



Anatomy of the Healthcare Reform

THE UNIVERSALITY OF EXCLUSION

© MINGO VENERO

www.reder162012.org



We are a network of collectives, movements, organisations and individuals committed to the defence of universal access to healthcare and to the denunciation of its infringement:
www.reder162012.org

Report coordinated by Médicos del Mundo.
Department of Advocacy and Communication.

Graphic design: Cósmica®

MADRID, SEPTEMBER 2015

Anatomy of the Healthcare Reform

THE UNIVERSALITY OF EXCLUSION



We are a network of collectives, movements, organisations and individuals committed to the defence of universal access to healthcare and to the denunciation of its infringement.

REDER defends universal public healthcare without a reimbursement scheme and for this reason REDER is against any type of parallel network of public health system.

REDER considers - and this is how the Spanish constitution describes it - that it is both the State's and the Autonomous Regions' obligation to provide healthcare services of identical quality for the entire population.

REDER believes any change of the healthcare model should be the product of a social consensus and should be made with the necessary democratic guarantees.

REDER claims that health is not a business. The trend towards privatisation implies a lack of protection for the most vulnerable groups of the population who cannot pay the amounts requested by the insurance companies.

REDER understands primary healthcare as the main focus of the national healthcare system where socio-economic inequalities can be prevented and reduced, promoting a more egalitarian society.

For this reason we defend that access to primary healthcare for immigrants should be a priority. Furthermore, investment in healthcare should be prioritised over other sectors of the public budget.

Currently REDER has 300 members (individuals and social organisations) including: la Sociedad Española de Medicina de Familia y Comunitaria (the Spanish Society for Family and Community Medicine), Doctors of the World, el Observatorio del Derecho Universal a la Salud de la Comunitat Valenciana (the Observatory for the Universal Right to Health of the Region of Valencia), Andalucía Acoge (Andalusia Providing Refuge), la Plataforma Salud Universal Aragón (the Aragón Universal Health Platform), la Plataforma per una Atenció Sanitària Universal a Catalunya (the Platform for Universal Health in Catalonia); la Sociedad Española de Salud Pública y Administración Sanitaria (the Spanish Society for Public Health and Administration), la Federación de Asociaciones por la Sanidad Pública (the Federation of Associations for Public Health), la Asociación de Refugiados e Inmigrantes de Perú (the Association for Refugees and Immigrants from Peru) and la Red Transaccional de Mujeres "NetworkWoman" (the Transnational Network of Women "NetworkWoman").

For more information please consult:
www.reder162012.org

Summary

06 SUMMARY

10 AN UNJUSTIFIED REFORM TO THE HEALTHCARE SYSTEM

12 For 3 Years they have not been Listening

16 AN IN-DEPTH ANALYSIS OF THE HEALTHCARE REFORM

16 Basic Statistics about the Sample

17 Lack of Information as the Denial of a Right

18 The Double Infringement: the Systematic Failure to Fulfil Promises on Protected Exemptions

20 The Especial Vulnerability of Asylum Seekers and Victims of Human Trafficking

22 Older Relatives: Lost in a Maze of Jurisdiction and Legalities

25 The Lack of Efficacy of a Patchy Piece of Legislation

26 CONCLUSIONS

28 RECOMMENDATIONS

Summary

Royal Decree-Law 16/2012 established the regulated exclusion from the healthcare system of foreign nationals with an irregular immigration status. Since this law came into force there have been many Spanish voices as well as voices from around the world warning of the backward step this measure represents in respect to Human Rights as well as of the risks in terms of healthcare management and the failure to respect one of the key principles of the Spanish national healthcare system. REDER represents the widespread mobilisation throughout the Spanish territory against the withdrawal of the healthcare card. The mobilisation is expressed through citizens' initiatives to offer solidarity and support to those affected as well as through the organising of protests. Over 300 social organisations make up REDER (either as member bodies or through the networks and platforms which are part of REDER), united under the common goal of achieving the return of the universal right to health.

M is a Bolivian woman who came to Spain to look after her daughter who was due to be operated from a cancer. However, not long after her arrival several lumps appeared on her neck and because she did not have a healthcare card she went to the emergency ward. Several serious lymphomas which required immediate chemotherapy were detected. She received two sessions of chemotherapy but the hospital had not warned her that the treatment could not continue unless she showed them a healthcare card or paid for the cost of the sessions herself. She is currently receiving treatment thanks to healthcare staff that is defiantly treating her via "backchannels". (Madrid)

Over the last three years many of the organisations which integrate REDER have documented and published reports and testimonies highlighting the seriousness of the consequences of exclusion

from the healthcare system. As the report on the impact and results of the healthcare reform – which the Ministry of Health, Social Services and Equality was meant to carry out – has not yet materialised, REDER is presenting this report based on more than 1,500 cases documented between January 2014 and July 2015 in 12 of Spain's autonomous regions. The sample is small but it is very representative in terms of portraying the suffering and the impact on human lives caused by Royal Decree-Law 16/2012 and the decision to deny foreign nationals with an irregular status a healthcare card.

The main conclusion of this report is that these cases of medical neglect are not exceptions to the rule caused by one-off mistakes made within the system. **It is a system of generalised exclusion** which is far from universal and is clearly disconnected from the key principles which have defined the Spanish national healthcare system since 1986. The cases documented here include only those of people who have been able to turn to one of the social organisations or one of the collectives that are part of REDER to receive support, advice or medical care thanks to engaged professionals committed with their Hippocratic Oath. Nevertheless there are many more people who lack social ties and social support networks and who have been suffering in complete isolation. We should also not forget that many of the victims of the healthcare reform are families who have been living in our country for many years and who have lost their residence permits as a consequence of the economic crisis and unemployment, and along with this they have lost the recognition of their social rights.

In 2012 several governments of the autonomous regions were already expressing their opposition to apply this measure which forced immigrants without a valid residence permit out of the public health system. This led to the implementation of various ways of expanding the number of exemptions and to regulate access to healthcare



© SALVADOR GUTIÉRREZ

for those groups excluded by Royal Decree-Law 16/2012. The fact that the majority of the governments of the autonomous regions have created these ways for widening the restricted healthcare coverage – as regulated in the RDL – shows the serious flaws of the Royal Decree-Law and calls for its urgent reform.

However, the figures presented by REDER show that these measures have not been sufficient and that they have not been backed up by the political will required to make them effective: at least 73% of the cases come from autonomous regions where healthcare programmes or regional rulings were created ad hoc to provide coverage to those excluded by the healthcare reform.

On the other hand, a number of parallel healthcare subsystems “for the poor” have been created, breaking with the principle of equality which,

supposedly, they were trying to reinforce. The regional reforms which have been announced in recent weeks to recognise universal access for those people excluded by Royal Decree-Law 16/2012 represent an important step forward but they are not enough to knit together this patchwork quilt of solutions to the problem created by the senseless healthcare reform.

Of the more than 1,500 cases documented by REDER in just over a year, we find 31 cases of cancer, 38 of cardiovascular diseases, 62 of diabetes, 14 of degenerative muscular diseases, another 8 cases of other types of degenerative diseases, plus 28 other cases which could potentially have been fatal if not given the appropriate care and treatment. 27 cases were documented of people with serious mental problems who were victims of the exclusion from healthcare imposed by the application of Royal Decree-Law 16/2012.

