



WRONG PRESCRIPTION

THE IMPACT OF AUSTERITY MEASURES ON THE
RIGHT TO HEALTH IN SPAIN

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EXECUTIVE SUMMARY

“These budget cuts don’t make sense ... We feel insulted, humiliated and powerless.”

Man using the public health system

“We have all suffered because of the cuts: nurses, doctors, patients, families, everyone.”

Nurse working in the public health system

This report analyses what impact the austerity measures, introduced by the government following the economic and financial crisis of 2008, have had on the right to health in Spain. Based on comprehensive desk-research and interviews with 243 people in Andalucía and Galicia, Amnesty International found that the austerity measures have resulted in a deterioration of the accessibility, affordability, and quality of health care in Spain. They have had a particular and disproportionate impact on people with lower incomes, and especially on people with chronic health conditions, people with disabilities, older persons, and people accessing mental health care. Amnesty International can conclude that the retrogressive impact of the austerity measures, combined with how they were developed and implemented, means that Spain is in violation of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

WHY IS AUSTERITY A HUMAN RIGHTS ISSUE?

Spain has ratified a range of international and regional human rights law treaties that require the right to health be respected, protected and fulfilled. The obligation to realise the right to health is a progressive one. Spain has an immediate obligation to take deliberate, concrete and targeted steps towards the full realization of the right to health. Under international human rights law, there is a strong presumption against deliberately retrogressive measures. Austerity measures, such as those introduced in Spain described above, usually involve reductions in public spending and structural changes in welfare systems to save costs. These often have the effect of causing a retrogression in the enjoyment of economic, social and cultural rights. Given these risks, human rights monitoring bodies have developed guidelines for how austerity measures should be developed and implemented by states to be consistent with their economic, social and cultural rights obligations. These criteria include demonstrating the existence of a compelling state interest; the necessity, reasonableness, temporariness and proportionality of the austerity measures; the exhaustion of alternative and less restrictive measures; the non-discriminatory nature of the proposed measures; protection of a minimum core content of the rights; and genuine participation of affected groups and individuals in decision-making processes.

THE ECONOMIC CRISIS AND INTRODUCTION OF AUSTERITY MEASURES

The impact of the global economic crisis combined with weaknesses in Spain's economy resulted in the Spanish economy officially entering recession in 2008. The economic crisis had a severe impact on people in Spain, with levels of financial vulnerability, poverty and inequality increasing. The unemployment rate, which had been falling steadily before the economic crisis, rose from 8.2% (2007) to 26.1% (2013). The percentage of households unable to meet an unexpected financial expense increased from 30.8% (2007) to 42.7% (2014). In-work at-risk-of-poverty rates, which measures poverty amongst people who are working, stood at 13.1% in 2015, amongst the highest in the EU. As the economic crisis unfolded in Spain, it impacted a range of factors – such as housing and employment - with potentially negative consequences for people's health. The increase in poverty and financial vulnerability combined with the risk of poorer health outcomes called for greater support to the public health system, particularly for marginalized groups who are often the worst affected. While the government's initial response to the economic crisis was to adopt a stimulus package and increase public spending, it later changed its strategy and began to reduce public spending, including by introducing austerity measures. Several measures introduced to limit public expenditure impacted existing social security protection and disposable incomes, which risked increasing financial vulnerabilities during the economic crisis.

In the context of health specifically, starting 2009, the government began to cut public spending on health. Total public health expenditure in 2013, including the central and regional levels, was 12.7% lower than expenditure in 2009. The government also introduced a range of policies to reduce the costs of the Spanish public health system (“Sistema Nacional de Salud”, hereinafter “SNS”), notably through the Royal Decree Law 16/2012 (hereinafter “RDL 16/2012”). It limited the health care that irregular migrants could access. The government also instituted measures to shift the burden of certain health costs on to individuals: it re-structured the common portfolio of services in the SNS to make it possible for more products and services to involve co-payments through future regulation. It introduced pharmaceutical co-payments in some instances for groups who could previously access health care freely, and increased the rates for some others. And finally, it added to the list of criteria based on which medicines would be covered or excluded from SNS financing, following which over 400 products were removed from SNS funding.

“We saw that with the RDL 16/2012, healthcare was impacted for those most vulnerable, and for those at heightened risk. This is an almost unbearable cruelty.”

Doctor working in the SNS

As a part of the reductions in public health expenditure, spending on remuneration for health workers also fell: in 2013, this spending was 10% lower than it was in 2009. One of the ways in which this was accomplished was through limiting hiring and changing working conditions. In the period between 2011 and 2014, the National Health System lost almost 28,500 workers and reliance on temporary contracts in the SNS increased. Cumulatively, these changes have impacted the health workers who continue to work in the SNS. All health workers interviewed told Amnesty International that their jobs had become harder after the austerity measures were introduced, and that they were seeing more patients and working longer hours than before, saying they felt “powerless” and “disillusioned with the system” after the budget cuts and changes to the health system described above. “At the start of the crisis we had more strength. As years have gone by, we have become more tired. For years, we have been carrying this burden,” one doctor said.

THE IMPACT OF AUSTERITY MEASURES ON THE RIGHT TO HEALTH

The austerity measures in the SNS resulted in a deterioration of the accessibility, affordability, and quality of health care. Many of these changes have had a particular and disproportionate impact on people with lower incomes, and within this group, on people with chronic health conditions, people with disabilities, older persons, and people accessing mental health care.

A. INCREASED FINANCIAL BURDEN OF HEALTH CARE

“I cannot live with the pain, I need to take my medicines. Either I take my medicines, or I kill myself [because of the pain] ... so if I have to starve myself, I do it, because I must buy medicines.”

Man using the public health system

Amnesty International spoke with 107 users of the SNS and their families and carers. Almost all of them said that the amount they spent on healthcare had increased since the crisis began and austerity measures were introduced. Even though the sums involved were not high, people explained that this created a significant strain because of their low incomes and/or because they are now supporting more dependants on their incomes. Many noted the anxiety and financial burden the increased costs of health care caused them. “It is a huge effort to pay for medicines,” L, an older woman who recently had surgery, told Amnesty International. Many people made it clear that they were only able to afford these medicines because they had support from family members, and would not be able to do so on their own income. Others told Amnesty International how they either did not access all the health care they needed for financial reasons – for example, take all their medication – or made choices about whether to pay for health care or other expenses. Most of the 75 health workers who shared information with Amnesty International also said that they had seen an increase in their patients struggling with and worrying about health care costs since the crisis began and austerity measures were introduced. As one doctor said, “I didn’t think this would be an issue, but after the crisis, I see a lot of old people who can’t cover medicine costs”.

B. DELAYS IN ACCESS TO HEALTH CARE

Increased waiting times to access health care emerged as a key issue in all interviews, including with experts, health workers or people using the health system. People told Amnesty International that they waited longer for appointment with specialists, for diagnostic testing, and for treatment options. These concerns are corroborated by data published by the SNS: for example, the number of people waiting for elective surgeries as well as the time they spend waiting have increased since the years of the crisis. In 2010, the average waiting time was 65 days; in 2016 it was 115 days, which is almost double. As a result, people using the SNS and their families described the difficulties caused by the waiting lists, including the anxiety they felt as a result of not knowing the cause of their pain or of the other symptoms they experienced. For example, S, a 32 year old woman, has a physical disability and uses a wheelchair. When Amnesty International met her, she had been experiencing a lot of pain in her legs. She underwent some tests to identify the cause of the pain in February 2017. She only got an appointment with a specialist to interpret the results in January 2018. “When I have pain, I have to wait a year to find out what the matter is. It makes you concerned that it might get worse. And anxious. But you still get no treatment”, she said. People explained how they had to live with their medical symptoms, including serious pain, for a much longer time because of the waiting lists. M, a 49 year old woman, suffers from a degenerative bone disease. She has been experiencing a lot of pain in her leg. In August 2017, she met her doctor who referred her to a specialist. She only got an appointment with the specialist for June 2018. While she waits for this appointment, she is also anxious about what might be causing the pain. “Right now I am taking painkillers and anti-inflammatory drugs to get by”, she told Amnesty International. “I want for us chronic patients to have more support,” she said. “We all have to endure a lot of pain before we actually go to the doctor [now]”.

C. REDUCED TIME WITH HEALTH WORKERS AND QUALITY OF CARE

In the years when the number of health workers decreased, the numbers of primary care medical consultations, consultations with medical specialists, and surgical interventions increased. The increasing demand for health care services combined with the reduction in numbers of health care workers has coincided with a reduction in the amount of time health workers spent on each patient, impacting quality of

health care. Almost all health workers who spoke with Amnesty International confirmed that the consultation time they had per patient had decreased. This has a particular impact on types of care that are potentially time-intensive. Mental health care is one example. All the people Amnesty International interviewed who were seeking mental health care through the SNS felt the amount of time they spent with their mental health professional has reduced since the crisis started, and was insufficient. One man receiving mental health care and counselling for many years said, “Earlier I had more time with [my psychologist]. Now it’s just 5 minutes. I left the last appointment feeling exactly how I did when I came in”. In several interviews with health workers and health system users, the quality of medical equipment also emerged as a concern.

D. ALL ALTERNATIVES WERE NOT EXHAUSTED

“The patient is the least important thing. We don’t feel represented.”

Man using the SNS

Furthermore, the manner in which the austerity measures were developed and implemented was inconsistent with criteria developed by international human rights monitoring bodies. Measures that saved costs in the SNS without unduly compromising the right to health were implemented after, and not before, the measures that have had a retrogressive impact. No human rights impact assessments were conducted before the public health budget was cut or RDL 16/2012 was enforced. The levels of participation and consultation in how the austerity measures were developed and implemented were inadequate. And many of the changes introduced to the health system, notably RDL 16/2012, were not temporary and remain in force.

ROLE OF THE EU

The recommendations by EU institutions through the Excessive Deficit Procedure and European Semester increased pressure on the Spanish government to put in place the austerity measures that it did. EU institutions made multiple recommendations to Spain to reduce its budget deficit, knowing that this was being accomplished through cuts in public health expenditure. In some instances, specific recommendations were also made to make public health spending more “cost effective”. Simultaneously, however, public studies by other EU bodies, as well as statements by European and international institutions, were pointing to the risks and possible human rights impact that reductions in welfare spending, particularly spending in public health, could have. Given these risks, EU institutions should have played a greater role in identifying and mitigating the human rights impact of these policies. Instead, they have either steered the Spanish government towards policies that were incompatible with Spain’s obligations to fulfil the right to health, or not done enough to mitigate potential human rights impact.

RECOMMENDATIONS

In light of the findings and conclusions above, Amnesty International makes the following recommendations (a full list of recommendations can be found at the end of the report):

1. The Ministry of Health, Social Services and Equality should urgently:
 - a. Repeal Article 3, 3 *bis* and 3 *ter* which limit the categories of people who can access health care under the SNS, and ensure that all persons, including irregular migrants, can access public health care on equal terms, free from discrimination.
 - b. Revise Article 8, 8 *bis*, 8 *ter*, and 8 *quarter*, and restore the structure of the common portfolio of services to before RDL 16/2012 came into force. Until this is done, ensure that the structure of any new co-payments includes adequate safeguards to ensure that particular groups – including people with disabilities, older persons, people with chronic health conditions, people accessing mental health care, and people who are on low incomes and economically vulnerable – are not disproportionately disadvantaged; and that health care is affordable to all.
 - c. Revise Article 85 *ter* to restore coverage to medicines “indicated in the treatment of minor symptoms”. Until this is done, consider:
 - i. Introducing financial safeguards or exceptions for groups who are regularly prescribed these medicines, and are disproportionately impacted by their removal.

- ii. Gradually restoring coverage to the medical products that were removed from the SNS catalogue as a result of this amendment, starting with those that are important for groups that are particularly impacted, including people with chronic health conditions and older persons.
 - d. Revise the new structure for co-payments introduced by Article 94 *bis* to, at a minimum, ensure that the co-payment structure guarantees affordable health care for all, and does not result in undue financial burdens on economically vulnerable people, with a view to restoring the situation as it was before RDL 16/2012 came into force.
2. The Ministry of Health, Social Services and Equality should urgently conduct a human rights impact assessment to assess how austerity measures have impacted the right to health in Spain, particularly the rights of groups at risk of greater impact, including people with disabilities, people with chronic health conditions, people accessing mental health care, and older persons. Make the results of this assessment public.
 3. The Ministry of Health, Social Services and Equality should improve the working conditions of health workers, including those that impact the accessibility and quality of healthcare. In particular, restore benefits, reduce the precariousness of health worker contracts, and ensure that adequate numbers of health workers are hired to meet the demand for health services.
 4. Regional Governments, in particular the governments of Andalucía and Galicia, should prioritize increasing budgetary allocations for public health at a regional level, with a view to, at a minimum, restoring total and per capita expenditure on health to before the imposition of austerity measures, as soon as possible.
 5. Regional Governments, in particular the governments of Andalucía and Galicia, should urgently address the difficulties with respect to access, affordability, and quality regarding the right to health identified in this report.
 6. EU Institutions should ensure that recommendations and targets for fiscal consolidation made in the course of the European Semester and the EDP do not undermine states' ability to fulfil their economic and social rights obligations.
 7. EU Institutions should conduct human rights impact assessments of all economic reform programs and financial assistance programmes.

METHODOLOGY

TERMINOLOGY

This report uses the term “austerity measures” to refer to government policies that aim to reduce public deficits during a time of economic and financial crisis, including by reducing government spending (for example, through budget cuts in social spending) and increasing government revenue (for example, through increased taxes). In literature on this issue, the terms “fiscal consolidation” and “structural adjustment” policies are often used to describe similar measures. The use of “austerity measures” is consistent with the terminology, commentary and standards developed by the UN Office of the High Commissioner for Human Rights,¹ treaty bodies and special procedures,² the Council of Europe,³ and the International Labour Organization.⁴

REGIONAL FOCUS

This report expands Amnesty International’s analysis of the impact of austerity measures on economic and social rights in Spain beyond Madrid and Catalonia (which looked at the right to housing) and Comunidad Valenciana, Castilla-La Mancha and the Balearic Islands (which looked at the right to health of irregular migrants), to Andalucía and Galicia.⁵ These regions were selected based on consultations with public health experts and civil society groups. Andalucía is the largest and most populous region in Spain. It is one of the regions with the lowest per capita health spending,⁶ and was severely affected by the economic and financial crisis. Galicia has a higher per capita health expenditure, and contains a higher concentration of some of the demographic groups this report focuses on, e.g. older persons. The interviews were conducted in and around eight cities: Santiago, Pontevedra, La Coruna and Lugo in Galicia; and Granada, Seville, Malaga and Huelva in Andalucía.

PROFESSIONALS, EXPERTS AND PEOPLE USING THE PUBLIC HEALTH SYSTEM

Amnesty International conducted the following interviews between June 2017 and January 2018:

1) Individual or small-group interviews with 107 individuals who were either seeking or had sought health care through the public health system, and their families and carers.

1 UNOHCHR, Report on austerity measures and economic and social rights, 2013,

www.ohchr.org/Documents/Issues/Development/RightsCrisis/E-2013-82_en.pdf [hereinafter: OHCHR, Report on austerity measures, 2013].

2 Committee on Economic, Social and Cultural Rights [hereinafter: CESCR], Letter dated 16 May 2012 addressed by the Chairperson of the CESCR to States parties to the International Covenant on Economic, Social and Cultural Rights, 16 May 2012 [hereinafter, CESCR Letter, 16 May 2012]; CESCR, Public debt, austerity measures and the International Covenant on Economic, Social and Cultural rights, UN Doc.

E/C.12/2016/1, 22 July 2016; UN Human Rights Council, Report of the Independent Expert on the question of human rights and extreme poverty, Magdalena Sepúlveda Carmona, UN Doc. A/HRC/17/34, 17 March 2011; UN Human Rights Council, Development of guiding principles for assessing the human rights impact of economic reform policies, UN Doc. A/HRC/37/54, 20 December 2017.

3 Parliamentary Assembly of the Council of Europe, ‘Austerity measures – a danger for democracy and social rights’, 26 June 2012, <http://assembly.coe.int/nw/xml/XRef/Xref-XML2HTML-en.asp?fileid=18916&lang=en>; Council of Europe, The impact of the economic crisis and austerity measures on human rights in Europe, 2016, <https://edoc.coe.int/en/fundamental-freedoms/7304-the-impact-of-the-economic-crisis-and-austerity-measures-on-human-rights-in-europe.html>.

4 International Labour Organization, ‘Global Employment Trends 2012: Preventing a deeper jobs crisis’, 24 January 2012, http://www.ilo.org/global/research/global-reports/global-employment-trends/WCMS_171679/lang-en/index.htm.

5 Amnesty International, Spain: “La Crisis De La Vivienda No Ha Terminado” El derecho a la vivienda y el impacto de los desahucios de viviendas en alquiler sobre las mujeres en España (EUR4110017); Amnesty International, Spain: El derecho a la vivienda y los desalojos hipotecarios en España (EUR4170015); Amnesty International, Spain: Sin Tarjeta, No Hay Derecho: Impacto en derechos humanos de la reforma sanitaria en Castilla-La Mancha y en la Comunitat Valenciana (EUR4140015) [hereinafter AI Spain, 2015]; Amnesty International, Spain: El Laberinto De La Exclusión Sanitaria. Vulneraciones del derecho a la salud en las Islas Baleares (EUR4160013) [hereinafter AI Spain, 2013].

6 Ministry of Health, Social Services and Equality, Annual Report on the National Health System of Spain 2011, p. 104, www.mssi.gob.es/organizacion/sns/planCalidadSNS/pdf/equidad/informeAnualSNS2011/06_INFORME_SNS_2011_INGLES.pdf

Based on consultations with civil society groups and public health experts, Amnesty International chose to focus on groups that would have been disproportionately affected by the economic crisis and austerity measures generally, such as people with lower incomes, and within this group, people with chronic health conditions, people with disabilities, older persons, and people accessing mental health care. Interviews were arranged through referrals from organizations working on public health and human rights, as well as patients associations. It is likely that we have not been able to reach the most vulnerable individuals, who may not be associated with such organizations and are not getting even this level of support. We have not named the people we spoke with to protect their anonymity. Amnesty International asked questions about the problems people faced accessing health care after the economic crisis and austerity measures and the recommendations they had for the government.

2) Individual or small-group interviews with 36 health workers, including doctors, nurses, and nursing assistants. All health workers interviewed had worked in the public health system before and after the economic crisis and austerity measures. Furthermore, 39 health workers in the public health system in Andalucía and Galicia responded to an online survey from Amnesty International about the impact of the austerity measures. Health workers were asked questions about the impact of austerity measures on their working conditions, on access to health care and on health. In total, the report reflects the perspectives of 75 health workers.

3) Individual or small-group interviews with 61 public health experts, human rights activists, non-profit service providers, experts on budget analysis, and academics working on public health issues, for background and context on the impact of austerity measures on the health system in Spain, and to confirm information that emerged from the other qualitative interviews.

Furthermore, this report is based on extensive desk research including: (a) examining the changes in public health expenditure in Spain at the central and regional levels between 2009 (when the effects of the economic crisis began) and 2015 (date of the last published data, at the time of writing this report) to assess the extent of the cuts, the impact of the cuts on health expenditure relative to other types of spending, and specific areas within health spending that were affected; (b) analysing a broad range of health system indicators in this period, to assess changes, if any; (c) analysing health-related laws and policies, as well as reviewing changes introduced after the economic crisis in the public health system (“Sistema Nacional de Salud”, hereinafter “SNS”); and (d) reviewing secondary literature, including governmental and non-governmental studies on the impact of the economic crisis and austerity measures on the SNS and on health.

The conclusions in this report have been drawn from the quantitative data and secondary literature described above. The qualitative interviews were analysed to identify and highlight the common themes that emerged, and supplement these conclusions. They seek to demonstrate how austerity measures have specifically impacted the groups this report focuses on, and how they have impacted health workers.

GOVERNMENT AND EUROPEAN UNION

Amnesty International sent letters requesting meetings, and containing a detailed list of questions, to the Ministry of Health, Social Services and Equality; the Ministry of Finance and Civil Service; the Regional Ministry of Health, Andalucía; the Regional Ministry of Economy and Revenues, Andalucía; the Galician Ministry for Health; and the Regional Ministry of Economy, Employment and Industry, Galicia. Amnesty International met with representatives from the Andalusian health service in January 2018; and with representatives from the Galician health service and Ministry of Health, Social Services, and Equality in February 2018. Amnesty International sent a list of questions to the Ombudsman, who responded in writing in March 2018. Amnesty International met with representatives of the European Commission’s Directorate-General for Economic and Financial Affairs and Directorate-General for Health and Food Safety in February 2018.

SCOPE

The analysis in this report focuses on the impact of austerity measures on the enjoyment of the right to health in Spain.⁷ It does not comment on how the austerity measures impacted individual people’s health.

⁷ There are many reasons why it is hard to say with certainty what impact these measures have had, or will have, on health status. There is often a time-lag between any real-world event and the publication of health data. Therefore, it might take some years for data to reflect any impact. The long-term health effects of austerity measures might also take years to manifest. Finally, it would be difficult to distinguish the effects of the economic crisis itself, which also presents risk to health, from the effects of the austerity measures. However, many experts have pointed to evidence of change in health status in countries where austerity measures were introduced. See: G Quaglio et al, ‘Austerity and health in Europe’, *Health Policy* 113, 2013, p. 13-19; M Karanikolos et al, ‘Financial crisis, austerity, and health in Europe’, *The Lancet*, 2013, 381 (9874), p. 1323–31; L Maynou et al, ‘Economic crisis and health inequalities: evidence from the European Union’, *International Journal for Equity in Health*, 2016, Volume 15, p. 135; D Stuckler et al, ‘The Body Economic’ 2013 [hereinafter: *The Body Economic*]. This is true of studies related to Spain as well, see: X Bosch et al, ‘The Painful Effects of the Financial Crisis on Spanish Health Care’,

The implementation of austerity measures in Spain also coincided with an increased reliance on private service providers.⁸ While acknowledging the links between these two developments, this document does not analyse the impact of this reliance on private services providers on access to health care in Spain.

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International Journal of Health Services, 2014, 44 (1) p 25; J Gené-Badia et al, 'Spanish health care cuts: Penny wise and pound foolish?', 2012, *Health Policy*, 106 (1), pp. 23-28; H Legido-Quigley et al, 'Erosion of universal health coverage in Spain', 2013, *The Lancet*, 382 (9909), p. 1977.

⁸ For example: H Legido-Quigley et al, 'Will austerity cuts dismantle Spain's healthcare system?' 2013, *British Medical Journal*, Volume 346, p. 18 [hereinafter: Legido-Quigley, 2013].

