



Quality in and Equality of Access to Healthcare Services

Country Report for Spain *March 2008*

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Acronyms

AC(s)	Autonomous community(ies)
NHS	National Health System
CISNS	Interterritorial Council of the NHS
PHC	Primary Health Care
SHC	Specialised Health Care
EU	European Union
NGO	Non-governmental Organization
CABG	Coronary artery bypass graft
PTCA	Angioplastia coronaria transluminal percutanea
IMSERSO	Institute for Elderly people and Social Services, which is governed by the Ministry of Employment and Social Affairs
FAISEM	Andalusian Foundation for the Social Integration of the Mentally Ill
FEAFES	Mentally Ill and Family Associations Andalusian Confederation
MoH	Ministry of Health and Consumption
NAP	National Action Plan for the Modernization of the Social Model and Social Inclusion
EASP	Andalusian School of Public Health

1 Introduction

This country report for Spain is part of a joint work between eight European countries to document and analyse access to health care services for given vulnerable groups most exposed to exclusion; immigrants, elder people and mental health patients.

The report represents first hand information about the specific situation on barriers to access and policy initiatives aimed at improving access and equity of care. Most of the information gathered and analyze comes from institutional grey reports and interviews to key professionals of the Spanish health system. Literature review gave scarce information as lack of research on this topics is common.

Policy reforms are currently being undertaken in areas of interest to this project thus adding difficulties to our research due to lack of available information or restrictions to access it because of the elections scheduled for March 2008.

The structure of the report follows the common template prepared by the coordinating team.

1.1 Country profile

Spain has a population of 42 million people in a territory of roughly 505.000 Km². It is divided in 17 Autonomous Communities (AC) and 2 autonomous cities (Ceuta & Melilla). Its GDP is 87%.

On 1978, with the Spanish Constitution, a process of political and social reorganization of the country started and the health care system also benefit from that changes.

Article 43 of the Spanish Constitution of 1978 establishes the right to the protection of health and health care for all citizens. The fundamental principles

and criteria that underlie this right are regulated by the General Law on Health 14/1986 and are specified therein as:

- Public financed, universal and free health services
- Specific rights and duties for citizens and public authorities
- Political decentralisation of health to autonomous communities (AC)
- Provision of integral high quality health care that is duly evaluated and controlled
- Integration of the different structures and public services with the health service under the Spanish National Health System (NHS).

This Law facilitated the change from the old “Social Security Health” model to the current “National Health System” model. The Spanish NHS comprises all the health services of the state government and AC and integrates all the functions and health services that the public authorities need to provide in order to fulfil citizens’ right to the protection of health (1).

The Law covers the principles of health coordination at the state level. It also specifies collaboration instruments and creates the National Health System Inter-territorial Council as a coordination body (Consejo Interterritorial, CISNS). The CISNS is composed of representatives of the MoH and representatives of the Departments of Health of AC. The structure of CISNS reflects the current distribution of power in terms of responsibility for health care.

The State (Ministry of Health and Consumption) maintains control over the general coordination of health (including financing the system and defining the services provided by the Spanish NHS), foreign health and international health relations and agreements, legislation on pharmaceutical products, university and postgraduate training and management of health in the Autonomous Cities of Ceuta and Melilla.

The process of transferring competences to the AC began in 1981 and ended in 2002. Each AC has a “Health Board”, an administrative and management

structure that integrates all centres, services and establishments in the AC and other intra-community regional administrations and has competences in health planning, public health, and health care. Thus AC have assumed functions and services, assets, rights and obligations relating to competences, personnel and allocated budgets.

Health care in Spain is a non-contributory service that is financed by taxes and is included in the general financing of each AC. There are two other funds that also contribute to financing: a “Cohesion Fund” controlled by the Departments of Health and Consumption and a “Temporary Assistance Programme for Temporary Incapacity”. Health care constitutes one of the main instruments of the compensatory income policies of Spain: each person pays taxes based on their economic capacity and receives health services based on their health needs.

Given its universal and supportive nature, the Spanish NHS needs to ensure equal access to services for every citizen. Thus the provision is organised in two levels of care: primary health care and specialised health care.

The first level of health services, Primary Health Care (PHC), is characterised by major accessibility and adequate technical capacity to treat frequent health problems in an integral way. Attendance is provided in health care centres or at the patients home, by multidisciplinary teams composed by general practitioners, paediatricians, nursing staff and administrative staff. Sometimes also social workers, midwives and physiotherapists. They deliver health promotion, clinical assistance, health education, sickness prevention and rehabilitation.

The second level, Specialised Health Care (SHC), provided by in specialised health centres and hospitals, is equipped with complex and costly diagnostic and/or treatment methods. Patients access SHC primarily by instruction from PHC doctors. A global overview of the patient’s medical health and treatment between both levels of care is guarantee by the patient’s medical records.

Health care resources distribution is based on the idea of securing proximity of services to users. Delimited demographic zones called “Health Areas”,

established by AC, have specific SHC structures, attend 250.000 inhabitants, and are subdivided into “Basic Health Zones” with 5.000 to 25.000 inhabitants, where health care centres provide PHC. Each area has a general hospital that supports SHC.

1.2 Promoting social inclusion through policy action at the system level

In the Spanish National Strategy for the Modernization of the Social Model and Social Inclusion 2006-2008, (NAP) the focus on social cohesion and sustainable development is permanent. The adequacy of economic growth and social welfare ensures inequality reduction and increases the prevention of people socially excluded (2).

The key challenges identified in Spain are: break the intergenerational transmission of poverty, in particular by reducing the high rate of early school leavers; continue efforts to promote the active inclusion of vulnerable groups by reducing persistent inequalities in income, access to education and labour integration and to promote affordable housing; enable a greater participation in the labour market of women and older workers.

The major objectives of the NAP are: (1) promote access to employment, (2) guarantee the minimum economic resources, (3) achieve equity in terms of education, (4) support the social integration of immigrants, (5) and guarantee the attention for people in situation of dependency. The vulnerable groups considered are: older people, disabled people, women, young people, childhood, families, Gypsy community, emigrants, homeless people and the prison population.

Besides these objectives, the Spanish NAP considers others measures to consolidate progress achieved in other related social exclusion areas like housing, health, inclusion in information society, and other actions focused on vulnerable social groups. The principle of equality between women and men is integrated in all the NAP.

In terms of health, the focus is on promoting equity to respond adequately to the needs of social inclusion, specially addressing health determinants. The objectives of the national strategies of health care and long-term care in the NAP are oriented to reduce inequity in access to health care for all citizens independently of sex, social class, educative level, functional limitations and area of residence and for groups at risk of social exclusion. Also special attention is given to narrow health inequalities and develop research in this area.

The Spanish NAP (2006-2008) broadly reviews policies and programmes made by the Spanish NHS to contribute and ensure social inclusion. No formal evaluation is made. Target groups according to national priorities are revised, but of interest to the present country report no detailed information is given on mental health patients, immigrants and older people. Key information regarding health determinants and inclusion policies follows.

It highlights policies on health basket, smoking prevention and HIV-Aids prevention specially for vulnerable groups and annual agreements between MoH and the Foundation of Gypsy Secretariat since 2004. This initiative has specific budget to develop technical assistance and training projects for health issues focused on Gypsy population. It includes the elaboration of material and training guide tailored to their needs.

In order to support people living with chronic diseases, the MoH has developed in 2007 a National Strategy to developed palliative care in the Spanish NHS. Other strategies are now currently being developed and all of them include the improvement of access to health care services among their objectives, i. e. Cancer Strategy, Diabetes Strategy, etc.

The Spanish NHS, with the 2006 Plan of Quality, has developed strategies and objectives to ensure highest quality in health services for all and increase cohesion in the health system by guaranteeing equity in health care for the nation regardless of place of residence.

1.3 *Quality in and Equality of Access to Healthcare: summary of main findings*

This part of the report reviews available information in Spain relating to equality of access to health care, along with the barriers faced by the general public when attempting to obtain access to health services, with particular attention to vulnerable groups that are at risk of social exclusion. It provides details on the main political initiatives operating at national level that attempt to guarantee equality of access.

Section 2 describes the situation with regards to the main obstacles that impede access, which were identified during the course of this project. First, we describe the universal coverage provided by the public health system. The cost of health care does not represent an impediment to access. Prostheses and medication are the only elements that are financed via a system of joint payment (users pay 40% of the total). Vulnerable groups are exempt from this payment. Second, attention is paid to access barriers associated with territorial inequalities and organisational issues, such as the existence of waiting lists. Third, we analyse available information relating to the sustainability of the health system in terms of the needs of specific individuals and groups. Finally, attention is drawn to the main political initiatives that have been implemented in order to improve equity within the health system.

In point 3, we analyse the situation of the three groups that are the object of this study (immigrant population, the elderly and individuals with mental health problems) in relation to the aforementioned access barriers. The case study on individuals with mental health problems focuses on the situation in Andalusia.

Guaranteeing equality of access, irrespective of an individual's place of residence, is particularly relevant in the Spanish context, given the irregular population distribution amongst the various AC. The main political initiatives aimed at curtailing inequalities in terms of access to health services have focused on this objective. (The Cohesion and Quality Act, Royal Decree 1030/2006). Organisational obstacles have also been addressed via the enforcement of maximum waiting times for certain surgical interventions.

The sensitivity of health services towards the needs of each person (cultural sensitivity) and the influence of views within health care relating to patient attitudes are aspects that have not been investigated to a sufficient extent in Spain.

Population aging and the increasing presence of an immigrant population are two factors that have influenced the conception and development of the most recent political initiatives to combat social exclusion. The Law to Promote Personal Autonomy and Care for Dependants, 2007 aims to create a National System of Care for Dependants that guarantees care and treatment for individuals in a situation of dependency (the elderly, individuals with mental and physical disabilities, individuals with mental health problems, minors under the age of three years with serious disabilities). With regard to the immigrant population, the Strategic Plan for Citizens and Integration (2007-2010), aims to strengthen social cohesion via the promotion of public policies based on equal rights and opportunities, establishes a coherent global framework for the long term, which takes into consideration all factors generated by immigration and integration. Finally, the Mental Health Strategy 2007 establishes general principles for improving access to health services for mental health patients in a homogenous and comprehensive manner within the Spanish NHS.

2 Major barriers of access

2.1 Introduction

The General Law on Health 14/1986 declares universal coverage as one of the basic characteristics of the Spanish NHS in terms of extending public health care to the entire population free of charge at the point of delivery. It also establishes equity as a general principle of the Spanish NHS, which means guaranteeing that access to health care and services is effective and egalitarian. Each AC includes this principle in their regulations.

Both equal access and quality are the rights of citizens, patients and users of the Spanish NHS. The MoH is currently developing health strategies to improve access to programs and health services, including those focusing on the needs of the most disadvantaged social groups (2).

The health care model applied in Spain at the moment is centred on the patient and his or her right to choose. National Law 41/2002 which regulates the autonomy of patients as regards information and medical documents has unified the regulatory framework on the rights and obligations of patients, users and professionals. This norm governs the obligation to inform citizens of all actions regarding their health and to offer patients all the available information concerning their health. The legislation of each AC regulates aspects such as the free will to choose professionals, services and health centres, the rights of patients to a second medical opinion, and informed consent.

Together with the fragmentation of the Spanish NHS we have lost consistency in the essential sources of information used to understand and compare achievements in health and equity of access in different AC. Inequalities in access to health services are less visible due to hidden nuances as regards data, different definitions (portfolio of services, programme coverage) and the absence of information.

2.2 Population coverage for health care under public programmes

2.2.1 Main system of coverage

Access to health services in Spain is governed by the General Law on Health 14/1986 and the specific regulations drawn up for immigrant groups. Access for all Spanish citizens and registered residents is guaranteed, free of charge.

According to this law, all Spanish citizens and foreign citizens covered by the terms of Organic Law 4/2000 have the right to health protection and health care. The rights of EU member state citizens are governed by European community law and agreements signed by the Spanish state. In the case of non community

citizens the right to health care depends exclusively on the latter. Independent of their legal situation all immigrants have the right to emergency public health care, and minors and pregnant women have the right to access health care under the same conditions as Spanish citizens. Access to services is via an Individual Health Card issued by the Health Board of each AC. This document identifies the citizen as an NHS user (1).