Three years after this ruling came into effect many people continue to visit the various organisations which are part of REDER **simply to get information** about their right to some type of medical care. Over the period of January 2014 to July 2015 **12% of the total of registered** cases fit into this category of event. We should also add to this figure the **22% of the total number of cases** who had not applied for their healthcare card simply because they did not know they had such right. Finally, **12% of the total number of cases** refers to people who were denied a healthcare card in a health centre even though, according to the legislation, they

had the right to one. This happened because **the information which the administrative staff had been given about the different documents and requirements was incorrect.**

Furthermore, there are recurring situations where minors (**109 documented cases**) have been denied healthcare as well as events taking place in the **emergency services, with 224 documented cases** (133 women and 91 men). In REDER we have also registered **78 cases of pregnant women** who have seen their right to medical care violated in one way or another (with situations varying



© DAVID DELAPORTE

from refusing to give them a healthcare card as a pregnant woman to cases where treatment deriving from complications at birth has been denied because this is not recognised as part of the compulsory care established under the Royal Decree-Law). A special mention should be made for the cases of women who have been denied voluntary termination of pregnancy under the framework of the current legislation, with the subsequent risk that they abort without the proper health guarantees, putting both their health and their lives at risk.

Royal Decree-Law 1192/2012 widens the scope of exemptions from the RDL, including asylum seekers and, during a so-called "reflection period", victims of trafficking. These provisions are clearly insufficient. For those people requesting international protection, the right to care is restricted to those people have been authorised to stay in Spain, excluding therefore those people who are still waiting to complete the process of obtaining international protection. For victims of trafficking the right to healthcare is recognised only for those who have been recognised as such and consequently are in some way under the protection of the authorities. Moreover, this is only granted during the "period of rehabilitation and reflection", a period of time which is clearly insufficient.

The application of Royal Decree-Law 16/2012 has also had an indirect impact on the immigrant population who do have a regular immigration status, because they are victims of the dissuasion and fear invoked by current administration (such as the use of posters in hospitals and health centres or the lack of adequate information about the scope of the law's application). Particularly worrisome are the cases of people who have a regular status thanks to family reunification. These are normally elderly people and find themselves stuck in a legal and administrative limbo, with no access to public healthcare. Although, all-in-all, this group represents but a small part of the total

number of immigrants, these are very painful cases which demand a more humanitarian approach by the Administration. REDER has documented up to **25 cases of people in such a situation**, including people suffering from heart disease, hypertension, potentially fatal chronic respiratory diseases, arthritis and other rheumatisms, and people who needed follow-up care for surgery carried out in their country of origin. None of these had received care by the date of publication of this report.

KCM is a 9-month-old baby born in Spain from Nigerian parents who have a valid residence permit. They have a family record book and a Spanish birth certificate but the baby does not have a healthcare card because you must have a passport to get one. The family lacks the financial means to apply for one. They received a bill for a consultation with a paediatrician. With the support of a social organisation they have issued a plea, the result of which has been put on hold until the new regional legislation is approved (The Autonomous Region of Valencia).

In light of this situation the organisation and people who comprise REDER call for **the urgent reform of Royal Decree-Law 16/2012 and the subsequent Royal Decree-Law 1192/2013** which define the status of insurance holders and beneficiaries of the national health system and exclude people with an irregular immigration status. We also observe that any measure to be adopted for further reform of the healthcare system should always be submitted in advance to a public and transparent evaluation and to a later assessment of which is the impact of such measures on Human Rights, public health and gender, as established under the Organic Law for the Effective Equality of Women and Men (2007) and the General law on Public Health (2011).

An Unjustified Reform of the Healthcare System

Era April 2012 Spain was at its lowest point of the economic crisis and the Government declared that the national healthcare system was at serious risk of collapse because it had accumulated 16 billion euros of debt. Using this argument a major reform of the healthcare system was approved – via a legislative mechanism only to be used in situations of emergency – justified under the goals of making financial savings and improving the efficacy of the system. The new ruling disguised a radical transformation from a model of universal healthcare to a return to an insurance-based system.

“ According to the Court of Auditors, the fraud, the hole, the sieve, the disaster of uncovered healthcare - given away for free - is not caused by immigrants but rather by foreigners who are well settled in our country or who come for healthcare tourism”.

Rafael J. Álvarez, *El Mundo*. 2013, “Cuánto ganamos, cuánto perdimos” (“How Much We Won, How Much We Lose”).

The measures for economising introduced by the healthcare reform consisted mainly of two things: firstly a reduction of the basic budget for services, which meant that families had to pay for more medication, services and healthcare resources where public financing had been reduced. The second measure was the exclusion from the healthcare system of those foreign nationals without a valid residency permit. In fact, the withdrawal of the healthcare cards was included as one of the measures in the Programa Nacional de Reformas (National Reform Plan) presented to the European Commission in April 2013. But has the exclusion of more than 800,000 people⁰¹ from our healthcare system really saved the finances of our public health system? Or were there other motives for such decision?

We can still hear the echoes of public speeches made by various political representatives justifying a healthcare reform approved without any previous parliamentary or social debate. Unfortunately, these are not just echoes from the past as we have recently heard different political leaders restating such arguments.

Ana Mato, former Minister of Health, Social Services and Equality: “We have guaranteed the universality of healthcare for all Spaniards and at the same time we are going to take the necessary measures to end the improper use of the healthcare services by certain foreign nationals as well as abuses which these foreign nationals sometimes commit to gain access to the healthcare system when they have no right to it”, Press Conference of the Council of Ministers, 20 April 2012.

Juan Ignacio Échaniz, former Minister for Health and Social Services in Castilla-La Mancha: “We must not forget that free healthcare has been essential in encouraging the pull effect. Many people have jumped into boats because they knew that in Spain there was guaranteed healthcare”, *El Mundo*, April 2012.

Xavier García Albiol, former Major of Badalona: “It is a social injustice that an immigrant with an irregular status has the same rights as a regularised immigrant and natives”, Comments made on RAC1, *La Vanguardia*, May 2012.

More than three years have gone by and they have not yet made public any economic report carried out in advance to justify this discriminatory measure. Nor have they provided any later evaluation of its impact in terms of regaining the sustainability of the national health system and, above all, of its impact on the human right to healthcare or on the health of those individuals affected by it. We, the organisations and social movements, have been the ones denouncing the unwarranted suffering that this xenophobic and unjustified healthcare reform has inflicted on thousands of people who live alongside us in our towns and cities.

“Healthcare today is more universal than ever before” is one of the mantras repeated by

HEALTHCARE AND SOCIAL SECURITY ARE NOT THE SAME

This reform has once again highlighted the confusion and lack of understanding amongst politicians, the media and the public about the way the national health system is financed.

On 1 January 1999 the State assumed total responsibility for the financing of healthcare, getting rid of the contribution of social contributions and making a clean break between healthcare and social security. From this date onwards the Spanish healthcare system has been internally financed through general taxes which come from the public budget, independent of the legal situation. The revenue is collected via the many distinct forms of tax which the State requires to possess the funds necessary to provide for all of the services which it must offer (VAT, Income Tax, Special Taxes, etc.).

This is not free healthcare for everyone, as it is often described. What happened was a change in the means of obtaining the public money to

finance it, taking it from one unique fund from all people residing in Spain, instead of some of it being weighted on the working population – via direct taxes on salaried workers - and the rest falling on the shoulders of those people living in Spain.

Up until 2012 our healthcare system was based on the principles of solidarity and progression. Meaning that each person contributed according to their financial resources and each person was treated according to their needs, guaranteeing the right to healthcare for the entire population, independently of any differences. The healthcare reform imposed by Royal Decree-Law 16/2012 is a step towards a system which implies a privatised access to healthcare.