1. THE ECONOMIC CRISIS AND INTRODUCTION OF AUSTERITY

WHY IS AUSTERITY A HUMAN RIGHTS ISSUE?

Spain has ratified a range of international and regional human rights law treaties that require it to respect, protect and fulfil the right to health, amongst other human rights. Spain has an immediate obligation to take deliberate, concrete and targeted steps towards the full realization of the right to health. The government is required to use the maximum of its available resources to fulfil the right to health for all. There is a strong presumption, under human rights law, against any deliberately retrogressive measures. Austerity measures usually involve reductions in public spending and structural changes in welfare systems to save costs. These can have the effect of causing a retrogression in the enjoyment of economic, social and cultural rights.

Given the human rights risks associated with austerity measures, human rights monitoring bodies have developed guidelines for designing and implementing these measures in line with states' economic, social and cultural rights obligations. These criteria include demonstrating the existence of a compelling state interest; the necessity, reasonableness, temporariness and proportionality of the austerity measures; and the exhaustion of alternative and less restrictive measures. Such measures must also be non-discriminatory and protect the minimum core content of economic and social rights. Governments must ensure genuine participation of affected groups and individuals in decision-making processes.

This report does not comment on whether austerity policies, in general, improve or detract from recovery in times of economic crises. It examines whether the austerity measures introduced by the Spanish government, which impacted the health system, were consistent with its human rights obligations.

The Spanish economy had been growing at a rate higher than the EU average for most of the 2000s.⁹ The impact of the global economic crisis combined with weaknesses in Spain's economy resulted in the Spanish economy officially entering recession in 2008. There was a sharp decline in economic activity: the annual Gross Domestic Product (GDP) growth rate fell from 4.2% in 2006 to -3.6% in 2009. While it improved to 0% in 2010, the country entered a second recession soon after, with the annual GDP growth rate falling again to -2.9% in 2012.¹⁰ Government debt, which had been falling since before 2000, rose from 41.7% of GDP in 2007 to its highest in 2014, at 118.4% of GDP.¹¹ The deficit worsened, going from a surplus of 1.9%

⁹ Government of Spain, 'Reforms by the Government of Spain: Combatting the Crisis with Determination' Madrid, September 2012, available at: www.kas.de/wf/doc/kas_8049-1442-1-30.pdf?121029115956.

¹⁰ Eurostat data on changes in real GDP growth rate by volume, available at: ec.europa.eu/eurostat/web/national-accounts/data/main-tables?p_p_id=NavTreeportletprod_WAR_NavTreeportletprod_INSTANCE_7JJfnOXKXwXI&p_p_lifecycle=0&p_p_state=normal&p_p_mode=view&p_p_col_id=column-2&p_p_col_count=2

¹¹ General government debt-to-GDP ratio is the amount of a country's total gross government debt as a percentage of its GDP. OECD (2018), General government debt (indicator). doi: 10.1787/a0528cc2-en.

of GDP in 2007 to a deficit of 11% of GDP in 2009 and 9% in 2011.¹² In this period, the Spanish government was under immense pressure, both from within Spain and from the EU, to take strong action to urgently reduce its deficit and stimulate economic growth.

1.1 INCREASED FINANCIAL VULNERABILITY, POVERTY AND INEQUALITY

The economic crisis had a severe impact on people in Spain:

- The unemployment rate, which had been falling steadily before the economic crisis, rose from 8.2% (2007) to 26.1% (2013).¹³ Youth unemployment rose from 18.1% (2007) to 55.5% (2013).¹⁴ Long-term unemployment, that is, people who have been unemployed for 12 months or more, increased from 20.4% (2007) to 52.8% (2014).¹⁵
- During the crisis, unemployment rates were slightly higher amongst women (26.7%) than men (25.6%). In 2015, the CEDAW Committee - the body of independent experts that monitors implementation of the CEDAW - also noted that the austerity measures had “a severe and disproportionate impact on women, in particular women with disabilities [and] older women”, and pointed to areas of concern, including the persistent gender wage gap and the concentration of women in part-time work.¹⁶
- Median income was over 10% lower in 2014 than in 2009.¹⁷ Household disposable income was 2.7% lower in 2012 than in 2009.¹⁸ The percentage of households unable to meet an unexpected financial expense increased from 30.8% (2007) to 42.7% (2014).¹⁹
- The poverty rate increased from 14% (2012) to 15.9% (2013); the rates were much higher amongst children.²⁰ 30% of the population was at risk of poverty in 2013 (29.5% in 2016).²¹ In-work at-risk-of-poverty rates, which measures poverty amongst people who are working, stood at 13.1% in 2015, amongst the highest in the EU.²²
- The Gini Coefficient – a commonly used measure of inequality – rose from .324 (2007) to .344 (2014).²³

1.2 INCREASED RISK OF POOR HEALTH DURING THE ECONOMIC CRISIS

Economic crises can lead to poor health outcomes because of their impact on the wide range of socio-economic factors necessary to lead a healthy life, also known as the underlying social determinants of health.²⁴ As the economic crisis unfolded in Spain, it impacted a range of factors – such as housing and employment - with potentially negative consequences for people’s health.²⁵

¹² General government deficit is defined as the fiscal position of government after accounting for capital expenditures. OECD (2018), General government deficit (indicator). doi: 10.1787/77079edb-en.

¹³ OECD (2018), Unemployment rate (indicator). doi: 10.1787/997c8750-en. These were the second highest unemployment rates in the EU, and more than double the average unemployment rate in the EU. They have since improved, and stand at 17.2%.

¹⁴ OECD (2018), Youth unemployment rate (indicator). doi: 10.1787/c3634df7-en

¹⁵ OECD (2018), Long-term unemployment rate (indicator). doi: 10.1787/76471ad5-en

¹⁶ Committee on the Elimination of Discrimination against Women, Concluding observations on Spain, UN Doc. CEDAW/C/ESP/CO/7-8, 29 July 2015, para. 28 [hereinafter CEDAW Committee, Concluding observations on Spain (2015)].

¹⁷ Eurostat, Mean and median income by age and sex - EU-SILC survey, available here: ec.europa.eu/eurostat/en/web/products-datasets/-/ILC_DI03

¹⁸ OECD (2018), Household disposable income (indicator). doi: 10.1787/dd50eddd-en

¹⁹ Eurostat, Inability to face unexpected financial expenses - EU-SILC survey, available here:

appsso.eurostat.ec.europa.eu/nui/show.do?dataset=ilc_mdex04&lang=en

²⁰ OECD (2018), Poverty rate (indicator). doi: 10.1787/0fe1315d-en. For children - 23.5% (2013) and 22.1% (2015).

²¹ Eurostat, People at risk of poverty or social exclusion by age and sex, available here: http://ec.europa.eu/eurostat/statistics-explained/index.php/People_at_risk_of_poverty_or_social_exclusion

²² Eurostat, In work at-risk-of-poverty rate, available here: <http://ec.europa.eu/eurostat/web/products-datasets/product?code=tsdsc320>

²³ OECD (2018), Income inequality (indicator). doi: 10.1787/459aa7f1-en

²⁴ CESCR, General Comment No. 14: The Right to the Highest Attainable Standard of Health, UN Doc. E/C.12/2000/4, 11 August 2000, paras. 4 and 11 [hereinafter: CESCR, General Comment 14].

²⁵ www.easp.es/project/impacto-de-la-crisis-economica-en-la-salud-y-en-el-sistema-sanitario-en-espana/

1.2.1 UNEMPLOYMENT

Several studies by academics and public health groups have made links between unemployment and poor health outcomes in Spain. In general, unemployment can lead to increased stress and anxiety.²⁶ Furthermore, it is likely to increase financial vulnerability which decreases a person's ability to afford health care; as well as their ability to access other factors that improve health, such as nutritious food. A population based study found a deterioration in mental health among men in Spain during the economic crisis, which was attributed to employment status.²⁷ Another study compared the prevalence of certain mental health conditions in patients visiting primary health care centres before the crisis (in 2006) and after the crisis (in 2010). It found substantial increases in patients with mood disorder, anxiety, and alcohol-related disorders. It also noted links between mental health concerns and unemployment, difficulties meeting mortgage repayments and evictions.²⁸ Researchers looking at data on suicides before and after the crisis found that the economic crisis was associated with an increase in the rate of suicides in Spain, with men and people of working age being at particular risk.²⁹ A study specific to Andalucía found a sharp increase in suicide attempt rates after the crisis, particularly associated with unemployment rates in men.³⁰ Another study concluded that the mental health of migrant workers in Spain had worsened during the crisis, and that this was particularly associated with men who were unemployed and who had lower salaries.³¹

1.2.2 RISK OF HOMELESSNESS AND EVICTIONS

The economic crisis in Spain has also meant that thousands of people were unable to make their rental or mortgage payments, which placed them at a high risk of eviction and homelessness. Rental and mortgage evictions continued in large numbers through the crisis years.³² As a previous Amnesty International report demonstrated, rental evictions had a particular impact on women facing multiple and intersecting forms of discrimination, such as single mothers, women with care responsibilities, migrant women, women with disabilities and survivors of violence.³³

The stability and quality of housing is closely linked to health. Inadequate housing conditions can cause or contribute to preventable diseases and injuries.³⁴ The risk of eviction and homelessness can lead to stress, anxiety, and other mental health conditions.³⁵ Homelessness can also have an impact on the ability of people to pay for health care. Studies in Spain have begun to find these correlations.³⁶ For example, a study observed changes in the health status of people in situations of housing instability, including people with high mortgages, who were facing foreclosure, and who had been evicted. It found worsening mental health and self-reported physical health in this group.³⁷ Another study in Granada found that people in the process of an eviction showed poorer health than the general population.³⁸

The increase in poverty and financial vulnerability combined with poorer health outcomes due to negative impacts on the social determinants of health calls for greater support to the public health system in times of economic crises, particularly for marginalized people who are often the worst affected.

²⁶ Body Economic, p. 143.

²⁷ X Bartoll et al, 'The evolution of mental health in Spain during the economic crisis', *European Journal of Public Health*, 2014, 24 (3), p. 415.

²⁸ M Gili et al, 'The mental health risks of economic crisis in Spain: evidence from primary care centres, 2006 and 2010' *European Journal of Public Health*, 2013, 23 (1), p. 103.

²⁹ J Bernal, et al, 'The effect of the late 2000s financial crisis on suicides in Spain: an interrupted time-series analysis' *European Journal of Public Health*, 2013, 23 (5), p. 732.

³⁰ J Córdoba-Doña, et al, 'Economic crisis and suicidal behaviour: the role of unemployment, sex and age in Andalusia, Southern Spain' *International Journal for Equity in Health*, 2014. See also: R Urbanos-Garrido et al, 'The influence of the economic crisis on the association between unemployment and health: an empirical analysis for Spain' *European Journal of Public Health*, 2015, p. 175; G Robert et al, 'From the boom to the crisis: changes in employment conditions of immigrants in Spain and their effects on mental health' *European Journal of Public Health*, 2014, 24 (3), p. 404.

³¹ A. Agudelo-Suarez, 'Impact of economic crisis on mental health of migrant workers: what happened with migrants who came to Spain to work?' *International Journal of Public Health*, 2013, 58(4), p. 627.

³² There were 26,467 rental evictions and 16,992 mortgage evictions in the first 9 months of 2017 alone. General Council of the Spanish Judicial Authorities, see: www.poderjudicial.es/cgpj/es/Temas/Estadistica-Judicial/Estudios-e-Informes/Efecto-de-la-Crisis-en-los-organos-judiciales/

³³ Amnesty International, Spain, "La Crisis De La Vivienda No Ha Terminado" El derecho a la vivienda y el impacto de los desahucios de viviendas en alquiler sobre las mujeres en España (EUR4110017).

³⁴ www.euro.who.int/en/health-topics/environment-and-health/Housing-and-health

³⁵ news.rice.edu/2015/03/09/eviction-can-result-in-depression-poorer-health-and-higher-stress-according-to-new-rice-and-harvard-study/

³⁶ A Novoa et al, 'Impact of the crisis on the relationship between housing and health' *Gaceta Sanitaria*, 2014, 28 (S1), p. 44.

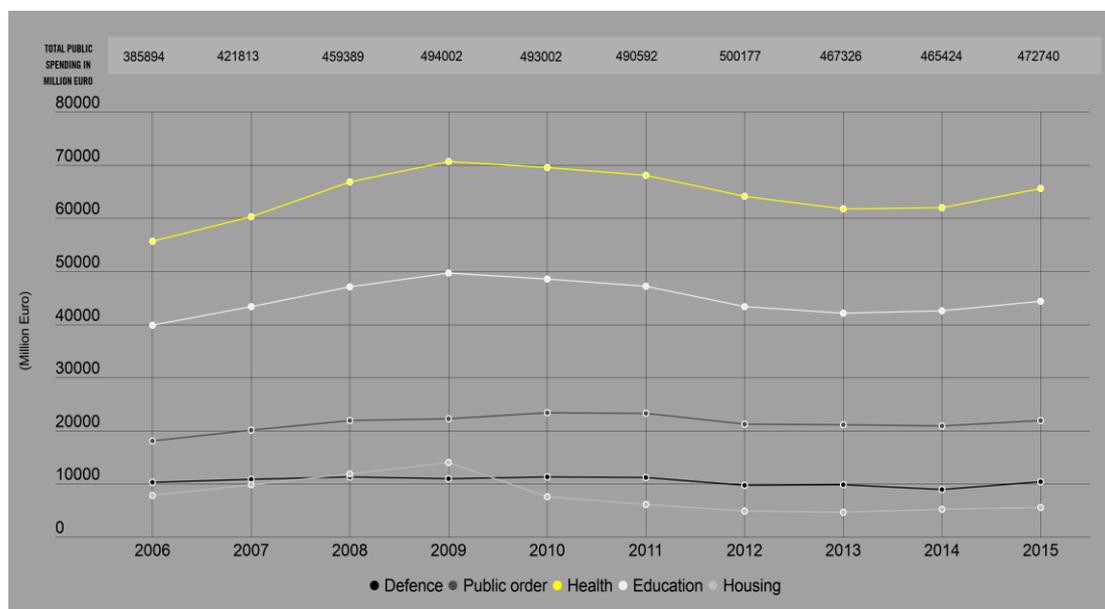
³⁷ H Vásquez-Vera et al, 'Foreclosure and Health in Southern Europe: Results from the Platform for People Affected by Mortgages', *Journal of Urban Health*, 2016.

³⁸ J Muñoz et al, 'The health of adults undergoing an eviction process' *Gaceta Sanitaria*, 2016, 30(1), p. 4.

1.3 INTRODUCTION OF AUSTERITY MEASURES

The government's initial response to the economic crisis was to adopt a stimulus package and increase public spending, which included approximately €8 billion of investment in infrastructure projects; tax cuts; and credit lines for businesses.³⁹ However, the government later changed its strategy and began to reduce public spending, including by introducing austerity measures.⁴⁰ As the table below indicates, there was a reduction in total public spending, and in spending in several key sectors:⁴¹

Graph 1. Changes in government spending by sector in millions of euros:



Total government spending fell between 2009 and 2011, increased in 2012, and began to fall again. Government spending on defence began to fall in 2008-2009; government spending on education, health and housing began to fall in 2009-2010; and government spending on public order and safety began to fall in 2010-2011.

Several measures introduced to limit public expenditure impacted existing social security protection and disposable incomes, which risked increasing financial vulnerabilities during the economic crisis. For example, as the table above indicates, the government reduced spending on housing, health, and education. The government also:

- Increased the rates of general VAT from 16% to 18% in 2009, and then to 21% in 2012.⁴² This amounts to a total increase of 5 percentage points in the general VAT rate, effectively making consumption more expensive.
- Reduced total and per capita spending on some social protection benefits,⁴³ including by restructuring some welfare systems as explained in the context of the Dependency Law (Box 1, below).
- Introduced a series of reforms to reduce public spending on pensions.⁴⁴

³⁹ *New York Times*, 'Spain unveils €11 billion economic stimulus package' 27 October 2008; www.nytimes.com/2008/11/27/business/worldbusiness/27iht-peseta.4.18215053.html; *Reuters*, 'Spain unveils 11 Billion euro public economic stimulus plan' 27 November 2008, uk.reuters.com/article/sppage016-lr662180-oiscp/spain-unveils-11-bln-eur-public-economic-stimulus-plan-idUKLR66218020081127

⁴⁰ *The Telegraph*, 'Spain's economic crisis: a timeline,' 8 June 2012, www.telegraph.co.uk/finance/financialcrisis/9319175/Spains-economic-crisis-a-timeline.html.

⁴¹ All information in this table was sourced from OECD Statistics on Government expenditure by function, available here: stats.oecd.org/Index.aspx?DataSetCode=SNA_TABLE11#, except for the data on health, which is based on the latest Public Health Expenditure Statistics (EGSP) [hereinafter: EGSP data] to be consistent with the data in this rest of this report, available here: www.msssi.gob.es/estadEstudios/estadisticas/inforRecopilaciones/gastoSanitario2005/home.htm.

⁴² Eurostat Data on Indirect taxes, available at: https://ec.europa.eu/taxation_customs/business/economic-analysis-taxation/data-taxation_en

⁴³ OECD Statistics on Government expenditure by function, available here: stats.oecd.org/Index.aspx?DataSetCode=SNA_TABLE11#

⁴⁴ These included gradually increasing the retirement age from 65 to 67, over a period of 15 years; changing the rules for early retirement; and increasing the contribution period from 35 to 38.5 years. Ley 27/2011, Real Decreto 1716/2012, Ley 23/2013.

As the table above indicates, starting 2009, the government began to cut public spending on health. Total public health expenditure in 2013, including both the central and regional levels, was 12.7% lower than expenditure in 2009. The government also introduced a range of policies to reduce the costs of the Spanish public health system (“Sistema Nacional de Salud”, hereinafter “SNS”), notably through the Royal Decree Law 16/2012 (hereinafter “RDL 16/2012”).⁴⁵ It limited the health care that irregular migrants could access. The government also instituted measures to shift the burden of certain health costs on to individuals: it re-structured the common portfolio of services in the SNS to make it possible for more products and services to involve co-payments through future regulation. It introduced pharmaceutical co-payments in some instances for groups who could previously access health care freely, and increased the rates for some others. And finally, it added to the list of criteria based on which medicines and medical devices would be covered or excluded from SNS financing, following which over 400 products were removed from SNS funding.

“We saw that with the RDL 16/2012, healthcare was impacted for those most vulnerable, and for those at heightened risk. This is an almost unbearable cruelty.”

Doctor working in the SNS⁴⁶

Furthermore, the government reduced spending on remuneration for health workers by changing their working conditions. These measures and their impact on the right to health in Spain will be discussed in detail in the following chapter.

⁴⁵ Royal Decree-Law 16/2012, of April 20, on urgent measures to guarantee the sustainability of the National Health System and improve the quality and safety of its benefits.

⁴⁶ Amnesty International interview, Galicia, January 2018.

BOX 1: LONG-TERM CARE AND THE DEPENDANCY LAW

Long-term care involves services and interventions that enable people who experience significant difficulty in their ability to perform daily tasks for various reasons, including age, illness and disability, to receive necessary care and support.⁴⁷ Long-term care systems can be crucial to ensure access to health for people who may otherwise find it hard to physically access health care, particularly routine primary health care, and can help reduce the use of health care services and health expenditure.⁴⁸

Since coming into force in 2007, the Law 39/2006 for the Promotion of Personal Autonomy and Care for People in a Situation of Dependency [Dependency Law] has been the primary instrument regulating long-term care in Spain. Prior to the enactment of the Dependency Law, care-giving in Spain was largely informal, and carried out by women. The Dependency Law was designed to provide appropriate benefits and support to persons “in situations of dependency”, that is, people who needed long-term care. Crucially, under the Dependency Law, long-term care is regarded as a universal right. Individuals are entitled to benefits and services, such as day care services, personal carers, or financial benefits, based on the level of dependency. The Dependency Law was to be implemented gradually from 2007 to 2013, starting with people assessed to be at higher degrees of dependency.

The implementation of the Dependency Law was affected by the economic crisis and the reduction in public expenditure in several ways.⁴⁹ First, the government introduced a series of regulatory changes that postponed the timeline for the full implementation of the act.⁵⁰ Second, the number of people who were assessed as eligible for benefits under the Dependency Law, but who had not actually received these benefits, grew.⁵¹ Third, the government revised the regulations around economic benefits for family care, that is, the remuneration family carers would receive. For example, it allowed for these payments to be suspended for two years after people were assessed as being entitled to them. As a government review of the functioning of the Dependency Law has noted, this delay has had a huge impact on informal carers, who are mostly women, who would have been paid for their work or had the chance to enter the labour market.⁵² This has added to the burden families were facing during the crisis.

The Spanish Constitution was amended in 2011 to limit to the amount of debt the national and regional governments could incur.⁵³ Amongst other things, the amended article 135 states that: (i) the Spanish central and regional governments cannot incur a structural deficit that exceeds the limits established by the EU for their member states; and (ii) loans to meet payment on the interest and capital of the State’s Public Debt shall always be deemed to be included in budget expenditure and their payment shall have absolute priority.⁵⁴ This amendment established the priority of the payment of public debt over any other state expenditure, subject to very limited exceptions, thus restricting the scope of how much central and regional governments could spend, including on health.⁵⁵

High levels of unemployment, the austerity measures and cuts in social services, and a perceived lack of transparency on the part of public officials in adopting these measures, generated a wave of protests in Spain.⁵⁶ In particular, health workers and users of the SNS protested across cities in Spain against the austerity measures, in a series of protests called the “white tide.”⁵⁷ Protests against the austerity measures in the health sector have continued into 2018.⁵⁸

⁴⁷ This is based on understanding of long-term care used by the World Health Organization (www.who.int/ageing/long-term-care/en/) and OECD (www.oecd.org/els/health-systems/long-term-care.htm).

⁴⁸ www.who.int/ageing/long-term-care/en/

⁴⁹ See generally, L Longobardo et al, ‘The Spanish long-term care system in transition: Ten years since the 2006 Dependency Act’ *Health Policy*, 2016, 120(10), p. 1177.

⁵⁰ Report of the Commission for the Analysis of the Current Situation of the System of Dependence, of its Sustainability, and of the Current Mechanisms of Financing, October 2017, part 1, available here: http://www.dependencia.imserso.gob.es/InterPresent1/groups/imserso/documents/binario/inf_comision_analisis_20171006.pdf [hereinafter Commission report on the Dependency Law, 2017]

⁵¹ Commission report on the Dependency Law, 2017, p. 98.

⁵² Commission report on the Dependency Law, 2017, p. 61.