Subsequently, Law 16/2003 of 28 May concerning the cohesion and quality of the Spanish NHS defines the accessibility guarantee in terms of universality, and defines equity as an implicit criterion.

In addition there are various special systems that civil servants and their dependents are invited to use, these are civil mutual insurance companies MUFACE (general mutual insurance company for civil servants of the state), MUGEJU (general mutual legal insurance company), and ISFAS (Armed Forces Social Institute); all of these are public organisms. These mutual insurance companies have signed collaboration agreements with private insurance companies to provide health services to the aforementioned groups.

The Spanish NHS ensures a series of health services to all citizens regardless of income level. Coverage is almost universal (almost 99.5% of the population). According to the most recent information available in 2005, 95% of the population was served by the Spanish NHS and there were only slight differences recorded between AC (see table 1), while 5.1% of the population is protected by the special systems mentioned above. The remaining 0.5% of the population is self employed people with high earnings who opt for private health insurance (3, 4).

In recent years private health care has increased in importance in Spain. It plays an important role as a complement to health services offered by the Spanish NHS in terms of specific services that are not covered by the public system (e.g.: dental health services). They are an alternative for obtaining faster access to specialised outpatient health care and/or for receiving more personalised care.

According to the Health Barometer carried out by the MoH in 2004, 7.9% of respondents had contracted private medical insurance on an individual basis. In the same year, it is estimated that 15% of the population were covered by private health insurance (11.7% were covered by voluntary health insurance or insured by the companies they work for and the remainder were insured under the special systems for civil servants referred to above). Private insurance is concentrated in Madrid, Catalonia, the Balearic Islands, and other major cities (3).

A study carried out in 2006 by the Women's Health Observatory analysed the evolution of social inequalities in health, lifestyles and the utilisation of healthcare services in the period 1993 to 2003. Considering social class on the basis of occupation (according to the National Occupation Classification), the study showed that people from the more advantaged classes possessed higher levels of private or mixed coverage (32%) and that this percentage gradually drops in less advantaged classes (3%) (5).

2.2.2 People not covered directly by any health care system

As previously mentioned 0.5% of people in Spain do not use the NHS. This population group is characterised by high earnings which allows them to take out private health insurance (3).

Given the high levels of coverage under the Spanish NHS due to universal access to health care services and special systems, there are very few people who have no health care system coverage. Only immigrants who are not registered as residents of a town or city have "limited" access to health services, as they only have the right to emergency health care.

2.3 *The scope of the health basket*

The Spanish NHS's catalogue of services has widened due to advances in health care and innovations. Recently, Royal Decree 1030/2006 of 15 September defined the NHS's portfolio of regular services. The portfolio

guarantees citizens' rights to the same services regardless of the AC and the providers identity (2).

As explained below, as a result of the decentralisation process, most competencies relating to health issues were transferred to the AC, which has given rise to inequalities in terms of the provision of health services. Whilst each AC is under the obligation to provide all services contemplated by the Law, certain AC's have broadened and developed the range of services they provide to a greater extent than others. The Royal Decree takes in the entire range of services provided by the health system without introducing any new elements. However, in contrast to the previous regulation, it provides in-depth details and includes the obligation to develop several complex services, such as palliative care. With regards to ordinary clinical services, this Decree establishes the appropriate method of coordinating and organising the provision of healthcare, thereby contributing to the improvement of access to health care in remoter areas.

This measure will contribute to ensuring each citizen's access to effective and egalitarian conditions, defining quality health care, improving cohesion and helping structure the Spanish NHS. Some of the criteria used to elaborate the portfolio are: care for less protected groups and high risk groups and care for those with greater social needs.

Services included in the Spanish NHS's portfolio of special interest to groups at risk of social exclusion are comment below:

Health promotion, prevention and preventive health services

Health promotion, prevention and preventive health services are carried out via inter-sector transversal programmes aimed both at improving lifestyles and preventing illnesses, deficiencies and injuries. It includes vaccinations for citizens of all ages, secondary prevention activities (such as screening and early diagnosis), family care and community care. There are programmes that are specifically targeted at population groups that have special needs in order to reduce inequalities in health.

Some studies have shown that privileged classes with less risk of contacting certain illnesses often benefit more from preventive programmes (5, 6).

Home visits by a general practitioner

Home visits are included in the portfolio of services for requested visits, (made by the patient and organised by prior appointment), planned visits and emergency visits. They also include prevention and health promotion activities, activities covered by health care programmes targeted at children, adolescents, women, risk groups, the seriously ill, patients with restricted movement, terminal patients and home hospitalisation.

It has been shown that certain groups have problems accessing this type of service as some home visit services are designed in relation to living conditions (for example care for terminally ill patients, home dialysis, home hospitalisation and pain control home units). In some cases these technical criteria exclude the most disadvantaged patients. For example, a main carer is required to act as an intermediary with technical personnel; this means there must be someone available who has a certain level of education (7).

Home visits by other providers

Includes visits from social services personnel who work in coordination with the health services. They are responsible for the management of economic aid and support on domestic tasks or caring assistance.

Medication

Covers doctors' instructions, prescriptions and pharmacological treatment. In the case of non hospitalised patients, medication services cover doctors' instructions, prescriptions and the distribution of medication, individual anti-allergic and bacterial vaccinations. While in the case of hospitalised patients it covers medication that patients require.

Maternity services

Includes pregnancy, puerperal and prenatal diagnosis in risk groups, intensive and neonatal care. Deliveries are hospital based and epidural anaesthesia is available on request.

Family planning and sexual health services

Includes information, instruction and oral anti contraceptive methods, intrauterine devices, tubal ligation and vasectomies (excludes reversing either), genetic advice for risk groups and voluntary pregnancy termination (if legal requirements are fulfilled). Also included are assisted reproduction treatments in response to sterility diagnoses or medical indication. Some autonomous communities like Andalusia, Navarra, Balearic Islands, Catalonia and Extremadura, include the free provision of the post-coital pill in family planning centres, emergency services and health care centres.

Some studies have found differences in access to preventive gynaecological services related to socioeconomic levels, given that women with higher earnings use private health care to avoid waiting lists for this type of service (8).

Dental services

Covers information and education on oral dental health, treatment of acute dental operations, pharmacological exodontic treatment, minor surgery of the oral cavity, oral check ups to detect premalignant injuries early and biopsies of mucosa injuries. It also includes preventive screening for pregnant women and prevention (fluor treatment) and treatment measures for infants. The following are excluded: repair treatment for temporary teething, orthodontic treatment, extracting healthy teeth, aesthetic treatment and dental implants.

The Basque Country, Balearic Islands, Navarra, Extremadura, Cantabria, Galicia, Castilla la Mancha, Aragón and Andalucía provide complete and free dental care for infants. Castilla León also offers these services free to people with disabilities and elderly people (9).

Dental health care is covered mainly by the private sector as public sector services are limited to diagnosis and extraction. This means that financial capacity to pay for services is what determines access. As diverse studies have shown, this introduces a pattern of inequity in the use of dental services. Less people attend the dentist as you go down the social scale (5, 6, 7, 10). According to a 2005 Living Conditions Survey 46% of people who were unable to have dental treatment stated finances as the primary reason.

Physiotherapy

Covers basic rehabilitation activities and rehabilitation for patients with a functional deficit that can be cured. It includes respiratory physiotherapy, physiotherapeutic treatment to control symptoms and provide functional improvements in chronic muscular skeletal operations and neurological disorders. It also includes home visits if a patient's medical situation limits accessibility. Also included are occupational therapy and speech therapy if directly related to the pathological process treated in the Spanish NHS.

Wheelchair and Zimmer frames

Covers surgical implants, external prosthesis, orthosis and special orthoprosthesis, economic help is available for the latter. Includes manual wheelchairs and wheelchairs with an electric motor for patients who are permanently incapacitated and accessories for both (batteries, spare parts, etc.). Also included are: special orthoprosthesis like crutches and walking frames. For the latter a patient must make a financial contribution of between 12 € and 30€, respectively. Orthoprosthesis articles for sports are excluded as are those for aesthetic purposes and those that advertise to the general public. Andalusia offers some extra services in its portfolio such as orthopaedic insoles, and also provides free orthosis and special prosthesis.

Hearing aids, glasses and incontinence pads

The Spanish NHS portfolio of common services does not include these services. Incontinence pads are included with a special prescription that requires the approval of the pharmaceutical inspection. This procedure takes

place in the primary health centre. Economic aids are available for acquisition of hearing aids and glasses.

Mental health counselling

Includes health prevention and promotion activities, advice and support for dealing with mental health over the different stages of a patient's life cycle.

Primary health care activities are aimed at detecting and handling health problems in an integral way as regards people in high risk situations or at risk from social exclusion, such as minors in care, ethnic minorities and immigrants. There are also specific programmes to help care for elderly people, taking into account a patient's risk factor based on characteristics such as age, health and socio-family situation. Coordination between health teams and social services teams is essential to these activities.

As regards private health insurance in Spain, companies offer three types of insurance:

- Health care insurance: is the most common insurance. It provides the insurance holder with medical care, hospital care and surgical care in the event of illness or accident, via a system of medical staff and health care centres, clinics and hospitals, with whom the insurance holder is registered via a service contract. It does not cover the payment of a service in capital terms. Rather it includes basic medical services: general medicine, paediatrics, childcare, nursing services, permanent hospital emergency services and emergency home visits and all types of diagnostic methods (clinical analyses, radiology, etc.). In addition it includes specialists' services and offers surgical and medical hospitalisation, hospitalisation in intensive care units and ambulance services.
- Reimbursement policies: Allows users to choose a health care doctor. First the patient pays the costs of the services and later the company reimburses the cost of the medical care.

- Assistance policies: These policies do not cover health care, but provide the client with economic compensation.

2.4 Cost-sharing requirements as barriers to access

Patients received free medical care at the point of delivery. Medication is free of charge during hospitalisation and for specific treatments even in ambulatory care. However, most medication services and prosthesis (including hearing aid devices and corrective lenses) are financed via a system of co-payment whereby users are required to pay a percentage of the cost.

There is no evidence about social inequalities in access to health care explained by the cost-sharing requirements in Spain. Lostao et al evaluated the association between social class and health services use in three countries with universal health coverage, including Spain. After adjusting for the need of health care, they found that in our country persons belonging to a low social class had more physician visits and hospital admissions than those belonging to a high social class (11).

Decisions about financing pharmaceutical products and special prescription and dispensation conditions under the Spanish NHS correspond to those of the MoH. Co-financing policies were introduced in order to increase income, contain health sector costs, reduce excess demand and encourage consumer responsibility.

Users participate in the payment of medication provided by the Spanish NHS, calculated at 40% of the public sales price, and is free of charge for over 65 years, disabled and for special disease. According to a study carried out in 1999, 39.5% of the population share the cost of medication. This cost is concentrated among 2% of the population, which suggests there is an equality problem (3).

For more vulnerable groups there are mechanisms to help deal with co-payment. For example patients are only required to pay 10% of the cost of medication to treat chronic or serious illness as well as items and accessories.

Pensioners and similar groups suffering from toxic syndrome * and people with disabilities are in some cases exempt from making any contribution. This is also the case for patients who require treatment due to accidents at work and professional illnesses, and products provided within health care premises.

Users contribute 40% of the cost of prosthesis, which may vary between 12 € and 36 € at most. Prosthesis implants by surgical operation are free of charge. Health services in each AC decide the price of prosthetic products.

There have been a number of legislative reforms in Spain that have had direct implications on access to pharmaceutical provisions. In order to reduce pharmaceutical costs in the nineties a series of pharmaceutical products were excluded from public financing as they were determined to be of low therapeutic value. Patients paid the full cost of these products.

Subsequently various administrations (state and regional) promoted a series of policies to encourage the use of generic pharmaceuticals. These pharmaceuticals play a fundamental role both in making the system financially sustainable and facilitating access to medication among the most vulnerable social groups due to lower costs. It is compulsory to prescribe a generic when it is available in the market. Pharmacist are obliged to dispense generic medicines or, in case of supplies run out, a medicine with the same composition that not exceed the maximum price established.

