EU-TRHeaDS
EU Citizens' Transnational Rights and Health-related Deservingness at the Street-level

Intra-EU mobility and national healthcare systems.

Policies and practices in Belgium and Spain

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Table of content

Introduction

Healthcare systems in Europe are characterised by significant differences in terms of regulation, financing and service provision. Although comparative healthcare research has developed different typologies of healthcare regimes (Böhm et al., 2013; Wendt et al., 2009; Frenk & Donabedian, 1987), it is common to distinguish between three main types:

- the National Health Service (NHS): residency-based, with the state being responsible for the regulation, financing and service provision to a large extent (includes all Nordic EU countries, Anglo-Saxon countries, Italy Portugal and Spain); when private actors are relevant in healthcare provision (Anglo-Saxon countries and Italy), some scholars identify a National Health Insurance sub-type;
- the Social Health Insurance (SHI): contributory-based; societal actors dominate the regulation, financing and service provision, with the possibility for the state to hold a stronger role in regulation or not (Austria, Belgium, France, Germany, Luxembourg, the Netherlands, the majority of Central and Eastern EU countries, and Switzerland);
- the Private Health System: based on private insurance, the market dominates the three core elements (among OECD countries, it can be found only in the US).

This variation in the institutional structure of healthcare systems implies differences in how healthcare solidarity is balanced with individual responsibility for healthcare and healthcare costs. In general, National Health Services operate with greater solidarity than insurance-based systems. In the latter, the majority of residents are individually responsible for a significant proportion of their own healthcare costs. In residency-based systems, on the contrary, the majority of residents are directly responsible for only a minimal proportion – if any – of their own healthcare costs.

Moreover, differences in the institutional structure of healthcare systems influence people's attitudes towards healthcare solidarity and the role of the state in guaranteeing healthcare to the population. The thesis that different types of healthcare systems generate different public discourses about and perceptions of healthcare beneficiaries has been the object of less investigation compared to the analysis of welfare regimes. For the latter, research has pointed out that individuals in liberal and conservative welfare regimes prove more reluctant to welfare redistribution and solidarity than those in social-democratic ones (among others, see: Dallinger, 2010; Larsen, 2008).

According to the last available data from the European Social Survey (2008), 84.4% of respondents believed that the government is responsible for ensuring healthcare, with values ranging from 61.8% in Switzerland to 90.9% in Greece (Table 1), with substantial variation across regimes.[1] On average, respondents living in countries with NHSs (green rows) appear to be more supportive of the role of the government in ensuring healthcare compared to the ones living in countries with SHIs (blue rows). The

[1] However, research has systematically pointed out that people are more supportive of individuals with healthcare than other social protection needs (Eick & Larsen, 2022; Jensen & Petersen, 2017; van Oorschot, 2006), what Coughlin (1980, p. 117) called a 'universal dimension of support' As Jensen and Petersen (2017) suggest, this broad consensus among the public for healthcare depends on the fact that sickness – differently from other life course and social risks, such as unemployment - is implicitly tagged as a need that is randomly caused, making sick people deserving of help.

COVID-19 pandemic may have changed these attitudes. However, the extent to which these eventual crisis-induced changes are structural or just temporary remains to be assessed.

Table 1. Percentage of people supporting the government's responsibility to ensure healthcare, 2008

	Support for public healthcare
Belgium	70,74
Bulgaria	87,44
Croatia	81,47
Cyprus*	82,30
Czech Republic	75,27
Denmark	87,52
Estonia	81,58
Finland	87,33
France	68,45
Germany	76,70
Greece**	91,26
Hungary	86,53
Ireland	81,69
Latvia	89,80
The Netherlands	77,73
Norway	89,41
Poland	86,35
Portugal	83,57
Romania	67,01
Slovakia	75,75
Slovenia	80,33
Spain	87,19
Sweden	82,30
Switzerland	62,34
United Kingdom	84,86
Mean	**84,37**
Mean SHI*	***76,62***
Mean NHS*	***85,23***

Source: ESS4-2008, [gvhlthc], Health care for the sick, governments' responsibility. Note: The table report the percentage of respondents who were truly supportive about government's responsibility to ensure adequate healthcare. The ESS4-2008 includes a question framed as follows: "People have different views on what the responsibilities of governments should or should not be. How much responsibility do you think governments should have to ensure adequate health care for the sick?". Answers are obtained on an 11-point scale with the endpoints "Governments should not be responsible at all" (0) to "Should be entirely governments' responsibility" (10). Respondents choosing 8 or above were coded as truly supportive. Blue rows identify countries with SHI schemes, while green rows refer to countries with NHSs.

*: Cyprus: the healthcare system of Cyprus consists of two parallel systems: a public one, which reflects the characteristics of NHSs in terms of regulation, financing and service provision, and a large private system, which is financed mostly by out-of-pocket payments and to some degree by voluntary health insurance (Theodorou et al., 2021).

**: Greece: Greece's healthcare system is a mixed system comprising elements from both the public and private sectors. In the public sector, a NHS type coexists with a SHI model, where taxes and social health insurances account for approximately 30% each of the funding of healthcare, while users' private spending makes up the remaining 41% (Economou et al., 2017).

*** Greece is excluded from the calculation of the means by type of healthcare system, due to the mixed nature of its public system.

Taking into account these differences in healthcare institutional structures and healthcare solidarity across MSs, how do different healthcare systems interact with intra-EU mobility? Are differences in healthcare solidarity in policies and public attitudes across countries characterised by different healthcare regimes when it comes to mobile EU citizens?

Article 167(7) of the Treaty on the Functioning of the European Union (TFEU) clearly states that the EU has no competence in matters related to the regulation, financing or provision of healthcare in Member States. However, this does not mean that the EU has no impact on public healthcare systems. As reminded by the Court of Justice of the European Union (CJEU), EU membership 'inevitably' results in the need to introduce some changes in the functioning of countries' social protection.[2]

In particular, the free movement of EU citizens interact with public healthcare systems in two concrete ways. On the one hand, the definition of the different categories of mobile EU citizens has a potential impact on the funding of healthcare. Tax-based, National Health Systems (NHSs), which are supposed to provide healthcare coverage to the population on the basis of residency, may receive variable income from workers and little or no income from economically inactive EU citizens. Countries with insurance-based systems (Social Health Insurance schemes, SHIs), on the contrary, may experience little or no variability in the funding of public healthcare from EU national residents, as financing originates from public resources and individuals' sickness premium (de Mars, 2019).

On the other hand, the transposition of the EU framework into national laws and the interpretation of the different conditions associated with the right to reside in another MS for mobile EU citizens have significant consequences on the their access to public healthcare in different MSs, particularly when it comes to economically inactive EU nationals (for a detailed discussion of the different categories, see: Perna (2022). EU-TRHeaDS – Deliverable no. 1). Different interpretations of who a 'worker' is, the requirement for sickness insurance and what a 'burden for the healthcare system' entails, may result in the granting or denying access to a public healthcare system.

Focusing on the cases of Belgium and Spain, two MSs characterised by different healthcare regimes (SHI in Belgium, NHS in Spain), this document provides a descriptive analysis of the ways in which the two different healthcare systems interact with intra-EU mobility. For each country, the document will present an overview of the main characteristics of the healthcare system, of the policies regulating the access to residency and healthcare rights for different categories of mobile EU citizens, as well as to the changing attitudes towards the healthcare-EU mobility nexus over the last decades.

[2] Case C-372/04 The Queen, on the application of Yvonne Watts v Bedford Primary Care Trust and Secretary of State for Health, ECLI:EU:C:2006:325, para 121.

1. Belgium: access to healthcare for mobile EU citizens in a SHI type

1.1. An overview of the Belgian healthcare system

The Belgian healthcare system is based on a Bismarkian-type compulsory health insurance scheme with solidarity across Belgian residents, administered by sickness funds. The main source of financing is social contributions, proportional to income. The provision of healthcare is based on the principles of independent medical practice, free choice of physician and healthcare facility, and fee-for-service payment (Gerkens & Merkur, 2010; 2020).

The origins of the Belgian healthcare system trace back to the XIX century when, in the context of industrialisation, workers created voluntary mutual-aid organisations to protect their members against the risk of disease, unemployment and incapacity to work (Gerkens & Merkur, 2010). At the end of the century, these organisations were granted official status as sickness funds by the state and, reflecting the 'pillarisation' logic of the Belgian society, they were progressively grouped into national associations according to their political or ideological background: the National Alliance of Christian Mutualities (1906); the National Union of Neutral Mutualities (1908); the National Union of Socialist Mutualities (1913); the National Union of Liberal Mutualities (1914); and the Union of the Free and Professional Mutualities (1920).

In 1944, the Social Security Act of 28 December set the foundations of the Belgian social security system. It created the National Social Security Office (ONSS-RSZ) to collect social security contributions for all sectors and the National Fund for Sickness and Disability (current National Institute for Health and Disability Insurance, INAMI-RIZIV) to manage health insurance in particular, and established the first compulsory health insurance scheme for all dependent workers. Then, the Health Insurance Act of 9 August 1963 defined the key characteristics of the Belgian system as based on the principles of independent medical practice, free choice of physician and hospital, and fee-for-service payment. Importantly, the 1963 Act introduced the so-called '*nomenclature*', which lists and values the medical services covered by the compulsory health insurance, as well as a system of agreements and conventions negotiated by healthcare providers and sickness funds to set fees and reimbursement levels. In addition, it created a new category of beneficiaries – including widows, orphans, pensioners and disabled people – having a preferential reimbursement rate for healthcare costs (Gerkens & Merkur, 2010).