⁵³ Article 135, Constitution of Spain, available here: <http://www.congreso.es/consti/constitucion/indice/index.htm>

⁵⁴ See Organic Law 2/2012 on Budget Stability and Financial Sustainability.

⁵⁵ Article 135 (4), Constitution of Spain, available here: <http://www.congreso.es/consti/constitucion/indice/index.htm>

⁵⁶ Amnesty International, *Spain: The Right to Protest Under Threat* (Index: EUR 41/001/2014).

⁵⁷ RT, ‘Thousands of Spanish medical workers protest healthcare cuts, privatization’ 17 February 2013, www.rt.com/news/spain-health-care-protests-424/

⁵⁸ elpais.com/ccaa/2018/01/25/catalunya/1516894532_939761.html?rel=estr_articulo#1518954653149; www.20minutos.es/noticia/3243209/0/sos-sanidade-publica-rechaza-recortes-privatizaciones-llama-cambiar-rumbo-sanidad-galicia/.

2. IMPACT OF AUSTERITY MEASURES ON THE RIGHT TO HEALTH

“We have all suffered because of the cuts: nurses, doctors, patients, families, everyone.”

Nurse, SNS⁵⁹

Spain has ratified a range of international and regional human rights law treaties that require the government to respect, protect, and fulfil the right to health of all persons. The right to health includes, among other things, access to timely and appropriate health care for everyone without discrimination; that health care is affordable for all, including socially disadvantaged groups; and that health care information, goods, and services are of good quality.⁶⁰

Prior to the economic crisis, almost all persons resident in Spain could access public health care.⁶¹ The public health system covered around 99.5% of the population.⁶² Since 1999, the public health system has been (and still is) primarily funded through general taxation. With the exception of pharmaceuticals and some ortho-prosthetics in certain circumstances, provision was free at the point of delivery.⁶³ The health care system in Spain is decentralized: the primary responsibilities for public health organizing, expenditure and delivery vests in the regional governments of the 17 autonomous communities. The central government is responsible for a set of limited functions, including medical training, research and innovation, and pharmaceutical policy.⁶⁴ This devolution is evident in patterns of public health spending. Over the past 10 years, the regional governments have been responsible for over 90% of annual public health expenditure.⁶⁵

⁵⁹ Amnesty International interview, Galicia, October 2017.

⁶⁰ General Comment 14, para 12.

⁶¹ General Health Law No. 14/1986.

⁶² Health Systems in Transition (HiT) profile of Spain, available here <http://www.hspm.org/countries/spain25062012/livinghit.aspx?Section=7.1%20Analysis%20of%20recent%20reforms&Type=Section> [hereinafter Spain HiT Profile]

⁶³ Spain HiT Profile.

⁶⁴ Spain HiT Profile.

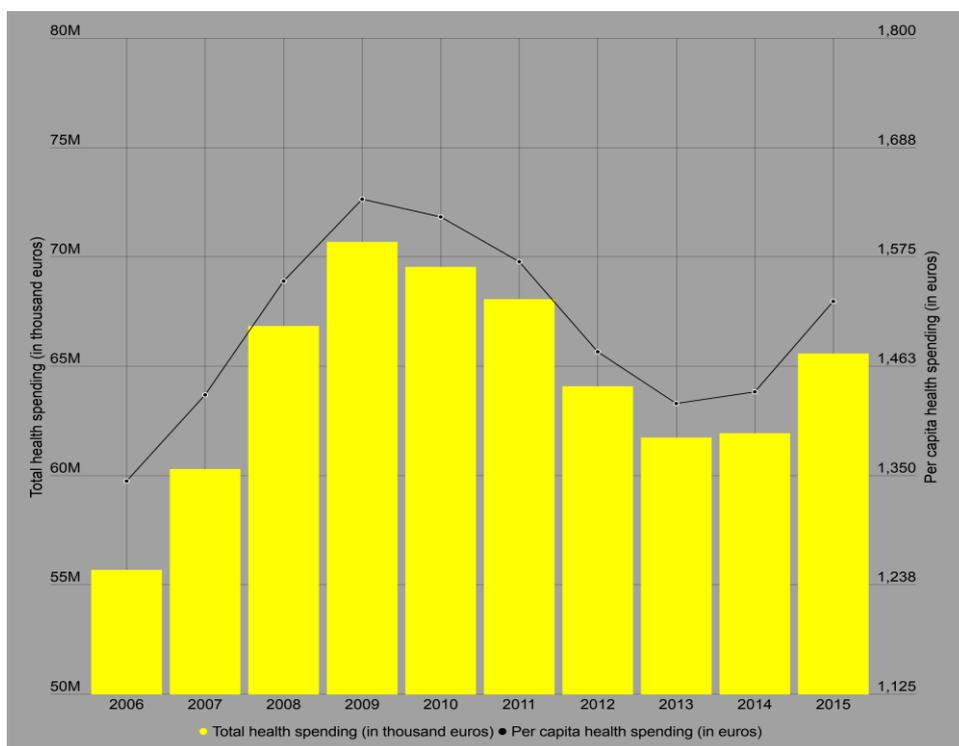
⁶⁵ EGSP data, Table 1.

2.1 REDUCTIONS IN PUBLIC HEALTH EXPENDITURE

“I feel angry. I believe health care is very important. There should be no cuts here ... Public health care should be untouchable. It deals with the most important thing for people.”

Nursing assistant, SNS⁶⁶

Graph 2: Public health spending in Spain, total and per capita⁶⁷



Before the economic crisis, public health expenditure in Spain was gradually increasing. In the period between 2002 and 2009, public health expenditure increased by approximately 83%.⁶⁸ Starting 2009, this trend reversed. The government began to cut public spending, including expenditure on health. As Graph 1 indicates, total public health expenditure and per capita health expenditure (health expenditure per person) have fallen since 2009. At its lowest, in 2013, total public health expenditure was around € 8,950 million (12.7%) lower than expenditure in 2009. While both total and per capita health expenditure have increased after 2013, they have not reached pre-crisis, 2009 levels. Trends were similar in the regions, including in Andalucía and Galicia.

⁶⁶ Amnesty International interview, Andalucía, October 2017.

⁶⁷ This is a self-constructed graph, based on EGSP Data, Table 1 and Sistema de Cuentas de Salud (SCS) Data Table 23. SCS Data is available here: www.msssi.gob.es/estadEstudios/estadisticas/sisInfSanSNS/SCS.htm

⁶⁸ EGSP data, Table 1.

In general, most of the health budget is spent on hospital and specialized health care, pharmaceutical products, and primary health care.⁶⁹ The reductions in public health expenditure applied across the board and affected all three key budget line areas, no item was particularly protected.⁷⁰ Some of these savings came from measures that improved the efficiency and cost-effectiveness of the SNS without unduly compromising the accessibility, affordability, and quality of care. For example, part of the reduction in pharmaceutical spending came from a greater reliance on generic drugs; reductions in the price of drugs; and amendments in how drugs were purchased, packaged and dispensed.⁷¹ While this is positive, other changes and reductions (described below) negatively impacted the affordability, accessibility and quality of health care.

2.2 DETERIORATION IN THE AFFORDABILITY OF HEALTH CARE

2.2.1 AUSTERITY MEASURES THAT SHIFTED SOME COSTS OF HEALTH CARE TO INDIVIDUALS

The government introduced measures that shifted certain health costs on to individuals. Many of these measures were introduced by RDL 16/2012. The decree was introduced with the aim of improving the “sustainability” of the SNS (including by reducing its costs) and promoting equality in access to health care across Spain, by developing common criteria to reduce regional differences in how health care was provided. RDL 16/2012 promoted several measures that reduced unnecessary costs, and improved the sustainability of the SNS as described above. However, specific changes in RDL 16/2012 also shifted some health costs on to individuals by:

- Increasing the rates of co-payment for medicines for certain groups. People who earned between €18,000 and €100,000 annually would pay 50% (earlier at 40%), and those who earned over €100,000 annually would pay 60% (earlier at 40%).
- Introducing co-payments for medicines for some groups who previously did not have to pay. Notably, pensioners, who were previously completely exempt from co-payments, had to pay a percentage of costs of medicines based on their income following the RDL 16/2012. Pensioners who earned less than €18,000 a year would co-pay 10% subject to a monthly ceiling of €8; those who earned between €18,000 and €100,000 would co-pay 10% subject to a monthly ceiling of €18; and those who earned over €100,000 would co-pay 60% subject to a monthly ceiling of €60. Some groups were exempt from contributions (e.g. people receiving non-contributory pensions and unemployed persons not on unemployment benefits) and some drugs for chronic conditions were subject to reduced contributions.
- Expanding the criteria based on which medicines and medical devices would be covered or excluded from SNS financing.⁷² The criteria for adding new products were modified to be more conscious of costs.⁷³ Criteria for the removal of products from the catalogue were added as well, such as “indicated in the treatment of minor symptoms”. Over 400 products were removed from SNS coverage following this.⁷⁴ As discussed below, this included medicines for pain relief, as well as symptoms related to chronic health conditions.
- Restructuring the common portfolio of services in the SNS, and introducing three sub-categories:

⁶⁹ For example, in 2009, 57% of health expenditure by autonomous communities was on hospitals and specialized care; 20% was on pharmaceuticals; and 14.5% was on primary health care.

⁷⁰ EGSP data, Table 3.

⁷¹ RDL 16/2012 introduced and / or supported many of these changes.

⁷² Article 85b, RDL 16/2012.

⁷³ For example, where the old criterion was “Rationalization of public expenditure for pharmaceutical benefit”, the new criterion was “Rationalization of public expenditure for pharmaceutical benefit *and budgetary impact in the National Health System*” [emphasis added]. Similarly, where the old criteria was “Existence of drugs or other alternatives for the same conditions”, the new criteria was “Existence of drugs or other therapeutic alternatives for the same conditions *at a lower price or lower treatment cost*” [emphasis added]. The previous criteria are available here: <https://www.global-regulation.com/translation/spain/1446301/law-29-2006-of-26-july%252c-on-guarantees-and-rational-use-of-medicines-and-medical-devices.html>

⁷⁴ www.boe.es/diario_boe/tx.php?id=BOE-A-2012-10952

- The basic common portfolio contained health services that were fully publicly funded.
- The supplementary common portfolio contained services that could be regulated at a national level to carry a co-payment, and included non-urgent emergency transport, ortho-prosthetics, pharmaceuticals and dietetic products. Previously some of these services were fully publicly funded in certain regions, and carried no co-payment.
- The common portfolio of accessory services contained services that are not deemed essential, or which support the treatment of an illness or chronic condition, and would also carry a co-payment.

With the exception of the changes to pharmaceutical provision, which were implemented almost immediately, future regulations were needed before the other aspects of this restructure would be implemented: for example, before introducing co-payments for non-urgent emergency transport. The co-payment structure applicable to pharmaceuticals would apply to the supplementary and accessory portfolios, but the same caps would not apply. While regions could supplement the common portfolio of services with health care financed from their individual budgets, to do so they would need to meet specific criteria regarding budgetary stability.

At the same time, individuals continued to pay for health care that had never been covered by the SNS, including large parts of dental and optical care.

2.2.2 THE INCREASED FINANCIAL BURDEN OF HEALTH CARE

In the years prior to the economic crisis, both public and household expenditure on health were increasing in Spain. Following the on-set of the economic crisis and austerity measures, household expenditure on health continued to increase as before, while public expenditure on health decreased (as explained previously). While the role of direct payments from households in total health expenditure reduced from 2004 to 2009, it started to increase after. It reduced from 21.7% (2004) to 18.9% (2009) and then increased to 24.3% (2014).⁷⁵ Households continued to spend more on health and, more crucially, devoted a greater percentage of household expenditure to health-related costs.⁷⁶ This disproportionately impacted groups that were economically vulnerable, which is evident from statistics on unmet health needs due to financial reasons. In general, Spain has very low rates of self-reported unmet health needs,⁷⁷ which is positive. However, self-reported unmet needs due to financial reasons for health care and dental care increased more for people in the lowest income bracket, as compared to people in the highest income bracket between 2008 and 2014.⁷⁸ A recent EU report noted that the difference in unmet need between the lowest and highest income brackets grew from 0.2 percentage points in 2008 to 1.6 percentage points in 2014, which is “a significant change”.⁷⁹ The report also stated that 4.4 % of the population stopped taking prescribed medications because they were too expensive.⁸⁰



J'S STORY:⁸¹

“I have always been poor, even before the crisis. My income was never enough,” J told Amnesty International. “However, after the crisis it is much harder ... everything has become more expensive.” J's monthly income is about €1400, and she pays €480 in rent. She uses this income to support her

⁷⁵ SCS Data, Table 3.

⁷⁶ From 2003 to 2008, households in Spain spent an average of 3.3% of household expenditure on health. Starting 2009, this began to increase, to a high of 4.1% in 2014. Eurostat Data, Household consumption by purpose, available here: ec.europa.eu/eurostat/statistics-explained/index.php/Household_consumption_by_purpose

⁷⁷ Eurostat, Unmet health care needs statistics - EU-SILC survey, available here: http://ec.europa.eu/eurostat/statistics-explained/index.php/Unmet_health_care_needs_statistics. Self-reported unmet needs for medical and dental care “concern a person's own assessment of whether he or she needed examination or treatment for a specific type of health care, but did not have it or did not seek it”.

⁷⁸ Eurostat, Unmet health care needs statistics - EU-SILC survey, available here: http://ec.europa.eu/eurostat/statistics-explained/index.php/Unmet_health_care_needs_statistics. Unmet health needs grew from 0.4% (2008) to 1.3% (2014) within the first quintile (lowest income); but decreased from 0.2% (2008) to 0 within the fifth quintile (highest income). Unmet need for dental care for financial reasons increased from 8.3% (2008) to 17.5% (2014) for the first quintile. It only increased from .8% (2008) to .9% (2014) for the fifth quintile.

⁷⁹ European Commission, Country Report Spain 2018, SWD (2018) 207, available here: <https://ec.europa.eu/info/sites/info/files/2018-european-semester-country-report-spain-en.pdf>

⁸⁰ European Commission, Country Report Spain 2018, SWD (2018) 207, available here: <https://ec.europa.eu/info/sites/info/files/2018-european-semester-country-report-spain-en.pdf>

⁸¹ Amnesty International interview, January 2018.

husband, who does not work, and her three children. In 2014, J received an eviction order to leave the house she was renting for 10 years. She spent 18 months challenging this order. J was eventually relocated to a new house, and now receives a housing subsidy. Even though she works long hours, J is constantly anxious about her financial stability, and whether she will be able to provide for her family. “If my fridge is broken I don’t have money to fix it. I can’t afford dental treatment for my children. We sometimes don’t heat our home because I don’t have money” she said. J’s doctor also recently advised bariatric surgery for her obesity, but she does not want to do the surgery, since it would involve additional costs. “They [the supplements and medicines] can cost about €50 a month. I am worried I can’t afford it”, she said. She can’t afford any extra-curricular lessons for her children and is worried about whether she will be able to pay for their higher education. “No matter how hard I tried it was not enough ... It is very tiring”, she said. J believes that the anxiety and stress caused by the eviction order and her financial difficulties have contributed to her health problems. “My obesity and my mental health problems are linked to my emotional well-being. If I wasn’t involved in the [eviction] law suit, if I didn’t have so much stress, if I had more time for myself, I would feel better”, she said.

Amnesty International spoke with 107 users of the SNS and their families and carers. Almost all of them reported being worried about increased financial burdens and costs, since the crisis began and austerity measures were introduced. This was for a combination of reasons: many were unable to find employment during the crisis; many described how the value of their income had decreased (for example because salaries and pensions had not increased at the same rate as costs, or because they were unable to access necessary benefits); and some had more dependants to support on the same income as before. “I can’t make ends meet with my pension now”, one woman told Amnesty International. “I live day by day – I have three children who are unemployed”, another woman said.

All of them told Amnesty International researchers that the amount they spent on healthcare had increased since the crisis began and austerity measures were introduced. This was largely linked to the newly introduced or increased co-payment (depending on the individual’s circumstances) and that they paid for medicines they did not have to pay for before, combined with health care costs that were never covered by the SNS. Even though the sums involved are not high, people explained that they create a significant strain because of their low incomes and/or because they are now supporting more dependants on their incomes.

Most cancer survivors Amnesty International interviewed explained how a lot of medication to treat the side effects of their cancer treatment, as well as possible follow up problems linked to the cancer, were not covered by the SNS. They had to pay the full amount for these if prescribed. Many noted the anxiety and financial burden the increased costs of health care caused them. “It is a huge effort to pay for medicines,” L, an older woman who recently had surgery, told Amnesty International.⁸² “If my son had a regular job, it would be easier and we would not have so many concerns,” she added. Q, another older woman who is a cancer survivor and who pays about €90 a month, said “I just hope I don’t have to take more medicines”.⁸³

Many people made it clear that they were only able to afford these medicines because they had support from family members, and would not be able to do so on their own income. For example D,⁸⁴ a woman who had a mastectomy and received chemotherapy for breast cancer in 2017, explained that she paid about €100 a month for medicines that were prescribed to treat the side effects of the cancer and treatment. These included nutritional supplements, creams and lotions to relieve pain, and cough syrups to address the side effects of chemotherapy. She had not been able to work for the period of her illness and treatment (over a year), and relied on her savings and on support from her parents for her medical expenses. “Luckily my father is retired and he has a pension, but what happens if you don’t have this family support?” she said.



R:⁸⁵ “WITHOUT MY SISTER ... IT WOULD BE DIFFICULT TO PAY FOR MEDICINES”

R has been receiving mental health care through the SNS. He receives a non-contributory pension of €368. He lives in a government-run residence for people with mental health conditions, for which he has to pay €248. That leaves him with only €120 for all his monthly expenses. R has been trying to find a job, but it has been difficult because of his health condition and because employment opportunities are low.

⁸² Amnesty International interview, Galicia, October 2017.

⁸³ Amnesty International interview, Galicia, October 2017.

⁸⁴ Amnesty International interview, Galicia, October 2017.

⁸⁵ Amnesty International interview, Andalucía, October 2017.

Therefore, even when he needs regular medicines – like cough syrup or cream for warts – he has to ask for help from his family or he goes without. The main earner in his family is his sister, and R and his mother are both dependent on her. “Without my sister ... it would be difficult to pay for medicines,” he said.

Others told Amnesty International how they either did not access all the health care they needed for financial reasons – e.g. take all their medication – or made choices about whether to pay for health care or other expenses. For example, V, a man living with a physical disability, and who feels a lot of pain in his leg has been struggling with the cost of medicines. He told Amnesty International, “I cannot live with the pain, I need to take my medicines. Either I take my medicines, or I kill myself [because of the pain] ... so if I have to starve myself, I do it, because I must buy medicines”.⁸⁶

E,⁸⁷ a 44 year old woman, has experienced a very wide range of health conditions. She was recently treated for breast cancer, she also has rheumatoid arthritis, spondylitis and Crohn’s disease.⁸⁸ In 2017, the symptoms of her Crohn’s disease became very severe. In March 2017, her doctor put her on the list for surgery, saying she would get surgery within three to four months. When Amnesty International spoke with her in October 2017, she was still waiting for the surgery. Meanwhile, she has been prescribed medication to address the symptoms of the disease, and many of these medicines are not covered by the SNS. She has to pay about €60 a month. E does not work and lives off a small pension linked to her disability; she worried about the cost of her medicines. “I take less than what the doctor prescribed me ... I try to use less... in order to make them last longer”. As a consequence, she continues to be in discomfort as a result of her symptoms. “If I had more money, I’d go to the private system,” she said. “What’s happening, it is shocking”.

Amnesty International researchers also spoke to other cancer patients who are struggling to pay the costs of the medicines they require. G, a 44 year old woman,⁸⁹ told Amnesty International that she often did not buy the medicines she needed for two-three months for financial reasons. G stopped working because of her cancer, and has not been able to find work since. For example, she explained how she went into early menopause as a result of her cancer. She was prescribed creams for vaginal dryness, without which she said “life would have been painful” for her. However, none of these creams were covered by the SNS. “The medicines they prescribe [to] you, you have to pay for, and it’s a lot of money. And my income is very low. So sometimes I couldn’t afford to pay for the medicines ... I asked [the doctors] to prescribe something within the catalogue, but they said none were.”

O, who also had cancer, is a 53 year old woman.⁹⁰ She told Amnesty International that many of her medical costs are not covered by the SNS, particularly costs related to alleviating the side effects of her cancer. These include creams that provide relief for pain and rashes caused by her breast prosthesis, as well as medicines for constipation. The cream, for example, costs €20 a tube and in some weeks she needs it about once a week. O is divorced and is the primary care-giver for her child. Her only regular income is from a pension linked to her disability, she gets about €385 a month. Because of her fear about her finances, there are months when she doesn’t buy some medication. She has been trying to get a job, but her health condition has made this difficult since there are many types of jobs she is physically unable to do, such as those requiring physical labour and long hours.



C:⁹¹

C, a 65 year old woman, is a regular user of the public health system in Spain. “I have many health problems and many complications. So I use a range of different services”, she said. She has had breast cancer, metastases in her lungs, two hip replacements, two knee replacements, four different prostheses and has been using a wheelchair for the past three years. Until a week before Amnesty International spoke with her, she also needed continuous oxygen therapy. C lives alone and has a full-time carer living with her. “I need help all day. I need help for showering. I couldn’t put on the oxygen mask without help. I

⁸⁶ Amnesty International interview, Andalucía, January 2018.

⁸⁷ Amnesty International interview, Andalucía, October 2017.

⁸⁸ Crohn’s disease is a long-term condition that causes inflammation of the lining of the digestive system. Symptoms include severe abdominal pain and diarrhoea, see: www.nhs.uk/conditions/crohns-disease/

⁸⁹ Amnesty International interview, Galicia, October 2017.

⁹⁰ Amnesty International interview, Galicia, October 2017.

⁹¹ Amnesty International interview, Andalucía, October 2017.

can't take my clothes off to go to the bathroom or to shower, because I have barely any strength in my arms. I also wake up many times at night, and need help then."

After the crisis, C's biggest concern has to do with the costs of her health care. Her expenditure on her health is between €60 and €80 a month, much higher than it used to be before the crisis. She pays the new co-payment for medicines for hormone therapy linked to her cancer. She did not pay for this before the Royal Decree Law 16/2012 was introduced. She pays for many medicines she did not have to before, including medicines for gas, for chronic coughs, and creams for her breast prostheses. She also has to pay for many items associated with her health condition that are not covered by the health system. "I wear a breast prosthesis, because of the breast cancer ... I need special bras for this, and these bras cost between €80 and €100. And of course I need to have more than one bra." She told Amnesty International that previously she used to receive a subsidy for the bra. Furthermore, she also pays about €30 a month for private physical rehabilitation services, since there is a very long waiting list to access physical rehabilitation through the SNS.

