (from 40% to 50%, or 60%, co-payment, with no monthly ceiling). Although the effects seemed temporary, with patients returning to adherence rates equivalent to those observed prior to the reform 18 months after their implementation, this gap in adherence among a highly vulnerable population may have a relevant impact on clinical outcomes, and probably also on long-term costs. Similar effects have been studied for patients on antidiabetics, antithrombotics and drugs against asthma (Puig-Junoy et al., 2016).

Moderate co-payments can contribute to reducing the pharmaceutical bill by increasing the individual responsibility of patients, but they may negatively affect essential treatments, with the highest price-elasticity found among the poorest, and those in worst health (Puig-Junoy, 2004). Co-payments may operate as an efficient mechanism to displace consumption towards drugs with a better cost-effectiveness, through the application of differential rates of cost-sharing.

2.6 Basic recommendations to reduce inequalities in access to the SNS

- Increases in public healthcare expenditure (to the levels of European countries of similar development) should be considered in order to respond to transformations of Spanish society (population ageing, growing expectations from an increasingly educated population, introduction of cost-effective medications and health technologies).
- The workload of healthcare professionals should be reduced, notably in primary care, as well as waiting lists for hospital treatments. The saturation of emergency services should be addressed and, in general, the trend towards a deterioration in the quality of care provided should be reversed.
- The functioning of the SNS should be simplified by re-establishing a residence-based universal entitlement to healthcare. This could reduce administrative costs and bureaucratic discretion, as well as conflicts among different levels of the healthcare administration, while improving the health status of the most vulnerable segments of the population, at no significant additional cost.
- Minimum standards of services across regions should be guaranteed by strengthening resource-allocation mechanisms and linking national and sub-national health budgets to objective measures of the health needs of the population.
- Attention should be paid to inequalities in healthcare access related to socio-economic status, gender, territory and nationality.
- The SNS should be adapted to the changing profile of healthcare demand, away from acute interventions, and towards the increasing salience of chronic illnesses.
- Consideration should be given to the idea of fully exempting high-risk, chronic and low-income patients from co-payments for pharmaceuticals. Reducing financial/economic barriers to evidence-based medication could improve health outcomes, while reducing the number of costly non-fatal events.

3 Discussion of the measurement of inequalities in access to healthcare in the country

This report has been drafted using the indicators considered to be most relevant to highlighting the problems of access that characterise the current functioning of the Spanish SNS.

Regarding healthcare availability, we place particular emphasis on information on waiting lists. This is a key indicator that has been subject to significant controversies in Spain (some autonomous governments unilaterally changed the way they measured waiting times, or refused to provide this information to the central government, in order to obscure their responsibility for the increase in waiting times for treatment in their SRS), since it clearly reflects the differential access of patients to medical procedures, therefore showing the performance of SRS.

In relation to affordability, we referred to the two main mechanisms by which Spanish patients pay for healthcare out of their own pockets: private healthcare insurance and pharmaceutical co-payments. Information on the nature of the healthcare enjoyed by citizens (public, private, or both) is collected by different surveys (*Barómetro Sanitario*, EHIS, *Encuesta Nacional de Salud*), and it is also provided by the federation of private healthcare insurance companies (with a relative coincidence between those different sources). Different surveys include information regarding co-payments for pharmaceuticals, and the extent to which those cost-sharing schemes represent both a burden on citizen’s finances and, ultimately, an obstacle to accessing healthcare.

Despite the definition of different levels of benefit packages included under the SNS, most relevant treatments are included under the basic package covered by the public healthcare system, with some notable exceptions including dental treatment for adults, as well as non-urgent medical transportation, and prostheses.

Information regarding coverage of the SNS is relatively limited in its capacity to grasp the situation of those populations excluded from the system, and those falling out through the interstices between the regulations governing the public healthcare system. Although, according to standard indicators, the SNS covers between 99.8% and 99.9% of the population, the exact size, nature and situation of those groups excluded from the system remains relatively unclear. Groups explicitly excluded from the SNS (undocumented migrants, Romanian and Bulgarian migrants without adequate documents proving that they are not covered by the healthcare system of their country of origin, and wealthy Spanish citizens without links with the social security system) are not adequately grasped in surveys due to their relatively small size and dispersion, and the general difficulty of either including them in samples or actually reaching them through those carrying out the survey fieldwork.

An additional difficulty in collecting, managing and analysing information on inequalities in access to healthcare services in Spain has to do, once again, with the profoundly decentralised nature of the SNS, and with the complexity of setting up a system (and managing to mobilise, and get the cooperation of, the different regional health authorities) that may allow for an aggregated treatment of this data. Steps have been taken in this direction, such as: (a) the creation in 2014 of the healthcare innovation online platform (PINNSA) aimed at facilitating the gathering, evaluation and diffusion of innovative experiences in healthcare within the different SRS; or (b) the establishment in December 2015 of the national registry on rare diseases, aimed at coordinating the information available on those conditions and the cases existing in the different regional health services in Spain[36]. Nevertheless, much remains to be done in this area.

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[36] 1095/2015 Royal Decree establishing the National Registry of Rare Diseases, http://goo.gl/4DkxAr.

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