www.reder162012.org

Five years. Five years. This is the time that has passed since on 20th April 2012 the Government approved Royal Decree-Law 16/2012 (RDL), a highly controversial measure that imposed a major change on the National Health System *(Sistema Nacional de Salud, SNS),* excluding from it hundreds of thousands of people and reducing the basic portfolio of services for the population as a whole.

Five myths. The outcry from international and European human rights organisations and social and professional organisations of the healthcare sector to condemn the serious violation of rights deriving from this measure has been continuous during this long five-year period. Despite this, far from rectifying the situation the Executive has sought to conceal the true effects of this reform behind a smokescreen of fallacious messages which we unmask below.

MYTH # 1 ☐ TRUE ☒ FALSE

"An inevitable reform to save the health system"

The Spanish SNS had always aroused great admiration on the international scenario in that it provided very wide cover at a relatively low cost compared with other countries in Western Europe[1]. The system had been built up by consensus over more than two decades and was highly regarded by Spanish citizens as one of the basic pillars of the country's welfare state.

Nevertheless, in 2012 the Government alleged that the system was on the verge of collapse as a consequence of an accumulated debt of 16,000 million euros. On the basis of this sole argument and without presenting an economic report to clarify the origin of this debt or to argue in a reasoned manner the need for the specific measures that were taken, the Executive imposed a radical reform of the SNS. This lack of justification in itself constitutes a violation of Spain's international obligations, as human rights rules only allow the eroding of rights under exceptional circumstances when it is proven that there is no alternative.

What is more, five years later the Government has made no analysis of the impact in order to assess the effect that the RDL has had on the individual and collective health of people living in Spain. On the contrary, several reports from social and professional organisations indicate that the Spanish SNS is now more unjust, less caring, and less efficient.

[1] 9.4% of the GDP in 2011 compared with the Netherlands (11.8%), France (11.6%), Germany (11.3%), or Austria (11.1%).

MYTH # 2 ☐ TRUE ☒ FALSE

"In Spain no-one is without health care"

"Illegal immigrants do not have the right but they are attended": this is how the current Minister of Health defined the situation during her appearance at the Commission in Parliament on 20th December. These declarations are not only unfortunate (the Minister should be reminded that no-one is illegal)


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but are at variance with the daily situation of thousands of people. **From January 2014 to March 2017 the organisations making up REDER have had knowledge of 3340 cases of people who have been excluded from the SNS** (of which 1840 were people in an irregular administrative situation). As our organisations lack the capacity to detect all the cases of exclusion that have occurred during this period, this figure only serves to record the existence of a serious situation, the actual extent of which we sense to be much greater.

Those excluded can only be attended in a series of exceptional situations (pregnant women, minors, urgent cases, victims of trafficking during the reflection period, and asylum seekers). Nevertheless, once again the facts reveal that these obligations have been systematically violated. This is borne out by the **146 cases of pregnant women, 243 cases of minors, 26 cases of asylum seekers, and 341 cases of refusing attendance or improper invoicing of attendance in emergencies** documented by REDER.

It is therefore not only untrue that in Spain no-one is without health care; it is clear that many people are deprived of essential care, including cases as serious as **51 of cancer, 74 of cardiovascular disease, 107 of diabetes, 87 of hypertension, 53 of serious mental health, and 26 of VIH among others we have documented.**

MYTH # 3 ☐ TRUE ☒ FALSE

"Today health is more universal than ever"

No argument is so frequently repeated by the Government and by leaders of the *Partido Popular.* According to their version, RDL 16/2012 gave access to the SNS to the long-term unemployed who had lost their unemployment benefits; consequently they warn that the possible revocation of this ruling would imply the exclusion of these people. A simple analysis of the facts shows the manipulation of reality and language implicit in this contention.