C is not working because of her health condition. She gets a monthly pension of €1,600. She spends €600 on a mortgage, €600 to pay her carer, €63 in taxes, and has a remainder of a little over €300 for all her living costs, including medicines, electricity, and food. "There are months that I cannot make it" she told Amnesty International, "The month I need to buy a bra, I take only half my pills, so I spend less".

Most of the 75 health workers who shared information with Amnesty International for this report also said that they had seen an increase in their patients struggling with and worrying about health care costs since the crisis began and austerity measures were introduced. Some explicitly referred to the co-payments in this regard. "Many people tell me 'please prescribe something cheap so I can afford it'", one doctor said.⁹² Another doctor said, "I didn't think this would be an issue, but after the crisis, I see a lot of old people who can't cover medicine costs".⁹³ Similarly, another doctor mentioned that her patients often told her "if you give us a prescription now, I will buy the medicines in the beginning of next month, when I get paid".⁹⁴ A coordinator of a civil society group working with people living in poverty said: "We used to have a great public health system. After the crisis, we have seen some big cuts. I see people face a lot of difficulty accessing medication".⁹⁵ He said this was particularly true of people who were homeless after the crisis.

These observations are also echoed in other qualitative studies involving health care workers. In a study in Madrid, primary health care physicians reported that they had seen co-payments create access barriers, including with patients not adhering to treatment for financial reasons, or requesting changes to cheaper medicines.⁹⁶ In a different study, health care professionals in Valencia also shared several stories of patients being unable to afford medication because of co-payments.⁹⁷ The Commissioner for Human Rights of the Council of Europe also found that increased co-payment for medication and cuts in public health services have had "a disproportionate impact on persons with disabilities".⁹⁸

⁹² Amnesty International interview, October 2017.

⁹³ Amnesty International interview, October 2017.

⁹⁴ Amnesty International interview, October 2017.

⁹⁵ Amnesty International interview, Andalusia, October 2017.

⁹⁶ J Heras-Mosteiro et al, 'Health Care Austerity Measures in Times of Crisis: The Perspectives of Primary Health Care Physicians in Madrid, Spain', *International Journal of Health Services*, 2015, 46(2), p. 283 [hereinafter, J Heras-Mosteiro et al, 2015]

⁹⁷ F Cervero-Liceras et al, 'The effects of the financial crisis and austerity measures on the Spanish health care system: A qualitative analysis of health professionals' perceptions in the region of Valencia' *Health Policy*, 2015, 119, p. 100 [hereinafter F Cervero-Liceras et al, 2015].

⁹⁸ Report by Nils Muižnieks, Commissioner for Human Rights of the Council of Europe, Following his visit to Spain from 3 to 7 June 2013, Comm. DH (2013) 18, available here: <https://rm.coe.int/16806db80a> [hereinafter CoE, Commissioner for Human Rights Report, 2013].

THE IMPACT OF CO-PAYMENTS

In the context of the economic crisis, the World Health Organization has said that introducing co-payments is a measure likely to decrease access,⁹⁹ as many users struggle to meet the sudden additional costs. An OECD Working Paper on austerity measures in health care noted, “co-payments remain a blunt policy instrument that can have many unintended consequences particularly when the economic crisis simultaneously reduces incomes for many citizens. The risk remains that citizens forego effective care that can have long-term adverse health outcomes”.¹⁰⁰ The introduction and increase of co-payments in Spain during the economic crisis increased the financial burden of health care on people already struggling with the impact of the crisis. Quantitative studies have analyzed government data on the numbers of prescriptions dispensed in Spain after the changes in the structure of co-payments were introduced. They found that while the total number of dispensed prescriptions fell in several regions in the first 14 months after the changes, the levels have since began to adjust towards pre-austerity levels.¹⁰¹ However, this quantitative data does not indicate which groups might be disproportionately impacted by the co-payments or which medicines might be particularly impacted.¹⁰² As Lopez-Valcarcel et al note: “*Because no upper limit is set to the co-payment payable by non-pensioners (unlike pensioners) ... the cost of medication may represent a catastrophic level of spending for poor families*”.¹⁰³

Furthermore, the full content of the supplementary and accessory portfolios have not yet been developed.¹⁰⁴ The amendments introduced by the RDL 16/2012 mean that future regulations can include co-payments for services that were previously free. Since then, the national government has tried to introduce co-payments for non-urgent transport, dietetic products, and certain ortho-prosthetics.¹⁰⁵ This proposal was criticised by health care users, patients associations and professional bodies for the disproportionate financial burden this would place including on older persons, persons with chronic health conditions, and people with disabilities.¹⁰⁶ A report by the State Council also questioned how much would be saved by this proposal, given the costs to put in place a regulatory mechanism to collect these co-payments.¹⁰⁷ The proposal was subsequently withdrawn.¹⁰⁸ The AECC, an association working on cancer, warned that there is a risk that services important for cancer survivors - such as psychological care after the illness – could be included in the common portfolio of accessory services when this catalogue is developed, and require a co-payment.¹⁰⁹

⁹⁹ World Health Organization, Health policy responses to the financial crisis in Europe, Policy Summary 5, p ix-x, available here: http://www.euro.who.int/_data/assets/pdf_file/0009/170865/e96643.pdf [hereinafter: WHO, Health policy responses to the crisis]. For the impact of co-payments more generally, see also: journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1001490

¹⁰⁰ K Gool et al, ‘Health, Austerity and Economic Crisis: Assessing the Short-Term Impact in OECD Countries’ OECD Health Working Papers, No. 76 (2014).

¹⁰¹ Puig Junoy et al, ‘Paying for formerly free medicines in Spain after 1 year of co-payment’ *Applied Health Economics and Health Policy*, 2014, 12(3), p. 279. B Lopez-Valcarcel et al, ‘Economic Crisis, Austerity Policies, Health and Fairness: Lessons Learned in Spain’ *Applied Health Economics and Health Policy*, 2017, p. 13 [hereinafter: B Lopez-Valcarcel et al, 2017].

¹⁰² The Galician health system conducted a study on the impact of the new co-payments in 2013. The study measured the difference in the rates of buying prescribed medicines, between groups who were making co-payments and who were not making co-payments. It indicated that for some medicines, the rates were not very different, meaning that people were buying medicines regardless of whether they needed to make a co-payment. For other medicines, people who needed to make a co-payment were buying prescribed medicines at a reduced rate. The government explained this by saying that the medicines with no difference in rates were “necessary”, hence people were buying them. And the medicines with a difference in rates were for “less urgent” conditions, including painkillers and paracetamol, hence people were choosing not to buy them. Therefore, they believed that the co-payment did not have any impact. The findings of this study should not be used to support the conclusion that the co-payments did not have any impact, for two reasons. Firstly, the study did not compare changes over time amongst the same groups. It did not, for example, compare changes in medication purchase amongst pensioners who did not have to co-pay before 2012 and had to now. The study compared people who were co-paying with those who weren’t in 2013. Secondly, all medicines in the study had been prescribed by doctors, and therefore, were seen as medically necessary. The government’s distinction between medicines that were “necessary” and “less urgent” does not change the fact that people who had to co-pay were buying lesser amounts of certain prescribed medication, as compared to people who did not.

¹⁰³ B Lopez-Valcarcel et al, 2017.

¹⁰⁴ The supplementary common portfolio contained services that could be regulated at a national level to carry a co-payment, and included non-urgent emergency transport, ortho-prosthetics, pharmaceuticals and dietetic products. Before this, some of these services were fully by certain autonomous communities, and carried no co-payment. The common portfolio of accessory services contained services that are not deemed essential, or which support the treatment of an illness or chronic condition, and would also carry a co-payment.

¹⁰⁵ elpais.com/sociedad/2012/12/12/actualidad/1355347847_448190.html;

www.elmundo.es/elmundo/2012/04/24/espana/1335249973.html;

www.eladelantado.com/nacional/cada_trayecto_en_ambulancia_no_urgente_costara_cinco_euros/

¹⁰⁶ See for example: ecodiario.economista.es/salud/noticias/4469285/12/12/ALCER-confia-en-que-no-se-aplique-el-copago-en-el-transporte-sanitario-no-urgente-para-los-pacientes-en-hemodialisis.html; www.madridiario.es/noticia/216358/social/los-discapacitados-rechazan-que-las-muletas-y-sillas-de-ruedas-entren-en-el-copago-farmaceutico.html;

¹⁰⁷ On file with Amnesty International.

¹⁰⁸ elpais.com/sociedad/2014/01/13/actualidad/1389632716_166997.html

¹⁰⁹ Asociación Española Contra el Cáncer, Análisis de las medidas del Real Decreto-Ley 16/2012 en las prestaciones sanitarias y su impacto en el colectivo de pacientes de cáncer, 2013, available here: https://www.aecc.es/Investigacion/observatoriodelcancer/Estudiosrealizados/Documents/Informe_Impacto_RDL16_2012_aecc2013.pdf

The Ombudsman told Amnesty International that their office received several complaints from people who have to co-pay for medicines and pay for medicines that are no longer funded by the SNS.¹¹⁰ In their most recent report, the Ombudsman noted that the 2012 reform “has left important gaps and contradictions that harm the situation of many patients in a situation of vulnerability”, and has recommended that more groups are excluded from co-payments (e.g. people with limited resources, people with disabilities and chronic patients) and the co-payment model is made more progressive.¹¹¹ The 2015 Annual Report on the National Health System of Spain stated that 65.8% of citizens thought that there should be additional income brackets in the existing co-payment structure, “so as to ensure a better match between the required co-payment and the patient’s income level”.¹¹²

2.3 DETERIORATION IN THE ACCESS TO AND QUALITY OF HEALTH CARE

2.3.1 AUSTERITY MEASURES LINKED TO ACCESS TO AND QUALITY OF HEALTH CARE

A. CHANGES IN ENTITLEMENT FOR SNS COVERAGE

RDL 16/2012 changed the nature of the SNS from a universal system, to one where free access to public health care was limited to people classified as being “insured” and their “beneficiaries”: that is, people employed in Spain, pensioners, and recipients of other social security benefits.¹¹³ While it confirmed that all unemployed persons could freely access the SNS, it effectively excluded non-nationals who were “not registered or authorized as residents in Spain”, or irregular migrants, from free SNS coverage. They were previously able to access free health care through the SNS. After RDL 16/2012, they are only entitled to free emergency health care, antenatal care, care during pregnancy, and post-natal care. All children are entitled to free health care.¹¹⁴ “Applicants for international protection”, and victims of trafficking are covered for emergency care, the basic treatment of diseases, and any “necessary medical or other assistance”.¹¹⁵ Amnesty International assessed the implications of the changes in law for non-nationals in previous publications and hence has not focused on this issue in the current report.¹¹⁶

¹¹⁰ Email to Amnesty International, 7 March 2018, in response to questions.

¹¹¹ Defensor del Pueblo, ‘Informe anual 2017 y debates en las Cortes Generales: Volumen I. 2 Crisis económica y desigualdad’ Madrid 2018, p.68, available here: www.defensordelpueblo.es/wp-content/uploads/2018/03/Informe_anual_2017_vol.I.2_Crisis_economica.pdf

¹¹² Ministry of Health, Social Services, and Equality (MoHSSE), ‘Annual Report on the National Health System of Spain’, 2015.

¹¹³ Article 3, RDL 16/2012.

¹¹⁴ Article 3 ter, RDL 16/2012.

¹¹⁵ RDL 1192/2012.

¹¹⁶ AI Spain, 2015 and AI Spain, 2013.

ACCESS TO HEALTHCARE AND IRREGULAR MIGRANTS

The exclusion of adult irregular migrants from freely receiving many aspects of health care was one of the most controversial aspects of the RDL 16/2012. From 2012, it is estimated that almost 750,000 migrants have been excluded from free SNS coverage.¹¹⁷ Several regional governments disagreed with this decision, and restored access to health care for irregular migrants, within their jurisdiction.¹¹⁸ However, in a previous report, Amnesty International documented how some health care centres continued to charge for emergency services or deny access to health care for people who should have been covered.¹¹⁹ The discrepancy in rules at the national and regional level on access acted as a deterrent: many people did not seek health care they were entitled to, thinking they would be turned away.¹²⁰ Civil society groups, including Amnesty International, have opposed this measure as violating the right to health.¹²¹ Several UN bodies and international experts have asked that this be revised.¹²²

In a 2017 decision, the Constitutional Court declared unconstitutional a decree passed by the government of the Basque Country effectively granting irregular migrants free access to public health care, on the grounds that the regional government did not have the jurisdictional competency to make these changes.¹²³ This raises questions about the extent to which regional governments can make policy choices that are at odds with central-level health regulation, including other provisions in RDL 16/2012.

B. MODIFYING THE WORKING CONDITIONS OF HEALTH WORKERS

As a part of the reductions in public health expenditure, spending on remuneration for health workers also fell: in 2013, this spending was 10% lower than it was in 2009.¹²⁴ One of the ways in which this was accomplished was through limiting hiring and changing working conditions. The central government introduced changes to the working conditions of all staff working in the public sector. This included doctors, nurses, and all other health workers who were a part of the SNS. The government extended working hours to 37.5 hours, with no corresponding increase in pay (prior to 2012, health workers in the public sector had a 35 hour work week).¹²⁵ It introduced restrictions on new hiring, and limited the replacement of staff in case of vacancies, retirements, etc. to 10% of the vacancies.¹²⁶ It also reduced salaries and benefits, including freezing promotions and professional development, reducing holidays, training days, etc.¹²⁷ The economic crisis also saw greater reliance on temporary contracts in the SNS, worsening working conditions. In an interview with Amnesty International researchers, representatives from the Galician and Andalusian health service confirmed that they had hired health workers on temporary contracts to fill necessary gaps during the years when replacement rates for vacant positions were capped.¹²⁸

The period between 2011 and 2014 has seen a reduction in the numbers of health workers being employed by the SNS. According to official data from the Ministry of Treasury (Ministerio de Hacienda y Funcion Publica) the National Health System lost almost 28,500 workers between 2012 (when the total number was

¹¹⁷ AI Spain, 2015, p. 4.

¹¹⁸ www.es.amnesty.org/en-que-estamos/noticias/noticia/articulo/cientos-de-miles-de-personas-sin-tarjeta-sanitaria-ausencia-de-evaluacion-del-impacto-en-sus-vidas/

¹¹⁹ AI Spain, 2015 and AI Spain, 2013.

¹²⁰ AI Spain, 2015 and AI Spain, 2013.

¹²¹ See, for example, the REDER Network, comprising of Federation of Associations for the Defense of Public Health (FADSP), Médicos del Mundo, the Plataforma per una Atenció Sanitària Universal a Catalunya (PASUCAT), the Spanish Society of Family and Community Medicine (semFYC) and the Spanish Society of Public Health and Health Administration (SESPAS). Their critique of RDL 16/2012 is available here: <https://reder162012.org/>

¹²² CESCR, 'Consideration of reports submitted by States parties under articles 16 and 17 of the Covenant' UN Doc. E/C.12/ESP/CO/5, 6 June 2012, para. 19 [hereinafter, CESCR, Concluding Observations – Spain, 2012]; CEDAW Committee, 'Concluding observations on the combined seventh and eighth periodic reports of Spain', UN Doc. CEDAW/C/ESP/CO/7-8, 29 July 2015, para. 30 and 31; European Commission against Racism and Intolerance, ECRI Report on Spain, 5 December 2017, para 80.

¹²³ www.es.amnesty.org/en-que-estamos/noticias/noticia/articulo/el-tribunal-constitucional-profundiza-la-exclusion-sanitaria-y-limita-la-capacidad-de-las-comunidad/

¹²⁴ ESGP Data. This has started to improve, but as of 2015 (the last year for which data was available at the time of publication) it has still not reached 2009 levels. For example, it was €31336619 in 2009; €27778955 in 2013; and €28908257 in 2015.

¹²⁵ Article 4, Royal Decree Law 20/2011.

¹²⁶ Article 3, Royal Decree Law 20/2011. This has since been increased, and in 2016 the permissible replacement levels reached 100%. However, not all positions have been filled.

¹²⁷ Health workers' salaries were cut by 5% in 2010, and then frozen for a period of 4 years. In 2012, they did not receive the regular annual bonus payment. Some regional governments introduced additional wage cuts. Estimates suggest that these measures have resulted in an effectively salary decrease of between 5% to 9% for health workers in this period, and a drop in purchasing power of up to 30%. See www.cesmgalicia.org/blog/?p=11578; www.eldiario.es/economia/saldo-crisis-salarios-cayeron_0_581642051.html; www.consalud.es/profesionales/cual-es-de-verdad-el-sueldo-de-los-sanitarios-que-montoro-promete-incrementar_46376_102.html.

¹²⁸ Amnesty International interviews, January and February 2018. Recent reports suggest that 170,000 health care workers have been hired on short-term contracts as "temporary staff" <http://hspm.org/countries/spain25062012/livinghit.aspx?Section=3.6%20Payment%20mechanisms&Type=Section#42TheWorkforceintheNationalHealthSystemhasfallenby6%since2012>

505,185) and 2014 (when the total number was 476, 689).¹²⁹ Since then, the number increased, but it has not returned to 2012 levels (in 2017, the number was 490,509).¹³⁰ These figures include all staff working in the SNS – social workers, pharmacists, psychologists, etc - and not just doctors and nurses. According to the annual report of the health system, published by the Spanish government: there were 1,229 fewer doctors in Spain between 2012 and 2013, and 2913 fewer nurses in the period between 2011 and 2013.¹³¹

C. PERFORMANCE-BASED “INCENTIVES”

While remuneration structures for health workers can differ based on the region, in many cases this involves a fixed salary amount, and a small percentage that is paid depending on whether pre-established, performance-based objectives have been met, also known as “incentives”.¹³² In interviews with Amnesty International, several health workers noted that after the on-set of the crisis, health workers were under increasing pressure to comply with incentives that were linked to ensuring economic savings for the SNS. As one nurse told us, “Previously our objectives were more around the quality of care. Now they are purely economic.”¹³³ While the incentives structure is different across regions, Amnesty International obtained a list of incentives for health care workers in hospitals from Galicia for 2017. Examples of economic incentives on this list included keeping the “Average cost per prescription” under €12.8, and upper limits on the cost of care per user, with an adjustment for age.¹³⁴ While the savings-linked incentives in Galicia were a small percentage of the total incentives, health workers told Amnesty International that they were not under as much pressure to comply with these incentives before the crisis, as they are after.¹³⁵

Like with the incentives for health workers, Amnesty International was told in interviews that the criteria based on which health centres were assessed have also become increasing oriented towards economic savings. Amnesty International also reached out to 20 randomly selected health centres in Andalucía and Galicia for a list of criteria. Only one health centre in Andalucía responded with a document, according to which the criteria included reducing the numbers of referrals in some types of specialised care; and reductions in the cost of care per patient.¹³⁶

Several health workers explained the reason they found economic-based incentives problematic. “This can promote behaviour that is not the best. It is not the best practice medically – to make medical decisions reliant on economic criteria”, one doctor said.¹³⁷ Another said, “Economic incentives can promote behaviour [in doctors] that will not lead to the best medical treatment. Instead it’s only looking for savings”.¹³⁸ Some health workers felt that such incentives were a way to put the responsibility for budget cuts and savings on health workers: “The incentive system puts pressure on professionals. It’s a way to put responsibility for the cuts on the doctor, without it looking like a political decision”.¹³⁹ Many health system users felt it had made a difference in the care they received. One patient said how his doctor complained to him, saying “I need to prescribe an expensive medicine for you, but I’m going to be lectured about it”.¹⁴⁰

Amnesty International requested copies of these criteria and a list of incentives for health workers from the regional governments of Andalucía and Galicia. The government of Andalucía told Amnesty International these agreements were not publicly available. The government of Galicia shared a broad list of indicators based on which hospitals were assessed. This list did not have any such economic indicators. They told Amnesty International that individual management units could develop their own indicators, and they did not have a record of each one. However, they believed they would know if problematic indicators were developed. Furthermore, the government of Galicia confirmed that they believed since health workers made

¹²⁹ In 2012 the total number was 505,185. See Ministerio de Hacienda y Administraciones Públicas, “Boletín estadístico del personal al servicio de las Administraciones Públicas. Registro Central de Personal Enero” [hereinafter: Registro Central de Personal] 2012, http://www.sefp.minhfp.gob.es/dam/es/web/publicaciones/centro_de_publicaciones_de_la_sgt/Periodicas/parrafo/Boletin_Estadis_Personal/Bol_estad_pers-ener12-INTERNET.pdf. In 2014, the number had dropped to 476 689. See Registro Central de Personal 2014, http://www.sefp.minhfp.gob.es/dam/es/web/publicaciones/centro_de_publicaciones_de_la_sgt/Periodicas/parrafo/Boletin_Estadis_Personal/BE_ENE-2014-PROTEGIDO.pdf

¹³⁰ In 2017, the number was 490,509 (2018 data is not available). See Registro Central de Personal 2017, http://www.minhfp.gob.es/AreasTematicas/FuncionPublica/boletin_rcp/B_enero_2017_BIS.PDF.pdf

¹³¹ Based on numbers in the MSSSI’s Annual Reports on the National Health System from this period, available here: www.msssi.gob.es/estadEstudios/estadisticas/sisInfSanSNS/tablasEstadisticas/InfAnSNS.htm

¹³² Health system review: Spain, 2010, p. 109, available here: http://www.euro.who.int/_data/assets/pdf_file/0004/128830/e94549.pdf

¹³³ Amnesty International interview, October 2017.

¹³⁴ On file with Amnesty International.

¹³⁵ Amnesty International interviews, October 2017.

¹³⁶ On file with Amnesty International.

¹³⁷ Amnesty International interview, October 2017.

¹³⁸ Amnesty International interview, October 2017.

¹³⁹ Amnesty International interview, October 2017.

¹⁴⁰ Amnesty International interview, October 2017.

decisions with public money, “they should make expenditure decisions that were cost effective”, and felt that in general such goals were effective.¹⁴¹

D. IMPACT ON HEALTH WORKERS

“At the start of the crisis we had more strength. As years have gone by, we have become more tired. For years, we have been carrying this burden.”

