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Effects of undocumented immigrants exclusion from health care coverage in Spain.

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Highlights:

1. Spain excluded undocumented immigrants from basic public health care in 2012.
2. Most political parties and health professional groups opposed such legislation.
2. Some regional authorities granted coverage, which might have contained negative health effects.
3. To date, a slight impact on infectious diseases has been reported.

Abstract

BACKGROUND:

In 2012, in response to the economic crisis, the Spanish government passed Royal Decree Law16/2012 (RDL). This RDL redefined who is entitled to public healthcare. The Beveridgean principles of universal citizen coverage to health care were distorted to accommodate rather more insurance-based principles by which getting care was linked to make a Social Security contribution. As a result, undocumented immigrants in Spain were excluded from basic public financed health care.

AIM:

To identify the distinct traits of such policy and review its health and economic impact.

RESULTS:

Most political parties and health professional groups opposed RDL, and a substantial number of Spanish regions with competencies in health care organisation either declined to apply RDL or applied it partially. To date, the RDL has had sizeable effects on undocumented immigrants' access to public healthcare and over 870.000 people were excluded. A slight increase of infectious diseases was reported, albeit less than originally predicted.

CONCLUSIONS:

Regions in Spain have reacted to RDL in different ways. Regional legislation favouring undocumented immigrants coverage might have acted as a counterweight and contained negative health effects on this population subgroup. Further surveillance and continuous monitoring is encouraged.

Keywords: migrant, coverage, austerity, crisis, decentralisation

1. Political and economic background

In April 2012, the People's Party (*Partido Popular*) in government in Spain passed Royal Decree-Law 16/2012 (RDL) under the title: "Urgent measures to guarantee sustainability of the National Health System and improve the quality and the safety of its services" [1]. This RDL brought major changes into the Health System and was presented to Parliament and to the population as a necessary policy response to the economic crisis and to the pressure by the so-called Troika (European Commission, European Central Bank and International Monetary Fund) for austerity to avoid financial bailout.

One of the most controversial measures passed by the RDL redefined whom was entitled to publicly financed healthcare. Indeed, before the RDL, entitlement was largely guaranteed by residency in the country (universal access) very much in the line of a National Health Service Beveridgean model. After RDL access to public health care was conditioned by making a Social Security contribution. As a result, undocumented immigrants in Spain were excluded from basic public financed health care. The aim of this paper is to identify the distinct traits of such policy and review its health and economic impact.

2. Health Policy Process

2.1. Origins of the health policy idea.

According to a research published by the European Observatory on Health Systems and Policies [2], countries affected by the financial crisis have responded very differently to the situation. Some countries, including Ireland, Greece, Spain and Portugal, adopted rather stringent austerity policies [3]. In this respect, the RDL in Spain aimed at controlling public health expenditure by cutting on benefit packages, increasing users direct contributions, and reducing the percentage of population covered [4]. Indeed, the new regulation aimed at denying health care to any person unauthorized to reside in Spain (non-European immigrants in irregular situation) or not registered as a resident (EU citizens). This paper focuses particularly on the latter.

2.2. The project.

Before the implementation of the RDL, a Spanish reference piece of health legislation was the General Health Act (GHA14/1986) that set the basis for a National Health System largely financed through taxes and with universal coverage. Residency was then the base for public health care access. However, RDL –as well as a subsequent Royal Decree 1192/2012 [5]– explicitly state that entitlement to public health care coverage should be granted only to those individuals labelled as "insured" or "beneficiaries of an insured person". An insured person is that who contributes –or has contributed– to the Spanish Social Security System. That includes those that are actually affiliated to the Social Security System, namely those that have a legal paid job, pensioners, those under unemployment benefit, those other registered as jobseekers, and those who benefit from any other social security payment. Further, RDL considers that the husband/wife to an insured person, dependant former husband/wife and

children/youngsters under 26 –or with a significant disability– should be considered as "beneficiaries". Those other citizens who do not enjoy either an insured or beneficiary status can only access healthcare on a fee for service bases or paying for an additional insurance.

In the case of undocumented immigrants, RDL redefines their rights to access public healthcare originally established by GHA14/1986 and by Law4/2000 on the Rights and Freedoms of Foreigners in Spain. As a result, undocumented immigrants in Spain only have access to emergency care, maternal care (pregnant women, natal and post-natal services), children under 18, asylum seekers and victims of human trafficking.