In the first place, the unemployed referred to in these arguments had already been included in the SNS by the General Law of Public Health of 2011 in its Sixth additional precept. On the contrary, the RDL left hundreds of thousands of people outside the system, as the Government itself certified by referring to the 873,000 health insurance cards withdrawn as from the coming into effect of the regulation. Exclusion was not confined to people in an irregular situation. The RDL also substantially restricted the right to attendance of European Union citizens living in Spain who pay no National Insurance Contributions. This measure has particularly affected people of limited means. REDER has gathered **619 cases of the exclusion of people with European Union nationality.**

873,000
HEALTH CARDS WITHDRAWN
AFTER THE COMING INTO EFFECT OF RDL 16/2012

Another particularly worrying case is that of parents and grandparents who arrive in Spain owing to a family regrouping process. These people are generally elderly and in poor health and their residence in Spain has been authorised by the law on aliens. Nevertheless, RDL 16/2012 and RD 1192/2012 (a development of the former) prevents them from being considered beneficiaries of their sons and daughters and denies them the medical assistance which is vital to many of them. All this is despite the fact that several court rulings have recognised that they are entitled to it. **REDER has documented 66 cases of this kind.**

In the face of this evidence, continuing to maintain that the Spanish health system remains universal makes this concept meaningless.

MYTH # 4 ☐ TRUE ☒ FALSE

"Giving health cards to people in an irregular situation encourages health tourism"

Of all the arguments used, the confusion generated between two phenomena that are as radically opposed as irregular immigration and health tourism is one of the most scandalous in that it helps to paint a false picture of the migrant as a person who abuses and overloads the health system, thus encouraging the proliferation of xenophobic attitudes.

The profile of a health tourist is that of a person of means and European citizenship who comes to Spain for the sole purpose of receiving specialised medical treatment. Prior to the RDL, European Community directives and regulations already contemplated the mechanisms necessary for invoicing this attention without it being a burden on the state, and European Directive 2011/24[2] on patients' rights regarding cross-border health care (which came into effect in October 2013) strengthens this regulation, the practical application of which is well documented by the EU itself[3]. On the contrary, migrants in an irregular situation are generally young people in good health who come to Spain to live and work. In consequence and as is borne out by several studies, these people use the health system appreciably less than Spaniards (with an average cost of between 69% and 77%). What is more, according to several reports **only 3% of people migrating to Europe do so for health reasons[4].**

It is also as well to remember that our health system is not financed by national insurance contributions but rather by means of taxation both direct (such as income tax) and indirect (such as VAT, the tax on cigarettes, etc.). Therefore, anyone in an irregular situation living in Spain contributes by consumption towards maintaining the health system from which he/she is excluded. What is more, several studies show that the immigrant population gives more to the state coffers by means of various contributions than what it receives in benefits.

MYTH # 5 ☐ TRUE ☒ FALSE

"With the new regulations of the autonomous regions health exclusion no longer exists"

From the moment when the RDL was approved, and in particular after the elections in the autonomous regions of May 2015, several regional governments and parliaments reacted against the health reform by approving measures to minimise its effect and thus cover the excluded groups. To date all the autonomous regions (with the exception of Castilla y León and the autonomous cities of Ceuta and Melilla) have implemented some measures of this kind.

Although there is no doubt that these precepts have had a positive impact by mitigating the serious effects of the RDL, the problem is far from being resolved. Since the approval of these measures REDER has documented **687 cases of people excluded in spite of everything.**

On the one hand, the rules themselves include administrative obstacles that are hard to overcome for many people. This is the case of requirements such as being registered on the census or the obligation of presenting a consular certificate (which is required of nationals of EU countries and of countries with which Spain has signed a bilateral agreement, and which for many people is very difficult and costly to process). On the other hand, in most cases these measures have not been accompanied by suitable information campaigns aimed at both health centre personnel and the people affected themselves. In consequence, many potential beneficiaries of the new regulations are still unaware of their rights, and even when they attend the centres they continue to encounter staff who refuse to attend them owing to their lack of knowledge of the new regulation. Finally, the scope of these regulations is limited by the very competences of the autonomous regions which do not allow them to reverse the change of model of the 2012 health reform and return to the excluded people the human right that was taken from them.

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[2] http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2011:088:0045:0065:EN:PDF

[3] https://ec.europa.eu/health/sites/health/files/cross_border_care/docs/2015_operation_report_dir201124eu_en.pdf
https://ec.europa.eu/health/sites/health/files/cross_border_care/docs/2015_msdata_en.pdf

[4] https://mdmeuroblog.files.wordpress.com/2016/11/observatory-report2016_en-mdm-international.pdf

Moreover, it should not be forgotten that the Government has appealed against most of these measures to the Constitutional Court and that these appeals are pending resolution. After the ruling of this Court of July 2016 we are not very optimistic as to the result of these appeals.