Doctor, SNS¹⁴²

All health workers interviewed told Amnesty International that their jobs had become harder after the austerity measures were introduced, and that they were seeing more patients and working longer hours than before. In the words of a nurse “We feel exploited. We are underpaid and we have so many responsibilities”.¹⁴³ “They ask for more with the same or less resources,” another doctor said.¹⁴⁴ One doctor said “There were days when I had to attend the equivalent of twice the normal, usual patient schedule”.¹⁴⁵ Another nurse told us “We know of many cases where nurses have quit their jobs because of the stress. Many nurses attend to 33 complex cases a day. They’ve had to quit because it was impossible for them”.¹⁴⁶ Another doctor explained, “Burn out levels amongst doctors has increased. The level of involvement of doctors in the health care sector has gone down at a level I have not seen before”.¹⁴⁷

Furthermore, many health workers explained that this was exacerbated by an increasing number of patients sharing emotional and difficult stories of their lives with them, particularly in the context of the crisis. As one doctor described: “I had a personal crisis. My patients were coming to me with anxiety and telling me their daily problems. Almost 20 a day. And I wasn’t sure what to do, because this was new for me – should I provide low level psychotherapy? Should I be a doctor or a nice neighbour? This has taken a huge emotional toll on us. If you have two-three patients who tell you their emotional stories, it’s OK. 20 people a day is an emotional burden for us, especially if you know them for years”.¹⁴⁸

“As a professional, I felt powerless. I felt I was asked to solve issues that I had no control over, like economics.”

Doctor, SNS¹⁴⁹

Health workers consistently told Amnesty International that they felt “powerless” and “disillusioned with the system” after the budget cuts and changes to the health system described above. Health workers told Amnesty International that they felt obliged to do as much as they possibly could for their patients, even in difficult circumstances: “This has caused health care professionals to stand up to the circumstances and do our best”, one doctor said. This is consistent with what health care providers have said in qualitative studies in Valencia,¹⁵⁰ Catalonia,¹⁵¹ and Madrid.¹⁵²

¹⁴¹ Amnesty International interview, February 2018.

¹⁴² Amnesty International interview, October 2017.

¹⁴³ Amnesty International interview, October 2017.

¹⁴⁴ Amnesty International interview, October 2017.

¹⁴⁵ Amnesty International interview, October 2017.

¹⁴⁶ Amnesty International interview, October 2017.

¹⁴⁷ Amnesty International interview, October 2017.

¹⁴⁸ Amnesty International interview, October 2017.

¹⁴⁹ Amnesty International interview, October 2017.

¹⁵⁰ F Cervero-Liceras et al, 2015.

¹⁵¹ Legido-Quigley, 2013.

¹⁵² J Heras-Mosteiro et al, 2015.

2.3.2 DELAYS IN ACCESS TO HEALTH CARE

A. LENGTHY WAITING LISTS

“Waiting lists have become longer because the system cannot respond. Access to health care isn’t what it used to be.”

Nurse, SNS ¹⁵³

Amnesty International found that the decrease in health workers and resources available in the SNS combined with a general increase in demand for health care has increased waiting times to access health care. This emerged as a key issue in all interviews including with experts, health workers or people using the health system. People said that they waited longer for appointment with specialists, for diagnostic testing, and for treatment options.

All the people Amnesty International interviewed who were seeking mental health care through the SNS also noted that since the crisis started, their appointments were further apart, and they had to wait longer to see a mental health professional. This is consistent with information in the “Sanitary Barometer” published by the Ministry of Health, Social Services and Equality: the average percentage of respondents who believes waiting lists were becoming worse was 9.8% between 2000 and 2008, and 26% between 2009 and 2016.¹⁵⁴

The SNS collects and publishes data on waiting lists for certain procedures and services, which represent a key indicator regarding access to the health system.¹⁵⁵ The concerns that people articulated in interviews with Amnesty International are corroborated by this data. For example, the graph below indicates changes in the average waiting times, and numbers of people waiting, for elective surgeries, between 2005 and 2016. Elective surgeries include all scheduled surgeries other than those performed on patients who were admitted unexpectedly to hospitals for emergency treatment including surgeries in cardiology, gynaecology, traumatology, urology, neurology, as well as general, digestive and plastic surgery.

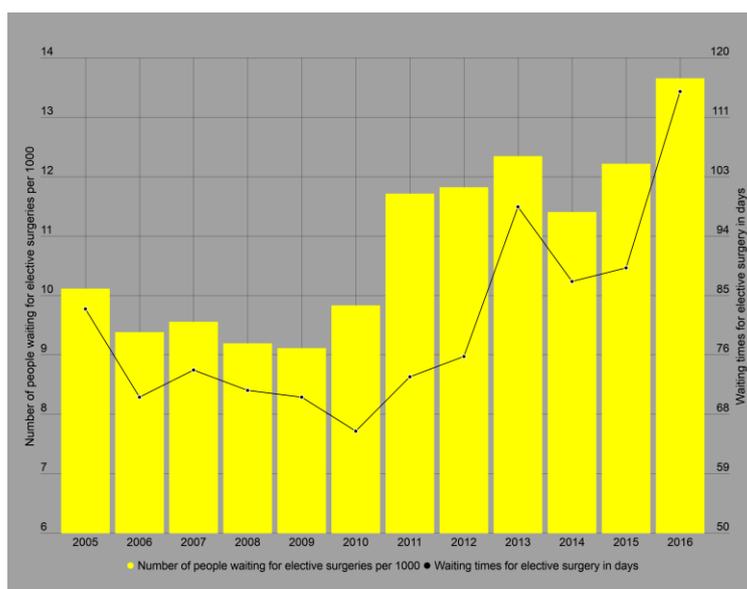
Graph 3: Waiting times and numbers of people waiting for elective surgery:¹⁵⁶

¹⁵³ Amnesty International interview, October 2017.

¹⁵⁴ MSSSI, Annual statistical results: Health Barometer 2016, Table 16, available here: https://www.msssi.gob.es/estadEstudios/estadisticas/BarometroSanitario/home_BS.htm

¹⁵⁵ National-level disaggregated data on waiting lists for diagnostic testing and for appointments with mental health professionals is not available. But available data and Amnesty International’s research indicate these are problems.

¹⁵⁶ Self-constructed graph based on data from MSSSI’s ‘Key Indicators of the Health System’, available here: <http://inclasns.msssi.es/main.html>



As this graph indicates, both - the numbers of people waiting for surgeries as well as the time they spend waiting – have increased since the years of the crisis. For example, in 2010, the average waiting time was 65 days; in 2016 it was 115 days, which is almost double. Similar trends are also visible in data on waiting times and numbers of people waiting for specialised consultations.¹⁵⁷

Amnesty International asked the regional governments of Galicia and Andalucía what measures they had taken to reduce the length of waiting lists. The Andalusian government told Amnesty International that it relies on maximum limits for waiting times, and increasing the workload of health workers, to deal with the increasing lengths of waiting lists.¹⁵⁸ The Galician government explained that they relied on a prioritization service to deal with lengthy waiting lists, through which they ensure that people who were in more urgent need of health care were expedited. They also had a maximum limit on waiting times for certain health conditions.¹⁵⁹ While these measures are important, data indicates that the problem is not solved. A 2017 study of Spain’s health by the OECD noted that waiting times remained “well-above other OECD countries such as Netherlands or Denmark”.¹⁶⁰

B. IMPACT OF DELAYS IN ACCESS TO HEALTH CARE

Over 70 people using the SNS and their families described the difficulties caused by the waiting lists, including the anxiety they felt as a result of not knowing the cause of their pain or of the other symptoms they experienced. S, a 32 year old woman, has a physical disability and uses a wheelchair. When Amnesty International met her, she had been experiencing a lot of pain in her legs. She underwent some tests to identify the cause of the pain in February 2017. She only got an appointment with a specialist to interpret the results in January 2018. “When I have pain, I have to wait a year to find out what the matter is. It makes you concerned that it might get worse. And anxious. But you still get no treatment”.¹⁶¹ U’s 23-year old son has Down’s syndrome.¹⁶² He has experienced several health problems throughout his life as a result, and is a regular user of the SNS. Amnesty International met U in October 2017. Her son had recently complained of stomach problems, was depressed, tired and had lost weight. She had waited for a consultation for four months, but had still not got an appointment. U was very anxious: “I don’t know what’s going on with him, it makes me nervous. It’s a very bad situation ... I worry because I don’t know what illness he has ... we don’t know the cause.”¹⁶³

¹⁵⁷ For specialised consultations, waiting times increased from 53 days (2010) to 72 days (2016), and patients waiting per 1000 people increased from 33 (2010) to 45.66 (2016). MSSSI’s ‘Key Indicators of the Health System’, available here: <http://inclasns.msssi.es/main.html>.

¹⁵⁸ Amnesty International interview, January 2018.

¹⁵⁹ Amnesty International interview, February 2018.

¹⁶⁰ OECD, Health policy in Spain, March 2017, available here: <http://www.oecd.org/els/health-systems/Health-Policy-in-Spain-March-2017.pdf>

¹⁶¹ Amnesty International interview, Galicia, October 2017.

¹⁶² Amnesty International interview, Galicia, October 2017.

¹⁶³ Amnesty International interview, Galicia, October 2017.

Most people told Amnesty International that they had to live with their medical symptoms, including serious pain, for a much longer time because of the waiting lists. V, an older man living with a physical disability, told Amnesty International: “My leg was amputated many years ago, and I have a prosthesis now. I have been feeling some pain in the leg, which the doctor thought was a benign tumour”. His doctor had referred him to diagnostic testing for the pain two months before Amnesty International met with him. “I am still waiting for all the tests” he said. At the time of the interview, he did not know what the cause of the pain was or what the next steps for treatment would be.¹⁶⁴ G, a man with spondylitis (a chronic health condition) has waited in a lot of pain for six months for a consultation with an orthopaedic surgeon.¹⁶⁵ W’s daughter started to gradually lose her hearing in 2010. In 2015, she lost all hearing and was deaf. She only got a diagnostic test to confirm this in mid-2016, and was put on the waiting list for a cochlear transplant. She finally received the transplant in April 2017, almost two years after she had lost all her hearing.¹⁶⁶



M:¹⁶⁷ “WE ALL HAVE TO ENDURE A LOT OF PAIN BEFORE WE ACTUALLY GO TO THE DOCTOR [NOW]”

M, a 49 year old woman, suffers from a degenerative bone disease. She has been experiencing a lot of pain in her leg. In August 2017, she met her doctor who referred her to a specialist. She only got an appointment with the specialist for June 2018. While she waits for this appointment, she is also anxious about what might be causing the pain. “Right now I am taking painkillers and anti-inflammatory drugs to get by”, she told Amnesty International. “I want for us chronic patients to have more support”, she said. Her anxiety is compounded by fears about her finances. M has a physical disability linked to her health condition, which seriously limits her mobility. Because of this, she has many limitations on the types of jobs she is able to do, and does not have a stable job. She receives about €300 a month as monetary support from the government linked to her disability. “This is not enough”, she said, “I rely a lot on family support to get by”.

Q, a 59 year old woman,¹⁶⁸ lives with several chronic health conditions. She is largely dependent on a pension linked to her disability, which amounts to about €400 a month, which she told Amnesty International was not sufficient. She was recently treated for breast cancer and a lymphoma, and also accesses the SNS for mental health care. She began to experience problems breathing about a year and a half ago. After being on the waiting list for over six months, she was diagnosed with sleep apnoea.¹⁶⁹ Her specialist recommended surgery, and she has been on the waiting list for surgery for about a year. She made several complaints on this issue at the hospital but no action was taken. She is still waiting, and the symptoms of sleep apnoea – including difficulties breathing and fatigue – continue to worry her. Because of her health conditions, Q has been unable to work for some years. She used to be a seamstress, but her cancer meant that she no longer has the arm strength to continue with this job.

All the people Amnesty International interviewed who were, or had been, seeking mental health care through the SNS (around 31 people) noted that since the crisis started, they had to wait longer to see their mental health professional. No data was available regarding general waiting times for appointments with psychiatrists and psychologists. However, experts and civil society organizations working on mental health care said this was about six months. People seeking mental health services explained to Amnesty International how this meant that their symptoms and problems went unaddressed for long periods of time, often adding to their anxiety. L, who has been seeking treatment for paranoid schizophrenia in the SNS for several years, said the system being followed after the crisis did not work for him. “If I have a [mental health] crisis, I should be able to see my psychiatrist [soon], not have to wait like I do now ... it takes too much time”, he said.¹⁷⁰ K, another man seeking similar treatment, described how his mental health medication needed to be closely supervised and changed depending on his response. He said, “I often wish I could see

¹⁶⁴ Amnesty International interview, Andalucía, October 2017.

¹⁶⁵ Amnesty International interview, Andalucía, October 2017.

¹⁶⁶ Amnesty International interview, Andalucía, October 2017.

¹⁶⁷ Amnesty International interview, Galicia, October 2017.

¹⁶⁸ Amnesty International interview, Galicia, September 2017.

¹⁶⁹ Sleep apnoea is a condition where “the walls of the throat relax and narrow during sleep, interrupting normal breathing”, available here: www.nhs.uk/conditions/obstructive-sleep-apnoea/#symptoms-of-osa

¹⁷⁰ Amnesty International interview, Andalucía, September 2017.

my psychiatrist a month or two sooner than I am able to, so they can adjust my medicines”.¹⁷¹ Both, K and L, see their psychiatrist once every six months.



T:¹⁷²

T has been seeking mental health care through the SNS for several years. She has been hospitalized four times between 2013 and 2017 because of her mental health condition. She is currently seeing a psychiatrist through the SNS. When she met Amnesty International in September 2017, she said she had last seen her psychiatrist in April 2017. However, she felt that the medicines she was previously prescribed were not working and she has been feeling more unwell as a result. She was unable to get an appointment to see the psychiatrist before November 2017. “I’m not feeling well ... the medical treatment the doctor prescribed is not good for me. I asked the nurse to see the doctor before November but it’s not possible”, she said. “I want to feel better ... I want to be able to clean and to look after my children and feel as happy as possible”, she told Amnesty International.

2.3.3 REDUCED TIME WITH HEALTH WORKERS AND QUALITY OF CARE

A. TIME SPENT WITH HEALTH WORKERS

“It is impossible to have unlimited treatments with [these] limited resources. Either we increase our health budget, or we decrease the quality and quantity of treatment we offer.”

Doctor, SNS¹⁷³

In the years when the number of health workers decreased (2011 – 2014), the numbers of primary care medical consultations,¹⁷⁴ consultations with medical specialists,¹⁷⁵ and surgical interventions increased.¹⁷⁶ The increasing demand for health care services combined with the reduction in numbers of health care workers has meant a reduction in the amount of time health workers spent on each patient.

Almost all health workers who spoke with Amnesty International confirmed that the consultation time they had per patient had decreased. Some doctors told Amnesty International that in some cases they were only able to spend between one and three minutes per appointment.¹⁷⁷ All health workers Amnesty International interviewed said that despite their best efforts, the changes caused by the austerity measures risked deterioration in the quality of services they were able to provide. In the words of one doctor, “If ... we have more responsibilities, more workload, and insecurity in the future ... the quality of the service deteriorates”.¹⁷⁸ Two nursing assistants explained the difficulties the austerity measures had brought to their jobs: the increase in workload meant that cleaning patients, bathing patients, and changing incontinence products, were often more delayed than they used to. “Also, sometimes we feel so stressed, we just cannot

¹⁷¹ Amnesty International interview, Galicia, September 2017.

¹⁷² Amnesty International interview, Andalucía, October 2017.

¹⁷³ Amnesty International interview, October 2017.

¹⁷⁴ 279 million in 2011 and 2012 to 375 million consultations in 2013 and 371 million consultations in 2014. Based on numbers in the MSSSI’s Annual Reports on the SNS, available here: www.msssi.gob.es/estadEstudios/estadisticas/sisInfSanSNS/tablasEstadisticas/InfAnSNS.htm.

¹⁷⁵ 71.8 million Consultations in 2011 and 75.5 million consultations in 2012 to 77.6 million medical consultations in 2013 and 78.9 million consultations in 2014. Based on numbers in the MSSSI’s Annual Reports on the SNS, available here: www.msssi.gob.es/estadEstudios/estadisticas/sisInfSanSNS/tablasEstadisticas/InfAnSNS.htm.

¹⁷⁶ 3.4 million in 2012 to 3.5 million consultations in 2013 and 2014. Based on numbers in the MSSSI’s Annual Reports on the SNS, available here: www.msssi.gob.es/estadEstudios/estadisticas/sisInfSanSNS/tablasEstadisticas/InfAnSNS.htm.

¹⁷⁷ Amnesty International interview, October 2017.

¹⁷⁸ Amnesty International interview, October 2017.

be nice to people”, one of them said.¹⁷⁹ Another nursing assistant said, “We often have to let patients go sooner, and hurry up the process”.¹⁸⁰ As one primary health care physician told Amnesty International, “The most important thing is to have more time with the patients. Right now we have about five minutes. We are fighting to have ten minutes per patient”.¹⁸¹ This is consistent with the findings of other qualitative studies involving physicians after the crisis and austerity measures were introduced in Spain. For example, a study of primary health care physicians in Madrid also reflected the deteriorating quality of care, linked to overcrowding and shorter appointment times.¹⁸²

B. IMPACT OF SHORTER CONSULTATION TIMES



X:¹⁸³ “I AM ALWAYS IN PAIN”

X, a 53 year old woman, is a regular user of the SNS. She has a rheumatic disease and fibromyalgia. “I need regular check-ups and a lot of medication”, she said. Four months before Amnesty International’s meeting with her in October 2017, she had had tests done for severe pain in her shoulder that she felt was linked to her fibromyalgia. But she had still not been called for an appointment to diagnose and treat the pain. X’s biggest concern is managing her pain, linked to her health conditions. She used to be treated at a pain unit, up until two years previously. It has since closed down. Now she relies on her primary health care physician to manage her pain. However, she has found it hard to access her physician and feels that the amount of time she is able to spend with her physician is not sufficient to address and treat her pain. “Now I only have a doctor to take care of me. I take opiates, and I decide how to take them ... People always say we overmedicate ourselves, but [in my case] there is no control by the doctor”, she said. “I feel powerless. I am at home all day, I feel ill and I am in a lot of pain. But I don’t feel like going to the doctor because I don’t get help there ... Only if it is unbearable, I go to the doctor”.

Like in X’s case above, a majority of health system users Amnesty International interviewed for this report said that they were often unable to get the care they felt they needed because of reduced consultation times. This has a particular impact on types of care that are potentially time-intensive. Mental health care is one example. All the people Amnesty International interviewed who were seeking mental health care through the SNS felt the amount of time they spent with their doctor, psychiatrist or psychologist (as relevant) had reduced since the crisis started, and was insufficient.

M, a man seeing a psychologist, explained how the reduction in the amount of time he could spend with the psychologist following the crisis impacted the care he was able to receive: “Previously, when I used to leave my psychologist, I used to feel better. He would teach me tools to cope with what I was feeling,” he said.¹⁸⁴ However, this was no longer the case. “We need time with the psychologist,” he said. T,¹⁸⁵ a woman accessing mental health services said that she wished she could spend more time with her doctor: “[The doctor] asks me whether I’m feeling well or not, if I take medicines, but nothing more”, she said. She said the staff at the health care centre had explained to her that the budget cuts had made the situation what it was. “As I understand it, there is an overcrowding of people [in the SNS] ... It’s normal that the doctors only devote 5 minutes per person”.

H, a staff member working at a governmental residential centre for people with mental health conditions, explained that she worked with patients to prepare for doctors’ appointment, so they didn’t forget anything. “If you only have [few] minutes, you feel pressured and you forget things. This happens also to healthy people, so imagine if you have a mental illness”, she said.¹⁸⁶ At the residence where she works, the number of staff has decreased from three to two for every 20 patients, because of the cuts. The staff have to accompany people living at the centre for their doctor appointments, and there always needs to be someone

¹⁷⁹ Amnesty International interview, October 2017.

¹⁸⁰ Amnesty International interview, October 2017.

¹⁸¹ Amnesty International interview, October 2017.

¹⁸² J Heras-Mosteiro et al, 2015.

¹⁸³ Amnesty International interview, Galicia, September 2017.

¹⁸⁴ Amnesty International interview, Andalucía, September 2017.

¹⁸⁵ Amnesty International interview, Andalucía, September 2017.

¹⁸⁶ Amnesty International interview, Andalucía, September 2017.

at the centre as well. She described how many appointments were cancelled because now there were only two people, hence one would stay in the centre and only one could accompany people to the doctor.

W, a 53-year old woman, told Amnesty International that she had been seeing a psychiatrist through the public health system for over 10 years, until a year ago, when she had to stop. She believes this was linked to the changes made following the economic crisis. “[My psychiatrist] told me he could not continue seeing me because he had too many patients ... this is the way things are, he told me”. She has not had an appointment with him for the past one year. Another man receiving mental health care and counselling for many years said, “Earlier I had more time with [my psychologist]. Now it’s just 5 minutes. I left the last appointment feeling exactly how I did when I came in”.

2.3.4 CONCERNS REGARDING THE QUALITY OF EQUIPMENT

“These budget cuts don’t make sense ... We feel insulted, humiliated and powerless.”

Man using the SNS¹⁸⁷

In several interviews with health workers and health system users, the quality of medical equipment emerged as a concern. Health workers believed the quality of medical equipment had deteriorated after the crisis because health spending had been reduced. “First they take into account price, and then the quality”, one nursing assistant said.¹⁸⁸ Nurses complained about the lower quality of needles in the tests for diabetes, which made testing more painful for patients. Other health workers and experts raised concerns that diagnostic equipment is not being replaced at the rates at which it should, because of reductions in public health expenditure.¹⁸⁹ These concerns were shared by patients as well. One man receiving home-based oxygen therapy explained to Amnesty International in detail the difference in quality of the equipment he received from the public health system before and after the crisis. There were differences in the quality of the oxygen mask, which did not fit well; of the tube, which was not flexible; and of the battery life of the machine.¹⁹⁰ A civil society group working with people with chronic health conditions confirmed that other people had similar concerns about this new equipment, which they said was being provided to them after the austerity measures were introduced.

All the people Amnesty International interviewed who used wheelchairs had concerns about the quality of wheelchairs being provided after the crisis. People using wheelchairs, organizations working with people with disabilities, and health workers that Amnesty International spoke to believe there was a difference between the wheelchairs that used to be provided before the crisis and those being provided now, describing the ones currently provided as being harder to use and to steer, that the brakes worked less effectively, and that it was less comfortable to be on the wheelchairs all day. “You don’t get a sense of safety”, one doctor said.¹⁹¹ Additionally, they stated that they found it harder to renew materials linked to the wheelchair, like cushions. B, a woman using a wheelchair, said she often got ulcers because her cushion was worn out and could not be replaced. And then she would have to spend money on creams for the ulcers, which were not covered by the public health system.

Amnesty International raised the specific concerns regarding reduced quality of wheelchairs with the governments of Andalucía and Galicia. In both regions, public spending on ortho-prosthetic equipment reduced during the crisis.¹⁹² Furthermore, in Andalucía, the regional health service had reduced the maximum permissible financing for ortho-prosthetics, which include wheelchairs, by 10% through a recent government directive, because they needed to comply with “budgetary adjustment measures”.¹⁹³ However,

¹⁸⁷ Amnesty International interview, October 2017.