With regards to informal payments, there is no evidence to suggest that they exist in Spain.

(See table 2)

• Toxic oil syndrome (TOS) was a disease caused by the consumption of illicitly refined rapeseed oil that struck Spain in 1981 affecting around 20000 persons. The greatest number of TOS-affected people were aged 30–50 years and belonged to the lower socioeconomic groups.

2.5 Geographical barriers of access to health services

Equity among and within regions is one of the priorities of the national and regional health authorities. The Law on Cohesion and Quality of the National Health System 2003 underlines the need to improve geographical equity and to guarantee the right of each citizen to receive medical care in the AC which they are, regardless on which they live in. This is particularly relevant in the Spanish context due to an unequal population distribution among AC.

The network of PHC centres makes a series of basic services available to the population in an isochrones of 15 minutes from any place of residence. According to the last National Health Survey (2003), the Spanish population takes an average of 14.46 minutes to reach the medical consultation location from their homes. Galicia has the highest value (17.93 minutes) and Murcia the lowest (11.39) (12) (Table 3). According to Eurostat information for 1999 41.5% of the Spanish population could get to a hospital in less than 20 minutes; there were no significant differences relating to income levels (13).

The implementation of a new PHC model (process started in the eighties) has evolved in a different rate of growth in different AC, and has led to differing levels of access to complementary services depending on the stage the reform has reached; Galicia, Cantabria and Catalonia lag furthest behind. These inequalities have been particularly obvious in the provision of mental health support units and care for women (Asturias and Madrid were worst equipped in 2001; La Rioja lacks home visit support systems). The situation is quite complex and difficult to draw conclusions about inequity. In addition to the PHC reform another reform now on psychiatric services and hospital management took place in the 90 which meant closing up of psychiatric hospitals and of chronic patients beds. Thus a decrease on number of beds does not necessarily mean inequalities in services provided. Even doe, inequities are obvious in other services such as emergency units and the number of minor surgery operations. As regards specialised health care there were different numbers of beds available in different AC in 2001, particularly in geriatric and psychiatric units. The current differences in available technology do not create problems of access due to a number of coordination mechanisms including the Cohesion

Fund. Patients are transferred to the best health centres outside their AC, thus guaranteeing equal access to this type of technology (14).

In order to improve the access to diagnosis and treatment of population living in remote areas, High Resolution Specialities Centres have been created in some AC. These centres are oriented to achieve a maximum diagnosis resolution in a minimum time period (one visit). The Department of Health of the Regional Government of Andalusia has created a new model of hospital, called High Resolution Hospital Centres. These centres are oriented to outpatient surgery and surgery that requires a very short period of hospitalisation. Diagnosis, emergency units, rehabilitation and, in some cases, primary care are provided too in these centres. The objective is that citizens have access to an integrated and high-resolution health care service in less than 30 minutes.

Another important matter regarding geographic barriers is transport to health centres, which is a determining factor in accessing health services. Royal Decree 1030/2006 determines the portfolio of common Spanish NHS services, which includes the provision of this service. It defines medical transport as the transfer of patients for purely medical reasons, whose circumstances prevent them from travelling by ordinary modes of transport. Sick people or people who have been in accidents have the right to avail of this service free when they receive NHS health care and it includes both assisted medical transport (with technical-health care en route) and non assisted medical transport.

Thus, access to health services (diagnosis and medical treatment) is guaranteed for people with real medical needs, including those who live in rural isolated areas. Like other services, AC can establish regulatory norms via the relevant health authorities.

Spanish statistics do not offer much information on emergency ambulance services. However according to information contained in the Spanish Report in the European Network Indicators of Social Quality (2004), 82% of calls received are attended in less than 15 minutes and 16% are attended in 15 to 30 minutes. It is very probable that the differences between rural and urban areas are relevant to this point (13).

2.6 Organisational barriers

In Spain opening hours of health centres is from 8:00 a 20:00 and emergencies units work 24 hours/day. PHC and SHC have units of intensive care and emergencies offering services out of office hours.

Waiting list

In terms of elective surgery, new less invasive technology and a gradually aging population has led to an increase in surgery requirements, accompanied by a relevant increase in demand and usage. Spain has one of the highest waiting lists for this type of surgery for an OECD country (15). According to Spanish NHS data there are significant waiting lists for elderly people with functional limitations awaiting surgery (hip replacement, knee replacement, cataract surgery, CABG and PTCA). For example, in the second half of 2006 there were 9.091 patients waiting for a hip prosthesis, 17.4% of whom had been on the list for 6 months. The average waiting time for this type of surgery was 124 days. In the case of cataracts, there were 62.948 people due to undergo surgical intervention and 5% had been waiting for more than 6 months; the average waiting time was 69 days. Further information for other interventions in this year is not available.

In 1996 the introduction of a package of waiting-time measures was effective in reducing waiting times. The package included extra funding for additional activity; maximum waiting-time targets and use of private sector. Since 1998 also financial incentives to the achievement of reductions in average waiting-times (16). But it was not until the Law on Cohesion and Quality of the NHS that this significant socio-health problem was tackled from a global perspective with explicit mechanisms. The law establishes guarantees concerning health system waiting times, with AC defining maximum access times for their portfolio of services. In Andalusia, maximum waiting times are 60 days for the specialist; 30 days for diagnostic proofs and 120 days for the most common surgical intervention.

Further more, waiting lists have extra burden from EU citizens demands to the Spanish NHS. Specially in AC with sun and beach were foreigners from the North of Europe prefer to live, public health centres and hospitals suffer an extra demand of medical services. In many cases these people are old and come to Spain for interventions such as hip or pacemaker replacement.

2.7 Supply-side responsiveness

Supply-side responsiveness has not been widely studied in Spain and main findings came from international comparative studies. In a study carried out in 2005 and aimed to compare European patients' views on the responsiveness of their country's health systems and health care providers (17), satisfaction with doctors' communication and choice of provider was very high and these findings were similar to other European countries. Differences regarding involvement in treatment decisions will be explained in section 2.8.

Socioeconomic status

Very few studies have analysed the influence of socioeconomic status in access to prevention and health promotion programmes. Muñoz et al analysed in 2006 wheter differences exist in social class or education level in coronary heart disease secondary prevention and in cardiovascular risk factor control in Catalonia. They found that coronary heart disease patients in the lower socioeconomic status received similar treatment for secondary prevention and achieved similar control of risk factors (18).

Gender

Research shows that the sex of the practitioner can modify some important aspects of interaction in patient-doctor relationship. Female general practitioner use more time in consultations and provide more information and their patients seem to be more active and participative during the consultation (19). In PHC men prefer male practitioner for genital and anus problems. However, more women indicate preference for female practitioner for psychosocial and familiar problems (20).

Other studies have analysed gender inequalities in access to clinical procedures. A study aimed to determine whether there are differences between women's and men's access to coronary revascularization procedures for acute coronary syndrome in Andalusia showed that women less frequently had access to these procedures than men (21). Nevertheless, social, cultural and biological factors in determining these differences are not clear and further research is needed to clarify them.

In Spain, there is increasing awareness about the importance of gender approach in health. Concepts like "gender-based-medicine" and "gender-sensitive" are actually integrated in health strategies. Most of the AC Health Plans have included the gender approach focusing on the need of further research in gender inequalities and health. Despite this, further research is needed on the role of gender stereotypes in health care decisions and gender connections between offer and supply of health services. (22).

Ethnicity

Lack of cultural sensitivity of health care services has been reported as a difficulty to improve access to them of minority groups to these services. Some studies indicate that there is a mutual lack of understanding between health services and minority groups as consequence of cultural differences, and health professionals are aware of this. In the study of Margalef, they identified the lack of training in anthropological issues as a factor that hinders access to health services for these groups (23). Other studies have reported the same difficulties faced by health professionals when they have to address unknown situations like bigamy (23, 24).

As regard to communicational barriers related to minority groups, several Departments of Health of AC have developed actions to improve the attention given to immigrants. For example in Andalusia, the Department of Health has recently elaborated a "Manual for the Immigrants' Healthcare" framed into the II Integral Plan for the Immigration in Andalusia. Also the Andalusian Health Service is actually introducing a simultaneously teletranslation system in the health centres in order to overcome idiomatic barriers. Other AC have promoted

similar initiatives, like Castilla la Mancha, "Guide for intervention with immigrant population in Primary Care" and a "Guide for clinical interview" edited in several languages. Catalonia have initiated actions for cultural training for health professionals, i. e. Training Plan on Health Care for immigrant population of Cataluña.

2.8 Health literacy, voice and health beliefs

The study referred above about European patients' views on the responsiveness of health systems also explored issues related to involvement in treatment decisions (17). The proportion of Spanish patients who felt the patient should have a role in treatment decisions was smaller compared with northern European countries. Regarding the extent to which patients felt they had been involved as much as they wanted in decisions about their care, the proportion responding positively was lower in Spain (40%). Other study compares the preferences for involvement in treatment decision making among European women with urinary incontinence from 15 European countries. This study conclude that women living in Southern European countries (Spain, Portugal and Greece) prefer the "passive role" (25)

As regards to the influence of health beliefs, there are some studies carried out in Spain that indicate that belief sets and attitudes are important components of prevention behaviours. A study that investigated the attitudes profiles of the women related to mammography mass screening showed that perceived severity of breast cancer and perceived susceptibility to this cancer are related to participation in screening. Results demonstrated that hypochondriacally beliefs, disease phobia and feared effects of symptoms were related to decreased participation level. (26)

2.9 Interlinkages and overarching policy initiatives

Because decentralization to AC the MoH is charged with promoting cohesion within the Spanish NHS and ensuring equality of access and the quality of the services provided.

Equity represents a priority objective of the Spanish NHS, as outlined in the General Health Act, which is understood to mean guaranteeing that access and the provision of health services operate under conditions of equality. This principle is present in all laws that regulate the basic characteristics of the Spanish NHS and therefore necessarily informs health policies in Spain.

Below, we provide an account of the main political initiatives set in motion in recent years with the aim of promoting equality of access to health services and reducing inequities in health care.

Cohesion and Quality Act (2003)

This law establishes the legal framework for coordination and cooperation between public health administrations with a view to ensuring equity, quality and social participation in the Spanish NHS. All users are ensured access to the Spanish NHS under conditions of equality.

This law obliges public administrations to focus health-related activities, incorporating active measures to prevent discrimination of any social group that, as a result of cultural, linguistic, religious or social factors, finds accessing Spanish NHS health services particularly difficult.

Health Quality Plan (2006)

The objective of this plan is to improve quality and increase cohesion within the health system by guaranteeing equity in health care for all citizens, regardless of their place of residence, and by ensuring that the care provided is of the highest quality.

The Health Quality Plan is founded on principles that offer guarantees to patients, users and health care professionals in order to achieve an Spanish

NHS focused on protection, health promotion and prevention, placing priority on research, centred on the needs of patients and users and concerned with the promotion of equity.

The Plan establishes 6 main areas: protection; health promotion and prevention; fostering equity; human resources; clinical excellence; and the use of new technologies and increased system transparency. These strategies and objectives must be implemented jointly within the AC by professionals, patients and social stakeholders.

In terms of equity, the main objective involves generating and disseminating awareness of inequalities in health, stimulating good practice in the promotion of equality within health care and reducing health inequalities via the Spanish NHS. Actions are divided into two main fronts: improving the health and access to health services of the most disadvantaged groups; and improving the health of all groups by reducing the health- gap, between the most disadvantaged groups and those who are in a more privileged position. Proposed strategies focus on generating and disseminating awareness of inequalities within health in order to establish policies and evaluate equality. The immigrant population and individuals with limited personal autonomy stand out as priority groups for forthcoming projects.