Overall, this has been reported as a major reform to Spanish healthcare system as it links receiving health care to contributing to the Social Security System. This is rather shocking since the Spanish health care system today is not financed through social security contributions but through taxation, just as the vast majority of Beveridgean models in Europe. That is, by means of a royal decree a major change was introduced in the model excluding undocumented immigrants from full public health care coverage despite this subgroup is actually contributing to the sustainability of the health care system through indirect taxation linked to their consumption of goods and services [4].

2.3 Adoption and implementation

Implementation of RDL required the participation of regional authorities (Autonomous Communities) since health care is largely decentralised to regions in Spain. Twelve out of seventeen Autonomous Communities (regions) have passed specific legislation (1 regional law, 3 orders, 8 instructions) as well as departmental directives so as to regulate entitlement to healthcare for undocumented immigrants. This has contributed to modulate the consequences of the implementation of RDL [6] in their territory (Table 1).

Some Autonomous Communities strictly complied with the RDL, but others established regulations and measures that increased flexibility in the practical application of RDL [7,8] (Table 1). Intriguingly, up to five Autonomous Communities governed by the same political party in Madrid created alternative administrative pathways to health care for undocumented immigrants. Despite coverage of undocumented immigrant varies across Autonomous Communities, the trend has been to gradually extend benefits to this population subgroup [7].

By September 2016, all Autonomous Communities (15/17) –except Castile and Leon, and La Rioja– had put in place legislative actions to neutralize the impact of RDL on undocumented immigrants access to public health care [9]. Notwithstanding the above, complete access to public health care requires in some regions that migrants prove a minimum required period of residency and that they have insufficient economic resources.

3.3. Analysis of actors

Central and Regional Governments

Three different politicians from the ruling People's Party have held the position of Minister of Health since RDL was approved: Ana Mato, Alfonso Alonso and Dolors Montserrat (present Minister).

In March 2015, Minister Alonso announced government's intention to carry out reforms to allow access to public health care, particularly primary care, to undocumented immigrants without granting them the status of "insured". This political intention never materialized. In December 2016, Minister Montserrat positioned herself in favour of RDL [10,11] using similar arguments as her predecessors and claimed that abolishing the RDL would result in the unemployed not getting public health coverage.

However, the political support of the People's Party has decreased since the RDL approval. Despite retaining government they need other party's support to gain some governmental stability (Figure 1). Further, Spanish decentralized political organization has allowed for other parties and regional parliament majorities to act on RDL implementation in many different ways. In response to regional legislation, the central government has filed appeals of unconstitutionality in some cases. Indeed, in July 2015, the Valencian Government passed Decree Law 3/2015 to guarantee universal access to health care acknowledging all registered persons (residents), including undocumented immigrants, their right to health care [12]. In March 2016 the Constitutional Court agreed that most of the contents of Valencian Decree-Law 3/2015 were valid [13]. In addition, six other regions (Andalusia, Basque Country, Canary Islands, Catalonia, Navarre and Asturias) followed Valencia and filed similar appeals of unconstitutionality against the RDL [6]. The Constitutional Court resolved such appeals by means of the sentence 139/2016, of July 21th [14], concluding RDL is in line with the Spanish Constitution.

Today, although no legal change at national level has been introduced, the central government seems to acknowledge the fact that undocumented immigrants are being attended by health care services all over the territory.

Political Parties

Most political parties in the opposition joined efforts in signing an Institutional Declaration for Universality of Health [15], which was promoted by fifty organisations. They further committed to include the "effective restitution of the universal right to health for all residents in Spain" in their respective 2015 election electoral programs. *Ciudadanos*, fourth party in today's Spanish political spectrum, did not sign the declaration arguing they favoured offering only basic assistance to undocumented immigrants, covering emergency care, children and pregnant women, as approved by central government [16].

Civil Society

There has been a wide response from civil society against RDL. In the weeks following the publication of RDL, civil society organisations produced numerous declarations and texts that were later reviewed by Suess et al. [17] concluding there was a broad civil rejection of RDL. The main arguments put forward were the defence of a public health system model in Spain, the limitation of access to healthcare, and the importance of strengthening health and social policies to curb the impact of the economic crisis.

Social and medical organizations have joined forces to create the REDER [18] platform. REDER brings together more than 150 organizations and its main objective is to force the

derogation of the RDL and restore universal coverage as a civil right.

A report of the Committee on Economic, Social and Cultural Rights –a United Nations body– disclosed great concern to maintain the principle of universality in access to healthcare and to evaluate the predictable impact on specific vulnerable groups. In addition, the European Public Health Alliance or Platform for International Cooperation on Undocumented Migrants (PICUM) expressed its support to citizen's mobilizations.

