Equity

Equity is a prominent target in the design of health policy, both in terms of the activities of the Ministry of Health and Consumers' Affairs and the autonomic health services. These objectives are usually defined in terms of equal access and the reduction of inequalities in health, and some plans of the autonomous communities are explicit in this sense[21]. Among the measures adopted by the different territories in this area, we can distinguish a first group of actions aimed at improving access in geographical terms, and a second group where action plans have been laid out for socially disadvantaged groups or groups that are particularly vulnerable (women, immigrants, the disabled, etc.).

The improvement of geographic access has been addressed by the autonomous communities in part by *redrawing their health maps* (increasing the number of health zones, or the associated infrastructures, etc.) as in Aragon, Catalonia, Extremadura and La Rioja. *Telehealth* is also seen as a way of improving access to specialist care, and is included among the actions mentioned by Asturies, Extremadura, Castile and Leon and Catalonia. Andalusia and Aragon, for their part, mention the setting up of *high resolution centres* which make specialised care available in rural areas or remote parts of the territory. The *other measures mentioned* by the autonomous communities range from increases in the coverage of emergency services (Extremadura) to the strengthening of mental health centres to facilitate access for rural areas (Castile and Leon) or programmes to enable patients to travel from their rural homes to the health centres (Castile and Leon and La Rioja).

Besides these, all of the autonomous communities have designed specific programmes aimed at groups requiring special protection, although the reach of these programmes as well as their level of precision and scope of services offered range from one community to another[22].

21 Some autonomous communities, such as the Basque Country, indicated in their reports that the priority given to the reduction of social inequalities in health is an innovative aspect of their service. The case of the Canary Islands is also worthy of notice, as it incorporates social factors into the elaboration of a number of health programmes, and Andalusia, which uses transversal planning in health policy to ensure attention is given to socially disadvantaged groups.

22 The measures summarised below are characterised in general by their aim of favouring access to health services of groups which might otherwise be deprived of the care they need or at least find themselves facing significant barriers to access.

Other actions could more appropriately be classified under the heading of "raising standards of quality". This would be the case, for example, of the programmes aimed at improving assistance

The principal social group towards which these actions of the health services of the autonomous communities are aimed is that of *women*. There has been a notable increase in the tendency to take into account a gender viewpoint and studies of gender inequities when designing health plans, and also when surveying access to and use of health services[23].

Practically all of the autonomous communities and cities have begun to implement protocols for health services in cases of gender-based violence, as well as preventive actions and other types of intervention, usually including training plans for professionals. In most cases, they are measures undertaken prior to 2007. The rapid expansion of this type of measure is undoubtedly due to the social importance the issue has acquired in recent years with the problem of violence against women. Besides this factor, the approval of the Common Protocol for a Healthcare Response to Gender Violence by the Interterritorial Board's Commission Against Gender Violence has boosted its adoption by a number of autonomous communities.

Some autonomous communities (Andalusia, Asturies, Castile and Leon) have also established specific programmes to support persons caring for dependent relatives[24] –in the case of Andalusia, there have also been training courses for carers of severely handicapped persons in obtaining access to health professionals. Finally, other communities mention the existence of comprehensive plans for women's health (Balearic Islands, Galicia, Murcia and Aragon).

The social phenomenon which has surely had the greatest impact in recent years –in the area of healthcare too– is that of *immigration*. This fact justifies the efforts made by the group of territories which make up the NHS in investing in the prevention of illnesses among immigrants, and in the improvement of their access to health services and the manner in which this is provided.

The legal measures adopted to ensure access to health services for foreigners without resources or individual health cards form part of the activities developed by the autonomous communities. This has been indicated by Andalusia, the Canary Islands, the Valencian Community or Extremadura, and in some cases they regulate the conditions of access by means of temporary health cards.

However, the regulation of the right to health services is the first essential step towards guaranteeing that immigrants receive the healthcare

at childbirth, which despite being included by some autonomous communities among their equity programmes, have not been included in this section.

23 Catalonia has even included gender perspective in its procedure for buying services.

24 Included in the group of measures aimed at women due to the elevated number of women in this group.

they require when they are in situations of need. For this reason the health services of the communities have created other types of actions which have enabled this right to be made effective in the best possible conditions. There have been many initiatives aimed at easing the transmission of health information to immigrant groups through translation of documents of many kinds (as in Castile-La Mancha, Catalonia, La Rioja or Madrid. Castile and Leon published material specifically aimed at this group). There have also been measures to enable communication between the patients and health professionals, as in Andalusia where a system of pictograms has been introduced to replace spoken language, the Balearic and Canary Islands, Castile and Leon or La Rioja, communities which have introduced teletranslation, or simultaneous translation projects. The figure of intercultural mediator – a person who can offer information and preparation for health services –and training activities for health professionals in treating immigrants are among the most widespread measures adopted. Andalusia, Aragon, the Balearic Islands, Cantabria, Castile and Leon, Castile La Mancha, Catalonia, Madrid, Murcia and Navarre refer to actions of this type[25].