Since then, the Belgian SHI system has progressively evolved to achieve universal coverage. Article 32 of the Coordinated Act on Compulsory Healthcare of 14 July 1994 (and its following amendments) defines the concept of beneficiary of the Belgian healthcare system.[3] Broadly speaking, it includes dependent and independent workers, job-seekers, people unable to work, students attending tertiary education, and people registered in the National Register of Natural Persons.[4] Dependent family

[3] Loi du 14 juillet 1994 relative à l'assurance obligatoire soins de santé et indemnités. Législation consolidée. https://www.inami.fgov.be/fr/publications/reglementation/Pages/loi19940714.aspx

[4] The National Register includes: all Belgians residing in Belgium; all Belgians residing abroad who are registered in the population registers kept in Belgian diplomatic missions or consular offices abroad; all foreigners residing in Belgium who are admitted or authorized to settle or stay in the Kingdom; all foreigners (and members of their families) who declare themselves to be refugees or who apply for recognition as refugees. The municipalities (and the Foreign Office for certain categories of migrants, including economically inactive EU citizens) are responsible for assessing the information provided by individuals and grant them registration in the list.

members of the beneficiary (partner, children < 25 year-old and ascendants, in case they lack sufficient resources on their own) are affiliated into the public healthcare system through the beneficiary ('*personne à charge*'). Simultaneously, the 1994 Consolidated Act explicitly excludes the following categories (Article 32, c.15):

- persons who are or may be entitled to healthcare under another Belgian or foreign healthcare insurance scheme;
- foreigners who are not entitled to stay in Belgium for more than three months or who are not entitled to settle or stay for more than six months.[5]

To date, compulsory health insurance covers 99% of Belgian residents, with 1% of the resident population not being covered due to non-compliance with administrative and/or financial requirements to be affiliated into the system (Gerkens & Merkur, 2020).[6] Next to compulsory health insurance, sickness funds and private for-profit insurance companies provide voluntary health insurance to cover services that are only partially covered, or are not covered, by the compulsory health insurance.

Governance of the system: regulation, financing and service provision

Reflecting the federal organisation of the country, healthcare regulation is shared between the state and the regions. The former is responsible for defining the basic principles and organisation of the system, including the rules regulating the national compulsory health insurance, the definition of hospital budget, health products and activities, as well as the regulation of healthcare professionals and patients' rights.[7] Regions are the main competent authorities in the fields of long-term care, mental care, primary and home care, and rehabilitation, as well as in the domains of health promotion and disease prevention. Provinces and municipalities have limited competences in the healthcare domain.

In particular, the Ministry of Health (Federal Public Service Health, Food Chain Safety and Environment) is responsible for the general organisation and planning of the system, while the INAMI-RIZIV manages all juridical, budgetary and medical aspects related to the compulsory health insurance, and exercise control powers over the sickness funds and health providers. Within the INAMI-RIZIV, a Directorate for International Relations manages the application of Belgian legislation in the case of international conventions on healthcare, i.e., the EU Regulations, the 2011 Directive on patients' rights, and bilateral agreements with third countries.

In the context of the EU Regulation, in particular, the INAMI-RIZIV plays the role of liaison body and, importantly, it represents the central point for the exchange of reimbursement claims between MSs. When a citizen of another MS receives healthcare in Belgium and is reimbursed by a Belgian sickness fund, the sickness fund establishes a claim, which is sent to the INAMI-RIZIV. The latter consolidates all reimbursement claims and send them to the competent institution of the MS of residence of the concerned citizens, which shall then reimburse those claims. Similarly, the INAMI-RIZIV receives

[5] However, exceptions to this exclusion apply in some cases, such as widows, orphans, or unaccompanied migrant minors who have been attending primary or secondary education for at least three consecutive months in Belgium.

[6] Specific categories are not included in this calculation, such as migrants with irregular residency status or foreign people working for international organisations.

[7] The health insurance budget, as well as decisions concerning the tariffs and reimbursement levels of healthcare services are negotiated with representatives of healthcare providers and sickness funds.

reimbursement claims from other MSs for those Belgian citizens who have received healthcare abroad, and it allocates these claims to the concerned sickness funds, which are the competent institutions.

Sickness funds constitute the key actor in the management of the compulsory health insurance.[8] In addition, they provide complementary health insurance to cover those services that are only partially covered – or not covered at all – by the compulsory health insurance, for which affiliates have to pay an additional flat-rate contribution (a community-rated premium). Competition among sickness funds concentrates mainly on these complementary services.

For what concerns health expenditure and financing, current health expenditure in Belgium has slightly increased in the last 10 years, from 10.23% of GDP in 2010 to 10.66% in 2019, less than 1 percentage point higher than the estimated EU28 average (9.96% in 2019 [Eurostat, healthcare expenditure by financing scheme; online data code: HLTH_SHA11_HF]). The main source of financing of the system is represented by social contributions paid to the ONSS-RSZ by employers and employees (proportional to income), together with government subsidies (mainly from personal income tax) and alternative financing sources (mainly value added taxes and, to a lesser extent, withholding tax). Next to public resources (76.8% of the current health expenditure in 2019), the system is financed by patients' out-of-pocket payments, i.e. official co-payments, non-reimbursed services and extra-billings (18.2% of the current health expenditure in 2019), and voluntary health insurances (5% of the current health expenditure in 2019) (Eurostat, online data code: HLTH_SHA11_HF]).

In terms of healthcare provision, it is based on the principles of independent medical practice, free choice of physicians and healthcare facilities (including public and private hospitals) without prior assessment by a general practitioner (no gatekeeping), and predominantly fee-for-service payment. Individuals in need of healthcare have to pay in advance the fees for services and then request reimbursement from their sickness fund.[9] A third-party payment system, in which the sickness fund directly pays its share, applies for the purchase of prescribed medicines and hospital/residential care, but this is being gradually extended to primary care for vulnerable social groups and chronic patients. The national 'nomenclature' establishes the official fees, which comprise official reimbursed tariffs and patient's co-payments (the so-called '*ticket modérateur/remgeld*'). Co-payments vary according to the service to be provided and patients' income, and they can either be a fixed amount or a proportion of the official fee. On top of national fees, extra-billing ('*supplementen d'honoraire'/'ereloonsupplement*') can be required by healthcare providers under some conditions.

According to recent evaluations (Gerkens & Merkur, 2020; Sciensano, 2020), the Belgian system was assessed as having overall good access to health services, despite some challenges have been identified for what concerns appropriateness of pharmaceutical care (particularly, overuse of antibiotics and psychotropics), availability of general practitioners (reducing in number due to the ageing of this group of professionals), and accessibility to some treatments, especially for the lowest income groups. Accordingly, the share of individuals reporting unmet needs for medical examinations

[8] Loi du 6 aout 1990 relative aux mutualités et aux unions nationales de mutualités. Législation consolidée. http://www.ejustice.just.fgov.be/img_l/pdf/1990/08/06/1990022427_F.pdf

[9] Reimbursement decisions are based on criteria such as the therapeutic added value of the intervention and the budget impact.

due to costs, waiting times, or travel distance was 2.2% in 2017, compared to 2.0% in the EU-15 (Gerkens & Merkur, 2020). In particular, cost was mentioned as the main reason for unmet needs in the country, with the share of individuals reporting this cause being higher than the EU-15 average (2.0% in Belgium, versus 1.1% in EU-15), especially among individuals in the lowest income quintile (5.6% versus 2.5%, respectively).

Likewise, the results of the Belgian health interview survey (Sciensano, 2020) indicate that 9.1% of Belgian households declared that they had to postpone healthcare for financial reasons in 2018, with large differences between the three regions (16.1% in the region of Brussels-Capital, 12.8% in the Walloon region, and 5.4% in the Flemish region). The study also revealed the existence of significant waiting times. In 2018, 48.4% of households declared they had to wait two or more weeks to get an appointment with a specialist (compared with 38.4% in 2013). Again, this indicator was higher in the Walloon region (55.6%) compared to the Flemish region (45.6%) and the region of Brussels-Capital (42.5%).

1.2. Intra-EU mobility in an increasingly 'hostile environment'

Since the early 1920s, and significantly after World War II, Belgium was among the main receiving immigration countries in Europe (Martiniello, 2003), initially attracting workers from Central and Southern Europe (Italy and Poland in particular) to be employed in the metal and mining industries in Wallonia and Limburg (Flanders) (Phalet & Swyngedouw, 2003). After World War II, in particular, the need for foreign labour force to sustain the country's post-war reconstruction led the government to sign agreements with 'labour-exporting' countries in Europe (Italy [1946], Spain [1956], Greece [1957], and Yugoslavia [1970]) and beyond (Morocco [1964], Turkey [1964], Tunisia [1969], and Algeria [1970]).[10] To convince workers to migrate to Belgium, it was common to advertise social protection benefits in the country (e.g., health insurance, family allowance measures, paid holidays) (Martiniello & Rea, 2012). At that time, welfare was used as a magnet for attracting a foreign workforce; it was a tool for 'workers shopping'.

With the breakdown of the heavy industries in the 1970s and 1980s and the rapid transition of Belgium to a post-industrial economy, attitudes towards immigration largely changed, with the government engaging into a 'zero-immigration' doctrine (Martiniello, 2003). Yet, immigration to Belgium continued under different patterns, among which intra-EU mobility represented a fundamental entry channels.