The situation is therefore by no means resolved: the precepts of the Autonomous Regions have been unable to reverse exclusion completely and the progress that has been achieved is at risk of being annulled.


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M. L. *is a Bolivian woman who has been a victim of trafficking for sexual purposes. Despite the fact that this situation had been confirmed by the sub-office of the Regional Government in Lugo, when M. went to the casualty department as a consequence of the injuries caused by gender violence she was billed for being attended. As if this were not enough, as M. is pregnant she attended hospital once more to give birth for which she was again billed.*

As a consequence of this situation M. has accumulated a debt of over 30,000 euros with the tax authorities; this prevents her from receiving subsidies for the three years that it takes to resolve her claim.

Unfortunately M.'s story is not an isolated case as our organisations have recorded similar incidents at the same hospital.

F. V. *is an African aged 33 who lives in Aragon with her Spanish partner and is in the process of regularising her administrative situation. One day F. began to feel sick and complain of a headache and went to casualty where she was diagnosed a serious contagious disease that makes her hospitalisation necessary.*

Her partner turned to one of the REDER organisations because he keeps receiving bills and no-one either at the hospital or the health centre can explain how F. can have access to the SNS, despite the fact that Aragon has had its own regulations from which F. could benefit since 2015.

J. G. *is a Venezuelan women aged 56. In 2014 she arrived in the Canary Islands owing to a family regrouping process. J. suffers from diabetes and needs insulin. However, although she is legally resident in Spain the National Social Security Institute (Instituto Nacional de Seguridad Social, INSS) refuses to issue her a health card. As a consequence of this refusal, J. is unable to obtain not only the medical follow-up she needs but also the insulin she must have as it is only available on prescription.*

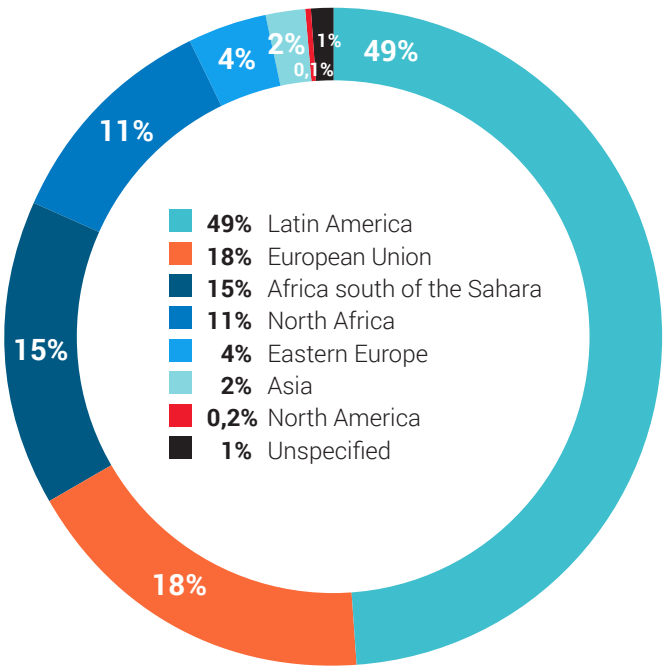
REDER calls for effective respect for the human right to health through a universal public health system

In view of the situation of the serious violation of the right to health described in this report and in previous ones, REDER considers that **a change in the law is essential and cannot be postponed any longer.** Therefore, and taking into account that the parliamentary majority is currently made up of political parties who have repeatedly declared their commitment to a universal public health system, we demand of **the different parliamentary groups the adoption of legislative measures to ensure:**