Comprehensive Health Plans

The MoH is elaborating Comprehensive Health Plans focusing on the most prevalent pathologies and those that entail a considerable burden for families, in order to guarantee comprehensive healthcare. Professional associations and patients are participating in the elaboration of these strategies, which focus on establishing minimum standards and criteria for the organisation of services. Each AC will incorporate the principles in accordance with their particular circumstances and population needs. The Strategy on Palliative Care and the Strategy on Mental Health have been drawn up and other strategies (Diabetes, Ischemic heart disease, EPOC and Ictus) are currently under development. Equity in access to health care services is an underlying aspect of all these strategies, mainly in the form of transparency of the information relating to the

process of accessing health services. Some of these strategies include recommendations to address specific problems and needs of vulnerable groups (women, immigrants).

Additional political initiatives aimed at improving the access of the vulnerable groups under study include:

Strategic Plan for Citizens and Integration (2007-2010)

The objectives of this Plan, drawn up in collaboration with the Department of Public Health of the MoH, include the adaptation of public policies to the needs of immigrants and the implementation of specific policies addressing health, education, employment, social services and housing. Focus is placed on responding to the needs of immigrants by increasing resources and incorporating intercultural concepts into public services. The Plan also underlines the importance of guaranteeing the rights of immigrants in terms of the protection of health and effective access to the Spanish NHS, as an objective within the context of integral health care. Other objectives involve applying treatment not only to the illness, but also the patient's social environment, support network and quality of life (27).

Support fund for the provision of refuge to and integration of immigrants and for educational intensification

The Fund was created in 2005 with the aim of promoting and strengthening public policy in these areas, thereby reinforcing social cohesion. The Fund currently operates within the context of the Strategic Plan for Citizens and Integration. It has enabled the definition and development of a framework for cooperation between General State Administration and the AC. The following areas for intervention have been outlined: 1) Strengthening public services; 2) Complementing action in areas that require a greater degree of intervention; 3) Training professionals in cultural sensitivity; 4) Transferring knowledge and good practice; 5) Providing impetus to the third sector and its administrative capacity. In terms of health, priority measures involve providing support to programs to promote health and attend to specific needs amongst the immigrant population; training health professionals to provide care to

populations with different origins and cultures; cultural sensitivity of services amongst professionals; and transferring knowledge and good practice. In 2007, the Fund was assigned a total of €198,000,000.

From a political perspective, the most important aspect, underlined in all the documents consulted and interviews conducted, involves equity in terms of access for all citizens, irrespective of the AC in which they reside. Members of the general public identified this as a main concern when asked to provide their opinions on the Spanish NHS. The 2006 Health Barometer (28) provides information on the opinions of citizens in relation to equity in terms of access to the Spanish NHS. The majority of citizens believe that access to the Spanish NHS is equitable, irrespective of age, income or nationality. A total of 87.8% of the interviewees felt that gender did not give rise to discrimination in terms of access. However, 46.1% felt that living in rural or urban area does influence access.

The access problems experienced by vulnerable groups are taken into account during the development and design of health policies. These policies are implemented via the health plans developed in each AC. Reducing inequality and tightening control over the health determinants of those groups at risk of social exclusion are objectives of the majority of health plans drawn up by them. Nevertheless, according to a study carried out in 2005, which analysed the health plans operating in each AC in the same year, scant attention was paid to health inequalities and very few plans included intervention aimed at groups that are socially excluded (29).

Attention should be drawn to the comprehensive approach to changing the realities of social exclusion in Andalusia adopted in the initiative implemented by the Andalusian Public Health System. The Plan for Action in Areas of Social Transformation has been functioning since 2002 in urban areas that are clearly demarcated, wherein the population suffers extreme structural poverty and social marginalisation, giving rise to problems in terms of housing, public fittings, truancy, high levels of unemployment, hygiene and sanitation deficiencies and phenomena relating to social disintegration. A model for managing, monitoring and evaluating activities aimed at preventing and

combating situations of vulnerability and socio-sanitary exclusion is being developed in these areas. In terms of health, activities focus on health care, promotion, protection and the recovery of the health of citizens living in these areas. A total of 150 Areas of Social Transformation have been identified.

Lack of information may represent one of the factors that is contributing to the insufficient development of policies and intervention to reduce inequality within health care. There is a growing interest in the area of inequalities in health over recent years in institutional, academic and professional spheres evidenced by increase in research and the existence of work groups (such as The Spanish Society of Public Health and Health Administration's Group for Women's Affairs and Public Health; the Spanish Society for Family and Community Medicine's Immigrant Care Group). Even so, the information systems of the Spanish NHS and the health systems of the AC do not include variables that enable adequate analysis of the needs and health problems of those groups that are in risk of social exclusion.

In recent years, health administrations have expressed a firm commitment to promote awareness of inequalities within health care and subsequently develop intervention aimed at improving the situation of vulnerable groups (i.e. the Quality Plan for the Spanish NHS), whereby we may expect increased attention to these areas in forthcoming health policies.

2.10 Conclusions

Key feature of policy initiative is that access to health services for all citizens and residents is regulated and guaranteed by a State Law, which was passed in 1986: health coverage is practically universal and free of charge at the time of use.

Achieving nation wide equity in health care is a primary objective of national and regional authorities and thus initiatives need to be tailored to diverse circumstances. The National Health System Cohesion and Quality Act ensures

that each citizen receives the necessary services, whenever and wherever they are required, irrespective of the citizen's place of residence.

Spain offers a health services basket, approved by the Council of Ministers in 2005 and binding on all AC, which ensures the sustainability of the system, the homogeneity of the services provided and territorial equity. In addition to the core services, AC may offer additional services. Each citizen is guaranteed the provision of health services (primary and/or hospital care) within a radius of 15 minutes from their place of residence.

Medication during hospitalisation is also free for the entire population. Citizens pay 40% of the market price of non-hospital prescribed medication, although such medication is free for people over 65 years and for the treatment a long list of chronic illnesses, such as cancer, AIDS and TB. Additional informal payments to achieve medical services do not exist.

Policy attention has been given to health inequalities, including access, and to social exclusion issues. Legislation, efforts and funding have been allocated accordingly. Importance on working across institutions and departments is emphasize to come out with successful approaches of tackling health and social problems. Spain's main challenges involve the following domains: fight against poverty and the transmission of poverty from one generation to the next; integrating vulnerable groups into mainstream society via education promotion; housing; improvement in employment and the promotion of the integration of women and older adults into the workplace.

Health strategies focus on reducing inequality linked to health determinants and guaranteeing equity of access to the system for all citizens, irrespective of their sex, age, social class, educational background or place of residence.

Access problems that are experienced by vulnerable groups are borne in mind when drawing up health care policies. They focus on providing them with extra help such as giving advice on eligibility and language support to immigrants and foreigners. Generally they are not evaluated. Nevertheless, very few AC health plans include actions specifically aimed at these groups.

The main problems faced by the Spanish NHS, both currently and in recent years, are as follows: the burden of demand; the high costs of medication and diagnostic and therapeutic technologies; the waiting lists for certain medical and surgical procedures; and, recently, the lack of doctors for certain specialised areas within hospitals.

Management models have been implemented in an attempt to alleviate the problems outlined above, such as the use of generics in medical prescriptions or work employing clinical procedures. In non-hospital centres in regions such as Andalusia, a recently developed model ensures diagnosis in a single visit, using the latest technological resources. This is a new management model that attempts to solve the problem of waiting lists, improve access for people who live far away from large cities, reduce the ever-increasing costs of hospitalisation and address medical problems whilst causing minimal inconvenience to patients.

There is currently no system that adequately enables us to gather the data and information to analyze the problems of groups that are in risk of social exclusion. Thus, the possibility of acquiring a sound awareness and understanding of the national situation and of comparing the advances made in the AC is lost.

Various initiatives have been set in motion at regional and local level, with the aim of improving access to health services for those groups at risk of social exclusion. However, there is little evidence on the interventions that most effectively reduce health concerns in Spain, as the majority of these interventions are implemented in a very short time scale and are rarely evaluated. Many of the projects involving palliative or preventative measures are implemented by NGO's, which often coordinate with each other at local level.

3 Improving quality of and access to health care for people at risk of poverty or social exclusion

3.1 *Migrants, asylum seekers and illegal immigrants*

3.1.1 Background

In recent years Spain has become a recipient country for immigrants and has witnessed a change in the migratory balance from a negative to a positive balance. According to the census preview of 1 January 2006 the immigrant population is numbered at 3.884.573 people. The number of foreigners registered as residents in 2005 represented 8.7% of the total population, variably distributed throughout the AC (4). In 2006 the number one continent of origin of immigrants was Latin America (35%), followed by Africa (24%), non EU countries (12%), and Asia and the rest of the world (8%). As regards countries of origin, Moroccans predominate (18%), followed by Ecuadorians (12%) and Colombians (7.5%). Both young men (54%) and women (46%) arrive and the majority of the immigrant population is made up of young people (21% under 20, 77% between 20 and 64) (27).

In Spain being a refugee and having the right to seek asylum are closely linked and regulated by Law 9/1994 of 19 May. This Law eliminates the double condition of asylum seeker and refugee that was previously covered by different statutes, and establishes that once the condition of refugee is accepted asylum is granted. The reform constitutes asylum as “protection provided by Spain to any foreigner recognised as a refugee in accordance with the Geneva Convention of 1951”. Spanish Law concedes refugees the right to live and work in Spain. According to the 2005 Statistical Immigration Report (30), 5.257 people requested asylum and 326 were admitted.

3.1.2 Barriers of access to the health system

There is evidence of barriers that block or make it difficult for the immigrant population to access PHC and specialised services. A description in accordance with barriers identified in the previous chapter follows.

- *Population coverage for health care under public programmes*

Health care for non community member immigrants is regulated by the Immigration Law, which establishes that those registered as residents can obtain the Health Card and have the right to full and complete health care, as do minors and pregnant women (even if not registered as residents) under the same conditions as Spanish citizens. It also establishes the right of all people to emergency health care regardless of their legal situation.

Various studies have highlighted that obtaining the documents required to register as a resident is one of the main factors that limits access to health services. To obtain a resident's certificate you need identification and a document that verifies that you are living in the country. In many cases this presents a difficulty. People may not have a document of identification and/or may not have a fixed address, or they may be homeless. The law allows homeless people to register as residents subject to an appointment with the police or social services; however due to a lack of knowledge of the immigration law and a sense of fear about contacting the police and other institutions, they fail to obtain the certificate that grants them the right to full health care (24, 31).

The X Report on Social Exclusion, drawn up by the NGO Doctors of the World in 2005 (32), also draws attention to the obstacles involved when registering as a resident in a municipality as one of the barriers that prevents people from obtaining a health card, thereby preventing access to health care. According to this organisation, the reform to the law concerning the rights and liberties of foreigners (Organic Law 14/2003 of November 20th, which reforms Organic Law 8/2000 of January 11th, concerning the rights and liberties of foreigners in Spain and their social integration), although presented as a means of improving management via the simplification of administrative procedures, in actual fact it does not remove the aforementioned obstacles, instead creating a situation of

differentiated treatment for the immigrant population in terms of access to the Public Administration. This modification, in conjunction with the Law concerning the Fundamentals of Local Government, which empowers the police to access the personal details of municipal residents, arises fear amongst the immigrant population, manifested as reticence to initiate steps to legalise their situation and obtain access to health care.

Asylum seekers in Refugee Reception Centres have the right to receive medical care in the event of a medical need and receive information on how to enter the health system. Health care is provided by the Red Cross and Social Work Unit of IMSERSO (Institute for Elderly people and Social Services, which is governed by the Ministry of Employment and Social Affairs). Once they have been granted asylum they can use social services, education and health services provided by the government the same way as any Spanish citizen, either directly or via an NGO. (33)

- *Scope of the health basket*

The main problems the immigrant population has in accessing the Spanish NHS services are linked to the administrative situation. As previously mentioned, immigrants registered as residents have access to all the services the NHS offers to Spanish citizens in exactly the same way. People who have not registered as residents have the right to emergency health care only. Nonetheless in many cases a lack of understanding of our health system and the care to which they are entitled means immigrants do not use services regularly. Primarily they use emergency primary and specialised care services - almost 30% use this form of health service. Another problem arising from reliance on the emergency service is that, although it resolves specific problems, there is no follow-up care (34).