In that declining socio-economic environment, which affected most particularly the industrial region of Wallonia, the legal differences in status between EC and non-EC migrants established by the treaties became progressively associated with normative judgements regarding these populations: as xenophobia towards non-EC immigrants was rising and immigration increasingly politicised by far

[10] At the time of the agreement signed with Italy in 1946, the process of European integration had not yet started, with the European Steel and Coal Community - composed by Belgium, France, West Germany, Italy, the Netherlands and Luxembourg – being founded in 1951. Similarly, when Belgium signed bilateral agreements with Spain (1956) and Greece (1957) in order to recruit workers, these two countries were not yet members of the European Economic Community. Hence, at that time, Southern European immigrants did not come to Belgium under Community provisions concerning the freedom of circulation as workers, but rather were admitted to the country under the same immigration rules applying for third-country nationals.

right parties (Vangoidsenhoven & Pilet, 2015), a process of idealisation of old EU immigrants was taking place (Martiniello & Rea, 2012; Lafleur & Stanek, 2017).[11]

With the accession of Central and Eastern European countries to the EU, however, the dichotomy between desirable and undesirable migrants has been applied within the category of EU migrants as well. In both 2004 (EU8 enlargement) and 2007 (EU2 enlargement), Belgium — along other EU Member States —implemented transitional measures to delay by 7 years the date at which workers from new EU Member States could access the Belgian job market without a prior work permit.

These decisions came along with increasing debates claiming against the presence of 'illegal Eastern European workers' and 'bogus self-employed people breaking Belgian employment regulations' to obtain the residence permit (EMN, 2006, p. 17). Accordingly, Belgian political elites have often questioned the legitimacy of the arrival of workers from Central and Eastern EU countries, who have been frequently accused by the authorities of competing unfairly against Belgian workers, as well as of welfare shopping (EMN, 2012, p. 17), turning intra-EU mobility into a high debated topic in media and public opinion (Lafleur & Stanek, 2017).

In that context, strengthening controls against social dumping by systematically monitoring the reports of social services concerning EU self-employed workers and restricting EU citizens' access to social rights have become tools to curb unwanted EU immigration to Belgium. Systematic monitoring of data concerning EU self-employed citizens in Belgium has been included as a tool to fight social dumping in the annual Federal Plans for the fight against social fraud since 2017.[12] In addition, the federal government has adopted several deliberations allowing the automatic exchange of information between welfare offices and the national Immigration Office to detect those EU citizens who did not qualify as workers but applied for social assistance benefits, to serve them with an order to leave the territory (Lafleur & Mescoli, 2018). Assuming Belgium's welfare generosity as a magnet for unwanted migration, restrictions in social entitlements have been framed as the logical response to deter (unproductive) EU migrants to settle in Belgium (Perna, 2021). As a research participant explained,

> We have had cases of people, self-employed workers from certain countries, who started working in Belgium, so they were entitled to healthcare, family benefits and so on, and when the contributions had to be paid [to the sickness funds], they disappeared. In the meantime, they had received healthcare but their contributions were not in order. To me, that is fraud. We have had also cases of people arriving in Belgium with planned care but trying to receive them with the EHIC. We have had cases of people from a certain region of a certain country arriving at a certain hospital in Belgium. So, there we saw a kind of organised system: they arrived in Belgium, all of a sudden they had very serious and urgent diseases, so on the basis of the EHIC… It was planned care but the authorization to receive healthcare abroad had been refused in the country of origin, so they attempted to do so via the EHIC. But sometimes, when we find this out after the sickness fund has intervened and we send the claim to the country of origin, the country refuses to pay the claim, because they say: 'it is not urgent but planned care', because they have additional information on that person that we have not in Belgium. In that case, the cost of the treatments received remains at the expense of Belgium, and we must try to recover it directly from the person. And this is not easy. (IN_BE01)

[11] Yet, Italian immigrants faced high levels of discrimination after World War II and were frequently accused of being too culturally different and too religious to integrate into Belgian society (Martiniello, 1992).

[12] All plans are available here: https://www.sirs.belgique.be/fr/plan-daction-lutte-contre-la-fraude-sociale-et-le-dumping-social-2021

As research has highlighted (Lafleur & Stanek, 2017; Lafleur & Mescoli, 2018), many of these cases concerned EU citizens who applied for a living allowance or asked for social assistance because they faced a specific difficulty (e.g. unexpected hospital or utility bills). Although Romanians and Bulgarians have been the most affected by this policy, nationals from EU15 MSs - whose mobility into Belgium had never been a contentious issue (as in the case of Dutch and French citizens), or had been idealised over the years (Italian, Spanish and Portuguese citizens) – have been targeted by these measures as well.

1.3. Residency rights of EU citizens in Belgium

The criteria and procedures regulating residency rights of EU citizens in Belgium are set by Law of 25 April 2007,[13] which transposed the Citizenship Directive into the Belgian immigration framework (Law of 14 December 1980).[14]

EU citizens and their family members who move to Belgium for a stay not exceeding three months are required to report their presence in the territory to the municipal administration of the place where they reside within ten working days of their entry into the Kingdom (Law of 14 December 1980, Article 40bis).[15] If the presence is not reported within this period, they may be subject to the payment of an administrative fine of 200 euros. Entry and stay for less than three months can be denied only in case of EU citizens who have used false or falsified documents, or when they have resorted to fraud to obtain the right to stay in the country, as well as for reasons of public order, national security or public health.

Without prejudice to more favourable provisions contained in European laws or regulations which Union citizens could avail themselves of, EU citizens and their family members who move to Belgium for more than three months are granted residency rights according to their occupational status (Law of 14 December 1980, Article 40), replicating the conditions set by the Citizenship Directive on temporary legal residence, in the following cases:

- workers and job-seekers: they are employed or self-employed in Belgium, or they enter the country to seek employment as long as they are able to demonstrate it and have real chances of finding employment;
- economically inactive citizens: they have sufficient resources not to become a burden on the Belgian social assistance system, and have health insurance covering all risks in the Kingdom;
- students: they are enrolled in an recognised or subsidised educational institution for the primary purpose of studying (including vocational training), they have health insurance covering all risks in Belgium and demonstrate that they have sufficient resources not to become a burden on the Belgian social assistance system during their stay.

[13] Loi du 25 avril 2007 modifiant la loi du 15 décembre 1980 sur l'accès au territoire, le séjour, l'établissement et l'éloignement des étrangers. Version consolidée. https://etaamb.openjustice.be/fr/loi-du-25-avril-2007_n2007000465.html

[14] Loi du 15 décembre 1980 sur l'accès au territoire, le séjour, l'établissement et l'éloignement des étrangers. Version consolidée [01-03-2022]. https://www.ejustice.just.fgov.be/img_l/pdf/1980/12/15/1980121550_F.pdf

[15] This requirement does not apply to those citizens who are staying in a lodging house subject to the legislation on the control of travellers (e.g., hotels).

For both economically inactive citizens and students, 'sufficient resources' must at least correspond to the level of income below which the person concerned is eligible for social assistance in Belgium.[16] In assessing this condition, the personal situation of the EU citizen, including the nature and regularity of his/her income and the number of dependent family members, should be taken into account. As commented by a research participant,

> In the case of inactive people, it is a large group, it is a diverse group. It can be a person who has a disability, or a pensioner. So, this person must demonstrate the amount [of her/his disability allowance/pension] to the Foreign Office: is it enough, is it not? If this person only receives this disability allowance or pension from one Member State, the Regulation 883 designates this other Member State as the competent one for the healthcare coverage in Belgium, and must issue a S1 document. At that moment, the two conditions of the Directive 2004 are fulfilled, which means that the person will receive the right of residence. The problem is mainly with people who do not have income from work or any replacement income paid by the social security [of their country of previous residence]. These people will have problems to obtain the right of residence and open their right to healthcare. Why do they have problems? One, if they do not have any income, it is already a condition [of the Citizenship Directive] that is not fulfilled. And secondly, they will have to prove that they have a health insurance. Therefore, for an inactive EU citizen who applies for residence in Belgium, but who has no income and no health insurance, according to the 2004 Directive, Belgium can refuse him/her residence in the country. (IN_BE02)

Accordingly, the Foreign Office may terminate the right of residence of EU citizens and their family members when 'they constitute an unreasonable burden on the Belgian social assistance system.' (Law of 14 December 1980, Article 41ter), in line with the Citizenship Directive. As discussed in Section 1.2., this practice has been largely and indiscriminately used by Belgium in the early 2010s. After widespread contestation (Lafleur & Stanek, 2017), in 2014 a clarification has been introduced in the text of the law on how to assess the concept of 'unreasonable burden' and the decision to terminate residency rights, in line with the EU Commission's guidelines (2009). Concerning the former, Article 42bis states that, in order to determine whether a EU citizen constitutes an unreasonable burden for the Belgian social assistance system, the temporary nature of the person's economic difficulties, the duration of the stay in the country, his/her personal circumstances, as well as the amount of the social assistance benefit granted, should be taken into account. Concerning the decision of terminate the residency right of EU citizens who are deemed to constitute an 'unreasonable burden', the Foreign Office should take into account the length of the person's stay in Belgium, age, health status, family and economic situation, social and cultural integration in the country, and the intensity of his/her ties in the country of origin.

For what concerns unemployed people, they retain their residency right as workers in the following cases:

- they are temporarily unable to work due to illness or accident;
- in case of involuntarily unemployed, after having been employed for at least one year and having registered as job-seekers with the competent employment service;
- in case of involuntarily unemployed at the end of a fixed-term employment contract of less than one year, or after having been involuntarily unemployed for the first twelve months,

[16] The threshold is set annually by Royal Decrees.

provided that they have registered as job-seekers with the employment office. In this case, they retain the status of worker for at least six months.

After five years of continuous legal residence in the country, EU citizens are entitled to the right of permanent residence (Law of 14 December 1980, Article 42quinquies). Once acquired, this right can be lost in case of absence from the country for more than two consecutive years, or for serious reasons of public order or national security.