¹⁸⁸ Amnesty International interview, October 2017.

¹⁸⁹ Interview with Sociedad Española de Oncología Radioterápica, June 2017; Interview with Organización Médica Colegial de España, January 2018; www.consosalud.es/saludigital/38/la-obsolencia-tecnologica-pone-en-peligro-la-evolucion-del-sector-sanitario_41328_102.html.

¹⁹⁰ Amnesty International interview, Andalucía, October 2017.

¹⁹¹ Amnesty International interview, October 2017.

¹⁹² In interviews with Amnesty International, both, the Andalusian and Galician government confirmed this.

¹⁹³ Orden de 26 de junio de 2014, available here:

<http://www.juntadeandalucia.es/servicioandaluzdesalud/library/plantillas/externa.asp?pag=/contenidos/servicios/BOJA14-126-00028->

the governments of Andalucía and Galicia said that they were trying to maintain a minimum quality requirement.¹⁹⁴ They suggested that the differences in quality perceived by the users of the wheelchairs could be explained by a routine change in provider, and was not a reduction in quality. Representatives from the Ministry of Health, Social Services, and Equality told Amnesty International that the reduction in quality could be because the catalogue for ortho-prosthetic products had not been updated for several years.

Changes in the quality of such ortho-prosthetic equipment have a very particular impact on the specific groups this report focusses on, including older persons and people with disabilities. The reduction in public spending on ortho-prosthetic products, combined with the perception by users, organizations working with people with disabilities, and health workers, that the quality of these products has decreased, is concerning. While it is beyond the scope of this report to conduct a definitive analysis across medical products to analyse possible changes in quality, it is crucial that such an analysis is done urgently by the government, to determine the specific impact the austerity measures might have had.

In conclusion, a study published by the WHO, that analysed the possible impacts of policy changes introduced by countries during the economic crisis, said that reducing population coverage; increases in waiting times for essential services; increasing user charges for essential services; and attrition of health workers caused by reductions in salaries, were all examples of policy changes that risked “undermining health system goals”.¹⁹⁵ Amnesty International’s findings are consistent with this study: while the government implemented some measures to save costs in the SNS without unduly compromising the right to health, many of the austerity measures described in this chapter are similar to those listed in the WHO study above. There has been a deterioration in the accessibility, affordability, and quality of health care in Spain in this period, particularly impacting people who were economically vulnerable, and had chronic illnesses, disabilities, and sought mental health care.

[11179-01_00050706.pdf](#). The government representative from Andalucía also suggested that this might be the reason for the perception of reduced quality.

¹⁹⁴ Amnesty International interview, January and February 2018.

¹⁹⁵ WHO, Health policy responses to the crisis

3. ALL ALTERNATIVES WERE NOT EXHAUSTED

Spain's obligation to respect, protect and fulfil the right to health is a progressive one, which means it must take appropriate measures towards the full realization of the right to health to the maximum of its available resources. This obligation recognizes that limited resources, including when a country is faced with an economic crisis, can hamper the full realization of the right to health. However, even in these difficult circumstances, human rights monitoring bodies have developed criteria for austerity measures that must be complied with. For example, there is a strong presumption that retrogressive measures, such as cuts to health spending which can negatively impact people's access to health care, are not permissible.¹⁹⁶ The Committee on Economic, Social and Cultural rights (CESCR) has stated that if States take any deliberately retrogressive measures regarding the right to health, they have the burden of proving that these measures have been introduced "after the most careful consideration of all alternatives ... in the context of the full use of the State party's maximum available resources".¹⁹⁷ These include demonstrating that less restrictive measures - such as "adjustments in tax policy" - have been considered and exhausted;¹⁹⁸ demonstrating the non-discriminatory nature of the proposed measures; ensuring genuine participation of affected groups and individuals in decision-making processes; and demonstrating the necessity, reasonableness, temporariness and proportionality of austerity measures.

¹⁹⁶ CESCR, General Comment 14, para 32.

¹⁹⁷ CESCR, General Comment 14, para 32

¹⁹⁸ OHCHR, *Report on austerity measures*, 2013, para 18.

AVAILABLE POLICY OPTIONS

The economic crisis affected several countries in Europe, albeit at differing levels of intensity. While all countries introduced policies to reduce the costs of medicines and promote their rational use, studies by the World Health Organization (WHO) suggest that the response to the crisis across Europe varied considerably across health systems.¹⁹⁹ Some countries like Spain made cuts in their health budgets,²⁰⁰ while in others expenditure on health increased during the crisis.²⁰¹ While some countries, like Spain, increased user charges for health care,²⁰² others chose to expand benefits.²⁰³ Similarly, while changes to restrict public health system coverage were reported in six countries, including Spain,²⁰⁴ others increased coverage during the crisis.²⁰⁵ Each country responded to a very different economic and health context, and therefore direct comparisons are not advisable and that is not the intention of this report. However, the range of policy tools available and used by countries is further indication that the austerity measures introduced by Spain in the public health sector were choices and reflected governmental priorities. They were not inevitable.

3.1 EXHAUSTION OF ALTERNATIVE AND LESS RESTRICTIVE MEASURES

In Spain the government only implemented some measures that saved costs in the public health system without unduly compromising the right to health, between 2013 and 2017, whereas measures that have had a retrogressive impact on the right to health - including horizontal cuts to the health budget (which included reductions in health worker remuneration), the introduction and increase of co-payments and exclusion of irregular migrants - were implemented earlier (between 2009 and 2012). When it was passed, the government said that RDL 16/2012 would generate €500 million in savings from the introduction of co-payments; €500 million from removing certain products from SNS coverage and €1 billion from centralized purchasing schemes (that is, purchasing commonly used products centrally, instead of at local levels, to benefit from better bargaining power and therefore cheaper prices, while keeping supplies to patients unaffected).²⁰⁶ The former two measures were implemented in July and August 2012.

The centralized purchasing of medical products took longer to implement, and the savings from these were realized over 2013-2017. In 2012, Framework Agreements were developed for the centralized purchase of certain vaccines, projected to save €31 million.²⁰⁷ In December 2012, the government approved tenders for the centralized purchase of certain medicines and health products that would save an estimated €80 million.²⁰⁸ In September 2013, a new tender for centralized purchases of medicines for haemophilia was authorized, with estimated savings of €4.5 million.²⁰⁹ In October 2013, a similar agreement was authorized for the centralized purchase of immune-suppressants which was estimated to save €14.66 million.²¹⁰ In October 2014, the government reached an agreement to centrally purchase the 20 most commonly consumed drugs, which they estimated would save €15 million over two years.²¹¹ A similar agreement was

¹⁹⁹ WHO, Health policy responses to the crisis, p vi; WHO, Economic crisis, health systems and health in Europe: Country Experience, 2015, available at: http://www.euro.who.int/_data/assets/pdf_file/0010/279820/Web-economic-crisis-health-systems-and-health-web.pdf?ua=1 [hereinafter: WHO, Economic crisis & health systems, Country Experience, 2015]

²⁰⁰ Bulgaria, Croatia, Estonia, Hungary, Iceland, Ireland, Italy, Greece, Latvia, Romania, Portugal. WHO, Economic crisis & health systems, Country Experience, 2015

²⁰¹ Austria, the Czech Republic, Poland, Slovakia, France, Denmark, the former Yugoslav Republic of Macedonia and Turkey. WHO, Economic crisis & health systems, Country Experience, 2015

²⁰² Armenia, Czech Republic, Denmark, Estonia, France, Greece, Ireland, Italy, Latvia, Netherlands, Portugal, Romania, Russian Federation, Slovenia, Switzerland, Turkey. WHO, Economic crisis & health systems, Country Experience, 2015

²⁰³ Austria, France, Ireland, Italy, and Hungary. WHO, Economic crisis & health systems, Country Experience, 2015

²⁰⁴ The others were Czech Republic, Latvia, Ireland, Slovenia and Cyprus. WHO, Economic crisis & health systems, Country Experience, 2015

²⁰⁵ France, Greece, Iceland, Russian Federation, Sweden, Belgium, Bosnia and Herzegovina, Estonia. WHO, Economic crisis & health systems, Country Experience, 2015

²⁰⁶ It is unclear how these amounts were calculated. Amnesty International didn't have access to this economic report: we requested a copy from the government but at the time of publishing we had not received it. Estimates here are from: saludequitativa.blogspot.co.uk/2012/04/el-gobierno-cifra-en-7267-millones-el.html; www.larazon.es/historico/9692-el-gobierno-cifra-en-7-267-millones-el-ahorro-con-el-decreto-sanitario-HLLA_RAZON_452824

²⁰⁷ www.msssi.gob.es/gabinete/notasPrensa.do?id=2537. This was extended the following year:

www.msssi.gob.es/gabinete/notasPrensa.do?id=2808

²⁰⁸ www.msssi.gob.es/gabinete/notasPrensa.do?id=2697

²⁰⁹ www.msssi.gob.es/gabinete/notasPrensa.do?id=2978

²¹⁰ www.msssi.gob.es/gabinete/notasPrensa.do?id=3038

²¹¹ www.msssi.gob.es/gabinete/notasPrensa.do?id=3444

signed in 2016 for vaccines, where, according to the government, the estimated savings exceeded €58 million.²¹² In July 2017, the government approved the first centralized purchase of ortho-prosthetic products, with an anticipated saving of €2.5 million.²¹³ In its 2017 Stability Program Update, the Spanish government reported that centralized purchasing has generated annual savings of about €100 million.²¹⁴

Taxation is one of the key tools to generate the resources necessary for the realization of human rights and ensuring equality.²¹⁵ The Special Rapporteur on extreme poverty and human rights has stated that the compatibility of austerity measures with the International Covenant on Economic, Social and Cultural Rights (ICESCR) “would therefore depend partly on whether the State has sought revenue-raising alternatives before making cuts in areas that are important for ensuring the enjoyment of economic, social and cultural rights”.²¹⁶ The Spanish government amended its tax policy as a part of its response to the crisis: VAT rates increased (16% in 2009, to 18% between 2010 and 2012, and they were then raised again to 21%),²¹⁷ as did top income tax rates (43% in 2007 to 52% in 2012 and then reduced to 45% in 2016).²¹⁸ Top corporate income rates rate, however, decreased in this period from 32.5% in 2007 to 30% from 2008 to 2014. It was further reduced to 28% in 2015 and 25% in 2016.²¹⁹

Spain’s total tax revenues fell by 8.5% in 2008 and 10.1% in 2009.²²⁰ This has since been increasing, but has not reached the pre-crisis, 2007 amounts.²²¹ As of 2016, Spain’s tax-to-GDP ratio was 34.1%, lower than the EU average, which is around 40%.²²² The composition of Spain’s tax revenue also evolved during this time: the percentage of total tax revenue coming from taxes paid by individuals and families (personal income tax and taxes on goods and services) grew, while the percentage of taxation from corporate income reduced.²²³ These changes are linked to, both, the changes in income, consumption and the effects of the recession in Spain, and the changes in tax policy.

During the crisis, indirect taxes like VAT increased while top corporate tax rates were reduced. CESCR criticised a similar trend in the UK, in 2016: “The Committee is concerned about the adverse impact that recent changes to the fiscal policy in the State party, such as ... the increase of the value added tax, as well as the gradual reduction of the tax on corporate incomes, are having on the ability of the State party to address persistent social inequality and to collect sufficient resources to achieve the full realization of economic, social and cultural rights for the benefit of disadvantaged and marginalized individuals and groups”.²²⁴ Similar concerns can be raised in the context of Spain as well. The government’s reasoning for reducing this was to encourage investment, employment, and economic growth in a time of recession. However, in effect, this policy reduced the “maximum available resources” at a time at which resources were necessary. At a minimum, the government should have demonstrated and published how it had considered and assessed all potential changes to tax policy, both to see whether they offered feasible alternatives to cuts in expenditure and in terms of their impact on different groups of people (such as through changes to VAT), which it did not do.²²⁵

Addressing the pervasive problems of tax evasion and fraud is one way tax revenues can be used as a tool to increase revenues. 2010 estimates by GESTHA, a union of tax inspectors, suggest that €88 billion were lost

²¹² www.msssi.gob.es/gabinete/notasPrensa.do?id=4047

²¹³ www.msssi.gob.es/gabinete/notasPrensa.do?id=4198

²¹⁴ Spain, Stability Programme Update, 2017-2020, p 51.

²¹⁵ CESCR, ‘General Comment No. 24 on State Obligations under the International Covenant on Economic, Social and Cultural Rights in the Context of Business Activities’ UN Doc No E/C.12/GC/24, 23 June 2017, para 23.

²¹⁶ UN Human Rights Council, Report of the Special Rapporteur on extreme poverty and human rights, A/HRC/26/28, 22 May 2014, para 28.

²¹⁷ Statutory tax rate tables, available at: ec.europa.eu/taxation_customs/business/economic-analysis-taxation/data-taxation_en [hereinafter: Statutory tax rate tables]

²¹⁸ Statutory tax rate tables.

²¹⁹ Statutory tax rate tables.

²²⁰ In 2007 (when it was €401,189 million) and 2008 (when it was €367,157 million) to its lowest in 2009 (when it was € 329,975 million), see: ec.europa.eu/eurostat/statistics-explained/images/e/e0/Total_tax_revenue_by_country%2C_1995-2016_%28year-on-year_growth_rates%2C_%25%29.png

²²¹ For example, in 2016, total tax revenue in Spain stood at € 381,466 million.

²²² Eurostat, Main national accounts tax aggregates, http://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=gov_10a_taxag&lang=en

²²³ In 2007, revenues from VAT comprised 16.3% of total taxation; by 2016, this has increased to 19.3%. In 2007, revenues from personal income taxes comprised 20.8% of total taxation; by 2016 this has increased to 21.8% (and this percentage was much higher in some of the intervening years, e.g. it was 23.6% in 2011 and 23.7% in 2012). However, the percentage contribution of revenues from corporate income tax fell, going from 13.1% of total taxation in 2007 to 6.9% in 2016. See Table 6, Indirect taxes, available at:

ec.europa.eu/taxation_customs/business/economic-analysis-taxation/data-taxation_en; Table 16, Direct taxes, available at:

ec.europa.eu/taxation_customs/business/economic-analysis-taxation/data-taxation_en; Table 18, Direct taxes, available at:

ec.europa.eu/taxation_customs/business/economic-analysis-taxation/data-taxation_en

²²⁴ CESCR, Concluding observations on the sixth periodic report of the United Kingdom of Great Britain and Northern Ireland, 14 July 2016, UN Doc E/C.12/GBR/CO/6, para 16.

²²⁵ Amnesty International asked representatives of the Ministry of Health, Social Services and Equality about what alternative measures – including possible increases in revenue through taxation – were considered before austerity measures and budget cuts in health care were introduced. They said they were not aware of any discussions on this. Interview with government representative, February 2018.

to tax evasion in Spain.²²⁶ Revenue from addressing tax evasion played a limited role in the fiscal consolidation effort during the crisis and the fiscal consolidation effort was mostly on the expenditure side.²²⁷ Spain introduced reforms to strengthen the efforts against tax fraud in 2012 and 2015. While these were positive, they were introduced after cuts had been made in welfare spending, and had limited impact. GESTHA, who monitor tax evasion and fraud in Spain, reported that the problem continues and over 90% of tax evasion was not detected in 2015.²²⁸ Their recommendations for improving the situation include increasing human resources dedicated to addressing tax fraud and evasion, and focussing on the entities who are responsible for a majority of the evasion.²²⁹

3.2 DISPROPORTIONATE IMPACT AND HUMAN RIGHTS IMPACT ASSESSMENTS

There have been concerns from several quarters that austerity measures have risked contributing to discriminatory outcomes, have disproportionately impacted, or have further entrenched inequalities for particular groups.²³⁰ Amnesty International's research shows that certain groups – for example, people who are economically vulnerable and within this category, people with disabilities, people using mental health services, older persons, and people with chronic illnesses – were particularly and disproportionately impacted by the austerity measures. During this research, health workers and experts also raised concerns that the budget cuts – particularly in the initial years of the crisis – were not specific or targeted.²³¹ Therefore, their impact was felt by a very large set of groups, often disproportionately disadvantaging certain marginalized groups. These concerns have also been raised by others.²³²

States should ensure that austerity measures are not directly or indirectly discriminatory, either in intent or effect.²³³ One way by which the possibly discriminatory effects of austerity measures can be identified and corrected is through conducting human rights impact assessments of these measures before and after they are developed and implemented. It is for this reason that several human rights monitoring bodies have recommended that Spain conduct such an impact assessment of the austerity measures implemented. For example, in 2012, the CESCR recommended “that the State party assess the impact of any proposed cuts on the access of the most disadvantaged and marginalized individuals and groups to health services”.²³⁴ In his report on Spain in 2013, the Commissioner for Human Rights of the Council of Europe noted “the need to ensure that members of social groups that are particularly vulnerable to and affected by fiscal austerity measures, such as children and persons with disabilities, are identified and effectively protected by the state on the basis of impact assessments”. The need for such assessments also came up during Spain's Universal Periodic Review (UPR) in 2015.²³⁵

Amnesty International asked representatives of the Galician, Andalusian and central governments about whether any human rights impact assessments were conducted before the public health budget was cut or RDL 16/2012 was enforced. Representatives of the central government said they were unaware of whether any such human rights impact assessments had been carried out. The Andalusian government pointed to the legal requirement in Spain to conduct a gender impact assessment of all budgets and laws under Ley

²²⁶ N Lusiani, *Rationalising the Right to Health: Is Spain's Austere Response to the Economic Crisis Impermissible Under International Human Rights Law?*, Economic and Social Rights after the Global Financial Crisis, ed. Aoife Nolan, 2014, p. 231

²²⁷ Amnesty International analysed Spain's annual Country Report – a document prepared by the European Commission that serves as an overall analysis of the government's efforts to reduce deficits – from 2010 to 2017. The reports indicate that deficit reduction focused more on expenditure side reforms and less on savings from addressing tax fraud. See here for all the reports: ec.europa.eu/info/business-economy-euro/economic-and-fiscal-policy-coordination/eu-economic-governance-monitoring-prevention-correction/european-semester/european-semester-your-country/spain/european-semester-documents-spain_en

²²⁸ www.gestha.es/index.php?seccion=actualidad&num=464

²²⁹ As per their monitoring over 70% of tax fraud in Spain is committed by large corporations and high-income individuals. Interview with Amnesty International, January 2018. See also: www.vozpopuli.com/economia-y-finanzas/Gestha-denuncia-recursos-combatir-fraude-pocos_0_1083193187.html

²³⁰ For example, CESCR, Concluding Observations – Spain, 2012 on the impact of RDL16.2012 on irregular migrants; CoE, Commissioner for Human Rights Report, 2013 on the impact of people with disabilities; and CEDAW Committee, Concluding observations on Spain (2015) on the health of migrant women.

²³¹ Interviews with health workers, Andalucía and Galicia, September 2017.

²³² J Gené-Badia et al, ‘Spanish health care cuts: Penny wise and pound foolish?’, 2012, *Health Policy*, 106 (1), pp. 23-28; B Lopez-Valcarcel et al, 2017.

²³³ OHCHR 2013.

²³⁴ CESCR, Concluding Observations – Spain, 2012.

²³⁵ UN Human Rights Council, Report of the Working Group on the Universal Periodic Review: Spain, 13 April 2015, A/HRC/29/8, para 131.123, available at: <http://www.ohchr.org/EN/HRBodies/UPR/Pages/ESIndex.aspx> [hereinafter: Spain UPR report, 2015].

Orgánica 3/2007. However, they did not share the findings of this assessment.²³⁶ While a gender impact assessment is crucial and is a positive step, this alone would not be sufficient, given the range of risks austerity measures pose. For example, it would not capture what specific risks that people living with disabilities, older people, people accessing mental health care, or people with chronic health conditions could face. The Galician government told Amnesty International that they had not conducted a social or human rights impact assessment of the RDL 16/2012, before it was implemented, since it was a central law and was not developed by them.²³⁷ However, they said they put in place measures to alleviate what negative impact they believed it could have.²³⁸ The Galician government also shared a study they had conducted after the co-payments were introduced to assess their impact, based on which they believed the impact of this change was limited.²³⁹ While any measures to assess impact is welcome, this study has been discussed in more detail in the previous chapter, which explains why it should not be used to support the conclusion that the new co-payments had no impact.

3.3 GENUINE CONSULTATION AND PARTICIPATION OF AFFECTED PEOPLE

“The patient is the least important thing. We don’t feel represented”

Man using the SNS²⁴⁰

“Nurses’ voices are not being heard”

Nurse, SNS²⁴¹

The right to health includes the right to participate in the development and implementation of health-related plans and policies.²⁴² This is key to ensuring that any developments or changes introduced as austerity measures are appropriate, and account for people’s specific health-needs. This is particularly relevant in the context of austerity measures: according to the CESCR, “the genuine participation of affected groups and individuals in examining the proposed austerity measures and alternatives is highly relevant to the necessity and permissibility of those measures”.²⁴³ Neither the Ministry of Health, Social Services and Equality, nor the regional governments of Andalucía and Galicia, described such a process in the context of the austerity measures discussed in this report.

The choice of legal instrument to enact the main change to the health system - the RDL 16/2012 - is telling. Unlike laws that are discussed and passed by the Spanish Legislature (Cortes Generales), a Royal Decree is introduced by the executive in times of “extraordinary and urgent need”,²⁴⁴ without the same level of scrutiny and consultation other laws receive. It is later ratified by the legislature. Amnesty International asked representatives of the Ministry of Health, Social Services and Equality what steps had been taken to consult with and ensure the participation of affected groups before RDL 16/2012 was implemented. The representatives said they were not aware of any such measures, and in general it would be up to the relevant

²³⁶ Amnesty International interview, January 2018.

²³⁷ Amnesty International interview, February 2018.

²³⁸ For example, they introduced targeted programs to ensure that irregular migrants could access health care. They also tried to reduce the burden of co-payments by ensuring pensioners would only make up-front payments up to their monthly limits, removing the need for greater up-front payments and later reimbursements. They did not, however, change the actual structure of the co-payments. Andalucía also implemented a similar scheme.

²³⁹ Amnesty International interview, February 2018. The government showed Amnesty International researchers the survey during the interview.

²⁴⁰ Amnesty International interview, September 2017.

²⁴¹ Amnesty International interview, September 2017.

²⁴² General Comment 14, paras 11, 34.

²⁴³ OHCHR, *Report on austerity measures*, 2013, para 21.