The “insurance” option for migrants represents a break with the principle of solidarity in the system for financing the healthcare system and privatises a universal right.

the Governing party. However the concept of “universal” in their discourse is given an excluding interpretation as it is limited to “all Spaniards”. The fallacy in the argument is clear: defining the Spanish healthcare system as “universal” and at the same time restricting the scope of this universality is contrary to the definition of Universal Health Coverage approved by the General Assembly of the United Nations, where it is specified that it implies access without discrimination, with a special emphasis on the poor, vulnerable and marginalized segments of the population⁰². For the United Nations’ Special Rapporteur on Extreme Poverty and Human Rights, as well as for other UN Special Rapporteurs, the Government’s arguments show an incorrect understanding of this key principle of Human Rights⁰³.

This report shows the figures relating to more than 1,500 cases documented by **The Network for Denouncing and Resisting Royal Decree-Law 16/2012 – REDER** – between January 2014 and July 2015 in 12 Autonomous Regions. Some of the networks and organisations which are part of REDER have spent almost three years documenting and sharing statistics and testimonies of the impact of exclusion from

the healthcare system on people’s lives. Via this nationwide network they have pooled together their efforts to show that situations of medical neglect caused by the withdrawal and denial of healthcare cards to people living in our country are neither exceptions to the rule nor the fruit of one-off mistakes in the system.

EThis first report by REDER refers to cases registered in 12 of the different autonomous regions which have occurred on all the different levels of care or healthcare management. It includes 1,567 real-life stories, but this is just a small part of the true impact of the measure approved in April 2012 and its subsequent development.

01 Information in the media. http://cadenaser.com/ser/2013/04/30/sociedad/1367288017_850215.html and the 2013 National Reform Plan http://www.empleo.gob.es/es/sec_trabajo/debes_saber/pnr/PNREspanya2013.pdf

02 *Global Health and Foreign Policy*. United Nations. Document A/67/L.36. Point 10. <http://www.un.org/es/comun/docs/?symbol=A/RES/67/81>

03 Various pieces of information supplied to the press, May 2014: http://www.eldiario.es/desalambre/ONU-Gobierno-espanol-universal-gratuita_0_258274859.html ; http://sociedad.elpais.com/sociedad/2014/04/29/actualidad/1398797567_706386.html

FOR 3 YEARS THEY HAVE NOT BEEN LISTENING

Since the moment when Royal Decree-Law 16/2012 was approved the Spanish Government has received a succession of warnings from different European and United Nations Human Rights bodies and institutions. The most recent of such recommendations came from the *Committee on the Elimination of Discrimination Against Women*, as a result of the review session on Spain in July 2015. In its concluding remarks this Committee recommends that the Spanish Government repeals Royal Decree-Law 16/2012 – which denies migrant women free access to sexual and reproductive health services and from the possibility of detecting cases of gender-based violence in the primary healthcare services. The Committee recommends universal access to healthcare to be restored, the right to abortion not to be restricted for 16 to 18 year olds and adequate treatment for all women with HIV/AIDS to be ensured.



If the economic crisis gets worse or continues to last and we are unable to balance the healthcare budget, what will be the next group that our government will propose to exclude? The most vulnerable? Those that represent the highest financial cost? Which one?"

Álvaro González, former President of Doctors of the World, 2013, "Cuánto ganamos, cuánto perdimos" ("How Much We Won, How Much We Lose").

Also in July 2015 the *Working Group on the issue of discrimination against women in law and in practice* published a report following their official visit to Spain encouraging the Government to ensure the universality of healthcare for all migrants. In this report the Working Group described Royal Decree-Law 16/2012 as a backward measure that is incompatible with Spain's international Human Rights obligations.

Similarly, between 2012 and 2014 many international Human Rights bodies - both European and from the United Nations - have warned that the ruling which reforms the conditions for accessing the healthcare system are incompatible with the International Conventions of which Spain is a signatory. In April 2013 the United Nations' special rapporteur on Extreme Poverty, alongside 5 other experts and other UN special rapporteurs⁰⁴ warned the Spanish authorities that Spain has positive obligations in respect to healthcare, including for the migrant population - no matter their administrative situation.

Rosa is a 71-year-old Uruguayan woman who has been living in Spain for many years with her daughter and her granddaughters, who are her only family. She registered more than three years ago and she used to have a healthcare card. She suffers from a chronic cardiovascular disease. She has had to go to the emergency ward on several occasions, because this is the only way for her to access the healthcare system. She has already received several invoices but she does not have the financial means to pay them.

She was referred to a specialist hospital with persistent respiratory insufficiency - she needed urgent surgery to replace an aortic valve. When she was discharged she received a medical report referring her for follow-up care with her general practitioner. But, to complete the vicious circle, she cannot receive this follow-up care because she does not have a healthcare card.

In parallel, over the last three years the voices from various social, scientific and political backgrounds, both from Spain and from around the world, have been pointing out that sustainability in the Spanish healthcare system will not be achieved by restricting or preventing access to healthcare services for a socio-economically vulnerable population. The existing bibliography notes that a lie is hidden behind the argument of "abuse" of the healthcare services by the immigrant population. We must bear in mind that the socio-demographic profile of an immigrant with an irregular administrative situation is that of a young person with no chronic diseases and who has emigrated to find a way to survive and to develop as a person. Several studies have noted that the immigrant population uses less healthcare services than the Spanish population does⁰⁵. According to these



Rosa Milca

calculations immigrants spend between 23% and 31% less than the native population. Therefore the public health expenditure for this population, according to these figures, would represent between 6% to 7% of total spending⁰⁶. We can conclude that the real impact of immigration on public health is low and that we do possess the necessary resources to give them proper care, as long as these are used correctly and distributed **in a rational manner**⁰⁷.

04 Joint letter of allegation, pg. 6 https://spdb.ohchr.org/hrdb/24th/public_-AL_Spain_21.11.13_%284.2013%29.pdf

05 *Salud y uso de servicios en los sistemas sanitarios en población autóctona e inmigrante de España*. Berra S, Elorza-Ricart JM.. Madrid: Plan de Calidad para el Sistema Nacional de Salud. Ministerio de Ciencia e Innovación. Agència d'Avaluació de Tecnologia i Recerca Mèdiques de Catalunya; 2009. Informes de Evaluación de Tecnologías Sanitarias, AATRM Núm. 2007/2008, 2009.

06 *Gasto sanitario e inmigración: una mirada en clave de integración*. Blanco Moreno A, Thuissard Vasallo IJ. Presupuesto y Gasto Público 61/2010: 93-13. Secretaría General de Presupuestos y Gastos. Instituto de Estudios Fiscales. 2010.

07 *Impacto de la inmigración sobre el Sistema Nacional de Salud*. Cañada JL. Revista Clínica Electrónica en Atención Primaria. 4. 2004. Biblioteca Josep Laporte http://www.fbjooseplaporte.org/rceap/articulo.php?idnum=3&art=03#_blank



NDenying a regulated means to access the public health system - the healthcare card - is above all a rights violation, but it is also inefficient, it uses up more personal and material resources and achieves poorer results in terms of health. It has been shown that access to Primary Healthcare and to prevention programmes reduces morbidity and, for certain pathologies, prevention and early diagnosis are more efficient and less costly than curative treatments. In other words, providing undocumented immigrants with access only to emergency services rather than to Primary Healthcare is more costly in the long term⁰⁸. However, a limited access to Primary Healthcare via a parallel route "for the poor", "for immigrants", "for the excluded" - which is not linked to the organisational procedures and protocols between the different levels of healthcare - is not only unjust, but it is also contrary to the rules of public health and inefficient from a healthcare management perspective⁰⁹.

“ At the start of the decade, in 2000, with the arrival of a large number of immigrants, there was a feeling that the healthcare services had collapsed because of how these people were using them. This caught our attention because the profile of an immigrant is of a young, healthy person who should not, therefore, have many illnesses”.

Caridad Margarita Arias, Caridad Margarita Arias, Professor at CEU San Pablo University. 2013, “Cuánto ganamos, cuánto perdimos” (“How Much We Won, How Much We Lose”).