Finally, the Foreign Office can withdraw the residence right of EU citizens when they have used false or misleading information, or false or falsified documents, or when they have resorted to fraud or other illegal means to obtain the right to reside in Belgium (Law of 14 December 1980, Article 44).

In case of a decision to withdraw the residency right of a Union citizen, the Foreign Office shall issue an 'order to leave the country', which indicates the period within which the concerned person must leave the country (no less than one month from the date of notification of the decision). When an order to leave the country is issued, a ban on re-entry into Belgium can be imposed solely for reasons of public order, national security or public health (Law of 14 December 1980, Article 44nonies). Importantly, these reasons cannot be invoked for economic purposes, and decisions concerning the withdrawal of the right of residence must in any case respect the principle of proportionality (Law of 14 December 1980, Article 45).

1.4. Healthcare rights for EU citizens in Belgium

EU citizens who move temporarily to Belgium shall be guaranteed access to medically necessary care through their European Health Insurance Card (EHIC) according to the EU Regulation on the coordination of social security systems (for an overview on the EHIC, see Perna (2022), EU-TRHeaDS, Deliverable no. 1). Specifically, EU citizens - temporarily staying in Belgium, in need of necessary care and insured in their MS of residence - can access primary or specialised healthcare in Belgium by showing the EHIC, and an invoice will be issued for the treatments received. With that certificate and the EHIC, EU citizens can go a sickness fund of their choice, and they will be reimbursed according to the Belgian legislation. In the case of hospitalization, EU citizens do not participate directly in the reimbursement process. Rather, the hospital will contact a sickness fund on the basis of the data shown in the EHIC and ask whether the sickness fund wants to pay for the treatments the patient will receive on the basis of the EHIC. In case of a positive answer, the reimbursement mechanism via the INAMI-RIZIV presented in Section 1.1. will be activated. However, sickness funds may refuse to cover the costs of the treatment provided to the person (e.g., when they have doubts about the 'planned/unplanned' nature of the treatment). In that case, the costs of the treatment will remain on charge of the EU citizen.

According to a research participant,

> Almost 99% of the time, it works. Sometimes there are problems that, for example, a hospital has refused a EHIC. But it is true that, if we receive ten files on an annual basis, it is a lot. Other claims that we receive, they can concern a hospital that has asked for a deposit from the insured EU citizen. However, this is allowed by our legislation, although of course there are limits to the amount of the deposit that a hospital can ask… Sometimes there is a misunderstanding of the other system… For example, in our country, even in case of hospitalization, there is a co-payment to be paid by the patient. In some

> countries, healthcare in public hospitals is free in the sense that there is no co-payment. So, this person thinks: 'with my EHIC, there will be nothing to pay'. But this is not the case here! (IN_BE01)

After three months of residence, the possibilities for EU migrants to access the public healthcare system differentiate according to their residency status (temporary residence, permanent residence, no legal residence) and occupational status. In the case of temporary residence, entitlement to healthcare by occupational status is linked to the main categories identified by the Citizenship Directive (dependent and independent workers, students, economically inactive citizens). In the case of permanent residence, EU citizens should be treated under the same conditions that apply to Belgian nationals. Hence, the entitlement categories identified by the Coordinated Act on Compulsory Healthcare of 14 July 1994 apply: dependent and independent workers, people unable to work, students attending tertiary education, and people registered in the National Register of Natural Persons, and their dependent family members. When residency conditions are not fulfilled (e.g., when the residency application is rejected or when the residency right is withdrawn), EU citizens can be eligible for a residual social assistance benefit aimed at guaranteeing access to healthcare (Aide Médicale Urgente, AMU), as they were third-country nationals with irregular status (Perna, 2021).[17]

As Table 2 indicates, residence constitutes the first and most important demarcation point to understand how free movement of EU citizens interacts with the Belgian public healthcare system. EU citizens holding permanent residence constitute the most secure category: regardless of occupational status, they shall be treated under the same conditions as Belgian nationals in relation to the healthcare system, and their right to reside in the country is almost unconditional. At the opposite, EU citizens who do not comply with residency requirements lie at the edge of the system: considered as 'irregular migrants', they cannot be affiliated to a sickness fund and, thus, they are not entitled to public healthcare. In this case, access to healthcare may be guaranteed by the state under certain health, residency and economic conditions. However, as commented by a research participant,

> If you need to go to a hospital but you are not covered by the public system and you do not have a private insurance, in Belgium you can have access via the CPAS. If you go with this, you are considered as a burden already. Of course, you will not be forbidden [access to healthcare], because the doctors have the obligation to treat you, but you will be considered as a burden, and this can be an issue for your residence right. It happens. (IN_CS01)

[17] Introduced in 1996 for non-EU migrants with irregular status (Royal Decree 12 December 1996), this means-tested social assistance measure grants the person almost the same healthcare coverage as Belgian nationals, including any preventive and curative care, delivered either in hospital or ambulatory settings, as well as drug prescription. In procedural terms, the Belgian welfare offices (CPAS) are responsible for verifying applicants' compliance with AMU eligibility criteria. This evaluation is based on several criteria, including territoriality (the applicant has her/his effective residence on the territory of CPAS), lack of coverage (nobody else can cover healthcare costs for the applicant and she/he has not a valid healthcare insurance in her/his home country), and indigence status (no financial capacity of the applicant to pay for her/his healthcare). Nationality is not mentioned among such criteria. 'In the Law on CPAS we do not distinguish between European sans-papiers and sans-papiers from third countries. A sans-papiers is a sans-papiers, it's the same thing.' (INBE_07). If the person is declared eligible for AMU, the federal government will reimburse hospitals and health professionals for the treatment provided, acting as sickness fund. If not, she/he will have to pay the full cost of the treatment received.

Table 2. Entitlement to healthcare for EU citizens in Belgium

Lenght of stay/residency	Occupational status	Entitlement to healthcare
TEMPORARY STAY (less than 3 months)	Regardless of occupational status in Belgium	Healthcare coverage is guaranteed by the MS of origin (EHIC).
TEMPORARY RESIDENCE (more than 3 months, less than 5 years)	a) Workers	a) Compulsory healthcare insurance via affiliation in a Belgian sickness fund as dependent or independent worker.
	b) Job-seekers	b) Compulsory healthcare insurance via affiliation in a Belgian sickness fund as worker (for a limited period of time) or unemployed person
	c) Students	c) EHIC (if coverage throughout the entire period of temporary residence) or compulsory healthcare insurance via affiliation in a Belgian sickness fund as student
	d) Economically inactive citizens	d) Private sickness insurance covering against all risks in Belgium, or healthcare insurance via affiliation in a Belgian sickness fund as resident.
PERMANENT RESIDENCE (more than 5 years)	- Dependent or independent workers - Job-seekers - Students - Residents (not falling into the previous categories)	Compulsory healthcare insurance via registration in a Belgian sickness insurance, depending on occupational situation.
NO REGULAR RESIDENCY (unlawful stay for more than three months)	///	No affiliation to sickness funds. Access to healthcare can be provided via AMU (under certain conditions).

Source: author's elaboration, based on Law of 14 December 1980, the Coordinated Act of 14 July 1994 and Royal Decree 12 December 1996.

Acknowledging residence as a key demarcation point, the ways it is assessed at the everyday level of practices is central to understand some of the challenges that affect the realisation of the right to healthcare for EU citizens.

The 1980 law states that the right to reside in Belgium for more than three shall be granted as soon as possible and no later than six months after the date of the application (Law of 14 December 1980, Article 42). In cities with large amounts of registration requests, however, administrative delays may be significant (IN_BE02; IN_BE03), and EU citizens applying for residence may be pending for a registration certificate for several months. However, these delays may turn into bureaucratic barriers to enjoy healthcare rights.

According to the Citizenship Directive, possession of a registration certificate, of a residence card or of a permanent residence card, 'may under no circumstances be made a precondition for the exercise of a right or the completion of an administrative formality, as entitlement to rights may be attested by any other means of proof.' (Directive 2004/38/EC, Article 25). However, Belgian sickness funds frequently refuse to affiliate prospective beneficiaries who do not hold a residency certificate yet (IN_BE04; IN_BE05; IN_BE06), in spite of indications from INAMI-RIZIV against this practice.

Likewise, front-line workers at sickness funds often keep asking EU citizens moving from other Member States to provide an E104 form, a certificate that summarised all the insurance periods paid

for by a EU citizen in a Member State. With the entry into force of the EESSI system[18], this information should be exchange directly between competent institutions, without the need for the individual citizen to provide it. As explained by a research participant,

> Currently, for all exchange of information on documentation, opening and termination of rights, all MSs work with the EESSI system. And everyone who is at the counter [of a sickness fund] already knows the system. But we need to give it more time so that all front-line workers know how it works. We have already informed the sickness funds that they should no longer ask EU nationals to submit the E104 form in order to be affiliated into the system, but that they have to request this information through the EESSI system. But… I cannot control all workers. (IN_BE01)

[18] The 'Electronic Exchange of Social Security Information' (EESSI) system was launched in 2017 to further facilitate and speed up exchanges between MSs' social security institutions on sickness benefits and all other social security domains covered by the Regulations.

2. Spain: access to healthcare for mobile EU citizens in a NHS type

1.1. An overview of the Spanish healthcare system

The Spanish national healthcare system (*Sistema Nacional de Salud*, SNS) is based on the principles of universality, free access, equity and fairness of financing.[19] Accordingly, healthcare coverage is guaranteed to all people habitually living in the country, it is mainly funded from general taxation, and healthcare is predominantly provided free of charge at the point of access (with the exception of outpatient pharmaceutical prescriptions), and within the public sector, although significant differences exist across the 17 Autonomous Communities (Table 3 in the next sub-section).