²⁴⁴ Article 86.1, Constitution of Spain.

regional governments to ensure consultations and health user participation.²⁴⁵ They were also not aware of any consultation around the reductions in public health expenditure.

The government of Galicia explained that the Galician health system had a general system in place, which included a Patient Advising Council, through which patients could participate in how the health system was managed.²⁴⁶ When asked about specific consultations around the austerity measures, the Galician government said RDL 16/2012 was a national law, and therefore they did not consult on it in the region before it was enacted.²⁴⁷ After it was enacted, they did explain the provisions of the law to different citizen representatives and conducted meetings to identify possible risks, based on which they introduced some measures (described above). The representative told Amnesty International that many citizen representatives had asked for the law to not be implemented. The Andalusian government also described general avenues for citizen participation in the public health system, saying that patients could make complaints and register their opinions about specific policies through these channels, including periodic satisfaction surveys.²⁴⁸ However, they did not describe any consultative process that was specific to RDL 16/2012 or reductions in health expenditure.

None of the health workers who shared information with Amnesty International felt that there had been a meaningful or adequate consultative or participatory process regarding the budget cuts and austerity measures. This is consistent with other studies on this issue. One study of health workers noted an “overwhelming view that so far they had not been consulted throughout the process of agenda setting and policy making”,²⁴⁹ which was similar to findings in a study of health workers in Catalonia.²⁵⁰ Another expert wrote: “There is growing dissatisfaction among professionals for not being invited to participate in decision-making processes concerning cuts”.²⁵¹ An overwhelming majority of the health system users interviewed for this report said they did not know of any process in place to participate in how the austerity measures were developed and implemented. A few people told Amnesty International that they had been asked about some aspects of the austerity measures, because they were members of particular committees or patients associations. However, even they did not feel their participation was genuinely considered by the government, or reflected in the outcomes in any way.

3.4 TEMPORARINESS OF THE MEASURES IMPOSED

Human rights standards require that, when imposed, austerity measures should be temporary and only cover the period of the economic crisis. Some of the measures introduced during the crisis, including in the health sector, have been amended and are beginning to be reversed. For example, while it has not yet reached pre-crisis levels, public health expenditure has been increasing since 2014. Some of the changes made to health workers’ working conditions have been amended as well: the salary freeze was lifted, and the replacement rates on hiring have gradually increased.²⁵² This is, however, not the case for other changes introduced to the health system in Spain during this period. For example, RDL 16/2012 was not introduced as a temporary measure with a time-frame for when the changes would cease to be operational; instead, it was enacted as a permanent change to the structure of the health system in Spain. Ten years after the crisis began, and six years after RDL 16/2012 was enacted, the changes introduced by the instrument remain in force, including the introduction and increase of co-payments and exclusion of irregular migrants from free SNS coverage (with limited exceptions). The Ministry of Health told Amnesty International they had no plans to repeal or revise aspects of the RDL 16/2012. They explained that the law was not just about responding to the economic crisis, but was also important to improve the general efficiency of the health system in the long-term. The government of Galicia also confirmed that they had not heard of any plans to revise or repeal parts of the RDL 16/2012. “Now the challenge is not economic, but to account for the increasing demand,” the representative said.²⁵³

²⁴⁵ Amnesty International interview, February 2018. However they clarified that some regulations based on the RDL 16/2012, such as the elaboration of a catalogue for ortho-prosthetics, were being developed through “a very consultative process”.

²⁴⁶ Amnesty International interview, February 2018.

²⁴⁷ Amnesty International interview, February 2018.

²⁴⁸ Satisfaction surveys are available here:

www.juntadeandalucia.es/servicioandaluzdesalud/principal/documentosacc.asp?pagina=gr_encuestasatisf

²⁴⁹ F Cervero-Liceras et al, 2015

²⁵⁰ Legido-Quigley, 2013.

²⁵¹ J Gené-Badia et al, ‘Spanish health care cuts: Penny wise and pound foolish?’, 2012, *Health Policy*, 106 (1), pp. 23-28.

²⁵² Spain, Stability Programme Update, 2017-2020, p 73.

²⁵³ Amnesty International interview, February 2018.

4. ROLE OF THE EUROPEAN UNION

The EU and its institutions have human rights responsibilities. They are bound by the EU Charter on Fundamental Rights, which affirms economic and social rights. In particular, Article 35 states that “A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities”. Article 9 of the Treaty on the Functioning of the European Union (TFEU) provides that, in defining and implementing its policies and activities, the European Union should take into account the protection of human health. Article 6 of the TEU also states that the European Convention on Human Rights, which prohibits discrimination “shall constitute general principles of the Union's law”.²⁵⁴ The EU has ratified the Convention on the Rights of Persons with Disabilities (CRPD), Article 25 of which protects the right to health of persons with disabilities.

These obligations include the responsibility to take all necessary steps to ensure that the economic and fiscal policies promoted as a part of the EU's economic governance function, and the financial assistance programmes supported by the EU, do not undermine human rights protections or result in human rights violations where they are implemented. EU institutions influenced the economic policy choices that the Spanish government made during the crisis through the Excessive Deficit Procedure (EDP), by making specific recommendations during the European Semester, and through regular monitoring (called post-programme surveillance) following a financial assistance program.

Previous chapters of this report have described how the accessibility, affordability and quality of health care in Spain deteriorated in the aftermath of the austerity measures implemented by the Spanish government, with a particular impact on groups who were economically vulnerable, on low incomes, and people with disabilities, with chronic health conditions, older persons, and those seeking mental health services.

4.1.1 EXCESSIVE DEFICIT PROCEDURE

All EU member states are subject to the EDP, a process that is triggered when Member States' deficits or sovereign debt levels are considered 'excessive' and are not decreasing in a satisfactory manner.²⁵⁵ Once an EDP is launched against a state, the Council issues specific, time-bound recommendations to the state to correct the deficit, which is monitored by both the Commission and Council. States face the possibility of warnings and ultimately sanctions - such as fines up to 0.2% of GDP and a suspension of some EU financial assistance²⁵⁶ - if they persistently fail to take adequate action to address their deficits or debts.

In April 2009, the European Council, said an excessive deficit existed in Spain, and made recommendations to address the situation including fiscal consolidation of 1.25% of its GDP.²⁵⁷ Over the next few years, as the crisis worsened, recommendations for fiscal consolidation under the EDP were continually revised and the

²⁵⁴ European Convention on Human Rights, available here: http://www.echr.coe.int/Documents/Convention_ENG.pdf

²⁵⁵ The EDP is part of the Stability and Growth Pact and is triggered when the deficit is greater than 3% of GDP or debt is greater than 60% of GDP. See: ec.europa.eu/info/business-economy-euro/economic-and-fiscal-policy-coordination/eu-economic-governance-monitoring-prevention-correction/stability-and-growth-pact/corrective-arm-excessive-deficit-procedure_en

²⁵⁶ https://ec.europa.eu/info/business-economy-euro/economic-and-fiscal-policy-coordination/eu-economic-governance-monitoring-prevention-correction/stability-and-growth-pact/corrective-arm-excessive-deficit-procedure/stepping-or-abrogating-edp_en

²⁵⁷ Council of the European Union, Council Recommendation to Spain with a view to bringing an end to the situation of an excessive government deficit, 6 April 2009, Doc No: 7904/09.

timeline for their implementation was extended.²⁵⁸ The necessity to comply with these targets was evident by the fact that the Commission and Council initiated discussions on implementing a fine of 0.2% of GDP in 2016, because the Spanish authorities had failed to meet the structural adjustment targets in both 2014 and 2015. Eventually, they decided that the fine would be cancelled due to the difficult economic conditions Spain had already endured.²⁵⁹

Recommendations under the EDP are usually framed as broad targets for fiscal consolidation. However, public documents indicate that the EU Commission and Council were aware that Spain was meeting these targets through expenditure cuts in services like health. A 2012 Commission Staff Working Document (SWD, internal analysis to support the EU's economic monitoring) on Spain stated that "On the expenditure side, measures include cuts in spending on education and health care".²⁶⁰ While reviewing Spain's progress, a 2012 Council recommendation stated that: "The draft budget law and the Stability Programme foresee that total expenditure declines as a result of deep cuts in both capital and current spending, including from savings in the areas of health care and education at regional level".²⁶¹ A SWD from 2013 said that cuts in health and education amounted to 0.4% of GDP in 2012, 0.7% of GDP in 2013, and would amount to 0.75% of GDP in 2014.²⁶² Spain's 2013 Economic Partnership Programme suggested that: "*with the goal of improving the efficiency of spending, the rationalisation of spending on health care is particularly important. Here some measures have already been adopted [...] and other far reaching measures are now being drafted*".²⁶³ On the back of the Economic Partnership Programme the Commission informed the Council that '*the fiscal structural measures that Spain plans to implement are [...] the reduction in healthcare and public administration spending*' and that, '*regarding health expenditure, the revision of the basket of benefits [...] could result in a more efficient use of public resources*'.²⁶⁴

4.1.2 EUROPEAN SEMESTER

The EU's economic governance framework includes mechanisms for the regular monitoring of Member States' budgets; for the timely identification of potential economic problems; and for the prompt correction of these problems. These activities happen within the framework of the 'European Semester', an annual timeline of activities started in 2010 that aim to ensure sound public finances and prevent excessive macroeconomic imbalances.²⁶⁵ Individual governments submit their plans for budget, macroeconomic and structural reforms. The EU examines these, provides governments with country-specific recommendations, and governments must then take appropriate action based on these recommendations.

In 2011 and 2012, Spain only received broad recommendations to reduce the deficit and limit public expenditure. However, in 2013 and 2014 - when public expenditure on health started to grow again - the Council made specific recommendations asking that Spain "increase the cost-effectiveness of the health-

²⁵⁸ For example, later in 2009, the Council recommended an annual structural budgetary adjustment of 1.75% of GDP over the period 2010-2013. In 2012, both the Commission and Spanish authorities revised the structural adjustment targets upwards: the Commission and Council recommended that Spain ensure a fiscal consolidation of 2.5% of GDP for 2013. In 2013, the Commission and Council extended the deadline for correcting the excessive deficit in Spain by two years. The new revised adjustment targets were for 1.1% of GDP in 2013, 0.8% in 2014, 0.8% in 2015 and 1.2% in 2016. See all documentation here: https://ec.europa.eu/info/business-economy-euro/economic-and-fiscal-policy-coordination/eu-economic-governance-monitoring-prevention-correction/stability-and-growth-pact/corrective-arm-excessive-deficit-procedure/ongoing-excessive-deficit-procedures/spain_en

²⁵⁹ The Commission also granted an extension of the deadline for correcting the excessive deficit in Spain by two years. The deadline was moved to 2018 with a recommended deterioration of the structural balance by 0.4% of GDP in 2016 and a 0.5% improvement of the structural balance in 2017 and 2018. European Commission, Recommendation for a Council Decision giving notice to Spain to take measures for the deficit reduction judged necessary in order to remedy the situation of excessive deficit, 27 July 2016, Doc No. COM (2016) 518.

²⁶⁰ Commission Staff Working Document, Analysis by the Commission services of the budgetary situation in Spain, SWD/2012/0215 (final) available here: eur-lex.europa.eu/legal-content/EN/TXT/HTML/?uri=CELEX:52012SC0215&from=EN

²⁶¹ Council of the European Union, Council Recommendation to Spain with a view to bringing an end to the situation of an excessive government deficit, 9 July 2012, Doc. No. 12171/12, available here: <http://data.consilium.europa.eu/doc/document/ST-12171-2012-INIT/en/pdf>

²⁶² Commission Staff Working Document, Analysis by the Commission services of the budgetary situation in Spain, SWD/2013/0383 (final) available here: eur-lex.europa.eu/legal-content/EN/TXT/HTML/?uri=CELEX:52013SC0383&from=EN

²⁶³ Spain, Economic Partnership Programme, 2013, available here: http://ec.europa.eu/economy_finance/economic_governance/sgp/pdf/30_edps/other_documents/2013-10-01_es_-_epp_en.pdf

²⁶⁴ European Commission, Proposal for a Council Opinion on the Economic Partnership Programme of Spain, 15 November 2013, Doc. No. COM (2013) 902.

²⁶⁵ The EU's economic governance explained, available here: ec.europa.eu/info/business-economy-euro/economic-and-fiscal-policy-coordination/eu-economic-governance-monitoring-prevention-correction/european-semester/framework/eus-economic-governance-explained_en#coordinationthroughouttheyeartheeuropeansemester

care sector, while maintaining accessibility for vulnerable groups”.²⁶⁶ In 2015, the Council recommended that Spain “Improve the cost-effectiveness of the healthcare sector”.²⁶⁷

4.1.3 FINANCIAL ASSISTANCE PROGRAMME

Following a request from Spain in June 2012, the European Stability Mechanism made available up to €100 billion in assistance to Spain to assist its banking sector.²⁶⁸ The conditionalities in Spain’s Memorandum of Understanding (MoU) were broadly focussed on restructuring specific banks and strengthening the general, regulatory framework of the Spanish banking sector. However, the MoU also stated that “*There is a close relationship between macroeconomic imbalances, public finances and financial sector soundness*”.²⁶⁹ Linked to this, Spain committed to “*correct the present excessive deficit situation by 2014*” and “*implement the country-specific recommendations in the context of the European Semester*”.²⁷⁰ Eventually, Spain only borrowed around €41.3 billion: as of October 2017, Spain had repaid €9.612 billion.²⁷¹

As a country that received financial assistance, Spain is subject to regular reviews by the European Commission to monitor its repayment capacity.²⁷² These monitoring reports have emphasized the need to correct the budget deficit, keeping up the pressure on the Spanish Government.²⁷³ And some have pointed to how Spain was accomplishing this by “*curbing health-care expenditures*”.²⁷⁴ The most recent report stated that “*The consolidation effort... needs to continue*”.²⁷⁵

EU institutions, therefore, made multiple recommendations to the Spanish government to reduce its deficit, including by reducing public expenditure. Where general recommendations of this nature were made, EU institutions were aware that the Spanish government was meeting these targets by reducing public spending on health. Furthermore, in some instances, more specific recommendations were made regarding making public health expenditure more cost effective.²⁷⁶ The pressure on the Spanish government is evidenced in the preamble of the RDL 16/2012 which stated that the immediate application of the law was “*necessary, in the current socio-economic context*”, and that the measures were necessary to respond without delay to a number of factors, including the “*viability required by the European Union*”.

4.2 INADEQUATE ACTION TO IDENTIFY AND REDUCE RISK OF HUMAN RIGHTS IMPACT

Around the same time as EU institutions were making recommendations to Spain to reduce deficits, public studies by other EU bodies as well as statements by European and international institutions were pointing to the risks and possible human rights impacts of reductions in welfare spending, particularly spending in

²⁶⁶ Council Recommendation on the National Reform Programme 2013 of Spain and delivering a Council opinion on the Stability Programme of Spain, 2012-2016 Doc No. 2013/C 217/20, available here: eur-lex.europa.eu/legal-content/EN/TXT/HTML/?uri=CELEX:52013DC0359&from=EN; Council Recommendation on the National Reform Programme 2014 of Spain and delivering a Council opinion on the Stability Programme of Spain, 2014, Doc No. 2014/C 247/08, available here: [http://eur-lex.europa.eu/legal-content/EN/TXT/HTML/?uri=CELEX:32014H0729\(08\)&from=EN](http://eur-lex.europa.eu/legal-content/EN/TXT/HTML/?uri=CELEX:32014H0729(08)&from=EN)

²⁶⁷ Council Recommendation on the 2015 National Reform Programme of Spain and delivering a Council opinion on the 2015 Stability Programme of Spain, Doc No 2015/C 272/13, available here: [http://eur-lex.europa.eu/legal-content/EN/TXT/HTML/?uri=CELEX:32015H0818\(14\)&from=EN](http://eur-lex.europa.eu/legal-content/EN/TXT/HTML/?uri=CELEX:32015H0818(14)&from=EN)

²⁶⁸ Set up in 2012, the ESM describes itself as a “permanent solution for a problem that arose early in the sovereign debt crisis: the lack of a backstop for euro area countries no longer able to tap the markets”. In effect, the ESM provides financial assistance to euro area countries who request it because of a financial or economic crisis. See: <https://www.esm.europa.eu/about-us/history>

²⁶⁹ Memorandum of Understanding on financial-sector policy conditionality, para 29, available here, ec.europa.eu/economy_finance/eu_borrower/mou/2012-07-20-spain-mou_en.pdf [hereinafter: MoU]

²⁷⁰ MoU, para 30 and 31.

²⁷¹ <https://www.esm.europa.eu/assistance/spain>

²⁷² For more details, see: ec.europa.eu/info/business-economy-euro/economic-and-fiscal-policy-coordination/eu-financial-assistance/which-eu-countries-have-received-assistance/financial-assistance-spain_en

²⁷³ Spain – Post Programme Surveillance, Spring 2014, available here:

ec.europa.eu/economy_finance/publications/occasional_paper/2014/pdf/ocp193_summary_en.pdf

²⁷⁴ Spain – Post Programme Surveillance, Spring 2014, available here:

ec.europa.eu/economy_finance/publications/occasional_paper/2014/pdf/ocp193_summary_en.pdf

²⁷⁵ European Commission, Post-Programme Surveillance– Spain, Autumn 2017, available here: ec.europa.eu/info/sites/info/files/economy-finance/ip066_en.pdf

²⁷⁶ This is consistent with a more general public position adopted by the Council in 2010, which stated that “Ensuring the long-term sustainability of public finances is a challenge which should be reflected in all fields of economic policy coordination in the EU”, making suggestions for how states could “constrain excessive growth” in public health expenditure, available here: http://www.consilium.europa.eu/uedocs/cms_Data/docs/pressdata/en/ecofin/118273.pdf

public health.²⁷⁷ Given these risks, the EU should have taken concrete steps to identify and mitigate possible human rights impacts of the economic and fiscal policies promoted through their recommendations. However, as the section below demonstrates, adequate steps were not taken to this end.

4.2.1 HUMAN RIGHTS OBLIGATIONS NOT CONSIDERED IN THE DEVELOPMENT OF RECOMMENDATIONS

The European Commission's Directorate-General on Economic and Financial Affairs told Amnesty International that recommendations during the EDP and European Semester were prepared based on internal analyses, such as the Country Report and In-Depth Review. Other European Commission departments, such as the Directorate-General for Employment, Social Affairs & Inclusion and the Directorate-General for Health contributed to the recommendations. Amnesty International reviewed the internal analyses mentioned above. While they refer to some social indicators (unemployment, education, and poverty notably), they did not mention Spain's human rights obligations or need for expenditure associated with respecting, fulfilling and protecting human rights. The Independent Expert on the effects of foreign debt (appointed by the UN Human Rights Council and affiliated to the UN OHCHR) also noted that in the European Semester "Economic and financial policies are analysed on the basis of review and compliance reports, which tend to have a very narrow focus on meeting financial targets and programme implementation".²⁷⁸

In the context of health, the EU Commission recognizes the links between fiscal sustainability and public health spending.²⁷⁹ In a meeting with Amnesty International, representatives from the D.G. on Health and Food Safety said that the European Semester monitored EU health systems' "effectiveness, accessibility and resilience". The Country Health Profiles prepared by the DG on Health and Food Safety are a key document that indicate issues to reflect in the recommendations during the European Semester. However, unless indicators in the Country Health Profiles were very out of step with regional trends, concerns about health would not be reflected in country-specific recommendations.²⁸⁰ While reliance on health indicators is useful, the assessment ranks them across European countries, hence risks comparing countries at very different levels of health system development even within the EU, instead of measuring possible national-level retrogressions. It also does not account for the certain changes to the health system and reductions in public health expenditure which can produce long-term effects that will not be visible in these indicators in the short term.

In this context, the Independent Expert on the effects of foreign debt noted that "Country-specific recommendations should be scrutinized with regard to their potential human rights impact and social policy targets need to be adequately reflected therein". The Independent Expert recommended that the EU "Devise a monitoring and accountability mechanism for ensuring the protection and realization of social rights in the context of the European Semester" and "Strengthen the mandate and capacity of the European Union Agency for Fundamental Rights ... to promote a rights-based review of economic and fiscal policies in the context of the European Semester".²⁸¹

4.2.2 HUMAN RIGHTS IMPACT ASSESSMENTS

In a meeting with Amnesty International, representatives from the European Commission's DG on Economic and Financial Affairs confirmed that they had not conducted any human rights or social impact assessments of the recommendations made to Spain as a part of the EDP or European Semester, before or after they were

²⁷⁷ See chapter 6; Eurofound, 'Impacts of the crisis on access to healthcare services in the EU', 24 November 2013, available here, www.eurofound.europa.eu/publications/report/2013/quality-of-life-social-policies/impacts-of-the-crisis-on-access-to-healthcare-services-in-the-eu; DG for Internal Policies, "The impact of the crisis on fundamental rights across Member States of the EU- Comparative Analysis" Study for the LIBE Committee (2015), available here [http://www.europarl.europa.eu/RegData/etudes/STUD/2015/510021/IPOL_STU\(2015\)510021_EN.pdf](http://www.europarl.europa.eu/RegData/etudes/STUD/2015/510021/IPOL_STU(2015)510021_EN.pdf); Council of the European Union, 'Council conclusions on the economic crisis and healthcare', Luxembourg, 20 June 2014, <http://www.consilium.europa.eu/media/28051/143283.pdf> [hereinafter: Council conclusions on health care, 2014].

²⁷⁸ UN Human Rights Council, Report of the Independent Expert on the effects of foreign debt on his mission to institutions of the European Union, 28 December 2016, UN Doc: A/HRC/34/57/Add.1, para 10. [hereinafter, Report of the Independent Expert on the European Union]

²⁷⁹ https://ec.europa.eu/health/policies/systems_fr

²⁸⁰ Interview with Commission representatives, February 2018. This is consistent with the following paper by the Commission: European Commission, 'Identifying fiscal sustainability challenges in the areas of pension, health care and long-term care policies' October 2014, Occasional Papers 201, available here: http://ec.europa.eu/economy_finance/publications/occasional_paper/2014/pdf/ocp201_en.pdf

²⁸¹ Report of the Independent Expert on the European Union, para 83.

made.²⁸² According to the representatives it was not necessary, as per EU procedure. Their recommendations were largely based on their internal analyses, such as the Country Report and In-Depth Review. They also said that the recommendations were often very broad – e.g. just percentage targets for fiscal consolidation – and the exact policy choice was left to the Spanish government. It would therefore be difficult for them to conduct any impact assessment of such a broad recommendation. Amnesty International asked if the Commission asked the Spanish government to conduct human rights or social impact assessments of how they implemented these recommendations. While this question was asked in one instance by the Commission’s Social Protection Committee, representatives told Amnesty International there was no process for this, and this was not being monitored by them.