- *Cost-sharing requirements*

As for Spanish citizens, medication is the only service for which the immigrant population has to make an economic contribution. Co-payment of the cost of medication is in many cases subsidised by NGOs, which constitutes a barrier in the health care process for the immigrant population. In a study carried out in an

area of Andalucía, 24.2% of immigrants were unable to obtain the medication they needed mainly due to lack of finance (35).

Faced by this problem the initiative of the Official College of Pharmacists of the Council of Andalucía decided to finance immigrants without means to help them pay part of the cost of medication that the public service fails to cover. This activity, together with the Progress and Health Foundation is at the heart of the agreement on Public Health. However, these measures have not been implemented.

The limited services provided in this area and the fact that dental care is mainly a private sector service, mean that immigrant groups with greater social and financial needs cannot resolve dental problems, as is the case of the local population with limited means.

- *Geographical barriers*

The differences in health coverage for the immigrant population in AC represent inequalities in access to the Spanish NHS. In accordance with the classification made by the authors of the Health Basket project (9) there are three groups of coverage provided:

- Coverage similar to state law. This is the case in Aragón, Asturias, Cantabria, Castilla la Mancha, Canary Islands, Galicia and La Rioja.
- Full health care for residents and non residents, regardless of the administrative situation, such as Balearic Islands, Castilla León, Madrid, Basque Country and Andalucía.
- Total coverage for residents, regardless of the administrative situation, such as Murcia, Extremadura, Navarra and Catalonia.

- *Organisational barriers*

Health centre opening hours do not cater to the immigrant population's social condition or employment (for example employment hours), which has been identified as a barrier to access in some studies on Spain (23).

- *Supply-side responsiveness*

Some studies show that the relationship between immigrants and health services is characterised by a lack of mutual recognition and understanding caused by culture shock, evidenced by the complaints made by health care personnel in relation to immigrants (non compliance with regulations and medical treatment, unbalanced diet and hygiene, expression of unknown symptoms, etc.). Health personnel have also had difficulties knowing how to handle new situations such as bigamy and clitoral excision (23, 37).

These situations are worsened by communication difficulties between health care personnel and the immigrant population who speak a different language. In Spain these problems arise among the immigrant population from Africa (Morocco and Sub-Saharan African countries), and are particularly manifest in PHC consultations in rural areas and with Asian patients (21).

The Health Boards for different AC have promoted a series of initiatives aimed at improving health care for the immigrant population and to reducing linguistic barriers. An example of this is the “Guide to PHC action for the immigrant population” and medical appointment forms for foreigners who have difficulties understanding Spanish (Arabic, Bulgarian, Chinese, French, English, Romanian, Russian, other population groups in the community) (Castilla la Mancha, Andalucia and others), the “Immigration and Health” guide for PHC professionals (Aragón), a Plan to Train Professionals Attending to the Immigrant Population and the translation of educational health material into different languages (Andalusia, Catalonia).

- *Health literacy, voice and health beliefs*

The factors that impede or limit access to the health care system among the immigrant population are: ignorance of the Spanish NHS, of the right to health care, and of the administrative steps needed to use the system. According to a study by Doctors Without Borders carried out in Madrid in 2005, 31% of immigrants had not accessed health care because of ignorance of the system itself, 8% had not accessed it due to ignorance of their rights, and 29% due to lack of knowledge of administrative procedures (31). In response there have

been initiatives such as the Guide to Healthcare for Immigrants, edited by the Department of Employment and Social Affairs of Murcia in December 2006. The guide was aimed at newly arrived immigrants and immigrants who had been residing in Murcia for a few years. This guide attempted to facilitate relations between foreigners and the Spanish NHS, providing basic information about the health system, the services offered and the methods of access. The Guide is published in Arabic, English and Spanish.

For some groups of immigrants the Spanish NHS represents a radical change in the concept of their own health and for some access to the system means adapting to a system of prevention rather than a system of survival.

Studies have pointed to other barriers of access to health services. These are related to work and the immigrant person's socio economic context, for example some consider sickness an obstacle to work. Other factors are increased geographic mobility required to find employment and a fear of losing employment (36).

In response to this situation religious and NGOs are playing a fundamental role in the provision of health services to the immigrant population and asylum seekers, specially illegal immigrants Their work is essential in relation to providing direct health care, health promotion, help and advice throughout the process of integration in Spanish society, and help in completing forms that shed light on the public health situation of these groups. Many of these organisations receive financing from the government. However, the NGOs themselves point out that if the Immigration Law was applied effectively in these matters, immigrants would experience less difficulty integrating into the public health system, and thus government financing of NGOs would be unnecessary.

In summary, the biggest public health problems facing immigrants from developing countries are those related to access to health resources and difficulties in communication, not only linguistic difficulties, but also cultural. Specific programmes and other methods are needed to attend to this population: for example, multidisciplinary work teams that include medical assistants from the groups themselves, anthropologists, social workers, etc.

who prepare and advise health care personnel on the standardised network of services related to these cultural minority immigrant groups.

Some AC like Catalonia have created specific plans on immigration and health, the objectives of which include improving the immigrant population's access to health services and adapting services to a multicultural reality (37). At the state level a Strategic Citizen and Integration Plan (2007-2010) has been created. This plan underlines the importance of guaranteeing immigrants' rights to the protection of health and effective access to the health care system as one of its objectives in the context of integral health care. Another objective is to treat not only the illness but also the patient's social environment, support network and quality of life (27).

3.2 Older people with functional limitations

3.2.1 Background

As in other EU countries Spain's population of elderly people has grown considerably in recent years. In 2005 there were 7.477.761 elderly people aged 64 and over registered as residents in Spain, representing 16.84% of the total population. Approximately 50% was aged 74 or over (4). According to the municipal census of 2003, 58% of over 65s were women. Women also account for the majority of the segment of elderly people who are dependent on family members (69% women) (38).

According to the Survey on Disabilities, Deficiencies and State of Health carried out in 1999 (most recent available) there were 406.207 people in Spain over the age of 65 with moderate inability to carry out everyday activities , 473.464 had

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- Everyday activities refers to changing body position, getting up, lying down, moving about the house, getting around without transport, washing, controlling one's needs, dressing, eating and drinking (basic everyday activities), doing the shopping, making meals, cleaning and ironing, cleaning and taking care of the house and the welfare of each family member (instrumental everyday activities). These activities reflect the activities contained in the definition of dependents proposed by the Council of Europe in 1995.

severe inability to carry out everyday activities, and 553.944 were completely unable to carry out these tasks. Thus 19.5% of the people in this age bracket are dependent, 5-6% has moderate dependency and 3% have severe dependency. Women were shown to have higher levels of dependency (See table 4). According to the most recent study based on the National Health Survey of 2001, 36.2% of people over 65 need help to do some of the aforementioned activities and 17% need help to do both instrumental and basic tasks.

An increasing older population presents new challenges to the social protection and health care systems. In Spain as in other Mediterranean countries, families, and in particular women have been the providers of 80% of the long term care that dependent elderly people need, and of these, the majority are women between the ages of 45 and 69. In 2004, 84% of carers were women who do not work outside the home. However the number of carers who manage the double challenge of working and looking after an older dependent family member is increasing. Paid carers are becoming more common in families with higher earnings (39).

3.2.2 Barriers to accessing the health system

- *Population coverage for health care under public programmes*

Health services to which people over 65 years with functional limitations have access are regulated by the General Law on Health, Royal Decree 1.088/1989, the Law of Cohesion and Quality of the NHS and Royal Decree 1030/2006.

The universal coverage system provides dependent people with illness prevention and promotion activities, treatment, and rehabilitation. Almost all elderly people have health coverage through the Spanish NHS. Because of this, 98% of elderly people use public health when they need medical care. According to data from the National Health Survey of 2001, 96.8% of elderly people were covered by the Spanish NHS, 3.4% were protected by MUFACE and similar organisations, and 1.3% had private insurance (40).

- *Scope of the health basket*

PHC services provide the elderly with recommended vaccinations and cover other activities such as: detection of risk factors, education, attention and health care for people with chronic illnesses, treatment of specific health problems that affect the elderly, and treatment for patients who are immobile or terminally ill.

Furthermore, some PHC programmes are specifically targeted at this population group. The Programme for the Elderly aims to promote the physical, mental and social autonomy of people over 65 and guarantee the continuity of their health care. The target population of the Programme for Home Visits to Immobile and Terminally Ill Patients include people who suffer from chronic invalidity or another condition that stops them travelling to the health centre, and people who suffer from a health problem that requires frequent care but who cannot attend a health centre regularly due to socio-familial factors. Home Visit Support Teams and Palliative Care Units also attend to this population group.

As regards SHC, people over 65 with functional limitations have access to all specialities and services. Furthermore, there are a series of specific resources such as specialised geriatric assistance and multidisciplinary geriatric evaluation teams. There are hospitals and temporary stay units that provide care for patients with reversible disabilities with the aim of helping them adapt to their disability. For patients who require hospitalisation, medium and long term stay hospitals provide care, mental health care and treatment for addiction. More than half of these centres are private and thus access varies (39).

Lastly there are home visit support teams that care for geriatric patients on a regular basis in addition to home geriatric care, home hospitalisation units and day hospitals for the elderly.

- *Cost-sharing requirements*

Medication for pensioners and similar groups, as well as people with disabilities are exempt from cost sharing in certain circumstances. Recently the Law of Guaranteed Rational Use of Medication and Health Care Products (Law 29/2006) was passed to facilitate access to medication that does not require a

prescription. It allows people who cannot go to a pharmacy to purchase medication by Internet, as long as the medication is dispensed through an intermediary – a pharmacy and pharmacist who provide personalised advice. This measure has basically been taken to improve access to medication among people with functional limitations, and could help people in more disadvantaged socio economic groups.

Care services for people with dependencies are provided by both public and private services. In many cases these include public health centres; however some co-payment mechanisms may present problems of equality in access. We do not have enough data to establish the cost distribution based on beneficiaries' income levels.

- *Geographical barriers*

As regards hospitals and temporary and convalescent units there is a high level of variability among AC' health care plans, creating a lack of equality. Also medium and long stay hospitals and home hospitalisation units have developed unevenly. (39).

There is even greater variability when it comes to home help services due to municipal competence. According to a study carried out by IMSERSO at the end of the nineties the main differences between local councils were linked to the percentage of the population covered, the schedule of care provided to beneficiaries, and whether or not users had to share low intensity costs (10-20% of the cost of the service) (41)

- *Organisational barriers*

According to data provided by IMSERSO, 23.9% of the elderly state that they take less than 10 minutes to get to their consultations (31.8% for the rest of the population) and 42% state they take between 10-19 minutes. The length of time it takes to be attended is also low: 30.8% state that they are attended in less than 15 minutes, which is similar for the rest of the population (40).

- *Supply-side responsiveness*

No studies were found which focused on this issue.

- *Health literacy, voice and health beliefs*

No studies were found which focused on this issue.

Social and Health Care Interface

The Law of Cohesion and Quality of the NHS defines socio health care as “*a service that comprises the set of care services directed to chronically ill patients, who can benefit from simultaneous action and synergy in health and social services. It can also help increase autonomy, alleviate patients’ limitations and suffering, and facilitate the return to their social environment*”. In Spain, as in other European countries, dependent people receive treatment via the coordinated efforts of the Spanish NHS and the social system. The situation in Spain is characterised by a poor connection between both systems. Regional health services provide health care on the basis of universal care, while regional councils and autonomous governments provide care on the basis of social services; proof of income is needed to access services or cost sharing aid (34). However many AC have coordination bodies that manage socio health services and some have implemented socio health care plans (e.g.: Castilla and León, Canaries). There is still a lot to do to establish coordination strategies that guarantee sustained care for dependents.