Reflecting the political and territorial decentralisation of Spain, the SNS is organised at two levels – national and regional. The Ministry of Health is responsible for the definition of the basic principles for the regulation, financing and provision of healthcare across the countries, while the 17 Autonomous Communities (ACs) are in charge of the local implementation of national regulation, the development of regional regulations and policies, (co-)financing of the system and healthcare provision, via their regional healthcare systems.[20]

Since their inception, dating back to the adoption of the 1978 Spanish Constitution and the establishment of a quasi-federal political system, the role of the ACs in healthcare has progressively expanded to play an essential role in the regulation, financing and provision of healthcare (Moreno, 2009). Started with the adoption of the General Health Law in 1986, the process of decentralisation in healthcare was completed in 2001, when all ACs received full competences in healthcare. From then to 2012, policy reforms were aimed at better institutional coordination and cohesion of the system (Law 16/2003)[21], at strengthening the regulatory capacity of ACs in the organization, financing and management of public healthcare (Law 22/2009 and reforms of the Statutes of Autonomy of ACs)[22], and at expanding healthcare coverage and the basket of healthcare services to be provided (Law 33/2011 on Public Health,[23] which exhibited an unequivocal commitment to 'health in all policies' approach) (Bernal-Delgado et al., 2018, p. 26).

However, this path towards full universalization was suddenly reversed by Royal Decree-Law 16/2012 on 'urgent measures to guarantee the sustainability of the SNS',[24] adopted by the conservative government of Mariano Rajoy (Moreno Fuentes, 2015). As the name of the reform suggests, the harsh economic and fiscal crisis affecting Spain and ensuing austerity measures were cited to justify cuts to

[19] Two statutory subsystems coexist with the SNS, namely the public sickness funds for civil servants, the Armed Forces and the judiciary (MUFACE, MUGEJU and ISFAS); and public mutualities collaborating with the National Institute for Social Security in case of accidents and occupational diseases (*Mutuas de accidentes de trabajo y enfermedad professional*).

[20] Healthcare in the Autonomous Cities of Ceuta and Melilla falls under the responsibility of the central government via the Institute for Health Care Management (*Instituto de Gestión Sanitaria*, INGESA).

[21] Ley 16/2003, de 28 de mayo, de cohesión y calidad del Sistema Nacional de Salud, BOE no. 128 of 29/05/2003. https://www.boe.es/buscar/act.php?id=BOE-A-2003-10715

[22] Ley 22/2009, de 18 de diciembre, por la que se regula el sistema de financiación de las Comunidades Autónomas de régimen común y Ciudades con Estatuto de Autonomía y se modifican determinadas normas tributarias. BOE no. 305 of 19/12/2009. https://www.boe.es/buscar/act.php?id=BOE-A-2009-20375

[23] Ley 33/2011, de 4 de octubre, General de Salud Pública. BOE no. 240 of 05/10/2011. https://www.boe.es/buscar/act.php?id=BOE-A-2011-15623

[24] Real Decreto-ley 16/2012, de 20 de abril, de medidas urgentes para garantizar la sostenibilidad del Sistema Nacional de Salud y mejorar la calidad y seguridad de sus prestaciones. BOE no. 98 of 24/04/2012. https://www.boe.es/buscar/act.php?id=BOE-A-2012-5403

public healthcare spending, the alleged 'urgency' of which was used to pass the reform without parliamentary debate. In the introduction to the decree, retrenchment was justified contending that the 'lack of rigour and emphasis on the system efficiency has led the SNS to a situation of severe economic difficulty' (Royal Decree-Law 16/2012, p. 3). Cost-containment to reverse this 'unsustainable public deficit' was deemed necessary in order to sustain the SNS in the long term. Most importantly, the sustainability argument was invoked to introduce a radical shift in the process of healthcare universalisation. Although financing continued to be tax-based, the reform reintroduced the categories of 'insured persons' (workers, pensioners, unemployed receiving benefits and job seekers) and 'beneficiaries' (dependent relatives of insured persons under the age of 26) to define the groups entitled to the complete package of healthcare services provided by the SNS. On the contrary, undocumented migrants and legal residents earning more than €100.000 per year were excluded from public healthcare coverage (except for emergency care) and expected to purchase private insurance (Moreno Fuentes, 2015). As it will be commented below, this reform had significant exclusionary effects for vulnerable people, including certain groups of EU citizens.

With a new government in office led by the socialist party PSOE, the system underwent a counter-reform through the adoption of Royal Decree-Law 7/2018 'on universal access to the SNS',[25] which introduced important changes with regard to healthcare entitlements ('every person who resides in the Spanish state') and the policy goal ('access to the SNS in conditions of equity and universality'). Dismantling the contributory-based logic behind the 2012 reform, the 2018 counter-reform decoupled healthcare entitlements from insurance status while reconnecting it to residence in Spain. Even though the new law re-established universalist ownership of the right to healthcare (residence-based and regardless of nationality or legal status), it included more conditions for exercising this right compared to the pre-2012 framework, indirectly distinguishing between 'rightful' and 'conditional owners' of healthcare entitlements (Bruquetas-Callejo & Perna, 2020).

Although these changes have affected the extent of coverage of the SNS, to date the system is almost universal in terms of coverage (99% of the population, [OECD, 2019]). While citizens are entitled to comprehensive coverage on the basis of nationality, coverage of foreign residents depends on the interplay between immigration and health laws, meaning that non-citizen residents follow different entitlement paths, depending on their citizenship (EU or non-EU) and administrative legal status.

Governance of the system: regulation, financing and service provision

Replicating the quasi-federal organisation of the country, the Spanish healthcare system is organised at two levels – national and regional. At the national level, the Ministry of Health is responsible for the definition of the general functioning principles of the system, the minimum basket of services that shall be provided on equal grounds throughout the Spanish territory (*cartera de servicios comunes*, detailed below), and the planning of the annual healthcare budget. At the regional level, the 17 Autonomous Communities (ACs) and their Health Departments are responsible for the local implementation of the national regulation, the development of regional healthcare policies, (co-)financing of the system and for healthcare provision via their regional healthcare systems. The

[25] Real Decreto-ley 7/2018, de 27 de julio, sobre el acceso universal al Sistema Nacional de Salud. BOE no. 183 of 30/07/2018 https://www.boe.es/buscar/act.php?id=BOE-A-2018-10752#ap

overall coordination of the system shall be guaranteed through the Interterritorial Council for the SNS, which is composed by the Ministry of Health and the Heads of the 17 Regional Health Departments.

For what concerns the system's financing, since 2001, it has been regulated under the general regulatory frame for the financing of the ACs under the responsibility of the Council for Fiscal Policy and Finance (*Consejo de Política Fiscal y Financiera*), which is composed by the Spanish Ministry of Finances and the ACs' Finance Departments. Public funds come mostly from tax revenues (mainly VAT and income taxes), and ACs manage most of these resources (92.2% of public health expenditure and 64% of total health expenditure).[26]

Overall, health expenditure in Spain has steadily increased in the last 20 years, from 7.2% of GDP in 2000 to 10.71% in 2020 (Eurostat, health care expenditure by financing scheme – All financing schemes; online data code: HLTH_SHA11_HF). Public health expenditure in 2020 represented 7.5% of GDP, a value that has increased in the last decade (in 2011, it represented 6.4% of GDP. Next to public resources, which constituted 69.5% of the total health expenditure in 2020, private expenditure on health (i.e., voluntary health insurance schemes) has increased from 2011 (5.8% of the total health expenditure) to 2018 (7.6% of total health expenditure), to then decrease in 2020 (6.7% of total health expenditure). Finally, out-of-pocket payments constitute approximately 19.6% of the total expenditure on health in 2020, structurally decreasing since 2011, when they represented 22.3% of the total health expenditure in the country.

Finally, for what concerns healthcare provision, treatments and services are categorised into two basket of services: a common package (*cartera de servicios communes del SNS,* including core and supplementary services) for all 17 regional services composing the SNS; and a complementary package (*cartera de servicios complementaria de las Comunidades Autónomas*), which is defined and financed by each AC, thus falling outside the general financing of the SNS. Concerning the common package, the core package (*cartera común básica*) includes all those healthcare services that are fully covered by public expenditure, while the supplementary package (*cartera común suplementaria*) refers to out-patient care that requires co-payments on the side of users (such as pharmaceutical care, orthoprosthetic provision, or non-emergency medical transport).

Primary care constitutes a core element of the Spanish healthcare system, which is provided by healthcare professionals (family doctors and staff nurses) in public healthcare centres (*centros de salud*) allocated across the territory by way of an administrative distribution of the population (the so-called 'basic healthcare areas', *zonas básicas de salud*). Accordingly, users cannot choose their public healthcare centre of reference, but are assigned to the one corresponding to their residence address. At these public healthcare centres, primary care doctors are the gatekeepers of the SNS, as they refer patients to specialised and hospital care (inpatient and outpatient). For what concerns hospitals, their

[26] No taxes are specifically dedicated to the financing of regional healthcare systems, but rather to the financing of all welfare services in each AC, leaving wide margins for discretion to regional policy-makers on the specific allocation of these resources. To reduce funding imbalance across ACs due to the strong decentralization of the fiscal system, a complex mechanism of 'compensation funds' has been created. Hence, in addition to ACs' own fiscal revenues and the so-called Fund for Basic Public Services, health services are also funded by the Fund for Global Sufficiency, the Healthcare Guarantee Fund and various 'convergence funds' (for an explanation of the functioning of these funds, see Bernal-Delgado et al., 2018, pp. 61-62).

ownership and organizational models vary greatly across the country (for an in-depth analysis, see: Bernal-Delgado et al., 2018).