A number of policies aimed at disease prevention have also included a specific element in consideration of immigrant groups. These policies of "training activities" help in ensuring access for differentiated groups and contribute to improving equity, as Murcia affirms in its report.

The advances in providing care for *disabled persons* have to an extent, been stimulated by the development of the *Promotion of personal autonomy and care for dependent persons Act* (Law 39/2006), so that independently of its degree of development in each community, it can be considered an element common to the whole NHS. There is, however, a variety in what the different health services describe as their principal actions: programmes aimed at patients with mental disorders (Asturies, Castile and Leon, Madrid and Murcia), the elderly (the Canary Islands, Ceuta and Melilla), or early intervention programmes for children (Andalusia, the Balearic Islands, Cantabria, Castile-La Mancha and Madrid), among others.

Besides the specific programmes for women in situations of inequity, the immigrant population and the disabled, the autonomous communities have mentioned other groups who are held to be especially vulnerable and which are the object of actions aimed at improving equal access to the best healthcare services possible. This is the case, for example, of *persons living in poverty or social exclusion* (Andalusia, the Canary Islands, Catalonia, Madrid or the Basque Country). Both Andalusia and Catalonia refer to

25 The experience mentioned by Aragon is worth noting here. The Immigration Forum it set up was designed with the active participation of the immigrant population.

actions developed in specific geographical areas where a special need for assistance has been noted (through reinforcement of health services in areas undergoing social transformation in Andalusia and the programme of Health in the Neighbourhood in Catalonia). The elderly have also been the target of special attention (especially with reference to problems of abuse, as Catalonia and La Rioja mention), as have children (as mentioned by the Balearic Islands[26], Catalonia and Madrid). The importance of early intervention programmes for children should be noted, in the light of the fact that the health of the earliest years has a significant effect on the conditions of health for the rest of one's life.

Persons with *drug addictions* are another group which have been treated with special attention by some autonomous communities (among them Aragon and Galicia, which both have autonomic plans for drug addicts, as do Catalonia, Extremadura and Murcia). They have designed specific programmes for the prevention, diagnosis and treatment of drug addiction, the illnesses associated with drug consumption and also measures to enable easier access to treatments for the persons affected (as Asturies have emphasised). Andalusia and Madrid have both mentioned actions aimed at *persons engaging in prostitution.* Finally, Catalonia, La Rioja Navarre and the Basque Country also single out from among their action plans those which are aimed at encouraging health and the social inclusion of *gypsies*[27].

If we consider that the population in the lower social categories do not have the means to resort to the private sector for diagnosis and/or treatment when there are delays in the public services, then the efforts made towards improved management of *waiting lists* are another formula for improving equity in access to medical treatment. Although a number of autonomous communities have regulated the waiting period for surgery or diagnosis prior to 2007, some of the territories have mentioned measures related with this issue this year (Andalusia and Castile-La Mancha, with the adaptation

26 In the Balearic Islands the dental health service for children between 6 and 15 should be noted. Other autonomous communities also provide these services, although because they are more consolidated, they are not indicated as notable measures in their respective reports (as in the Basque Country). If we take into account the social and economic differences observed in dental care between those authorities that cover this service and those that don't, its inclusion in the charter of publicly financed services should be considered a notable measure in the improvement of equity.

27 The actions referred to in this section are not the only ones carried out by the autonomous communities, although they do contain the greater part of the efforts aimed at vulnerable groups. Among the remaining actions, we could single out as examples the improvement of the mechanisms of information on occupational health mentioned by Catalonia, or the support and subsidies granted to different NGOs and patients' groups mentioned by a number of communities.

and establishment of new time periods. The Balearic and Canary Islands, with the setting up and development, respectively, of the instruments required to manage their waiting lists. Madrid and Castile and Leon with the maintenance of their plans to reduce times, and Ceuta and Melilla with the adaptation of their information systems).

Many of the actions mentioned in this section correspond to the development of measures designed prior to 2007. Even so, it is worth mentioning that seven autonomous communities[28] include one or several of the actions in the area of equity among their *innovative experiences* this year. This should be viewed positively, as an indicator of the interest that the issue arouses, and the efforts that have been made in designing policies that are constantly more effective.

Although equity has always figured as one of the defining principles of the National health System, it is true to say that the end of the process of decentralization of health services has intensified the drive towards equity and cohesion of the NHS from a territorial or geographical point of view. However, the information obtained from the reports submitted by the different autonomous communities does not allow for an easy evaluation of the situation or any changes made. In any case, some indicators point towards a convergence of the different community health services, whether in the design of actions aimed at reducing inequities in health and improving access to health services for vulnerable or underprivileged sectors of society, whether by extending the infrastructure or increasing the spending per capita.