Coordination between the Spanish NHS and the social system is one of the aspects covered by the Law to Promote Personal Autonomy and Care for People in Situations of Dependency (Law 39/2006). The law, which entered into force on 1 January 2007, designates the National Dependence System as the fourth pillar of the Welfare State, together with the Spanish NHS, the education system and the system of pensions. The system is designed as a public use network and a diversified network that integrates health centres and services (public and private) in a coordinated way, and includes three types of services: services via health centres and public or state assisted programmes, financial

provisions linked to services (when adequate services are provided), and financial compensation for home care. Support for carers includes information programmes, training, periods of respite and Social Security contributions. The criteria used to determine access to these services is the level of dependence of potential beneficiaries.

3.3 Conclusions

The registered immigrant population, immigrants under the age of 18 and female immigrants who are pregnant have the right to free and comprehensive health care, in the same conditions as a Spanish citizen. The remaining immigrants have a right to emergency health care. The main obstacles encountered by the immigrant population are linked to the difficulty of obtaining the papers required to process the Health Card, a lack of knowledge of the health system and communication problems caused by different languages. Therefore, within the immigrant population, individuals without papers are in a situation of greater vulnerability. These factors imply that the emergency services are the first point of contact for immigrants, which hinders their integration into mainstream activities involving the prevention and promotion of primary health care.

The Strategic Plan for Citizens and Integration (2007-2010) is the most important policy initiative that includes intervention in health-related matters with the objectives of guaranteeing the right to health cover of the immigrant population, improving the process of identifying the socio-sanitary needs of the immigrant population and improving health professionals training in techniques focusing on the health of the immigrant population. The Plan contemplates measures that facilitate interaction between the immigrant population and the health system and heighten the sensitivity of the services towards the needs of immigrants, which includes the adaptation of health information services.

In general, the elderly do not experience problems when attempting to obtain access to health services and, moreover, are the most frequent users of these services. However, older adults in a vulnerable situation as a result of problems

relating to social integration may experience access problems, as is the case with all individuals in a vulnerable situation. Some interviews have drawn attention to difficulties relating to movement to and between the centres that provide health services.

4 Country information for the case study on mental health

4.1 Introduction

The Spanish mental health case study will focus in the Spanish situation. Nevertheless, section 4.5 describe policy initiatives taken in the Andalusian context.

a. Legislation

In Spain there is no a specific law on mental health. In the early 80's the Interministerial Commission for the Psychiatric Reform pointed out that a specific law could contribute to discrimination of people with mental health problems (1).

At national level, the General Law on Health 14/1986 has a chapter on mental health establishing that people with mental health disorders has the same rights that other patients (2). The Civil and Penal code have incorporated modifications to protect the rights of psychiatric patients and improve conditions for penal sentences for offenders with mental illness (3). The Law 51/2003 on Equal Opportunities, Non discrimination and Universal Accessibility for disabled people seek to protect those with disabilities from being treated differently from those without disabilities. The law considers disabled people those individuals with a permanent disability degree of 33% (4).

The Law on Civil Indictment 1/2000 allows the compulsory hospitalisation of people with mental health problems with a previous judicial approval (5). In 2004 the Catalan Parliamentary Group made a proposal to modify this law and regulate the non voluntary treatment following the initiative of the Associations Federation of Families of Mental Health Patients. The objective of this proposal was to extend the judicial authorization to allow the compulsory ambulatory treatment for people with serious mental health problems in order to guarantee a permanent health care in case of problems with the continuity of the treatment. However, several patients' associations and health professionals showed a strong opposition to the law because it could reinforce the stigma and discrimination, among others concerns (6).

The Law to promote Personal Autonomy and Care for People in Situations of Dependency (Law 39/2006), which came into force on January 2007, includes persons with serious mental disorders in the general framework of provisions for people with disabilities, and there exist a special instrument to assess the degree of dependency for people with mental health disorders (7).

There are no regional laws concerning mental health. National laws are applicable.

b. Policies

At national level, in 2007 the Ministry of Health has launched the NHS Mental Health Strategy to promote prevention, early diagnosis, treatment, rehabilitation and social integration activities. Before this strategy there existed no official policy on mental health issues at this level. This document has been elaborated with the participation of the ACs, scientific societies, and patients and family carers associations. Principles and values that hold this strategy are: autonomy, continuity, accessibility, understandibility, equity, personal recuperation, responsibility and quality. The objectives and recommendations contained in this strategy must guide the interventions implemented by the ACs. The strategic lines of the document are:

1. Mental health promotion and mental health disease prevention, eradication of stigma suffered by people with mental health problems.

2. Healthcare for mental health disorders.
3. Inter and intra institutional coordination.
4. Health professionals training.
5. Research on mental health.
6. Information system on mental health.

Access to general health care for people with mental health problems is not addressed in this document (1) and the National Action Plan for Social Protection and Social Inclusion (2006-2008) does not set out any specific policy besides this Strategy (8).

The most recent document that analyses the mental health situation in Spain is from 2002. It summarizes the aspects related to mental health services as coverage, specific programmes and ways of access, but access to general healthcare is not included in the analysis (9).

c. Plans and programmes

As mentioned above the National Health System Mental Health Strategy must guide interventions at regional level. A Mental Health Plan does exist in each of the 17 AC, framed in the health plan of each AC, being the first one from the late 1980s. A description of the Mental Health Plan for Andalusia follows below.

One of the objectives of the 3rd Health Plan of Andalusia (2003-2008) is to develop a Mental Health Plan. The purpose of the I Comprehensive Mental Health Plan for Andalusia (2003-2007) (10) is to meet the mental health needs of people living in the region by reorientating existing mental health care services, improving coordination and complementarity with social health care, and increasing the commitment of health professionals and the general public to mental health and the mentally ill. The plan was formulated taking into account the expectations and demands of patients, family carers, general public and health professionals.

One of the strategic lines of the Comprehensive Mental Health Plan for Andalusia (2003-2007) is to develop mental health information and communication efforts aimed at the general public and health professionals in order to combat stigmatisation and closing the gap between mental health care and physical care. Cooperation of institutions, health professionals, associations of families and users and the media is highlighted as successful factor. This plan does not mention access to general health services for people with mental health disorders. A brief summary of this Plan is provided in Annex X. A critical review and the evaluation of this plan is currently being elaborated.

Currently, a reflection process about the mental health situation in Andalusia is taking place in order to elaborate the 2nd Comprehensive Mental Health Plan (2008-2012). Tackling physical health of people with mental health problems will be one of the strategic lines of this plan. The group working on this subject is mainly focused in the health problems of people affected by severe mental health disorders. The specific objectives of this strategic line can be summarised as follows:

- To reduce the morbimortality of somatic diseases with higher prevalence in patients with severe mental problems.
- To promote healthy lifestyles (nutrition, physical activity, hygiene, tobacco and sexuality).
- To improve oral and dental health.
- To promote coordination and cooperation mechanisms between Primary and Specialised Care in order to guaranteeing an adequate attention of general health problems and continuity in healthcare.
- To promote training and knowledge on somatic diseases among health professionals, families and caregivers (11).

Also the intersectorial approach to attend the mental health needs of groups at risk of social exclusion (i.e. homeless, persons with addiction problems, persons

with intellectual disability) is being envisaged in the groups working in this process. This plan will be published before the end of 2007.

The last Andalusian Plan for the Social Inclusion (2003-2006) included among their objectives to promote access to health care for groups at risk of social exclusion. Persons with mental health problems without family support were considered as a target group (12).

The Comprehensive Action Plan for People with Disabilities in Andalusia (2003-2006) includes an action line for mental health aimed to promote early diagnosis of mental health disorders and to strengthen a comprehensive care for this people (13).

The Andalusian Foundation for the Social Integration of the Mentally Ill (FAISEM), created in 1993, under the responsibility of the Regional Department of Health, Work and Industry, Social Service and Economy, manages the social resources for the persons with mental health problems, mainly developing occupational activities, vocational training and employment support activities, leisure activities and a housing network with different degrees of support.

Open the Doors is an international program that was developed by the World Psychiatric Association (WPA) in 1996. Created to fight the stigma and discrimination experienced by people with schizophrenia, the program helps dispel myths and misunderstandings about the nature, causes, and treatment of the illness. In Spain a pilot study was carried out in Madrid in 1999. When the amount of stigma was explored, the stigma degree in the environment closer to the patient such as patient themselves, relatives, neighbours and health service staff was significant. Activities related to this group of people were undertaken specially by training psychiatrists to identify stigma and discrimination and to fight it. The outcome showed a great satisfaction among patients, relatives and physicians. The same experience has been repeated in the year 2000 and 2001 in the whole of Spain with the support of the Health authorities (<http://www.esquizofreniabrelaspuertas.com/>).

d. Research

There are no national or regional research activities regarding equity in access to health care for people with mental health problems. Most of the research is focused in prevalence data of mental health disorders and adequacy treatment..

e. Health services

Mental Health competencies, as part of health competencies, are transferred to the AC. The transformation of psychiatric care which has been carried out in Spain since the 1980s, under the name of "Psychiatric Reform", had produced as its most significant achievements: a) the development of a new organizational structure for mental health care, b) the integration of psychiatric patients in the general health care system, c) the creation of an extensive community network of mental health centers, d) and the adoption by the general public of more positive attitudes towards mental illness and its treatment and the passing of legislative measures aimed at improving the civil rights of these patients (14). Actually, 20 years later the beginning of the reform, the situation is characterised by the following aspects (15):

- There is an equal development of the mental health care between the ACs.
- In some ACs Community Healthcare plans and norms have not been totally applied
- Poor number of psychiatric beds compared with other EU countries.
- Socio-community resources have not been sufficiently increased in order to attend the needs of the outpatients.
- There are no common parameters for the realisation of comparative studies.

Regarding special services for provision of general health care to people with mental health problems they do not exist in Spain. They are served by both the mainstream health services and specialist services. Primary care services are

the main gateway to specialist services existing in the community, primary, secondary and tertiary sectors. There are community care facilities for patients with mental disorders. The community care is provided by mental health centres, which were initially developed as support units for the primary care and are integrated in the network of psychiatric facilities (3).

In Andalusia, mental health care is provided by a network of specialised centres located throughout Andalusia and comprehensive in the Andalusian Public Health System. This network is divided into management and organisational units, called Mental Health Areas. Each one has:

- A District Mental Health Team (ESMD): support centers for the primary care. Their functions are providing ambulatory care, being the gateway to the mental health network and the coordination of all mental health devices.
- A Mental Health Unit at the General Hospital (USMH): hospitalisation units for patients with severe mental disorders.
- A Child and Adolescent Mental Health Unit (USMI).
- An Area Rehabilitation Unit (URA): Day centers with rehabilitation activities for chronic psychotic patients.
- A Day Hospital (HD): centers providing partial hospitalisation for patients with severe mental disorders.
- A Therapeutic Community(CT): centers of middle and long-stay hospitalisation in which psychotherapeutic and psychosocial programmes are developed for patients with severe mental disorders. (15).

Mental health resources available in Andalusia were as follows in 2005: 72 ESMD, 19 USMH, 13 USMI, 9 URA, 5 HD, and 13 CT. Activity and diagnosis of these unities are collected in the Andalusian Mental Health Information System and other databases.

Integrated Healthcare Process Management is a central strategy for quality improvement that has been implemented in Spain by the Public Health Systems of the ACs. It constitutes a link between professionals and citizens. In the Andalusian Public Health System, this strategy is oriented to place patients in the center of all healthcare activities, to involve professionals as main actors of organisational changes, to guarantee a clinical practice in keeping with available scientific knowledge, to facilitate the continuity of care, and to evaluate the results. These management tools aims to overcome differences in the views from specialities and healthcare levels. Regarding mental health, three process have been defined: “Anxiety, depression and somatizations”, “Nutrition-related disorders” and “Several Mental Disorder”.

f. Civil society

Most of the patients and family carers associations in Spain emerged in the past two decades as self-aid groups at the local level. Now, most of them are gathered in the Mentally Ill and Family Associations Spanish Confederation (http://www.feafes.com/home_maqueta.asp). The mission of FEAFES is to promote the quality of life improvement of people with mental health disorders and to protect their rights. FEAFES offers information and training through the Information and Training about the Mental Illness Spanish Centre (CEIFEM). Created in 1998, this centre organises activities aimed to increase the knowledge about mental disorders among those affected by a mental health problem, families and caregivers, health and social services professionals and general public.