Restricting regulated access to healthcare for foreign women with an irregular immigration status is also contrary to the strategic objectives of the fight against gender-based violence as it has been shown that healthcare professionals play an important role in detecting cases of this. In fact, 60% of cases of violence against women identified in the health system are detected in Primary Healthcare consultations,

just as a large number of victims of trafficking for sexual exploitation are. Furthermore, women with an irregular administrative status have a limited access to sexual and reproductive health programmes, in particular to information and advice services about contraception and voluntary termination of pregnancy.

Regarding the partial solutions adopted by various autonomous regions, we should note that at least 73% of the cases documented by REDE¹⁰ have occurred in those regions where ad hoc health programmes or specific regional legislation to provide coverage to those excluded by the healthcare reform exist¹¹. The reality is that these measures are insufficient and are not very effective if there is no real political will behind them. As a result of this a series of parallel health subsystems “for the poor” have been created with public finances, these differ across the country and place restrictions on access and services. Clearly this is a model which, far from moving towards equality and efficiency, is taking us back towards an old system we surpassed decades ago.

⁰⁸ *Health-care access for migrants in Europe: the case of Spain.* Royo-Bordonada MA., Díez-Cornell M, Llorente JM. *Lancet*. 2013; 383: 393-4.

⁰⁹ Since 1978 and the Declaration of Alma-Ata, the World Health Organisation has been giving advice to states so that Primary Healthcare becomes an organisational strategy for the healthcare services, that these are projected and coordinated so that the entire population can have access to healthcare - and not just part of the population - that they be accessible, based on the needs of the population, that they promote public participation, that they seek an appropriate cost-benefit ratio in their actions and results, and that they be open to cross-sector collaboration.

¹⁰ The uneven amounts of events documented in each autonomous region does not depend upon the extent of the problem in each region, but rather the presence of members of REDER with the capability to document and register the cases they become aware of.

¹¹ Political change in many of the autonomous regions following May's elections has led to several legislative reforms which have replaced some of these “health programmes” for almost universal access.

An In-Depth Analysis of Healthcare Exclusion in the Spanish State

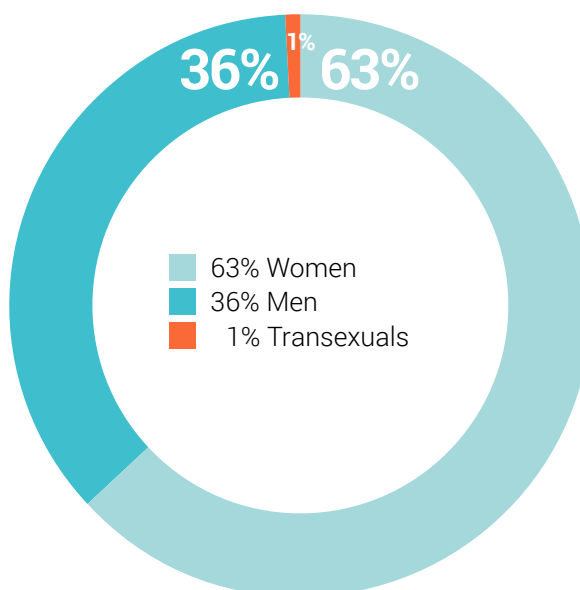
The 1,567 cases documented by REDER highlight the markedly discriminatory character of the reform imposed by Royal Decree-Law 16/2012. As expected the large majority of the cases are of **people directly excluded by the state ruling: more than two thirds of the total number of situations (1,067 cases)** refers to foreign nationals with an irregular administrative status. The majority of these were women. Furthermore we see that 68% are victims of a failure to take into account the exemptions outlined in the national and regional rulings. Almost 50% of the registered violations were related to a lack of information, either for patients or for staff in healthcare centres, about administrative procedures or the application of the current law.

Furthermore, it is striking that 14% of the total are people with European Union citizenship who have suffered from some type of exclusion in the domain of healthcare because of the application of the Royal Decree-Law, and due to their vulnerable socio-economic situation they have had to turn to a social organisation. These people are the victims of a legal limbo created by a very important legislative reform that was hastily passed and developed with legal and technical deficiencies, encouraging, from the institutions, a climate of social xenophobia.

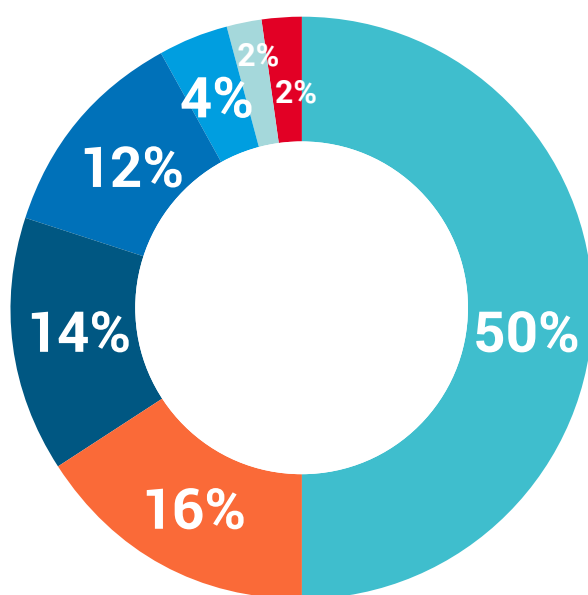
LOCATION WHERE THE INCIDENT TOOK PLACE	CASES
INS or regional administration in charge of issuing healthcare cards	55
Specialty Centre	19
Health Centre – Administration	543
Health Centre - General Medicine	94
Health Centre - Other Areas	14
Hospital – Admission	35
Hospital – Emergency Ward	201
Hospital – Other Areas	33
Other	573
TOTAL	1.567

BASIC STATISTICS ABOUT THE SAMPLE

SEX

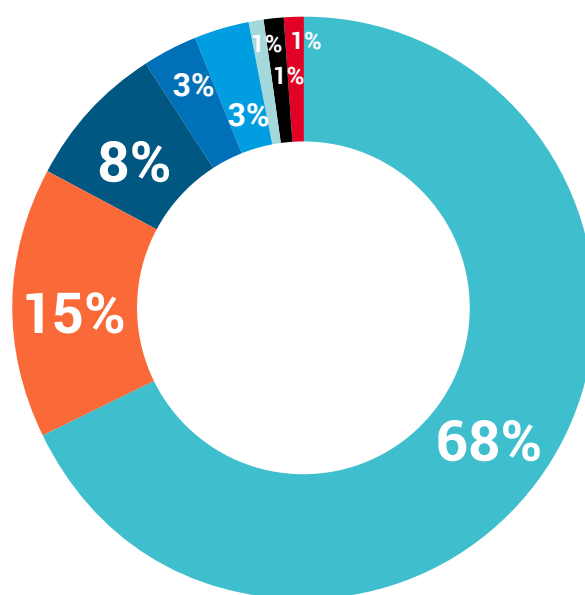


ORIGIN



- 50% Latin America
- 16% Sub-Saharan Africa
- 14% EU
- 12% North Africa
- 4% Eastern Europe
- 2% Asia
- 2% Did Not Specify

ADMINISTRATIVE STATUS



- 68% Irregular Status
- 15% Possess EU Passport
- 8% Possess Valid Residency Permit
- 3% Possess Tourist/Student Visa
- 3% Did Not Specify
- 1% Nationalised Spaniards
- 1% Asylum Seeker Process Ongoing
- 1% Residency Permit Process Ongoing
- 0% Nationalisation Process Ongoing

LACK OF INFORMATION AS THE DENIAL OF A RIGHT

Three years after this ruling - denying the right to a healthcare card for immigrants with an irregular status - came into effect many people continue to visit the various organisations which are part of REDER **seeking information** about their right to get some type of healthcare. Over the period of January 2014 to July 2015 **12% of the total of registered cases** fit into this category of event. We should also add to this figure the **22% of the total number of cases** who had not applied for their healthcare card because they did not know they had this right. Finally, **12% of the total number of cases** refers to people who were denied a healthcare card in a health centre because **the information which the administrative staff had been given about the application and requirements was incorrect.**

The number of people who, because they were unaware of their rights, did not go to a health centre or to one of our organisations to seek out information, would be even higher, and impossible to calculate. Thus, it is highly likely that because of the lack of internal and external information strategies by the health administration and because of certain dissuasive measures the impact has been greater than detected. Other reasons that may have dissuaded people from getting access to healthcare include the posters displayed in health centres and hospitals warning that persons without healthcare cards will not be given care. The word of mouth transmission of stories of people who have been denied care or who have been charged for care provided in the emergency ward has possibly further increased this dissuasive effect.