In previous reports of the Observatory on the National Health System, this tendency towards the reduction in the number of patients moved between autonomous communities has been taken as an indicator that the provision of infrastructures has become more balanced, a tendency that has continued in the following years as indicated by the statistics presented in table 38[29].

As regards *public health expenditure* per person covered, as defined in the workgroup paper created after the first Presidents' Conference[30], the coefficient of variation also shows a general tendency towards greater standardisation in expenditure compared with previous years, prior to the

28 Andalusia, Aragon, the Canary Islands, Madrid, Murcia, Navarre and the Basque Country.

29 It refers to the total number of patients whose hospital admission has taken place in one of the autonomous communities different from their place of residence.

30 To calculate the equivalent population covered, we should weigh each of the seven age groups previously defined by their relative expenditure based on the operational classification of health expenditure.

transfer of responsibilities, a figure which is greatly accentuated when one removes the data for Ceuta and Melilla from the analysis (table 39).

TABLE 38. Evolution of the movement of patients between autonomous communities, 2001-2005

	2001	2002	2003	2004	2005
Movement of patients between autonomous communities	60,449	61,207	60,581	58,746	58,556

From the Second Report of the Working Group on the Analysis of Health Spending (2007).

TABLE 39. Evolution of the coefficient of variation (CV) in expenditure per person covered equivalent (%), 1999-2005

	1999	2000	2001	2002	2003	2004	2005
CV	15.56	13.16	12.51	10.98	10.69	12.02	12.75
CV17	8.92	8.76	7.71	6.94	7.02	7.20	6.83

The first coefficient of variation includes the autonomous cities of Ceuta and Melilla in the calculation while the second considers only the 17 autonomous communities. Created from data in the Second Report of the Working Group on the Analysis of Health Spending (2007).

Despite the distance covered, there is still a long way to go as regards, for example, inequities in health. It is well-known that there is a significant correlation between social class and health, which has not declined in the last few decades despite the improvements in education and the distribution of wealth. In any case, the improvement in health and social and economic conditions for the majority of the population has been an important social achievement although it has not led to the reduction in social inequities in health that were hoped for[31]. As regards the inequities between men and women, there has been a convergence in some aspects related with lifestyles in recent years, but some basic indicators, such as the perception of one's health, indicate that these differences have not changed, as Catalonia affirms

31 Regidor E. Desigualdades socioeconómicas en la exposición al riesgo y en salud (Social and economic inequalities in the exposure to risk and in health). In: Rodríguez M, Urbanos R. Desigualdades sociales en salud: factores determinantes y elementos para la acción (Social inequities in health: Decisive factors and elements for action). Amsterdam: Elsevier, 2008; 11-40.

in its report. Further research is needed to explore the evolution of these inequities and especially the causes behind them. The advances noted by the Canary Islands in this context are worthy of comment with regard to the joint planning of the survey on conditions of life at home and the health survey, which shed some light on these questions.

The studies on equity from the perspective of equal use for equal needs by social class, as an indicator of equity in access, gives a favourable impression of the whole of the NHS[32], although there is as yet no research which offers a territorial breakdown or results for the autonomous communities that can be compared with the national results[33].

However, the analyses of the variations in medical practice (VMP) which were being undertaken by the NHS some years ago, and which counted on the collaboration of a number of autonomous communities demonstrate that there are still important inequities in the procedures of diagnosis and treatment of illnesses registered between different regions and between different areas within a single region[34].

The development of information systems which permit a reliable study of inequities through the analysis of small areas (as already happens in the Basque Country, Asturies or Catalonia) would be very useful in this context.

Finally, the evaluation of the actions to improve equity mentioned in this section and which have been undertaken by autonomous communities call for more and better information on the material and human resources employed, the organizational methods used and the indicators of the results. Only in this way will it be possible to know how effective they are and enable them to be adjusted more efficiently in future policies.

32 All research carried out so far indicate that individuals of lower social category tend to use primary care services to a greater extent –with equal need– , while the opposite occurs with specialised care.

33 The work of Costa and Gil (2008) represents the first attempt to date to apply equity statistics by region, although the methodology employed impede comparisons with the research over the whole of the National Health System. See Costa J and Gil J. Exploring the Pathways of Inequity in Health, Access and Financing in Decentralised Spain, LSE Health Working Paper 9/2007.

34 Meneu R, Peiró S. Efectividad de los tratamientos y desigualdades en utilización de los servicios sanitarios (Effectiveness of treatments and inequities in the use of health services). In: Rodríguez M, Urbanos R. Desigualdades sociales en salud: factores determinantes y elementos para la acción (Social inequities in health: Decisive factors and elements for action). Amsterdam: Elsevier, 2008; 167-184.