Next to public provision, individuals may purchase private voluntary insurances, usually for complementary coverage, which are frequently used to access services for which there are long waiting times in the public system or to access services that are not included in the public packages, such as adult dental care. On average, private voluntary schemes cover around 13% of the population, although there is significant variation across ACs (Table 3).

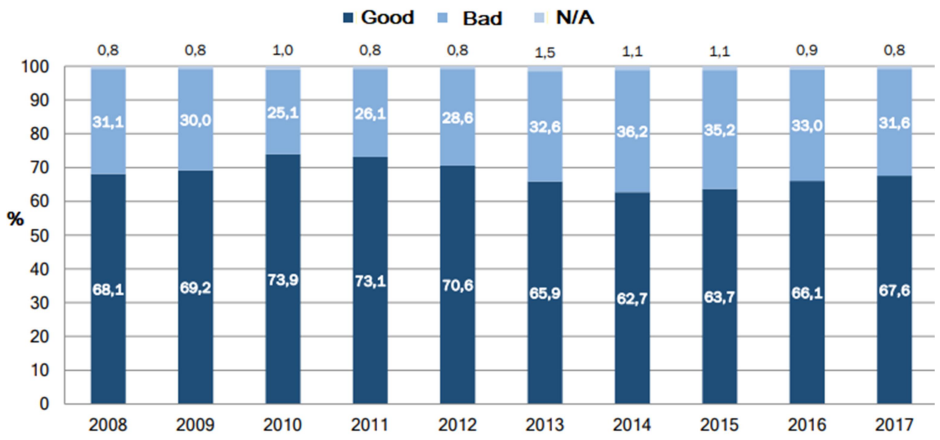
Table 3. Type of health coverage by AC

AC	Public only	Private only	Both	Other situations
Andalucía	90.8	2.3	6.6	0.4
Aragón	86.9	0.9	11.8	0.4
Asturias	86.1	0.3	13.5	0.1
Balearic Islands	74.1	0.7	25.0	0.2
Basque Country	79.5	0.6	19.9	0.0
Canary Islands	92.8	2.0	4.9	0.3
Cantabria	92.7	1.7	5.4	0.3
Castilla-León	88.8	0.7	10.4	0.1
Castilla-La Mancha	92.4	0.7	6.5	0.5
Catalonia	74.9	1.1	23.9	0.2
Extremadura	97.3	0.4	2.3	0.0
Galicia	91.1	0.3	8.5	0.0
Madrid	75.3	1.9	22.7	0.1
Murcia	91.6	2.4	5.4	0.6
Navarra	94.4	0.8	4.2	0.5
La Rioja	92.0	0.3	7.8	0.0
La Rioja	92.0	0.3	7.8	0.0
Valencia	88.5	1.8	8.8	1.0
Ceuta and Melilla	96.0	1.8	2.3	0.0
TOTAL	**85.1**	**1.4**	**13.2**	**0.3**

Source: Bernal-Delgado et al., 2018, p. 61

Overall, the Spanish SNS is considered to be among the most efficient healthcare systems in Europe, and the third one in the world, following Hong Kong and Singapore (Bloomberg Index 2022). Among the Spanish population, the level of satisfaction with the public health system is quite high (Ministerio de Sanidad, 2020), with 67.6% of the population rating the functioning of the system in 2018 as "good" and "fairly good" (Figure 1). However, several challenges remain in the SNS, including increasing obesity, the persisting gap in self-reported health across socioeconomic groups, as well as the existence of long waiting times for surgery, diagnostic procedures and specialised visits (Bernal-Delgado et al., 2018).

Figure 1. Level of satisfaction with the SNS – 2018



Source: Ministerio de Sanidad (2020, p. 9). Note: "Good" includes the answers "good" and "fairly good"; "Bad" includes the answers "fairly bad" and "bad".

1.2. Intra-EU mobility in Spain: dynamics and attitudes

Spain has been traditionally included in the so-called "Mediterranean model" (Pugliese, 2011) or "Southern European model of migration" (King, 2000; King & DeBono, 2013). Country of large-scale emigration until the early 1970s, Spain experienced a migration turnaround in the late 1980s, when the closure of Western European markets to further labour migration after the 1973 oil crisis on the one hand, and the improving economic situation of the country and its transition to democracy on the other hand, slowed down mass emigration. Simultaneously, immigration grew exponentially, driven in particular by the booming of construction and tourism industries in the early 2000s, a period in which Spain enjoyed a strong and sustained economic growth (Bermudez & Brey, 2017).

As Table 4 indicates, among EU nationalities, Romanian citizens represent the most relevant group in 2021 (644,473 citizens) and the ones that show the highest increase in the last two decades, followed at great distance by citizens from the UK (282,124 citizens in 2021), Italy (257,256), Bulgaria (118,120), Germany and France (both nationalities account for around 109,000 residents in Spain).

The 2008 Great Recession put an end to the period of economic prosperity mentioned above, with unemployment rates reaching 24.5 % in 2014 (more than 14 percentage points above the EU average in the same year). The macroeconomic context since 2010 in the country has been characterized by the global economic recession, which resulted in policies aimed at reducing public expenditure. Accordingly, policy decisions and priority setting mechanisms have been subordinated to macroeconomic conditions and the need to comply with the requirements of deficit and debt reduction set by the 2010 Stability Pact.

This economic landscape motivate a more defensive immigration policy against irregular migration (Cebolla-Boado & Gonzáles, 2007; Seoane Pérez, 2017), while leading to increased emigration from young and highly skilled Spaniards towards Western EU countries (negative migratory balance between 2011 and 2015) (Gonzales Enriquez & Martínez Romera, 2017). Due to the impossibility of restricting mobility inflows of citizens from other EU Member States, important restrictions to the access to residency and healthcare for EU migrant citizens were introduced by Royal Decree-Law 16/2012 on 'urgent measures to guarantee the sustainability of the SNS' (see Sections 2.3 and 2.4

below), revealing the use of the healthcare policies as an indirect tool of migration control (Ataç & Rosenberger, 2019).

Table 4. Foreign population in Spain (by descending order of relevance) – 2001/2021

	2001 (a.v.)	2021 (a.v.)	2001-2021 (%)
All foreign nationalities	1,370,657	5,440,148	296.9
EU27+UK			
Romania	31,641	644,473	1,936.8
UK	107,326	282,124	162.9
Italy	34,689	257,256	641.6
Bulgaria	12,035	118,120	881.5
Germany	99,217	109,556	10.4
France	51,582	109,397	112.1
Portugal	47,064	97,187	106.5
Poland	13,469	52,206	287.6
The Netherlands	23,146	46,833	102.3
Belgium	19,869	34,669	74.5
Sweden	11,137	20,011	79.7
Ireland	4,093	16,669	307.3
Lithuania	1,847	15,913	761.6
Finland	6,289	11,176	77.7
Hungary	912	10,610	1,063.4
Denmark	6,760	8,951	32.4
Austria	4,774	7,191	50.6
Czech Republic	97,187	7,004	-92.8
Slovakia	868	5,790	567.1
Greece	1,005	5,123	409.8
Latvia	210	5,063	2,311.0
Croatia	789	2,858	262.2
Estonia	104	2,731	2,526.0
Slovenia	178	1,705	857.9
Luxembourgh	360	642	78.3
Cyprus	103	480	366.0
Malta	65	370	469.2

Source: INE (2022). INEbase / Estadística del Padrón continuo / Población extranjera por Nacionalidad, provincias, Sexo y Año.

Likewise, while attitudes towards and media coverage of intra-EU mobility have been traditionally positive in Spain, particularly when compared to other EU countries (Eberl et al., 2019, p. 49), the last decade has been characterised by an increasing opposition towards intra-EU mobility inflows, mainly targeting Eastern EU migrant citizens. According to the Centre for Sociological Research survey 2846/2010, Romanians ranked as the most disliked migrant group in Spain (CIS, 2010). Likewise, research has pointed out as national and regional newspapers has often reported negative news relating to Romanian migrants as a group, with most of the stories relating to crime, robbery, or local Roma conflicts (Ciornei, 2014). By contrast, citizens from Northern and Western EU countries still enjoy a neutral image or are even welcomed, particularly the ones moving to southern localities of Spain after retirement (among others, see: Casado-Díaz et al., 2004; Legido-Quigley et al., 2012; Finotelli, 2021).

1.3. Residency rights of EU citizens in Spain

EU citizens' right to stay and residence in Spain is regulated by Royal Decree 240/2007 on the entry, free circulation and residency of EU citizens, which transposes the Citizenship Directive.[27]

For EU citizens whose stay in Spain, whatever its purpose, for less than three months, the possession of a valid passport or identity document shall be sufficient (Royal Decree 240/2007, Article 6).

EU citizens and their family members who move to Spain for more than three months are granted residency rights according to their occupational status (Royal-Decree 240/2007 [consolidated version], Article 7), replicating the conditions set by the Citizenship Directive on temporary legal residence. On this regard, it is interesting to note that the initial version of Royal-Decree 240/2007 did not differentiate among occupational status of EU citizens for what concerns the temporary legal residence, simply stating that EU citizens who intended to reside in Spain for more than three months were obliged to apply, within three months from the date of entry into Spain, for a residence certificate before the Office of Foreigners of the province where they intended to reside (IN_ES01). This vague disposition was reformed by Royal Decree-Law 16/2012 on 'urgent measures to guarantee the sustainability of the SNS' (final disposition no. 5). As stated in the Implementing Order detailing the procedural requirements EU citizens must comply with,[28] the non-transposition of the conditions set by the Citizenship Directive in Royal Decree 240/2007 had 'caused serious economic damage to Spain, especially in terms of the impossibility of guaranteeing the reimbursement of expenses incurred by the provision of health and social services to European citizens'.