As a consequence of not having a healthcare card these people are denied access to medical consultations, in the majority of

cases within Primary Healthcare, but also for access to specialist care too. This results in the impossibility of ensuring through continuity follow-up treatment, diagnostic tests or through accessing services or socio-medical resources.

M is a woman who came to Galicia in 2012 with her husband and her two sons, aged 2 and 5, thanks to a post-university study grant. Upon arrival she immediately started the applications to request a healthcare card, but she was initially refused by the Office of Social Security. With the support of a social worker from her health centre she was able to get medical care for her children, as they were minors, whilst her application for access to the Galician Programme for the Social Protection of Public Health was being processed, thanks to the support of a REDER member organisation. Firstly, this request was also rejected, and only after an appeal and showing INSS documentation was it recognised that these minors lacked regulated access to medical care and the regional delegation of La Coruña gave a positive response.

However, just 10 days later, M received a letter once again refusing healthcare via the Galician Programme because they had discovered that the parents of the two minors had a regular administrative status. As a consequence they cancelled and withdrew the healthcare cards. (Galicia).

Amongst the cases registered by REDER are 31 cases of cancer, 38 of cardiovascular diseases, 62 of diabetes, 14 of degenerative muscular diseases, another 8 cases of other types of degenerative diseases, plus 28 other cases which could potentially have been fatal if not given the appropriate care and treatment. 27 cases were documented of people with serious mental problems who were victims of the exclusion from healthcare imposed by the application of Royal Decree-Law 16/2012.

THE DOUBLE INFRINGEMENT: THE SYSTEMATIC FAILURE TO FULFIL PROMISES ON PROTECTED EXEMPTIONS

Royal Decree-Law 16/2012 sets out a minimum safeguard, permitting medical care under certain circumstances:

- ▶ emergency because of serious disease or accident, no matter the cause, until discharge.
- ▶ care during pregnancy, birth and during the postnatal period.
- ▶ in all cases foreign nationals below the age of eighteen will receive medical care in the same conditions as Spanish people.

However, the frequency with which this rule fails to be applied in these circumstances in practically all the regions is striking. REDER has registered, over the 19-month period where the sample was collected, up to **78 cases of pregnant women** who were denied this legally recognised right. These situations vary from refusing to issue the healthcare card up to cases where the necessary medical treatment was not given for complications related to the birth because these were not recognised as part of the compulsory care established under the Royal Decree-Law. A special mention should be made for the cases of women who have been denied voluntary termination of pregnancy under the framework of the current legislation, with the risk that they abort without the proper health guarantees, putting both their health and their lives at risk.

Additionally, situations where minors (**109 documented cases**) have been refused medical care are recurrent (they are not given the necessary vaccinations, they are not given appointments in paediatrics and even in the emergency ward, which has, on occasion, charged them...). In many of these cases the refusal occurs because the parent(s) do not have a social security number.

Lastly, the most frequent violations of the Royal Decree-Law amongst the registered cases are those which took place in the **emergency services, with 232 documented events** (138 women and 94 men). We have learnt of 44 cases of refusal of care in the emergency ward and 188 cases where the care given was charged for or



© GIORGOS MUSTAFIS

where a signature for a payment commitment was demanded as a condition for providing care. In such cases if the invoice was not paid it led to the issuing of warnings, threatening the application of surcharges if the payment remained unpaid. In other cases their names were published in the official regional newspaper, as a first step by the authorities in the process of collecting these funds.

We can imagine the feeling of anxiety amongst these people, who, with limited resources, are demanded to repay these bills of up to 5,000 Euros in some cases. This anxiety is worsened by the fear that having a debt to the Administration will have a negative impact on their regularisation applications.

Another widespread practice involved stopping care upon discharge from the hospital - rather than at medical discharge, as the law demands. As a consequence, the diseases detected in the emergency ward cannot be given medical follow-up or finish off the diagnosis in specialised care services.

In all of these cases we see a double infringement of the rights of those affected. The denial of the right to healthcare, which has prevented thousands of people from having access to a level of coverage in accordance with the minimum standards of human dignity, has been made worse by the breach of the few exemptions accounted for in the law. The result is the increased exclusion and marginalisation of these people.

THE ESPECIAL VULNERABILITY OF ASYLUM SEEKERS AND VICTIMS OF HUMAN TRAFFICKING

Royal Decree-Law 1192/2012 widens the scope of exemptions initially planned under Royal Decree-Law 16/2012, including two new categories:

- ▶ *Those people requesting international protection and whose stay in Spain has been authorised for this purpose will receive, as long as this situation remains, the necessary medical care, including emergency treatment and the basic treatment of diseases. In addition, the necessary care, either medical care or care of other sorts, will be given to those people requesting international protection who have special needs.*
- ▶ *Victims of human trafficking whose temporary stay in Spain has been authorised for a period of rehabilitation and reflection will receive, as long as they remain in this situation, the necessary healthcare, including emergency treatment and the basic treatment of diseases. In addition, the necessary care, either medical care or care of other sorts, will be given to those victims of human trafficking who have special needs.*

However, these provisions have clearly proven themselves to be insufficient. Regarding people requesting international protection, the right to care under the law comes with the condition that their stay in Spain “has been authorised”, which, in practice, means that asylum seekers and refugees are excluded from the system whilst they are still waiting to be given such status.

We must not forget the extremely vulnerable situation of people who are fleeing conflicts, ideological or political persecution or who are subjected to exploitation. Moreover uprooting and difficulties in communicating contribute to increase their isolation and vulnerability. For this reason they should be afforded special protection, particularly in relation to healthcare. However, the healthcare reform has led to the majority of these people being left in a situation of complete neglect. **REDER has documented 10 cases of people in such a situation.**

Regarding victims of trafficking, the right to healthcare is recognised only for those who have been identified as such and consequently are in

some way under the protection of the authorities. Moreover, this is only granted during the “period of rehabilitation and reflection”, a period of time which is clearly insufficient¹². (until last July this period was of 60 days).

The facts show the significant administrative barriers which victims of trafficking face when applying for a healthcare card as a consequence of both the lack of ID (traffickers regularly confiscate passports) and the brevity of the period of rehabilitation and reflection, which in many cases does not last long enough for the application processes to be completed.

The two cases documented by REDER suffice as illustrative examples of this reality: two foreign women with an irregular administrative status went to the emergency ward as it is the only means of access to medical care available to them. To make the situation even worse, this care in the emergency ward was charged to them. These two people received support from social organisations who are members of REDER and they show sufficient evidence as to be considered victims of trafficking.

On the other hand, the conditions of exploitation and abuse in which they find themselves put them in an even more vulnerable situation, if that is even possible. Therefore, the majority of victims of trafficking who have yet to be identified lack access to regulated care, which means the system loses an important means of detecting these cases of sexual exploitation.