Human rights impact assessments are necessary to understand what the possible impact of a particular policy might be, and to put in place measures to mitigate this impact. The Commission has a process in place to conduct Impact Assessments on some of its initiatives, including legislative and non-legislative proposals,²⁸³ when the expected economic, environmental or social impacts of EU action are “likely to be significant”.²⁸⁴ However, the Impact Assessment Guidance excludes “Economic governance: recommendations, opinions, adjustment programmes” as needing Impact Assessments because these are “Specific processes supported by country specific analyses”.²⁸⁵ Furthermore, the EU’s Impact Assessment guidelines have been criticised, including by OHCHR, for not adequately considering human rights concerns, particularly on economic and social rights. The Guidelines are primarily intended to assess economic, environmental or social impacts. While the Guidelines mention “fundamental rights” and some human rights concerns are included in the understanding of “social impact”, in the words of the OHCHR, “this does not sufficiently guarantee that human rights are systematically addressed”.²⁸⁶

4.2.3 INADEQUATE SAFEGUARDS

Lack of human rights impact assessments has meant that recommendations by the EU Commission and Council to address deficits often do not contain safeguards or suggestions necessary to ensure that their implementation does not result in reduced human rights protections. For example, none of the recommendations containing targets for fiscal consolidation under the EDP made reference to the need to respect Spain’s ongoing obligation to progressively realise economic and social rights, or the need to ensure that their implementation did not discriminate against or disproportionately impact marginalized groups. In 2013 and 2014, country-specific recommendations on the cost effectiveness of health expenditure asked that Spain do so while “maintaining accessibility for vulnerable groups”. While not a comprehensive safeguard, this practice is a welcome step through which to reflect a state’s human rights obligations in economic and fiscal choices. However, this caveat was removed in a similarly framed recommendation in 2015.²⁸⁷

Therefore, the recommendations by the EDP and European Semester increased pressure on the Spanish government to put in place the austerity measures that it did. EU institutions should have played a greater role in identifying and mitigating the human rights impact of these policies. Instead, they have either steered the Spanish government towards policies that were incompatible with Spain’s obligations to fulfil the right to health, or not done enough to mitigate potential human rights impact.

²⁸² Interview with Commission representatives, February 2018.

²⁸³ ‘The need for impact assessments’, available here: ec.europa.eu/info/law/law-making-process/planning-and-proposing-law/impact-assessments_en

²⁸⁴ “Tool #9. When is an Impact Assessment Necessary?” available here: ec.europa.eu/info/sites/info/files/file_import/better-regulation-toolbox-9_en_0.pdf [hereinafter: Tool #9]

²⁸⁵ Tool #9, p 51.

²⁸⁶ OHCHR, *The EU and International Human Rights Law*, p. 20, available here: www.europe.ohchr.org/Documents/Publications/EU_and_International_Law.pdf

²⁸⁷ When Amnesty International asked representatives of the DG on Economic and Financial Affairs why this safe-guard was removed, they explained it was because their internal analyses deemed it unnecessary. However, it is not clear what exact analysis this was, since none of the public documentation had made this assessment.

5. SPAIN'S HUMAN RIGHTS OBLIGATIONS

5.1 THE RIGHT TO HEALTH

Spain has ratified a range of international and regional human rights law treaties that require the right to health be respected, protected and fulfilled. These include the ICESCR and the Optional Protocol to the ICESCR;²⁸⁸ the Convention on the Elimination of All Forms of Discrimination against Women;²⁸⁹ the International Convention on the Elimination of All Forms of Racial Discrimination;²⁹⁰ the Convention on the Rights of the Child;²⁹¹ and the Convention on the Rights of Persons with Disabilities.²⁹²

The right to health requires that health care facilities, goods and services are available in sufficient quantity; accessible to everyone without discrimination, which includes physical accessibility, affordability, and information accessibility; acceptable to all person, that is, respectful of medical ethics and culturally appropriate; and of good quality.²⁹³ It also extends to the underlying determinants of health, which include food and nutrition, housing, safe water, adequate sanitation, safe and healthy working conditions, and a healthy environment.²⁹⁴ The “participation of the population in all health-related decision-making at the community, national and international levels” is also key.

These obligations include protections for specific groups, including those focussed on in this report. According to Article 25 of the Convention on the Rights of Persons with Disabilities, persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. A thematic study by the Special Rapporteur on the right to health noted that older persons were “especially vulnerable as a group” in terms of the right to health.²⁹⁵ Effective, transparent and accessible monitoring and accountability mechanisms are an essential feature of the right to health, and this includes the collection of relevant data that is disaggregated to capture the conditions of specifically marginalized groups.²⁹⁶

Furthermore, Spain has obligations under regional instruments that protect the right to health. The European Social Charter states that everyone has the right to benefit from any measures enabling them to enjoy the highest possible standard of health attainable, and Article 11 describes other measures that states should take to protect health.²⁹⁷ Spain has signed, but not ratified, the revised European Social Charter, which also protects aspects of the right to health.²⁹⁸ Article 168 of the Treaty on the Functioning of the European Union states that “A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities”. In 2014, the Council adopted conclusions on the economic crisis and

²⁸⁸ Article 12.

²⁸⁹ Article 12.

²⁹⁰ Article 5 (e) (iv).

²⁹¹ Article 24.

²⁹² Article 25.

²⁹³ CESCR, General Comment 14, para 12.

²⁹⁴ CESCR, General Comment 14, para 4.

²⁹⁵ UN Human Rights Council, Thematic study on the realization of the right to health of older persons by the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, UN Doc. A/HRC/18/37, 4 July 2011.

²⁹⁶ UN Human Rights Council, Report by the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, E/CN.4/2003/58, 13 February 2003; CESCR, General Comment 14, para 57 and 58.

²⁹⁷ European Social Charter 1961, available here: <https://www.coe.int/en/web/conventions/full-list/-/conventions/treaty/035>

²⁹⁸ European Social Charter (Revised), available here: <https://rm.coe.int/168007cf93>

health care, calling on states to “Continue improving further access for all to high quality healthcare services paying particular attention to the most vulnerable groups”.²⁹⁹

The Spanish Constitution protects the right to health in Article 43, which reads as follows: “(1) The right to health protection is recognised. (2) It is incumbent upon the public authorities to organise and safeguard public health by means of preventive measures and the necessary benefits and services. The law shall establish the rights and duties of all concerned in this respect”.³⁰⁰ It is listed under Chapter 3, titled, “Governing Principles of Economic and Social Policy”, meaning it is not enforceable in the same way as the rights listed in Chapter 2, titled “Rights and Liberties”. For example, Article 53 of the Spanish Constitution lays down a process by which the rights under Chapter 2 can be enforced, including through recourse to courts. However, Article 53(3) states that while substantive legislation, judicial practice and actions of the public authorities will be based on the “principles recognised in Chapter Three ... [they] may only be invoked in the ordinary courts in the context of the legal provisions by which they are developed”.³⁰¹

5.2 AUSTERITY & HUMAN RIGHTS

The obligation to realise the right to health is a progressive one, meaning, Spain has an immediate obligation to take deliberate, concrete and targeted steps towards the full realization of the right to health.³⁰² There is a strong presumption against deliberately retrogressive measures,³⁰³ and, if any deliberately retrogressive measures are taken, the State party must justify why this was done. Austerity measures, including those in Spain, usually involve reductions in public spending and structural changes in welfare systems to save costs. These often have the effect of causing a retrogression in the enjoyment of economic, social and cultural rights. Human rights monitoring bodies have noted, both, the human rights risks associated with austerity programmes and that states continue to have human rights obligations even “in times of economic crisis, [when] adjustments in the implementation of some Covenant rights might be inevitable”.³⁰⁴ On this basis, they have developed criteria for how austerity measures should be developed and implemented. There is growing international recognition based on general comments, concluding observations and statements of human rights mechanisms,³⁰⁵ that potentially retrogressive measures could only be regarded as consistent with economic, social and cultural rights obligations if these criteria are fulfilled.

Briefly, austerity measures should be (a) Temporary and only cover the period of the economic crisis;³⁰⁶ (b) Legitimate, with the ultimate aim of protecting the totality of human rights; (c) Necessary, in that they must be justifiable after the most careful consideration of all other less restrictive alternatives; (d) Reasonable, in that the means chosen are the most suitable and capable of achieving the legitimate aim; (e) Proportionate, in the sense that, the adoption of any other policy or failure to act would be more detrimental to the enjoyment of economic, social and cultural rights; (f) Not discriminatory and can mitigate the inequalities that can emerge in times of crisis; and they ensure that the rights of disadvantaged and marginalized individuals and groups are not disproportionately affected; (g) Protective of the minimum core content of economic, social and cultural rights; based on transparency and genuine participation of affected groups in examining the proposed measures and alternatives; (h) Subject to meaningful review and accountability procedures.³⁰⁷

²⁹⁹ Council conclusions on health care (2014).

³⁰⁰ Constitution of Spain, available here: <http://www.congreso.es/consti/constitucion/indice/index.htm>

³⁰¹ Constitution of Spain, available here: <http://www.congreso.es/consti/constitucion/indice/index.htm>

³⁰² CESCR, General Comment 14, para 30.

³⁰³ CESCR General Comment 14, para 32.

³⁰⁴ CESCR Letter, 16 May 2012.

³⁰⁵ The following experts have all developed and endorsed these criteria: the Independent Expert on the question of human rights and extreme poverty (appointed by the UN Human Rights Council); CESCR; OHCHR; and the Independent Expert on the effects of foreign debt. See: UN Human Rights Council, Report of the Independent Expert on the question of human rights and extreme poverty, UN Doc. A/HRC/17/34, 17 March 2011. CESCR Letter, 16 May 2012; See also CESCR, Public debt, austerity measures and the International Covenant on Economic, Social and Cultural rights, UN Doc. E/C.12/2016/1, 22 July 2016, which developed these standards further. OHCHR, *Report on austerity measures*, 2013. These criteria have also been referred to with approval by a Council of Europe study on this issue. The impact of the economic crisis and austerity measures on human rights in Europe: A Feasibility Study, Adopted by the Steering Committee for Human Rights (CDDH) on 11 December 2015.

³⁰⁶ OHCHR, *Report on austerity measures*, 2013

³⁰⁷ UN Human Rights Council, Report of the Independent Expert on the effects of foreign debt, UN Doc. A/HRC/37/54, 20 December 2017, para 29.

5.3 SPECIFIC OBSERVATIONS ON SPAIN BY HUMAN RIGHTS MONITORING BODIES

Several UN treaty and charter bodies have commented on the impact of the austerity measures on the right to health in Spain. In its 2012 report, CESCR recommended that Spain “ensure that all the austerity measures adopted reflect the minimum core content of all the Covenant rights and that it take all appropriate measures to protect that core content under any circumstances, especially for disadvantaged and marginalized individuals and groups³⁰⁸ ... and that, in all cases, such measures are temporary and proportionate ...”³⁰⁹ In the context of health, specifically, the Committee said that Spain must ensure that “the reforms adopted do not limit the access of persons residing in the State party to health services, regardless of their legal situation ... and that [Spain] assess the impact of any proposed cuts on the access of the most disadvantaged and marginalized individuals and groups to health services”.³¹⁰

In 2015, the CEDAW Committee observed that the financial and economic crisis and the austerity measures taken by Spain “have had negative effects on women in all spheres of life” and said it was concerned that “no study or evaluation has been conducted to monitor the gender-specific effects of the crisis”.³¹¹ In the context of health, specifically, it noted that the Royal Decree No. 16/2012 had a disproportionate impact on migrant women because it deprived them of free access to sexual and reproductive health services and recommended that Spain “Restore universal access to health care, including by repealing the amendment to Royal Legislative Decree No. 16/2012, with a view to ensuring health care for all women in the State party, regardless of their migration status”.³¹²

Similarly, the 2013 report by the Commissioner for Human Rights of the Council of Europe noted the impact of the economic crisis and fiscal austerity measures on persons with disabilities in Spain. In particular, the Commissioner noted that “No impact assessment of budgetary cuts on persons with disabilities has yet been carried out” and was concerned that “the important budgetary restrictions that have been implemented in the last two years, in addition to generating increased poverty among persons with disabilities, could lead to a retrogression in the enjoyment of some of the rights recognised in the last decade”.³¹³ His recommendations included ensuring that the introduction of co-payments for accessing a range of services, including health care, does not have a disproportionate impact on the income of persons with disabilities.³¹⁴

Several countries raised the impact of austerity measures in Spain’s 2015 UPR. Algeria recommended that Spain should systematically assess the impact of austerity measures on the most vulnerable social groups, especially children;³¹⁵ Brazil recommended that Spain take steps to ensure that the measures of austerity do not negatively impact economic, social and cultural rights, especially the rights to adequate housing, health, food and education;³¹⁶ Egypt recommended that any austerity measures adopted by the Government should be minimal, temporary, proportional, non-discriminatory, and take into account the needs of the poorest and most disadvantaged citizens;³¹⁷ and Cuba recommended that Spain resume the measures of social protection and care for the most disadvantaged affected by the international economic and financial crisis.³¹⁸ The government of Spain supported all these recommendations.³¹⁹

³⁰⁸ CESCR, Concluding Observations – Spain, 2012, para 8.

³⁰⁹ CESCR, Concluding Observations – Spain, 2012, para 17.

³¹⁰ CESCR, Concluding Observations – Spain, 2012, para 19.

³¹¹ CEDAW Committee, Concluding observations on the combined seventh and eighth periodic reports of Spain, UN Doc. CEDAW/C/ESP/CO/7-8, 29 July 2015, available here:

http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CEDAW/C/ESP/CO/7-8%20&Lang=En, [hereinafter: CEDAW Committee, Concluding Observations – Spain, 2015] para 8.

³¹² CEDAW Committee, Concluding Observations – Spain, 2015, para 30 and 31(a). Similar observations were also made by the Working Group on the issue of discrimination against women in law and in practice in 2015, see: UN Human Rights Council, Report of the Working Group on the issue of discrimination against women in law and in practice: Mission to Spain, UN Doc. A/HRC/29/40/Add.3, 17 June 2015.

³¹³ CoE, Commissioner for Human Rights Report, 2013, para 54.

³¹⁴ CoE, Commissioner for Human Rights Report, 2013, para 93.

³¹⁵ Spain UPR report, 2015, para 131.123.

³¹⁶ Spain UPR report, 2015, para 131.125.

³¹⁷ Spain UPR report, 2015, para 131.126.

³¹⁸ Spain UPR report, 2015, para 131.127. See also Venezuela’s recommendation, para 131.128.

³¹⁹ Anejo explicativo de las observaciones de España a las recomendaciones recibidas por España con ocasión del segundo ciclo del Examen Periódico Universal. (annex to document A/HRC/29/8/1), p 87, available at: <http://www.ohchr.org/EN/HRBodies/UPR/Pages/ESIndex.aspx>

6. CONCLUSIONS AND RECOMMENDATIONS

The austerity measures in the SNS – including reductions in public spending on health, structural changes in the public health system to reduce costs, and modifications in the working conditions of health workers – have resulted in a deterioration of the accessibility, affordability, and quality of health care in Spain. Health workers have been impacted as well: their working hours were raised, their pay and benefits were effectively reduced, and their workload increased. Many of these changes have had a particular and disproportionate impact on people with lower incomes, and within this group, on people with chronic health conditions, people with disabilities, older persons, and people accessing mental health care. Additionally, the manner in which these measures were developed and implemented was inconsistent with criteria developed by international human rights monitoring bodies. Measures that saved costs in the SNS without unduly compromising the right to health were implemented after, and not before, the measures that have had a retrogressive impact. No human rights impact assessments were conducted before the public health budget was cut or RDL 16/2012 was enforced. The levels of participation and consultation in how the austerity measures were developed and implemented were inadequate. And many of the changes introduced to the health system, notably RDL 16/2012, were not temporary and remain in force.

The retrogressive impact of the austerity measures, combined with how they were developed and implemented, lead Amnesty International to conclude that Spain is in violation of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

In light of the findings and conclusions above, Amnesty International recommends:

To the Ministry of Health, Social Services and Equality:

1. Regarding RDL 16/2012, urgently:
 - Repeal Article 3, 3 *bis* and 3 *ter* which limit the categories of people who can access health care under the SNS, and ensure that all persons, including irregular migrants, can access public health care on equal terms, free from discrimination.
 - Revise Article 8, 8 *bis*, 8 *ter*, and 8 *quarter*, and restore the structure of the common portfolio of services to before RDL 16/2012 came into force; Until this is done, ensure that the structure of any new co-payments includes adequate safeguards to ensure that particular groups – including people with disabilities, people accessing mental health care, older persons, people with chronic health conditions, and people who are on low incomes and economically vulnerable – are not disproportionately disadvantaged; and that health care is affordable to all.
 - Revise Article 85 *ter* to restore coverage to medicines “indicated in the treatment of minor symptoms”. Until this is done, consider: (i) Introducing financial safeguards or exceptions for groups who are regularly prescribed these medicines, and are disproportionately impacted by their removal; (ii) Gradually restoring coverage to the medical products that were removed from the SNS catalogue as a result of this amendment, starting with those that are important

for groups that are particularly impacted, including people with chronic health conditions and older persons.

- Revise the new structure for co-payments introduced by Article 94 *bis* to, at a minimum, ensure that the co-payment structure guarantees affordable health care for all, and does not result in undue financial burdens on economically vulnerable people, with a view to restoring the situation as it was before RDL 16/2012 came into force.
2. Urgently conduct a human rights impact assessment to assess how austerity measures have impacted the right to health in Spain, particularly the rights of groups at risk of greater impact, including people with disabilities, people accessing mental health care, people with chronic health conditions, and older persons. Make the results of this assessment public.
 3. Improve the working conditions of health workers including those that impact the accessibility and quality of healthcare. In particular, restore benefits, reduce the precariousness of health worker contracts, and ensure that adequate numbers of health workers are hired to meet the demand for health services.
 4. Urgently explore alternative options for how the budget deficit can be improved without resorting to measures that retrogressively impact the right to health.
 5. Support other policies with an impact of health and access to health care, such as those related to the social determinants of health, including by ensuring that the Dependency Law is adequately financed and fully implemented
 6. Conduct a human rights impact assessment before any future measures to improve the cost effectiveness and efficiency of the SNS are introduced, and ensure genuine consultation and participation with affected groups in how these measures are developed and implemented.

To the Ministry of Finance and Civil Service and the Ministry of Economy, Industry and Competitiveness:

1. Urgently explore alternative options for how the budget deficit can be improved by increasing revenues, for example, through effectively addressing tax evasion and tax fraud.
2. Develop mechanisms by which people can effectively participate in and contribute to discussions about budgets and public expenditure, before decisions to reduce public welfare expenditure are made in times of economic crisis.

To Regional Governments, in particular the governments of Andalucía and Galicia:

1. Prioritize increasing budgetary allocations for public health at a regional level, with a view to, at a minimum, restoring total and per capita expenditure on health to before the imposition of austerity measures, as soon as possible
2. Urgently address the deteriorations with respect to access, affordability, and quality of the right to health identified in this report, in particular:
 - Take urgent action to reduce the lengths of waiting lists and numbers of people waiting for care in the public health system
 - Ensure that any groups bearing a disproportionate financial impact of the austerity measures in the SNS are supported through targeted measures, so that health expenditure does not cause undue financial burdens.
 - Monitor and conduct an assessment of the specific impact of the economic “incentives” for health workers on quality of care;
3. Conduct a human rights impact assessment before any future measures to improve the cost effectiveness and efficiency of the regional health systems are implemented, and ensure genuine and adequate consultation and participation with affected groups in how these measures are developed and implemented.

To the Government of Spain:

1. Take steps to ensure that the Spanish Constitution recognizes and affirms the principle of indivisibility and interdependence of all human rights by giving equal status to all rights and ensuring that all economic, social and cultural rights are guaranteed akin to “fundamental rights” in Chapter II of the Constitution.
2. Ratify the European Social Charter (revised) and the 1995 Collective Complaints Protocol.

To EU institutions:

1. Ensure that recommendations and targets for fiscal consolidation made in the course of the European Semester and the EDP do not undermine states’ ability to fulfil their economic and social rights obligations.
2. Give states’ human rights obligations the same priority as is given to economic and fiscal targets while developing recommendations during the European Semester and the EDP, including by:
 - Using recent analyses of States’ compliance with economic and social rights obligations, as assessed by human rights monitoring bodies, as part of the internal analyses based on which recommendations are developed.
 - Giving social policy targets and human rights obligations greater priority in country-specific recommendations.
3. Conduct human rights impact assessments of all economic reform programs and financial assistance programmes, in line with the recommendations of the Independent Expert on the effects of foreign debt.
4. Conduct human rights impact assessments of Council and Commission recommendations under the European Semester and EDP that are specific and are likely to have an impact on human rights protections, and modify recommendations to introduce necessary safe guards and measures based on the results of these assessments.
5. Where it is difficult to conduct a human rights impact assessment of a particular recommendation because it is framed in general terms, but it is likely that it may impact human rights protections when implemented:
 - Introduce safeguards in the recommendation at the outset, asking the State to ensure that human rights are protected in its implementation, especially the rights of marginalized groups that may be at particular risk as a result of the recommendation. Amnesty International considers that recommendations asking States to reduce welfare spending or improve the “cost-effectiveness” of public welfare systems, carry this risk, and therefore should always be accompanied by safeguards.
 - Ask States to conduct human rights impact assessments before and after these recommendations are implemented, to periodically report back on the results of these assessments, and consider the results of these assessments while framing future recommendations.
6. Revise existing Impact Assessment Guidelines to ensure that all impact assessments evaluate how particular EU policies will impact human rights protections, including the ability of countries to respect, protect and fulfil the full range of their economic and social rights obligations.

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WRONG PRESCRIPTION

THE IMPACT OF AUSTERITY MEASURES ON THE RIGHT TO HEALTH IN SPAIN

The economic and financial crisis of 2008 had a severe impact in Spain, with people facing increasing levels of financial vulnerability, poverty and inequality. The government began to introduce austerity measures to urgently reduce its deficit, including cutting public spending on health. It also introduced structural changes to limit the costs of the Spanish public health system, including Royal Decree Law 16/2012, and measures that limited hiring and changed the working conditions of health workers.

This report examines how these austerity measures resulted in a deterioration of the accessibility, affordability, and quality of health care in Spain. Many of these measures have had a particular and disproportionate impact on people with lower incomes, and within this group, on people with chronic health conditions, people with disabilities, older persons, and people accessing mental health care. The retrogressive impact of the austerity measures, combined with how they were developed and implemented, lead Amnesty International to conclude that Spain is in violation of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.