Despite harsh criticisms and open opposition, the influence of civil society has shown limited effect.

Medical Community

Several national and international medical organisations have taken position against RDL since its publication. At national level, the Primary Care Physician Forum opposed the content of RDL in a public statement in May 2012, considering it an inefficient measure [19] that was contrary to both the medical code of ethics and the international medical law. The Forum was born in 2010 and claims to be a unified voice on behalf of primary care physicians in Spain and it comprises many major professional organisations and scientific societies in the country.

SemFYC, the Spanish Society for Family and Community Medicine, has also shown its disagreement and asked for RDL's withdrawal. The Society agreed on a conscientious objection document to help health professionals –not only doctors but also nurses and other health professionals– to state their objection to the law and claim the right to continue attending undocumented immigrants [20].

International medical organisations such as Doctors of the World (DoW) and Doctors Without Borders have also publicized their disagreement with RDL [19]. DoW, an international network with presence in 15 countries all over the world, launched its own campaign under the "Right to heal" motto to promote conscientious objection, offer public support to objectors, and campaign for the withdrawal of the law [20].

Finally, the medical students' community took position in May 2012, advocating for respect to the medical code of ethics [21].

Overall, one may argue that the Spanish NHS is largely considered to be a conquest of democracy that brought universal coverage as a civil right to the population. That may explain why the medical profession feels so strongly in favour of providing care to undocumented immigrants. However, despite the medical community is highly respected by society, its influence on the implementation of RDL has been limited.

4. Preliminary outcomes

We hereby differentiate between RDL impacts on the excluded population, mostly undocumented immigrants, and RDL economic impacts.

4.1. Impact on undocumented immigrants' health.

According to the 2017 REDER's report [22], some 873,000 people have lost their NHS Card since the entry into force of the regulation. Further, from January 2014 to March 2017, a total of 3,340 cases of people excluded from NHS services were recorded, of which 687 occurred despite regional laws being approved. Of the total reported cases, 1,840 (55%) were undocumented immigrants, 19% had EU passport and 8% had valid residence documents.

Minimum care situations covered by the RDL (pregnant women, children under 18, asylum seekers…) were not fully respected Further, lack of assistance to patients with chronic pathology has also been reported among those population subgroups excluded by the RDL[22].

Regarding HIV, for example, there is little and hardly accessible data in the official government records. In 2012, the committee of experts of the Group for the Study of AIDS (GESIDA) assessed the impact of RDL right after its approval to alert on the consequences of the interruption of antiretroviral treatment [23,24]. Further, the Public Health Agency of Barcelona [25] indicate an increase in AIDS mortality in population aged 15 to 44 years-old between 2011 and 2013, particularly in some of Barcelona's neighbourhoods with a higher percentage of immigrant population.

A very recent study evaluating the impact of RDL on mortality among the undocumented immigrant population proved no effects were observed if the totality of the population was considered, but an increase in tumours was reported for some Asian immigrants and an increase in HIV among those with an African origin. These findings must be considered cautiously given the very small size of the sample in the study [26].

The exclusion of access to primary care may result in medical consultations taking place at a more advanced stage of the disease, which will also increase healthcare costs [23].

It is difficult to differentiate between health impacts as a consequence of the financial crisis and impacts as a result of RDL [27-30]. Most studies published provide estimations of such impact [23,24,28,31], but none of them determine the specific effects of RDL on this subgroup of population. A higher prevalence of some infectious diseases such as tuberculosis, HIV and infectious hepatitis has been reported in immigrant population [29].

Table 2 shows the incidence of major sexually transmitted diseases [32-34]. The trend indicates a decline in the overall incidence of HIV and tuberculosis, and an increase in the incidence of syphilis, gonorrhoea and chlamydia since 2009, and particularly after 2012. Therefore, from the interpretation of the data, one might think the crisis has had a negative effect on the incidence of sexually transmitted diseases and the RDL has contributed to it.

The most relevant data obtained from the NEC is, possibly, the increase in hepatitis B rates in 2013 and 2014, after a downward trend since the beginning of the crisis. This finding could be related to the RDL enforcement. Thus, although evidence of the health effects of RDL is fairly limited, available data suggest that its enforcement may be affecting the health of the population.

All in all, it should be mentioned the fact that the delay in data publication is an important limitation at the time of assessing whether the observed increase in specific diseases during the last years is a punctual phenomenon or a growing trend.