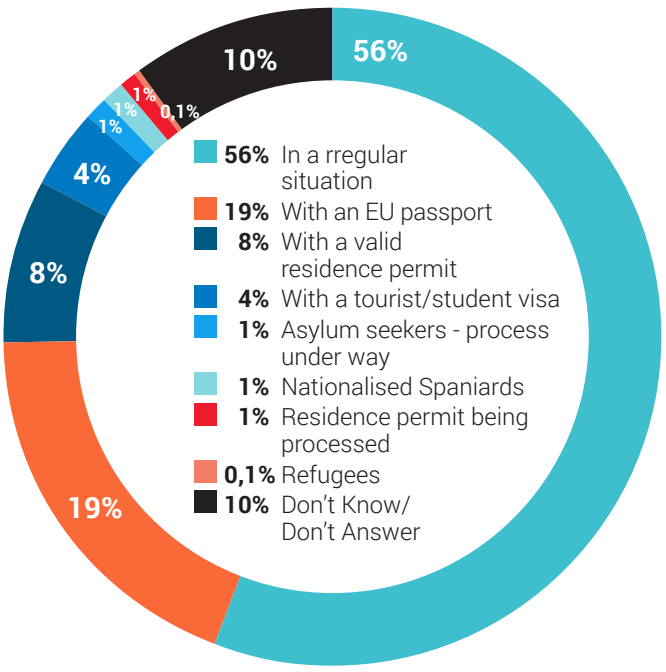
- **The elimination of the figures of the insured and the beneficiary and the recognition of the right to healthcare under equal conditions for all people living in Spain irrespective of their administrative situation.**
- **The inclusion of flexibility clauses to guarantee attention at all times so as to avoid the possibility of the lack of proof of a requirement** (e.g. registration on the census, a consular certificate, etc.) being an insuperable barrier.
- **The inclusion of means of assessment and follow-up** that guarantee the effectiveness of the regulation.

REDER asks the **governments of the autonomous regions** to reach the limit of their competences so as to guarantee that all people living within their limits have access to healthcare with no discrimination of any kind. In this sense REDER requests of them the adoption of measures to make good the current deficiencies of their regulations and collaboration with the social organisations that fight against health exclusion. We particularly **demand the implementing of complete informative campaigns aimed at both healthcare personnel and those having rights.** Despite our concern as a result of the recent ruling of the Constitutional Court and the consequences it may have on the pending appeals against the various regulations of the Autonomous Regions, REDER would like to remind **all public authorities of their obligation to respect international legislation on human rights.**