¹² Until last July this period was of 60 days, it is now 90 days, but this is still a very limited timeframe.





Natalia Duffy

© CARLOS BARRERO

OLDER RELATIVES: LOST IN A MAZE OF JURISDICTION AND LEGALITIES

Over these last three years the organisations and social collectives who have been working with people excluded from the national healthcare system have noted the increasing number of cases of immigrants with a regular residency permit who the Administration recognises neither as insurance “titulares” (holders) nor as “beneficiarias” (beneficiaries). Mainly this concerns elderly dependents who came to Spain via processes of family reunification. Prior to 2012, these people could register as beneficiaries of their sons and daughters. But Royal Decree-Law 1192/2012, which regulates the conditions of insurances holders and beneficiaries, excludes ancestors from the latter category. The incongruity is clear, the arrival of these people in Spain was authorised, they are suffering from serious health problems and yet they are denied access to the care that they so desperately need. Although, all-in-all, this group represents but a small part of the total number of immigrants, these are very painful cases which demand a more humanitarian approach by the Administration. REDER has documented up to **25 cases of people**

in such a situation, including people suffering from heart disease, hypertension, potentially fatal chronic respiratory diseases, arthritis and other rheumatisms, and people who needed follow-up care for surgery carried out in the country of origin. None of these people received care.

The dramatic situation of these people and their families gets even worse when we see just how impossible it is for them to obtain private insurance, as the insurers reject them precisely because of their fragile health and advanced age. The alternative of subscribing to the Convenio Especial de Prestación de la Asistencia Sanitaria (Special Agreement for the Provision of Healthcare), established under Royal Decree-Law 576/2013, is no more viable as it requests a minimum of one year of registered residency (with a resultant lack of protection for the entire previous year) and a monthly payment of 157 euros for people over the age of 65 and 60 Euros for people below this age, an amount which is out of reach for the majority of these families, who have very limited resources.

The incoherence of this legal cul-de-sac, into which these people have been pushed, has been highlighted by the courts. There have been many cases with these characteristics in which diverse judicial authorities have agreed with the people affected by this, arguing that

SPAIN IS LEAVING THE OLD AND SICK TO DIE WITHOUT HEALTHCARE

Carlos was 66 when he died with his daughter Natalia (photo on the page on the left) unable to make the Administration give him regulated access to the medical care he required. He was suffering from diabetes and Alzheimer's disease and had arrived in Spain, where all his children live, in 2009. He went to live in Galicia with his daughter and his son-in-law, where he had a healthcare card and received regulated treatment. However, when the family moved region, due to work reasons, Carlos was left without medical care. In the office of the INSS he was refused a healthcare card as his daughter's beneficiary and they demanded that he take out private insurance. In April 2014, he suffered a general deterioration and went to the emergency ward where it was recommended that he be admitted. However the insurance refused to pay for the cost of both the admission and the prescribed treatment. He therefore had to request voluntary discharge as the family could not afford to pay for this. As a consequence his situation deteriorated over the following weeks, leading to further admissions to the emergency ward. But he never received the appropriate treatment and follow-up care for his disease, and he died. Cases like Carlos' pile up without any signs of solutions for the powerless families and people who bravely try to help them see their right to healthcare recognised.

By fighting for their rights, some families are starting to see that the courts agree with them. This was the case for Margarita, an 81-year-old Colombian who had been living in Burgos for almost a decade until she was able to get a permit for family reunification. The INSS refused her a healthcare card, stating that "foreign nationals who request to be registered on the Registro

Central de Extranjería (Central Register for Foreign Nationals), or for the appropriate residency permit, after 24 April 2012 will not have the right to healthcare financed by the national health system". At the same time Hilda, a 77 year-old Venezuelan, was experiencing a similar story in Barcelona. A legal resident since 2011, thanks to a family reunification process, the INSS refused her a healthcare card claiming that Hilda should have had private health insurance when she requested legal residency in Spain in order to be granted this. In Madrid 80-year-old Colombian Víctor, suffering from COPD, had arrived in Spain in 2013 thanks to the efforts of his daughter in having him granted family reunification. However, this reunification did not come accompanied with a healthcare card, which he was refused by the INSS because he had never paid social contributions in Spain.

In all of these cases the law clearly sided with the affected people, arguing that the decision made by the Foreign Nationals Register to give residency to a person is, for all intents and purposes, a legal ruling, and the INSS has no competence to interpret these rulings nor to limit their scope -judging the requirements for a regularisation as being met and withdrawing the part of this relating to healthcare.

However, this situation continues today and there are many cases which still require urgent care. Like that of J.M.S., an 80-year-old Argentine man and Spanish resident since 2013. Despite having private insurance, they refused to pay for his treatment when he was diagnosed with COPD. Or that of C.S.C.M., an 80 year-old Cuban with hypertension and heart disease with mitral insufficiency who was refused a card by the INSS.

the National Institute for Social Security (INSS) has no competence to deny a healthcare card to a person whose regularisation process had already been authorised¹³. These cases open a new jurisprudential pathway which we hope will be used as precedent to avoid any repeating of the situations described above.

¹³ Various news pieces in the press:

http://sociedad.elpais.com/sociedad/2014/02/19/actualidad/1392846250_883061.html

http://www.eldiario.es/sociedad/tribunales-Seguridad-Social-exclusion-inmigrantes_0_342616229.html

http://www.eldiario.es/desalambre/Seguridad-Social-sanidad-anciano-papeles_0_393011116.html

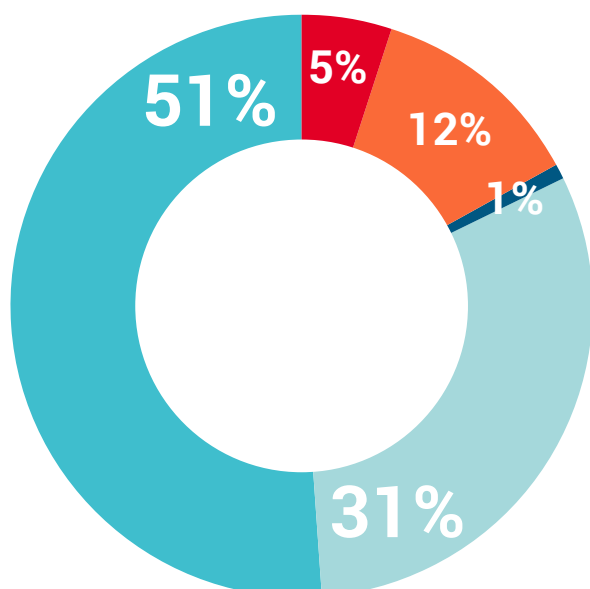


© CARLOS BARRERO

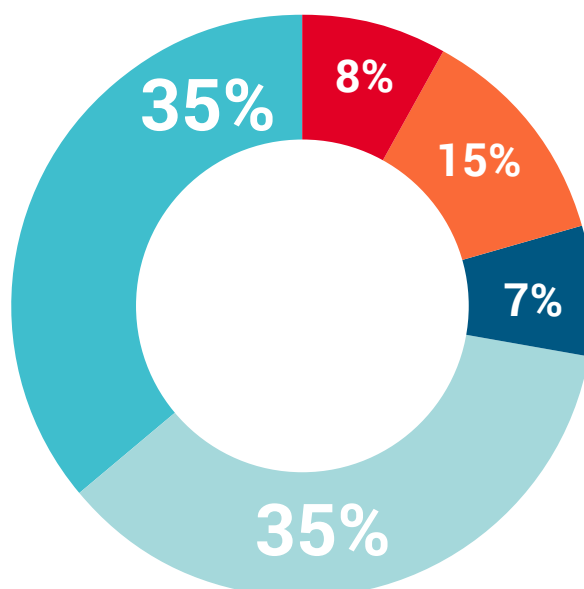
Carolina Bermúdez

- Impossible to access medication.
- Billing or a signature for a payment commitment for the medical service..
- Refused care in the emergency ward.
- Administrative obstacles.
- Lack of information.