Taking a comparative perspective, some countries severely affected by the financial crisis reported higher incidence of communicable diseases. In Greece, for example, there have been new outbreaks of malaria and West Nile virus and an increase in influenza mortality [35]. HIV infections have also been significantly increased, especially among intravenous drug users [35].

4.2. Economic impact

To date, the Minister of Health in Madrid has not provided data on the savings achieved by applying RDL directives to undocumented immigrants [31,36]. Restricted access to primary care for undocumented immigrants may lead to an increase in the use of emergency services, which have become the only valid access for many. Such an increase may raise health costs. Supporting this hypothesis, data indicate an increase in the use of emergency wards in high-tech hospitals in metropolitan areas and big cities, where the immigrant population is greater in number [37,25].

5. Conclusion

The RDL set the bases for a radical change in Spanish NHS. One of the greatest concerns among professionals and the population has been the exclusion from health care coverage of undocumented immigrants. Given the fact that regions in Spain enjoy most of health care competencies, following RDL they passed regional legislation to counterbalance some of the restrictions to health care access imposed by RDL. Despite this, cases of health care exclusion have been reported [22].

Nevertheless, the data available is scarce, short term, and provides little information on country of origin of the population studied. There is a need of longer-term studies to properly appraise the relationship between the observed increase in AIDS mortality, for example, and the exclusion of undocumented immigrants from public health care.

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Figure 1. Positions of key stakeholders and their influence at a glance

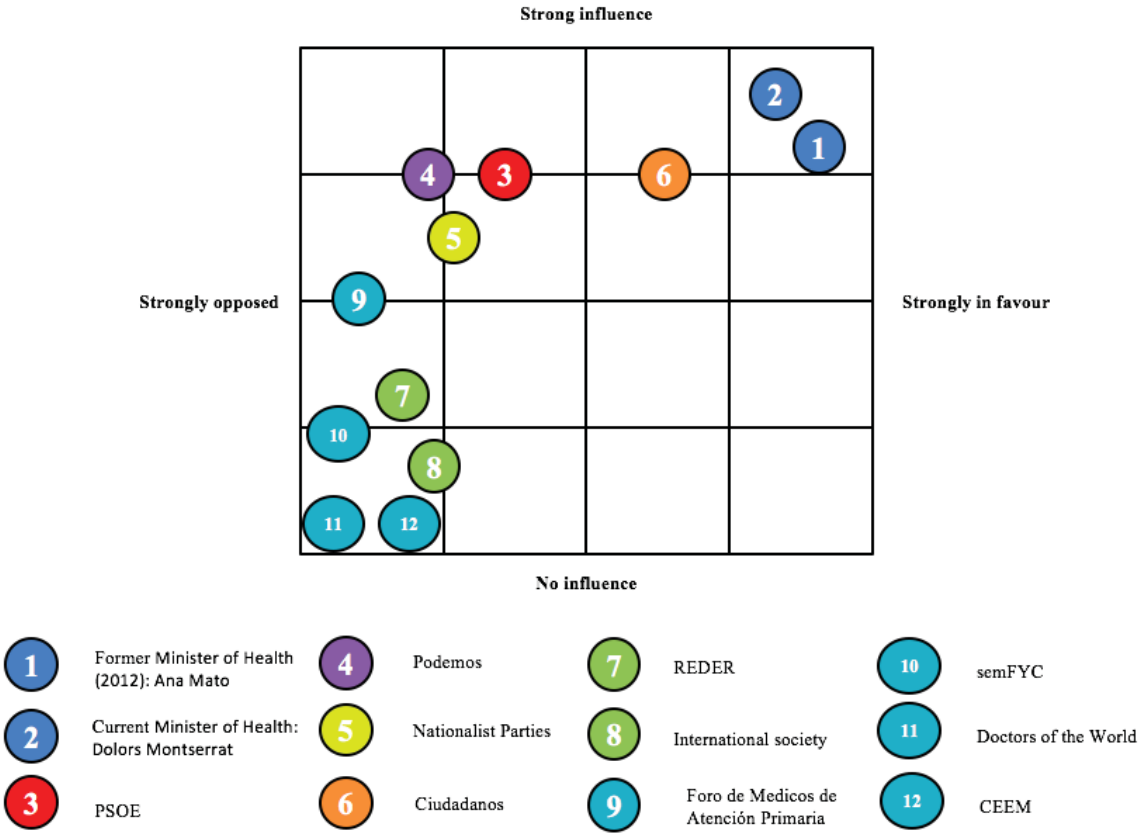

Table 1. Implementation of RDL 16/2012 across Spanish Autonomous Communities.