The majority of associations represents families and caregivers, but currently many users´ associations are arising. At national level, these associations are organised according to diseases. In Andalusia, users´ associations represent persons with mental health problems independently of the disorders suffered. Recently, a Coordinator Platform of User´s Association has emerged in Andalusia aiming to facilitate experiences exchanges and coordinate objectives and anti-stigma-awareness activities.

As explained in the policies and plans sections, they play an active role in the definition of mental health policy at both national and regional level, and they

are a key support for the people with mental health problems and their caregivers. They are mainly involved in advocacy, promotion, treatment and rehabilitation and they do not identify access to somatic health care services as main issue. Interviews conducted with the coordinator of the Platform mentioned above confirm this. Members of the Andalusian associations do not detect problems in access to somatic health care services and affirm that they are treated like other patients in terms of diagnosis and treatment.

g. Public opinion

Some studies have explored the knowledge and perception about mental disorders in our context. According to a sociological study carried out in 2005, 75% of people interviewed consider that persons with mental health disorders are socially excluded. (16). Other studies show that the Spanish population has a good knowledge about mental disorders but there are still some prejudices that make difficult both the treatment and the social readjustment of people affected. A survey carried out across Spain shows that 18% of people suffering depression hide their diagnosis, for fear of stigma at work (17).

A qualitative study with focus groups of clinically stable schizophrenic outpatients and relatives about stigma and discrimination concluded that there is a variety of stigma and discrimination experiences in all areas of life, including health care. Six categories of stigma were extracted from the patients' data: mental illness and lack of will, prejudice related to dangerousness, over-protection and paternalist, daily social discrimination, discrimination in health care and avoidance-social isolation. From relatives they extracted the following categories: discrimination towards the patients witnessed by relatives, discrimination suffered by the relatives themselves and discrimination exerted by the relatives on the patients (18).

The last study concerning the attitudes of the media is from 1987 and it was carried out by the Andalusian Institute of Mental Health (organism eliminated with the Psychiatric Reform). They found that mental illness was often associated with criminality and examples of people with mental health problem

living a normal life were never mentioned. There are no recent studies confirming or refusing the validity of these conclusions 20 years after (19).

4.2 Methods

A focused literature search was carried out to identify relevant papers (from 2001 to date) about access to general health care for people with mental health disorders in Spain. The following databases were consulted: Medline, Scielo (Scientific Electronic Library Online) and Doyma Electronic Database (to search Spanish scientific literature). The search was carried out using different combinations of the following terms:

- “mental health” or “mental illness” or “mental disorders” or “schizophrenia” or “depression” or “anxiety disorders” or “personality disorders”
- “attitudes” or “stigma” or “discrimination”
- “primary care” or “general health services”
- “health status” or “general health care”
- “access” or “barrier”
- “Spain” or “Andalucia”

Also government and institutional websites were consulted for regional plans and legislation.

To complete the lack of quantitative information and scientific literature about this subject, several interviews were held with experts and key-informants in the field of mental health in Andalusia and persons with management positions within the key institutions on mental health. These interviews provided qualitative information and descriptions about the current situation in our AC, and they were an important source of information for the elaboration of this report.

Experts and key-informants contacted include: José Arevalo (Coordinator of the Andalusian Platform of User's Association, Health for the Mind Association), Luis Fernández Portes (Technical of the Research, Evaluation and Programmes. Andalusian Foundation for Social Integration of the Mentally Ill), Yolanda Fornieles García (Consultant Expert, EASP), Marcelino López (Director Programmes Department, Andalusian Foundation for Social Integration of the Mentally Ill), Carmen Pérez Romero (Consultant Expert on Mental Health), Rafael del Pino (Coordinator of the Comprehensive Mental Health Plan for Andalusia), Isabel Ruiz Pérez (Psychiatrist and researcher, EASP), Dr. Francisco Torres González (Andalusian Group of Research on Mental Health, University of Granada).

4.3 Access to general health care for people with mental disorders

Spanish research on mental health is focused in prevalence data and there are no research regarding access to general health care or somatic health of people with mental disorders.

According to the last National Health Survey (2006), 14,73% of people older than 16 years of age suffer or have suffered depression, anxiety disorders or other mental health disorders. The most recent study on mental disorders in the Spanish population is the participation in the European Study of the Epidemiology of Mental Disorders. According to the results for Spain from this study, 19,5% of the individuals presented a mental disorder sometime in their lifetime and 8,4% in the last 12 months. The most frequent mental disorder was major depressive episode, specific phobia, alcohol abuse disorder, and dysthymia. Factors associated to presenting a mental disorder were being female, being separated, divorced or widowed, and being unemployed, on sick leave or incapacitated (20). According to the results of the ESEMeD study, only one third of the mental health treatments in Spain met minimal adequacy criteria: 31,8% in specialty medical treatment and 30,5% in general medical treatment (21).

Although according to several publications, mental disorders are associated with increased mortality and co-morbidity, very few studies in Spain have focussed on this issue. A very recent one (published August 2007) was carried out retrospectively reviewing medical records of patients attended during 2004 in PC centres of Barcelona and aimed to analyse the cost and use of PC health services by persons with mental health problems. It shows that 17,4% of those that came seeking care had a mental problem, that those patients usually had a higher number of co-morbidities and that costs to attend them were slightly higher than for the rest of patients. (72,6 E when adjusted for sex, age and co-morbidity). The annual number of health problems attended was higher in mental health patients and the presence of mental health problems was related with a higher probability of having the following diseases: malignant neoplasias (OR=2,1), arterial hypertension (OR=1,6), dyslipemia (OR=1,6), obesity (OR=1,6) and ischemic cardiopathy (OR=1,4) (22).

A study published in 1998 analysed mortality in all psychiatric patients living in an urban area of Valencia who contacted the mental health services during 7 years and compared these results with those of a general population sample. Patients suffering organic psychoses and those diagnosed with drug abuse or dependency exhibited a greater risk of death than the general population for the total causes of death. The fact of being a psychiatric patient was associated with a risk of death 1.44 times greater than that in the general population. Considering the different diagnostic categories, organic psychosis and alcohol/drug abuse or dependency were associated with a greater risk of death than that in general population. In the analysis of mortality according to psychiatric diagnosis and cause of death, patients with organic psychoses presented an almost 8-fold increase over the controls regarding the risk of death due to cardiovascular disease, an almost 5-fold increase in the case of respiratory pathology, and an 11-fold increase in the risk of death due to suicide or accidents. Schizophrenia, alcohol or drug abuse and neuroses/personality disorders involved a higher risk of death from liver disease. No psychiatric disorders was found to be associated with increased risk of cancer death (23). Other study analysed the relationship between mental disorders and mortality rates in a elderly community and found a significant association between

psychiatric morbidity and mortality. Both pure “organic” (dementia) and pure “depressed” cases (global depression, neurotic depression and neuroses) had higher mortality when compared with co-morbidity cases (24).

Excess mortality of people with mental health disorder is related with unhealthy lifestyles (poor nutrition, sedentary habits, smoking). A study explored the opinion of doctors in primary care about the frequency of patients at risk of malnutrition and 42% of doctors pointed out that suffering a mental disorders was a risk situation (25).

A study carried out in Catalonia in 2003 and aimed to determine which health-related factors are associated with psychiatric distress in the general population shows that the factor most consistently related to this disorder was the presence of one or more chronic physical conditions. It was the number rather than the type of declared chronic conditions the most important factor: with an OR from 1.1 for one declared condition to 5.6 in persons with over five chronic conditions (26).

Diagnosis problems and limitations are sometimes present but they are due to the difficulty of the doing a specific, accurate diagnosis in cases where no symptoms are present in early stages of the disease more than to lack of resources. Sometimes a given diagnosis can take more than one year to be made. Unlike to other health problems where technology has become an allied of the diagnosis and therapeutic process in mental disorders the clue still lies in patient-doctor relationship and different approaches of listening to the patient and dealing with his-her suffering.

Subgroups

“Ulysses syndrome”, depression and dysthymia are the most frequent psychiatric pathologies detected in the non regularised immigrant population in our country. Similarly to the Spanish indigenous population, anxiety disorders and readjustment disorders are the most common diagnoses among legal immigrants cared by Mental Health Services (27).

A study carried out in Madrid showed that being an immigrant having a monthly income of less than 240 € was one factor associated with a break in the continuity of care after discharge from a psychiatric hospitalisation (28).

According to a study carried out in 2001, the prevalence of mental disorders among the homeless in Spain varies from 25-33% (29).

4.4 Barriers in access to general health care for people with mental disorders

- *Gaps in coverage*

Access to health services is secured to all citizens in Spain, regardless of their mental health status. There are no studies that document any difference in accessibility depending on a diagnosis of mental health illness. No differences have been identified from one province to another in the Region. There are no reasons to believe that limited access to health services exist, except for those persons with severe mental disease who have a very de-structured life and can not follow scheduled indications whatever the subject (daily routines, medication, prevention). This situation will be common to anyone living a chaotic life.

Within the housing resources of FAISEM (apartments and boarding house), access to general health care is guaranteed through permanent contact with the corresponding health centre, specially with a nursing team which visits periodically these centres and develops health promotion activities to tackle the main health problems detected (diabetes, cardiovascular diseases, overweight and respiratory diseases).

- *Scope of health basket*

Health basket for mental health problems is not specifically defined. Their needs are covered within the general health services basket. Specific mental diseases attendance processes have been implemented, namely: depression and somatisation, severe mental disorder and nutrition disorders; the range of

services to which the patients should have access, how the services in primary health and specialist care (hospital or out patient units) coordinate or are accountable for given activities have been described and are currently on use in the public health system in Andalusia.

- *Cost-sharing*

Cost sharing is no barrier for mental health patients. They are entitled to free coverage either in Primary Health Care or hospital care. (as for the whole population). Medication cost-sharing rules applies as for the rest of the population and the rest of health problems.

Some studies have pointed out that financial barriers may be an impediment to appropriate care. Simeed et al evaluated the predictors of depression treatment in a diverse cross-national sample of primary care patients (including Spain) and they concluded that out-of-pocket cost was the most commonly reported barrier to treatment for this disease; the lowest percentage of patients who reported this barrier ranged was in Barcelona (24%) (30).

In the frame of the private health care sector, the care of psychiatric pathologies (including severe pathologies) is covered by all insurance companies, although they do establish maximum limits to the length of psychiatric hospitalisation. Psychotropic drugs (including newer ones) are subsidized by the social security system. A relatively small proportion of the population has additional health insurance, allowing them more freedom of choice for their health care.

People with mental health disorders has disability benefits. Psychiatric illness are considered as a transitory working disability and also a definitive one. In both cases its recognition gives right to an economic compensation, for the first case only if previously working and in the second case with different amounts, depending on whether the patient did contribute before or not to the social security system (3).

- *Geographical barriers*

Geographical barriers due to isolated rural areas can hinder access to health services but they will not be different than those for other patients. Access to

community resources, day-care hospital and crisis resolution units as well as for patients groups activities can be limited for patients living outside capital cities where most of these services are based (15).

- *Organisational barriers*

Health professionals feel themselves in need of training and support to deal with mental health patients. Also specific ways of treating mental disorders such as psychotherapy is lacking.

- *Supply-side responsiveness*

Some studies have explored health care staff's attitudes towards the mental illness and people with mental health disorders, but most of them have described them from the point of view of primary care professionals.

A study carried out in 2005 analysing these attitudes show that 90% of PC doctors consider that mental illness suffering is comparable with physical illness, the increase of mental health patients attending primary care services was disagreeable for 45%, and 47% of doctors pointed out that there was a lack of motivation among primary care teams to tackle mental health problems (31). Other studies have showed that healthcare professionals have positive attitudes towards persons suffering from mental disorders (32).

Doctor-mental health patient relationship has been described from the point of view of healthcare professionals by some studies in our country. A study carried out in the Girona Health Region shows that 100% of doctors interviewed thought that a good doctor-patient relationship improves adherence to treatment, and 76,5% saw this hindered by lack of time. Aggressive and manipulative patients caused a higher level of tension for doctors (70,6% and 66,7%) (33).