The 2012 healthcare reform detailed the conditions under which EU citizens can take up residence in Spain for more than three months in line with the Citizenship Directive. Consequently, the current policy framework distinguishes between workers, economically inactive citizens, students, and jobseekers (and their family members) (Royal-Decree 240/2007 [consolidated version], Article 7). Accordingly, EU citizens can reside in Spain for more than three months in the following cases:

- workers: they are employed or self-employed in Spain;
- economically inactive citizens: they have sufficient resources not to become a burden on the Spain social assistance system, and have health insurance covering all risks in the country;
- students: they are enrolled in an recognised or subsidised educational institution for the primary purpose of studying (including vocational training), they have health insurance covering all risks in Spain and demonstrate that they have sufficient resources not to become a burden on the Spanish social assistance system during their stay.

For both economically inactive citizens and students, 'sufficient resources' must at least correspond to the level of income below which the person concerned is eligible for social assistance or for the minimum pension scheme in Spain. In assessing this condition, the personal situation of the EU citizen,

[27] Real Decreto 240/2007, de 16 de febrero, sobre entrada, libre circulación y residencia en España de ciudadanos de los Estados miembros de la Unión Europea y de otros Estados parte en el Acuerdo sobre el Espacio Económico Europeo. BOE no. 51 of 28/02/2007. https://www.boe.es/buscar/act.php?id=BOE-A-2007-4184 [consolidated version].

[28] Orden PRE/1490/2012, de 9 de julio, por la que se dictan normas para la aplicación del artículo 7 del Real Decreto 240/2007, de 16 de febrero, sobre entrada, libre circulación y residencia en España de ciudadanos de los Estados miembros de la Unión Europea y de otros Estados parte en el Acuerdo sobre el Espacio Económico Europeo. BOE no. 164 of 10/07/2012, pp. 49603-49606. https://www.boe.es/buscar/doc.php?id=BOE-A-2012-9218.

including the nature and regularity of his/her income and the number of dependent family members, should be taken into account (Royal-Decree 240/2007, Article 7[7]).

Regardless of occupational status, the person complying with the requirements for temporary residence will obtain a certificate of registration (*Certificado de registro de ciudadano de la Unión*, Royal-Decree 240/2007, Article 14). As specified by Article 9bis, the recourse to social assistance of a EU citizen shall not automatically result in an expulsion measure. However, no specific indications are provided in the law on how to assess the concept of 'unreasonable burden' and the decision to terminate residency rights in line with the EU Commission's guidelines (2009). For what concerns unemployed people (Royal-Decree 240/2007, Article 9bis), they retain their residency right as workers in the following cases:

- they are temporarily unable to work due to illness or accident;
- in case of involuntarily unemployed, after having been employed for at least one year and having registered as job-seekers with the competent employment service;
- in case of involuntarily unemployed at the end of a fixed-term employment contract of less than one year, or after having been involuntarily unemployed for the first twelve months, provided that they have registered as job-seekers with the employment office. In this case, they retain the status of worker for at least six months.

After five years of continuous residence, EU citizens are entitled to permanent residency (Royal Decree 240/2007, Article 10), regardless of occupational status. An expulsion decision towards EU citizens who have acquired the right of permanent residence in Spain may be taken only if there are serious grounds of public order or public security. As stated by Article 15 of the 2007 Royal Decree, before taking such a decision, the duration of residence and the social and cultural integration of the person in Spain, his/her age, health status, family and economic situation, and the importance of the links with his/her country of origin should be taken into account.

It is important to highlight that, before registering as residents, either temporary or permanently, EU citizens have to:

- obtain a Foreign Identification Number (NIE), by filling in a specific model, where any documents proving the reasons for the person to register have to be included (i.e., for economic, professional or social reasons) and pay a corresponding tax;
- enrol in the local population register (*Padrón Municipal*) through the so-called '*empadronamiento*'. To do so, the following documents are required: the NIE, the passport/national identity document, and a document certifying the use of the house where they are settling (e.g., a document certifying the property of the house, a rent contract, an electricity bill indicating the name of the person requiring the registration and the direction of the house, …). However, the Municipality may require additional documents to verify the use of the house to double-check the veracity of the information provided.

1.4. Healthcare rights for EU citizens in Spain

The Foreigners Law 4/2000 gave every person with habitual residence in the country entitlement to healthcare on equal grounds with Spanish nationals. Through the mechanism of *empadronamiento*, access to healthcare was established regardless of an individual's legal status and formalised through

issuance of a healthcare card (*tarjeta sanitaria*). Overall, this policy framework strongly contributed to the definition of a 'healthcare citizenship' inspired by the principles of social justice and solidarity, aimed at overcoming social inequalities and paying particular attention to vulnerable groups, such as poor people, migrants with irregular status, and the homeless (Cantero Martínez & Garrido Cuenca, 2014, p. 97).

As mentioned before, however, this path was suddenly reversed by a Royal Decree-Law 16/2012 on 'urgent measures to guarantee the sustainability of the SNS', which was adopted by the central government led by the conservative party *Partido Popular* (PP). As the name of the reform suggests, the harsh economic and fiscal crisis affecting Spain and ensuing austerity measures were cited to justify cuts to public healthcare spending, the alleged 'urgency' of which was used to pass the reform without parliamentary debate. In the introduction to the decree, retrenchment was justified using arguments of economic efficiency, contending that the 'lack of rigour and emphasis on the system efficiency has led the SNS to a situation of severe economic difficulty' (RDL 16/2012, p. 3). Cost-containment to reverse this 'unsustainable public deficit' was deemed necessary in order to sustain the SNS in the long term.

Most importantly, the sustainability argument was invoked to introduce a radical shift in the process of healthcare universalisation in terms of both entitlement and coverage. RDL 16/2012 transformed the ethos and underlying philosophy of the system from a universalistic system to an insurance-based one, thereby changing the basis for entitlement from habitual residence to contribution to the social security system. Although financing continued to be tax-based, the reform reintroduced the categories of 'insured persons' (workers, pensioners, unemployed receiving benefits and job seekers) and 'beneficiaries' (dependent relatives of insured persons under the age of 26) to define the groups entitled to the complete package of healthcare services provided by the SNS. This excluded non-insured persons and their dependent relatives, turning healthcare into a contribution-based right and unveiling a new rhetoric of health-related deservingness: '[healthcare must be] for the ones who truly work like us and pay their taxes' (Ana Mato, PP Health Minister, quoted in Rincón, Sevillano & Sahuquillo, 2012).

Among those excluded, migrants with irregular status (both EU and non-EU nationals) made up the most targeted group, both in symbolic and practical terms. Like other non-insured persons, they were excluded from public healthcare (with the exception of emergency, maternal and primary childcare), and their healthcare cards were withdrawn. Importantly, presenting this group as abusers of scarce healthcare resources was a key tool used to legitimate the 2012 reform process.

Accordingly, justifications of the reform focused on abuses by non-Spanish citizens as a critical dimension of the problem. Citing a document issued by the Spanish Court of Audits in 2012 (Tribunal de Cuentas, 2012), RDL 16/2012 referred to 'some situations of healthcare assistance' that were 'weakening the sustainability of the SNS in an alarming way' (RDL 16/2012, p. 4). Specifically, it stressed that Spain was providing services for persons who were already covered 'either by their social security institutions back home or by private insurance', creating a serious problem due to the 'impossibility of guaranteeing reimbursement for the expenses made through the provision of healthcare services to EU citizens' (RDL 16/2012, p. 5). Hence, inefficiency was associated with intra-EU

movers and invoicing problems caused by the lack of effective coordination among Member States' social security systems.

However, PP politicians publicly blamed migrants with precarious legal status for abusing and misusing the system instead. Claiming that 'the universalistic healthcare system is not for the whole universe' (Rafael Hernando, PP deputy spokesman in the Congress, El País 2012b), the economic framing of the problem (financial unsustainability, lack of EU coordination on reimbursement procedures) merged with a vision of the SNS as a closed system, which clearly delineates its members and defines who deserves access to healthcare. From this perspective, PP politicians deployed a rhetoric of 'crusade', blaming previous legislation for enabling 'fraud with everybody's money', and universalism for acting as a magnet for foreigners willing to (ab)use the Spanish system. Therefore, the ultimate goal of the PP's reform was to put a stop to 'Spain being a country where people enrol in the local register (without residing here), with the sole goal of accessing healthcare and social services, when they don't even have a job' (Rafael Hernando, PP deputy spokesman in the Congress, El País 2012b). Within this framework, they claimed credit for the 2012 reform, as it made it possible to tackle abuses: 'For the first time in history, a government is establishing controls to avoid health tourism and the fraudulent use of health services by foreign citizens' (Spokesman of the Council of Ministries, quoted in La nueva España, 2012). By linking the problem (fraud, inefficiency, crisis) to the solution (excluding undeserving migrants), they expected to reach their intended goal (a sustainable health system) (Bruquetas-Callejo & Perna, 2020). However, as pointed out by a research participant,

> That [the access to healthcare for mobile EU citizens] was an intolerable excuse for the PP to remove the universality of the SNS. Because they are charged. With the EU there is an agreement with the Member States, who either pay you a fee for those [pensioners] who reside in Spain, or those who come sporadically for medical treatment. But they are charged and these treatments are well paid. And for other countries, there are bilateral agreements and charges are made. Foreigners are not a problem (IN_ES03)

With a new government in office led by the socialist party PSOE, the system underwent a counter-reform through the adoption of Royal Decree-Law 7/2018 'on universal access to the SNS', which introduced important changes with regard to healthcare entitlements ('every person who resides in the Spanish state') and the policy goal ('access to the SNS in conditions of equity and universality'). Dismantling the contributory-based logic behind the 2012 reform, the 2018 counter-reform decoupled healthcare entitlements from insurance status while reconnecting it to residence in Spain.