DISTRIBUTION **BY ORIGIN**

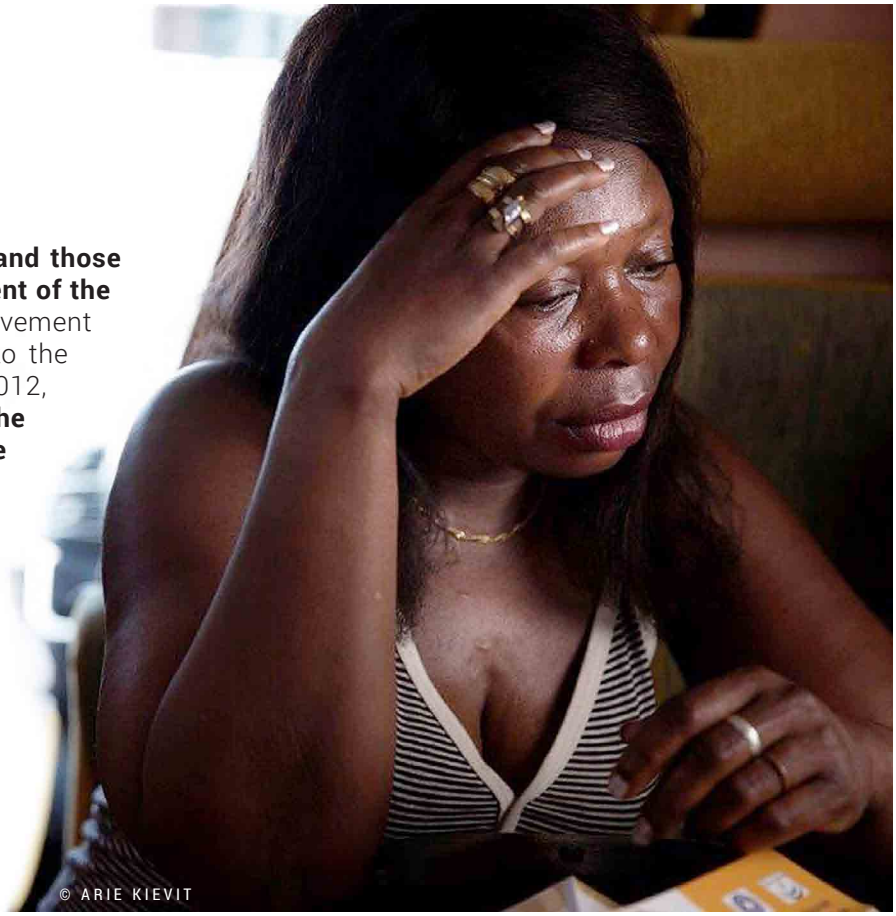


DISTRIBUTION **BY ADMINISTRATIVE SITUATION**



REDER invites **health professionals and those of the administration and management of the National Health System** to join the movement of conscious objection with regard to the application of Royal Decree-Law 16/2012, reminding them of the **existence of the right and the duty to not collaborate with the violation of human rights.**

We encourage **civil society** as a whole to support the mobilisations and actions of rebellion against the Royal Decree-Law.



INCIDENTS OWING TO A LACK OF INFORMATION	CASES
They have not processed the health card owing to a lack of information (they don't know they have the right or don't know how to obtain it)	681
Total lack of information as to their right to healthcare	628
Refusal to issue the health card (or similar document) owing to erroneous information from the administrative personnel	325
Dissuasive practices at the health centre	45
INCIDENTS OWING TO ADMINISTRATIVE OBSTACLES	**CASES**
Refusal to issue the health card owingto not fulfilling administrative requirements	766
Refusal to provide specialised attention owing to not having a health card	117
Refusal to provide primary attention owing to not having a health card	182
INVOICING OR SIGNING A COMMITMENT TO PAYMENT FOR THE MEDICAL ATTENTION RECEIVED	**CASES**
Total	357
Accident and emergency	243
OTHER	**CASES**
Refusing to provide accident and emergency attention	71
Impossibility of obtaining medicines	168

PLACE WHERE THE INCIDENT OCCURS	CASES
INSS or autonomous region administration in charge of issuing the health card	249
Speciality centre	37
Health Centre – Administration	930
Health Centre – General Medicine	309
Health Centre – Other	31
Hospital – Admittance	108
Hospital – Emergencies	342
Hospital - Other	74
Other	1260
TOTAL	**3,340**

3340 PEOPLE EXCLUDED FROM THE NATIONAL HEALTH SYSTEM SINCE 2014

146 PREGNANT WOMEN

243 MINORS

66 ELDERLY PEOPLE WITH THEIR PAPERS IN ORDER

REFUSED HEALTH CARDS

26 ASYLUM SEEKERS

341 CASES OF ATTENTION BEING REFUSED OR IMPROPER BILLING BY THE CASUALTY DEPARTMENT

51 CASES OF CANCER

87 CASES OF HYPERTENSION

26 CASES OF HIV

74 CASES OF CARDIOVASCULAR DISEASE

107 CASES OF DIABETES

53 CASES OF SERIOUS MENTAL HEALTH

REDER Red de Denuncia y Resistencia al RDL 16/2012

REDER is a network of groups, movements, organisations, and people involved in the defending of universal access to health and denouncing non compliance. Currently over 300 social and professional organisations form part of REDER, such as the Spanish Association of Family and Community Medicine (*Sociedad Española de Medicina de Familia y Comunitaria,* semFYC); Doctors of the World; the Observatory of the Universal Right to Health of the Region of Valencia (*Observatorio del Derecho Universal a la Salud de la Comunitat Valenciana,* ODUSALUD); Andalucía Acoge; the Aragón Universal Health Platform; the Platform for Universal Healthcare in Cataluña (*Plataforma per una Atenció Sanitària Universal a Catalunya,* PASUCAT); the Galicia Network in Defence of the Right to Health; the Association of Healthcare Users of the Region of Murcia; the "Citizens Against Health Exclusion" Platform; the Spanish Association of Public Health and Health Administration (*Sociedad Española de Salud Pública y Administración Sanitaria,* SESPAS): the Federation of Associations for Public Health (*Federación de Asociaciones por la Sanidad Pública,* FDASP), the Peruvian Association of Refugees and Immigrants (*Asociación de Refugiados e Inmigrantes de Perú,* ARI-PERÚ); and NetworkWoman. For further information: **www.reder162012.org**