AUTONOMOUS COMMUNITY	TYPE OF LEGISLATION[13]	INITIAL COVERAGE[10,14]	CURRENT COVERAGE[10,15]
ANDALUSIA	Instruction	Recognition of access to NHS	Recognition of access to NHS
ARAGON	Instruction	Full implementation of RDL. Denial of access to healthcare	Recognition of access to NHS
ASTURIAS	Instruction	Recognition of access to NHS*	Recognition of access to NHS*
BALEARIC ISLANDS	Internal directives	Full implementation of RDL. Denial of access to healthcare	Partial recognition of access to NHS
BASQUE COUNTRY	Order	Recognition of access to NHS*	Recognition of access to NHS*
CANARY ISLANDS	Order	Nuanced application	Partial recognition of access to NHS
CANTABRIA	Order	Full implementation of RDL. Denial of access to healthcare	Recognition of access to NHS Instruction
CASTILE LA MANCHA	Internal directives	Full implementation of RDL. Denial of access to healthcare	Partial recognition of access to NHS Humanitarian health card
CASTILE AND LEON	None	Nuanced application	Commitment of recognition of access to NHS
CATALONIA	Instruction 08/2015	Recognition of access to NHS*	Recognition of access to NHS
CEUTA (Autonomous city)	None	No data	No data
EXTREMADURA	Instruction	Full implementation of RDL. Denial of access to healthcare	Partial recognition of access to NHS
GALICIA	Instruction	Nuanced application	Partial recognition of access to NHS
LA RIOJA	None	Full implementation of RDL. Denial of access to healthcare	Recognition of access to NHS
MADRID	Instructions	Full implementation of RDL. Denial of access to healthcare	Partial recognition of access to the NHS
MELILLA (Autonomous city)	None	No data	No data
NAVARRE	Regional law	Recognition of access to NHS	Recognition of access to NHS

MURCIA	Internal directives	Full implementation of RDL. Denial of access to healthcare	Partial recognition of access to NHS
VALENCIA	Instruction, Regional law	Nuanced application	Recognition of access to NHS

* Access is not the same for irregular immigrants and insured: they are no recognized as insured, they need to prove insufficient resources or they are required a minimum period of registration.

Table 2. Changes in the incidence rate of major communicable diseases according to the reports of the National Epidemiology Centre (NEC).

Changes in the incidence rate of major communicable diseases according to the reports of the NEC.	
HIV	3.366 new HIV cases were reported in 2014 (incidence rate 7.25/100.000inhab.), of which 32.1% were foreigners. This rate is lower than in 2012, 8.5/100.00inhab. According to the specific report on epidemiological surveillance of HIV[46] published in 2016, the percentage of foreigners decreases between 2009 and 2015, although this trend is only significant in cases from Sub-Saharan Africa and Latin America.
Tuberculosis	Tuberculosis incidence rate also follows a declining pattern since 2008. In 2014, the incidence rate was 10.8/100.00inhab., 10% lower than in 2013 (12.4/100.000inhab.). Respiratory tuberculosis follows the same pattern: in 2012, the rate was 9.4/100.000inhab., while in 2014, it was 9.2/100.000inhab. Tuberculosis-specific epidemiological report[47] indicates that 30% of tuberculosis cases in 2014 were foreigners and that the number of cases in this group had declined, albeit at a lower rate than Spanish people.
Syphilis	The incidence rate of syphilis increased from 7.88/100.000inhab. (2012) to 8/100.000inhab. (2013) to decrease again until 7.68/100.000inhab. in 2014.
Gonorrhoea	Gonorrhoea has experienced a steady increase in incidence but in both cases the increase has been much more pronounced since 2012. Gonorrhoea incidence increased from 6.59/100.000inhab. (2012) to 9.82/100.000inhab. (2014), almost 50%.
Chlamydia	Like gonorrhoea, the number of reported cases of chlamydia went from 1.022 cases in 2012 to 2.342 in 2014, an increase of 129%.
Hepatitis B	One of the most relevant data is the increase of hepatitis B in 2013 and 2014, after a decreasing trend from 2008 to 2012. The incidence rate was 3/100.000inhab. in 2008 and reduced to 1.27/100.000inhab. in 2012. Since then, there has been an increase up to 2.8/100.000inhab. (2014).
Hepatitis C	Notification of hepatitis C as an individualized declaration disease began in 2014, and, as noted, the reports for 2015 and 2016 are not available yet, so the increased incidence cannot be assessed.