EVENTS IN AUTONOMOUS REGIONS WHICH HAVE SPECIFIC PROGRAMMES



EVENTS IN AUTONOMOUS REGIONS WHERE THE EXEMPTIONS HAVE BEEN WIDENED



THE LACK OF EFFICACY OF A PATCHY PIECE OF LEGISLATION

Just a few months after the beginning of the withdrawal of healthcare cards for foreign nationals with an irregular status, various regional governments drew up their own exceptions to the conditions for access to the services of the public health system, either through the creation of **specific health programmes** (which afford access to a basic budget for people who fulfil a set of criteria) or through a **widening of the exemption criteria** accounted for in the law.

The **657 cases** (428 women/ 226 men/ 3 transsexuals) **documented by REDER of people excluded from the regional healthcare programmes or from the widening of the exemptions**, even though they meet the required criteria, are the conclusive proof that this “patchy” legislation is ineffective and show that the reinstatement of universality is the only acceptable option. In addition, the lack of political will backing the creation of these programmes and regional exemptions has been noted in the lack of internal and external strategies for diffusing information, which social organisations have been denouncing.

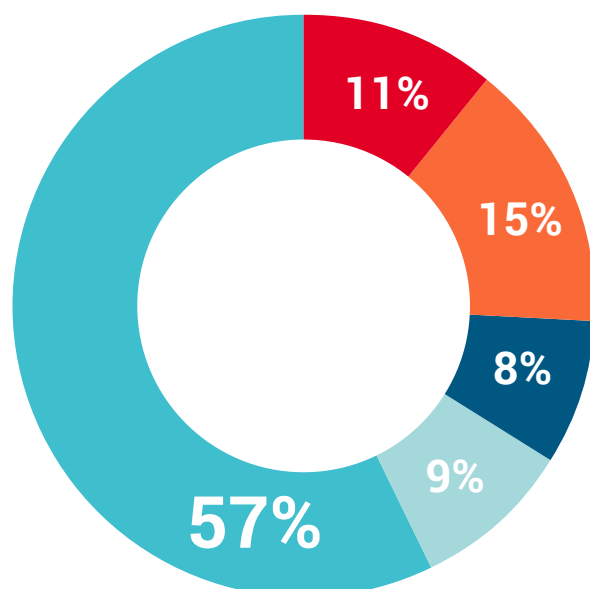
Between July and August 2015, four of the autonomous regions which had such healthcare

Carolina (image on the page on the left) is a 27-year-old from Nicaragua who is married to a Spanish man. Her residency permit was not approved because of a lack of financial resources and therefore she does not have a healthcare card either. She requested access to the Galician Programme for the Social Protection of Public Health. Firstly she had to go to the INSS to get a document to certify that she was not insured by the national health system. She came back with the documentation but she was then refused because she had a NIE (Identification Number for Foreign Nationals) and she was sent back to the INSS. Later she received a letter warning her that she could no longer request to enter the Galician Programme. At long last, almost three years after her first request, C.B.V. was able to be included in the Galician Programme for the Social Protection of Public Health.

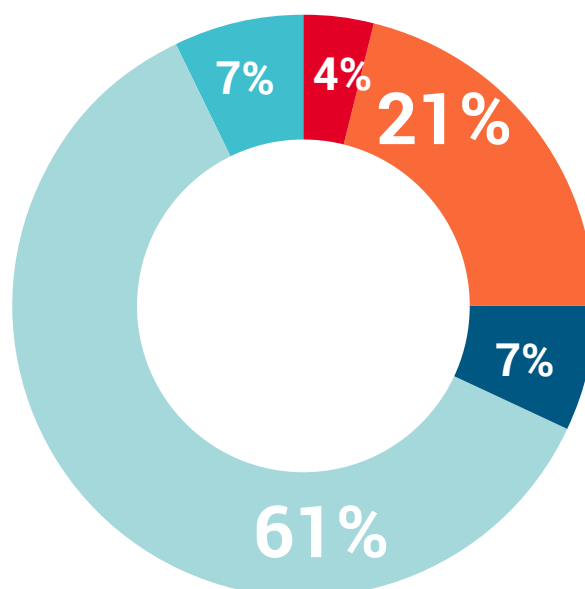
programmes to provide immigrants with an irregular status with access reformed their regional legislation to recognise universal access to the public health system. This was an important step towards these autonomous governments meeting their obligations and will put an end to many of the situations documented by REDER. Nonetheless, the map still contains very distinct models of healthcare, which has created significant territorial inequality within the national health system.

EVENTS IN AUTONOMOUS REGIONS WHICH HAVE APPLIED THE ENTIRETY OF RDL 16/2012*

*We only have data for Castilla-La Mancha.



EVENTS IN AUTONOMOUS REGIONS WHICH HAVE NOT APPLIED RDL 16/2012



Conclusions

The more than 1,500 people who have been, in some form, denied access to healthcare (the cases documented by our organisations in 12 Autonomous Regions in little over a year) are the clear proof that the current model for healthcare in Spain is far from being universal and loyal to the key principles which have defined the national health system since 1986. **When the arguments to justify the introduction of a piece of legislation which is discriminatory towards a sector of the population are not based on scientific evidence and are contrary to principles of ethics and Human Rights then we can only qualify this policy as arbitrary.**

REDER believes that the 2012 healthcare reform is unjustifiable from a Human Rights perspective, from a financial perspective, from a public health perspective and from a medical ethics perspective. Denying people access to the different levels of public healthcare based on their administrative status is contrary to the code of ethics and the Hippocratic Oath. Looking at this from an efficiency perspective we should point out that leaving the most vulnerable outside of regulated medical coverage, as well as being unjust, means excluding them from the proper coordination between the different socio-medical levels and from the protocols established with the purpose of prevention, and of protecting public health.

That several of the governments of the autonomous regions put in place, almost from the very first moment when the reform came into force, different ways of regulating access to healthcare via the public health system, shows that this is an ineffective ruling with serious planning flaws from a healthcare management point of view.

On the other hand, the sample of cases collected by REDER organisations have confirmed the diagnosis that different medical and social organisations have been denouncing since 2012:

- ▶ **a decline in healthcare management** as a result of the high level of confusion generated

amongst healthcare and administrative staff, given the lack of information and instructions on how to apply the Royal Decree-Law. As a consequence we are currently experiencing a **clear lack of symmetry** in its application between and within the different autonomous regions, which is creating a situation where the population is getting contradictory answers and finding a marked **lack of coordination between the different levels of care.**

- ▶ **a widespread failure to fulfil, by the Royal Decree-Law itself, on the few safeguards** it takes into account: the refusal of care for pregnant women and minors as well as the systematic billing of care in the emergency ward. We should add to this failure of the state norm the administrative difficulties which the majority of people are faced with when trying to access ad hoc healthcare programmes created in the autonomous regions.