Even though the new law re-established universalist ownership of the right to healthcare (residence-based and regardless of nationality or legal status), it included conditions for exercising this right, indirectly distinguishing between 'rightful' and 'conditional owners' of healthcare entitlements (Bruquetas-Callejo & Perna, 2020). Accordingly, Article 3 of Royal Decree-Law 7/2018 states that, to access public healthcare in Spain, a person:

- must have Spanish nationality and reside habitually in Spanish territory; or
- if Spain is not the usual place of residence, she or he must have a recognised entitlement to such right, as long as no other institution is obliged to cover her/his healthcare expenses; or
- be foreign-born with legal and habitual residence in Spain, and not under the obligation to show existence of any other sickness coverage.

The last condition applies to EU migrant citizens, who follow different entitlement paths depending on the length of their residence and occupational status in the country (Table 5). Accordingly, enrolment into the healthcare system takes place by the issue of a healthcare card ('*tarjeta sanitaria*') by the competent healthcare centre ('*centro de salud*') to those individuals who are recognised as 'insured persons' (*asegurado/a*) or 'beneficiaries' (*beneficiario*/a) by the National Institute of Social Security (*Instituto Nacional de la Seguridad Social*, INSS) in accordance with the provisions of Law 16/2003.[29] Regardless of nationality, the group of 'insured' people includes workers, job-seekers, pensioners, social benefits' recipients and registered residents. The status of 'beneficiary' applies to the spouse or person with an analogous affective relationship accredited by a corresponding official registration, the descendants and assimilated persons in charge of the insured person who are under 26 years of age or who have a disability to a degree equal to or greater than 65%.

Table 5. Entitlement to healthcare for EU citizens in Spain by residency and occupational status

Residency	Occupational status	Entitlement to healthcare
LESS THAN 3 MONTHS	Regardless of working status	Healthcare coverage is guaranteed by the EU country of origin/previous residence via the **EHIC**
TEMPORARY RESIDENCY (between 3 months and 5 years)		
	a) workers and their family members;	a) compulsory healthcare coverage via **enrolment in the SNS**
	b) job-seekers and their family members (provided that they are registered in a Public Employment Office)	b) compulsory healthcare coverage via **enrolment in the SNS**
	c) students	c) Healthcare coverage is guaranteed by the EU country of origin via the **EHIC, provided that it covers the entire period of residence for study.**
	d) economically inactive citizens and their family members	d) *sickness insurance*, public or private, contracted in Spain or in another country, **as long as it guarantees the same coverage provided by the SNS for the entire period of residence** (pensioners comply with this condition if they accredit coverage against sickness by the competent State for their pension via the S1 form).
PERMANENT RESIDENCY	Regardless of occupational status	Compulsory healthcare coverage via **enrolment in the SNS**.
NO REGULAR RESIDENCY (more than 3 months but unlawful stay)		**Healthcare coverage as third-country nationals with irregular status** (a certification of lack of coverage from the MS of origin/previous MS of residence must be provided).

Source: elaboration of the author on the basis of Royal Decree 240/2007, Royal Decree 1192/2012 and Royal Decree-Law 7/2018.

[29] Ley 16/2003, de 28 de mayo, de cohesión y calidad del Sistema Nacional de Salud. BOE no. 128, of 29/05/2003. https://www.boe.es/buscar/act.php?id=BOE-A-2003-10715

For what concerns EU citizens who move temporarily to Spain, they shall be guaranteed access to medically necessary care through their European Health Insurance Card (EHIC) according to the EU Regulation on the coordination of social security systems (for an overview on the EHIC, see Perna (2022), EU-TRHeaDS, Deliverable no. 1). Specifically, EU citizens - temporarily staying in Spain, in need of necessary care and insured in their MS of residence - can access primary or specialised healthcare in Spain by showing the EHIC. Considering that healthcare is free at the point of access of the public SNS, no invoice will be issued for the treatments received to the patient. Rather, the reimbursement procedure will directly involve the competent institution of the home MS of the person.

In this regard, it is interesting to note that Royal Decree 240/2007 did not include the limitations to equal treatment of EU citizens allowed by the Citizenship Directive concerning the access to social assistance benefits during the first three months of stay in the country. It is only with the adoption of Royal Decree 1192/2012 that it has been explicitly defined that EU citizens entitled to healthcare in application of the Regulations will have access to healthcare, provided that they reside in the Spanish territory in the form, extent and conditions established in the EU framework laws (in other words, by means of the EHIC or the S1 document for pensioners).

However, obstacles to access healthcare in Spain for holders of a EHIC have been frequently reported (IN_CS001). For instance, in 2013 barriers to access healthcare led to the starting of an infringement procedure against the country for the practice of rejecting the EHICs while asking EU citizens for private health insurances. This problem emerged in touristic areas, where certain hospitals – which provided treatments both within the SNS (thus, free of charge for the person) and outside it (thus, implying out-of-pocket payments) – rejected the EHICs of EU citizens (British ones in particular) and asked for upfront payments or private insurances instead (IN_ES02; Parliamentary questions E-010592/2013[30] and E-010736/2013[31]). As a result of this, an agreement was adopted by the CISNS to clarify the procedure to be followed by public healthcare structures of the SNS when receiving a EU patient.[32]

Moreover, in its final dispositions, Royal Decree 1192/2012 also clearly affirms that in no case EU citizens will be considered as third-country nationals with irregular status – thus entitled to healthcare under this administrative category – during the first three months of stay in Spain. However, this final disposition seems to contrast with EU law and the Spanish Immigration Law, according to which EU nationals should not enjoy fewer rights than non-EU nationals, even more those with irregular administrative status (Organic Law 4/2000, Article 1.3 and Royal Decree 240/2007, final disposition 4.2).

After three months of residence, the possibilities for EU migrants to access the public healthcare system differentiate according to their residency status (temporary residence, permanent residence, no legal residence) and occupational status (Table 5). In the case of temporary residence, entitlement to healthcare by occupational status is linked to the main categories identified by the Citizenship

[30] https://www.europarl.europa.eu/doceo/document/E-7-2013-010592_GA.html

[31] https://www.europarl.europa.eu/doceo/document/E-7-2013-010736_EN.html

[32] Consejo Interterritorial del Sistema Nacional de Salud, Acuerdo sobre criterios de actuación en el acceso a la asistencia sanitaria a ciudadanos europeos en el marco de aplicación del Reglamento (CE) Nº 883/2004, sobre la coordinación de los sistemas de seguridad social, y del Reglamento (CE) Nº 987/2009 por el que se adoptan normas de aplicación del Reglamento (CE) Nº 883/2004, de 23 de julio de 2013.

Directive (workers/job-seekers, students, and economically inactive citizens). In the case of permanent residence, EU citizens should be treated under the same conditions that apply to Spanish nationals.

Finally, EU citizens residing 'unlawfully' in the country for more than three months are entitled to free healthcare on equal grounds to Spanish nationals, provided that they can demonstrate not having healthcare coverage in their country of origin or in a previous MS of residence, according to EU law, and that there is not a third person liable for payment the (Royal Decree-Law 7/2018 and Guidelines of the Ministry of Health, 2019). Importantly, the 'official certificate of lack of coverage' from the country of origin/previous MS of residence must be issued by the competent insurance body in the home country. Likewise, the guidelines indicate that ACs are be in charge of determining the procedure for issuing the healthcare card to this group. Consequently, they are given wide room for discretion concerning the procedure to be followed, which, in turn, could result in territorial inequalities concerning access to healthcare for vulnerable EU migrants across the country (Bruquetas-Callejo & Perna, 2020).

As Table 5 indicates, residence constitutes the first and most important demarcation point to understand how free movement of EU citizens interacts with the Spanish SNS. EU citizens holding permanent residence constitute the most secure category: as their right to reside in the country is almost unconditional, so it is their entitlement to the SNS. At the opposite, EU citizens who do not comply with residency requirements lie at the edge of the system: considered as 'irregular migrants', they will be entitled to the SNS after three months of living – although irregularly – in the country. As pointed out in the previous pages, it is this category that has suffered the most the consequences of the 2012 reform and 2018 counter-reform, and whose access to healthcare is highly subject to territorial inequalities and bureaucratic discretion.

Acknowledging residence as a key demarcation point for the recognition of healthcare rights, the ways it is assessed at the everyday level of practices may affect the realisation of the right to healthcare for EU migrant citizens and their health status (Hernández-Quevedo & Jiménez-Rubio, 2009; Burón Pust, 2012; Huete & Mantecón, 2013). Although the possession of a registration certificate, of a residence card or of a permanent residence card, 'may under no circumstances be made a precondition for the exercise of a right or the completion of an administrative formality, as entitlement to rights may be attested by any other means of proof' (Directive 2004/38/EC, Article 25), Spanish healthcare centres do not enrol EU migrant citizens who do not hold a residency certificate yet. Moreover, the multiplication of the administrative paperwork for registering in the country (*empadronamiento* and *certificado de registro de ciudadano de la Unión*), for registering into the INSS (as 'insured person' or 'beneficiary'), and for enrolling into the SNS (application for the *tarjeta sanitaria*) may lead to large delays in the recognition of the residency and healthcare rights of EU migrant citizens. In cities with large amounts of registration requests, in particular, administrative delays and waiting time may be significant, and they have been increased even more in times of COVID-19 (IN_ES01).

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