Discrimination towards these patients is felt as been possible when key people are asked about this issue but recent studies are not available nor is this issue mentioned when talking about needs and problems with target groups (professionals, families of mental health patients).

▪ *Health literacy and user attitudes*

A research upon patients expectations and families of mental health patients expectations is currently taken place. A sound analysis of results is still pending but preliminary outcomes point out that “partial in-hospital units” are needed (something in between hospital and being at home for specific patients) and more resources to attend anxiety and depression situations in Primary Health.

Other barriers in access to general health care for people with mental disorders emerged in the interviews conducted with the key informants are:

- Mental illness in itself makes more difficult that people with acute mental disorders do an adequate appraisal of their general health status and go to the health centre.
- Health care professionals often underestimate physical health problems of people with acute mental health disorders and this can arise problems with the diagnosis, treatment and follow-up.
- Stigma and discrimination in health care centres.
- Lack of social support.

4.5 Policy initiatives and their impact on access to general health care for people with mental disorders

As explained above, this section will focus on policy initiatives in Andalusia.

In 2004 a Framework Agreement for the Social Awareness for People with Serious Mental Health Disorders was signed by the Health, Equality and Social Welfare, Education Departments of the Regional Government, the Public Enterprise of the Andalusian Radio and Television (RTVA), FEAFES-Andalucía and FAISEM. The objective of this agreement is to design and support an awareness strategy aimed to promote the knowledge and social acceptance of people with serious mental health disorders. The target groups of this strategy

are general public, journalists, students, health professionals, families and police (34).

Several activities have been developed in the framework of this agreement. Some of them were focused in the way in which mental illness is covered in the media: workshops, elaboration of guides for an appropriated treatment of this subject. Also patients' associations have developed many similar campaigns, specially during 2005 (declared Andalusian Year of Mental Health), but there is no evidence on their effectiveness.

In the health sector, the Andalusian Health Service created a Permanent Group of Mental Health Communication. This group is working in awareness activities and they have created a website for the knowledge management on mental health for health professionals (www.saludmentalandalucia.es). In September 2007 several awareness activities are being developed by the Health Department of the Andalusian Government. One of these initiatives is the communication campaign called "1 out of 4" (www.1decada4.com) launched by this Department in collaboration with the RTVA, and FAISEM. In the frame of this campaign, a Mental Illness Observatory has been created aimed at denouncing information that contributes to stigma appeared in the media. Also resources for journalist and health professionals are available in the official web of the campaign.

As explained above, the 2nd Andalusian Comprehensive Mental Health Plan (2008-2012) that will be published this year will tackle physical health of people with mental health problems. Activities aimed at the improvement of access to general health services through the creation of collaboration mechanism between PC and SHC will be developed in the frame of this Plan.

Recently, a Working Group composed by the coordinators of the Andalusian Comprehensive Mental Health Plan, the Andalusian Comprehensive Smoking Plan and the Andalusian Comprehensive Plan for the Cardiovascular Diseases has created by the Department of Health. The objective is to elaborate a document with recommendations to tackle the influence of unhealthy lifestyles on physical health of persons with mental health problems.

Although several policy initiatives are currently taking place in Andalusia, neither of them focus in access to general health care for people with mental health problems as main issue. Nevertheless, by reducing stigma and social discrimination towards these persons, it is expected that they have an impact on access to general health care, specially the Second Comprehensive Mental Health Plan. It can be assumed that other national policy initiatives, such as the National Health System Mental Health Strategy and the Law to promote Personal Autonomy and Care for people in a dependant situation should improve access to general health care.

4.6 Conclusions

- People with mental health disorders have in Spain the same rights to health care access as all other citizens. Accordingly and in theory, this specific group benefits from the same provision of public services tailored to their needs and on the same conditions as any other group. No much research and evidence has been found during our study to identify to what extend the PHC sector is providing adequate somatic health care to people with mental health disorders.
- An epidemiological overview of the health status of people with mental health disorders in Spain, or in Andalusia is not available. Limited research studies have been published, and they mainly focus on mortality.
- When addressing mental health issues, health policy proposals focus on a more adequate response to meet mental health needs. Initiatives to improve mental health services have focused on increasing resources, training professionals, improving coordination and collaboration between PHC and mental health specialists, and taking on board families and careers of these patients and patients representatives. The issue of how the somatic health needs of mental health patients are met seems to be out of scope and is not consider a priority.

- Access to general health care of people with mental health disorders is not seen broadly as a problem neither by professionals nor by patients representatives. Mental health patients representatives do not detect inequity problems in access to general health care and are very satisfied with the attention received.
- Improving access for somatic problems in mental health patients is seldom recorded as a priority by the above mentioned groups neither in grey reports nor during the interviews held during our research. Even though, references are made that patients with severe mental disorder could have difficulties in voicing their demand or/and could suffer from stigma when visiting the centre. Those barriers are similar to difficulties experienced by people from other vulnerable groups living chaotic lives.
- The biggest barrier suffered by people with mental health disorders is related to stigma and social discrimination, and this applies not only to health care services encounters but to their social and labour life. National and regional policy initiatives have recently been launched addressing stigma to mental health patients in the society.
- Initiatives aimed to increase the role of PHC professionals related to mental health disorders are focused on meeting mental health needs, in facilitating referral to specialist care and in improving collaboration among professionals. Somatic needs of mental health patients are not mentioned.
- Poor somatic health status of people with mental health problems is an issue arising in all the interviews conducted with professionals and patients representatives. Although not recorded data is available, the feeling is that mental health patients suffer frequently from diseases related to their lifestyles (tobacco, sedentary, diet.) and so cardiovascular and respiratory diseases and diabetes are common.
- Awareness on this problem has meant that the improvement of the somatic health of people with mental health disorders is envisaged as an objective in the strategies, plans and programmes related to the Mental Health Strategy for Andalusia.

5 Annex 1. Tables.

5.1 Table 1. Population covered by the NHS by CCAA, year 2005.

CCAA	Pop total	Pop covered	Pop covered (%)
Andalucía	7.849.799	7.372.398	93,9%
Aragón	1.269.027	1.193.252	94,3%
Asturias	1.076.635	1.041.621	96,7%
Islas Baleares	983.131	945.823	96,2%
Canarias	1.968.280	1.877.169	95,4%
Cantabria	562.309	539.710	96%
Castilla y León	2.510.849	2.340.502	93,2%
Castilla-La Mancha	1.894.667	1.801.002	95%
Cataluña	6.995.206	6.818.468	97,5%
Comunidad Valenciana	4.692.449	4.506.448	96%
Extremadura	1.083.879	1.013.125	93,5%
Galicia	2.762.198	2.613.836	94,6%
Madrid	5.964.143	5.555.935	93,2%
Murcia	1.335.792	1.254.811	94%
Navarra	593.472	578.130	97,4%
País Vasco	2.124.846	2.077.143	97,8%
La Rioja	301.084	287.468	95,5%
Ceuta	75.276	60.189	80%
Melilla	65.488	51.198	78%
TOTAL	44.108.530	41.928.228	95%

Source: Authors elaboration based on data from the Spanish NHS Annual Report 2005

5.2 Table 2. Scope of the health basket and cost-sharing in Spain

Services	Source	Scope on the health basket	Cost-sharing (“Patient’s participation”)
Health promotion, prevention and preventative health services (incl. screening)		Fully coverage, including vaccines for all age groups	No charges
Home visit by general practitioner		Fully coverage	No charges
Home visits by other providers (allied health professions for older people with reduced mobility)		Social worker’s visits are included	No charges Beneficiaries pay 40% of the price of medicaments. There is a 90% reduction of the price for certain special medicaments, with a maximum limit of €2.64. No charge whatsoever for: pensioners, patients undergoing residential hospital care, residents over 65 years of age with insufficient means of existence, and for victims of employment injuries and occupational diseases.
Medication (prescription drugs; limits of reimbursement)		Indication, prescription and monitoring are included	
Maternity services (pre- and post-natal up to age of six months of the child)		Fully coverage Information, indication and monitoring of oral contraceptives methods, intrauterine devices, tube ligation and vasectomy included. Assisted reproduction treatment are included. Some AC include free post-coital pill in certain cases.	No charges
Family planning and sexual health services (including oral contraceptives)			No charges
Dental services (including denture)		Comprising extractions and certain types of treatment. In the event of an employment injury or in the case of an occupational disease, oral and facial surgeries are also covered	
Dental prosthesis		Not included	Certain financial aids for dental prosthesis.

Physiotherapy (ambulatory/community provider)	Physiotherapy treatments for symptoms control, neurological disorders and muscle-skeleton process are included. Respiratory physiotherapy is included.	No charges
Wheelchair, Zimmer frames;	Full coverage.	Co-payment system: Beneficiaries pay 40% with a maximum of 30 €
Hearing aids, glasses and incontinence pads;	Incontinence pads are included with a special prescription.	
Mental health counseling.	Not included	

Source: Author's elaboration

5.3 Table 3. Time (minutes) inverted to reach health premises, by CCAA

CCAA	Minutos
Andalucía	14,54
Aragón	13,3
Asturias	14,82
Islas Baleares	17,41
Islas Canarias	15,26
Cantabria	17,44
Castilla y León	13,33
Castilla la Mancha	12,62
Cataluña	15,83
Comunidad Valenciana	12,64
Extremadura	14,73
Galicia	17,93
Madrid	13,96
Murcia	11,39
Navarra	12,31
País Vasco	14,39
La Rioja	11,69
Ceuta y Melilla	14,31
Total	14,46

Source: Encuesta Nacional de Salud 2003. Ministerio de Sanidad y Consumo.

5.4 *Table 4. People over 65 disabled to perform basic activities, by gender, age group and degree of disability. Spain, 1999.*

	All degrees of severity			Severe and total disability total		
	Male	Female	Total	Male	Female	Total
65 to 69 years	80.978	156.798	237.776	48.491	96.694	145.1185
70 to 74 years	96.662	197.860	294.522	64.153	133.455	197.608
75 to 79 years	100.455	229.667	330.122	69.842	154.776	224.619
80 to 84 years	77.639	197.033	274.672	54.354	145.835	200.190
85 to 89 years	57.751	162.513	220.264	43.426	131.813	178.240
90 to 94 years	21.591	61.068	82.659	16.653	51.781	68.434
95 to 99 years	7.136	17.664	24.800	5.922	16.718	22.640
Total	442.212	1.022.603	1.464.815	302.841	731.072	2.342.916

6 **Source: Instituto Nacional de Estadística. Encuesta sobre Discapacidades, Deficiencias y Estado de Salud 1999.**

Annex 2. List of stakeholder consulted

The following people were interviewed for preparing this report:

- José Arevalo. Coordinator of the Andalusian Platform of User's Association, Health for the Mind Association.
- Amapola Blasco Marhuenda. Director Racism and Xenophobia Spanish Observatory. Ministry of Labour and Social Affairs.
- Luis Fernández Portes. Technical of the Research, Evaluation and Programmes. Andalusian Foundation for Social Integration of the Mentally Ill. Regional Government of Andalusia.
- Yolanda Fornieles García. Consultant Expert, Andalusian School of Public Health.
- Marcelino López. Director Programmes Department. Andalusian Foundation for Social Integration of the Mentally Ill. Regional Government of Andalusia.
- Begoña Merino Merino. Head of Health Promotion Department. Ministry of Health and Consumer Affairs.
- Inés Palanca Sánchez. Technical Advisor. Health Planning and Quality Office. Ministry of Health and Consumer Affairs.
- Carmen Pérez Romero. Consultant Expert. Coordinator "Care for Mental Health in Andalusia: present and future", Andalusian School of Public Health.
- Enrique Terol García. Deputy Director of the Health Planning and Quality Office. Ministry of Health and Consumer Affairs.
- Assane Top. Granada Acoge NGO.
- Rafael del Pino. Coordinator of the Comprehensive Mental Health Plan for Andalusia).

- Isabel Ruiz Pérez. Psychiatrist and researcher, Andalusian School of Public Health.
- Francisco Torres González. Andalusian Group of Research on Mental Health, University of Granada.

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