From a medical perspective we have noted a series of direct consequences on the health and lives of the people who have been excluded from healthcare:

- ▶ **a break from proper follow-up care for serious or chronic diseases:** HIV sufferers who had received anti-retroviral treatment and medical follow-up for their diseases for months, or years, but who, after losing their jobs, also lost the possibility of continuing their treatment; patients diagnosed with cancer who cannot afford the cost of extra tests or of oncological treatment; people with advanced kidney disease who are not treated and people who receive transplants but who are denied follow-up consultations and immunosuppressive treatment, with the subsequent risk of losing the transplanted organ.
- ▶ **a loss of effect of healthcare prevention programmes in Primary Healthcare:** although the Royal Decree-Law allows for the possibility of diagnosis and prescription for diseases such as tuberculosis, when admitted via the emergency

ward, it makes difficult, or prohibits, a follow-up of the treatment and the study of contact which is absolutely key to be able to treat other infected people and to stop its spread. It also almost completely restricts access to methods to diagnose HIV, provide follow-up care and to prescribe the specific medication to control the virus.

The risk that is implied by the loss of effect of these programmes is undisputable, not just for the patients, but for the population as a whole; as is the obvious increase in costs for the healthcare system because of the rise in the number of hospital admissions as a consequence of the health complications these people are suffering from.

Furthermore, and as we have already mentioned, it makes it considerably more difficult to detect cases of gender-based violence and trafficking, which are frequently detected at the first level of care.

► **no access to the Public Services for Sexual and Reproductive Health:** Desde la entrada en vigor del Real Decreto-Ley 16/2012, las mujeres inmigrantes que se encuentren en situación administrativa irregular han quedado fuera del acceso a los servicios de contracepción y, en caso de necesitarlo, de Interrupción Voluntaria del Embarazo (IVE) a través del Sistema Nacional de Salud.

since Royal Decree-Law 16/2012 came into force female immigrants with an irregular administrative status have been left without access to services for contraception and, where required, from the voluntary termination of pregnancy services of the national health system.

In face of the consequences of the application of Royal Decree-Law 16/2012 the autonomous regions have been creating alternatives over these last three years to widen the pathways for access to the public health system. Thus, three years later we have a melting pot of legislative situations in the 17 autonomous regions, highlighting the limbos created by the state ruling to regulate access to the national health system. The lack of symmetry in the application of the ruling increases the climate of confusion amongst the different

levels of management and, as a consequence, causes confusion in the obstacles immigrants face to access the healthcare system.

The indirect consequences of healthcare exclusion on the lives of immigrant women are rarely mentioned. When access to public services is denied, who takes on the responsibility of caring for these ill dependents?

Currently - with the recent regional rulings announced between July and August 2015 – **in nine autonomous communities there is a legislative context which recognises regulated access to healthcare** for foreign nationals with an irregular status and whom are not recognised as being insured or beneficiaries (Andalusia, Aragón, Asturias, the Balearic Islands, Cantabria, Catalonia, Navarra, the Basque Country and Valencia). Five other regional governments announced, in August 2015, **forthcoming measures to widen the scope of healthcare coverage for immigrants with an irregular status** (the Canary Islands, Castile-La Mancha and Extremadura are on the same path as those previously mentioned, whilst Madrid and Murcia are waiting to hear the proposal presented by the Ministry of Health, Social Services and Equality).

Galicia is retaining, without any amendment, its Galician Programme for the Social Protection of Public Health, whilst Castile and León, as well as La Rioja, are keeping the circumstances and exemptions through which they widened healthcare coverage to the groups excluded by the Royal Decree-Law.

Over the last three years the voices from social, scientific and political backgrounds, from both Spain and the international community, have been pointing out that sustainability in the national health system will not be achieved by restricting or preventing the access of a vulnerable population to healthcare services as it has already been demonstrated that the immigrant population uses the healthcare system less than the rest of the population does. Denying a regulated access to the public health system, the healthcare card, is economically inefficient as well as unfair and contrary to the Human Rights framework.

Recommendations

REDER joins itself to those voices demanding **the urgent need to reform Royal Decree-Law 16/2012 and the subsequent Royal Decree-Law 1192/2013** which define the status of insurance holders and beneficiaries of the national health system and exclude immigrants with an irregular status.

In this regard, **REDER organisations reject the creation of any parallel access system to the public health system which is not the public health card system** that is currently used.

The **regional governments** also have international obligations in terms of the right to health and they **can and must push to the limit of their competency to ensure that the universality of this right is restored**. REDER applauds the reforms that have been set out in various autonomous regions following the May 2015 elections and encourages these to be completed until a solution has been found for the remaining unresolved issues, such as:

- the protection of people with residency permits for family reunification who have been refused the status of insured persons or beneficiaries;
- or European Union citizens and citizens from countries with which Spain has a bilateral agreement, who are unable to bring the necessary documentation from their countries of origin.

UNTIL THESE RECOMMENDATIONS HAVE BEEN FULFILLED

We urge **the Ministry of Health, Social Services and Equality** to take the following urgent and provisional measures:

- ▶ To carry out and publish a **rigorous and exhaustive analysis of the short and long-term impacts** of the measures which exclude large parts of the population living in Spain from accessing the non-emergency parts of the healthcare services, including an analysis of the health of the health and lives of the most vulnerable people.

- ▶ That any measure to be adopted for further reform of the healthcare system and the processes for accessing the national health system should always be submitted in advance for a public and transparent evaluation - which did not happen in 2012 - and for a later evaluation measuring the impact of such measures on Human Rights, public health and gender, as established under the Organic Law for the Effective Equality of Women and Men (2007) and the General law on Public Health (2011).

- ▶ **To draw up and publish adequate procedures to guarantee compliance in all autonomous regions of the assumptions of Royal Decree-Law 16/2012** which recognise the right to healthcare for minors, pregnant women, asylum seekers and victims of trafficking during the period of reflection, and in the emergency ward. Such procedures should ensure that this care should, under no circumstances, be charged for, or subjected to a signature for a payment commitment by the user.

- ▶ **To recognise the right to healthcare of all immigrants who meet the criteria established under Royal Decree-Law 16/2012**, independently of the date when the residency permit was approved or the reasons for its approval, and to duly guide the National Institute for Social Security (INSS) on this matter.

- ▶ **To make the identification requirements more flexible** for any application relating to healthcare, taking into account the financial and geographic difficulties that many foreign nationals face when trying to access consular services (which are inexistent or concentrated in just some cities) or who come from countries in a situation of crisis or conflict and where obtaining the appropriate documentation is impossible.

- ▶ **To adopt the necessary measures to fight against discrimination in health access**, independently of the origin and administrative situation of the person.



© KATHERINE FAWSETT

We urge **ministers of health**:

- ▶ To push on with **legislative reforms** in the autonomous regions which provide **universal access in equal conditions to the public health system** for immigrants with an irregular status, such as those with residency permits for family reunification, in the autonomous regions where this has not yet been launched. They should also ensure that these do come into force and that these are based on **accessible and attainable requirements**.
- ▶ **That in no circumstances should a minimum period of registered residency be demanded** as a necessary requirement for the recognition of universal access to healthcare and for pharmacy services. This condition is not only an administrative barrier for many immigrants with an irregular status, but it also introduces a criteria for discrimination with regards to the rest of the population.
- ▶ **To immediately put an end to the practice of charging for emergency care** or for other services, which implies non-compliance with the assumptions regulated by the Royal Decree-Law.
- ▶ **To effectively guarantee healthcare to minors and pregnant women, in all cases**, independent of whether they can show ID or if they are registered, and without this costing them anything.
- ▶ To obtain resources to **guarantee access to health and pharmacy services** for immigrants excluded from the national health system in the autonomous regions where no such measure is available, and when necessary, ensure that these come into force, based on accessible and attainable requirements.

Socio-medical, administrative and management staff of the national health system, we encourage you to join with the movement for the conscientious objection of Royal Decree-Law 16/2012, as we consider there is a right and duty to not collaborate with Human Rights violations.

Fellow citizens, we encourage you to support the mobilisations and protest action against the Royal Decree-Law.





www.reder162012.org



NETWORK MEMBER ORGANIZATIONS

