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Case Study
Health

REDER
Red de Denuncia y Resistencia al RDL 16/2012 - The Network for Denouncing and Resisting the Royal Decree-Law 16/2012

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Table of contents

1. Methods

This document is a review and content analysis of available documents from the successful practice of solidarity "REDER (Red de Denuncia y Resistencia al RDL 16/2012 – The Network for Denouncing and Resisting the Royal Decree-Law 16/2012)".

This review includes documents such as: annual reports, press releases, campaigns reports, social media messages, videos, and other documents provided from the participating organization. The selection of documents to be reviewed has been done with the objective of gathering information about:

a) Characteristics of the organization/programme/action

b) Impacts on improving people's living conditions (in terms of health)

Therefore, this document is highlighting data related to what type of stakeholders are involved in the organization; how are the stakeholders (personal characteristics); who develops the initiative; how decision-making is organized, what is the organization main purpose; what is the type of organization (public, private or mixed); what kind of logistics facilities the organization is using and providing; and what kind of impact evidence is being observed.

Besides, this case study description also includes the qualitative data collected from 6 interviews carried out with stake-holders linked with REDER.

2. Background

REDER (Red de Denuncia y Resistencia al RDL 16/2012) was created in 2014 with the commitment to defend universal access to healthcare and to the denouncing of its infringement.

REDER is a network of collectives, movements, organisations and individuals. Nowadays, REDER has 300 members. REDER emerged as a response to the austerity measures introduced in the Spanish healthcare system, particularly those that changed healthcare entitlements.

2.1.- Economic crisis and austerity measures in healthcare in Spain

Due to austerity measures carried out in response to the huge impact of the economic and financial crisis in Spain, the Spanish health system budgets have been subjected to large cuts (around 10.000 million euros less from 2009 to 2015).

In this context of austerity, the Royal Decree-law 16/2012 was justified by sustainability reasons, particularly the increase in co-payments, but it also affected the universalization principle of the Spanish National Health Service (hereinafter NHS).

The Royal Decree-Law (hereinafter RDL) prevents that undocumented migrants over the age of 18 accessing the full range of healthcare in Spain. With the new law, individuals losing entitlement to comprehensive care retain protection:

- if they are younger than 18 years;

- during pregnancy, delivery, and post-partum period;

- when in need of emergency care, and

- if they are asylum seekers and victims of trafficking during recovery and reflection period.

However, obstacles to access care have been documented even in these cases.

Since the announcement of the RDL, the government said that primary care services will be available to those under 65 years who pay a monthly fee of €59.20 and up to €155.40 for those over 65 years. Such payments may prove unaffordable and are more expensive than existing private insurance policies in Spain.

As a consequence of the above, after the RDL implementation in September 2012, about 873.000 non-residents lost entitlement to comprehensive care, including around 500.000 undocumented immigrants.

From a legislative point of view, the RDL undermines the principle of universal coverage in the Spanish NHS. For Spanish nationals, it made coverage more explicitly linked to Social Security entitlement; for undocumented immigrants it revoked their equal right to public healthcare granted by Law 4/2000.

Since the entry into force of the RDL, the National Institute of Social Security (INSS) is the entity responsible for recognizing the status of insured person or beneficiary of the NHS.

Furthermore, the implementation of the RDL has indirectly affected the immigrant population with regularized status, either as victims of the deterrent and fear-inducing effects of administrative actions (such as the placement of posters in hospitals and healthcare centers or the lack of adequate information on the limits instituted by the reform) or due to the absence of information campaigns by public administrations.

Finally, although the central government enacted the RDL based on economic reasons (avoiding the costs of healthcare tourism and abusive healthcare consumption from immigrants), all of the interviewees manifested that there are clear ideological or political reasons behind the RDL.

2.2.- Seventeen regional health systems

"Discretionality and informality generate vulnerability" (Interview 6)

Following Cimas et al (2016), we can say that Spain is a good case-study to analyse how a core national policy decision in highly important topic from a solidarity focus, such as public healthcare coverage of undocumented immigrants, might be differently applied by the different regions.

Tt is undeniable that the RDL generated important ethical conflicts which created strains within the system and may have political consequences. In this case, the restrictions imposed by this national normative had to be implemented by the Regional Health Authorities. As they have autonomy to pass legislation and to adopt different organizational arrangements due to the highly decentralized design of the SNHS, their decisions may have drawn very different scenarios for undocumented migrants within the same country.

Cimas et al (2016) have compared regional policies regarding entitlement to healthcare for undocumented migrants after RDL in the 17 Autonomous Regions by performing an exhaustive review of the health policy regulations published after the enactment of RDL. They concluded that "from a health policy point of view, the unequal implementation of the RDL 16/2012 in Spain is a paradigmatic example of the complexity of national regulation in key issues in decentralized health systems. Regional policies have diminished the intended effect of RD

16/2012, but there are huge differences in healthcare coverage for undocumented migrants among Spanish Regions". Moreover from the testimonies of the interviews we can add that there is an enormous misinformation about this issue even in the healthcare staff from the public administration leading to discretionality and informality in the application of the laws. The informality is "in favour" of the immigrant meaning that in fact they receive the requested treatment in most cases (through highly committed doctors and nurses), but leads to vulnerability because they do not have the right to receive care.

3. Democracy

REDER is a network of groups, movements, organizations and individuals committed to defending universal access to healthcare and denouncing non-compliance. The promoting organizations were: Sociedad Española de Medicina de Familia y Comunitaria (Spanish Society for Family and Community Medicine, SEMFYC); Doctors of the World; Observatorio del Derecho Universal a la Salud de la Comunitat Valenciana (Observatory on the Universal Right to Healthcare of the Valencian Community, ODUSALUD); and Andalucía Acoge (Andalusia Welcomes). The two first organizations have a national scope and the other two a regional focus.

REDER currently has 300 members (individuals, and civic organizations), such as the Sociedad Española de Medicina de Familia y Comunitaria (Spanish Society for Family and Community Medicine, SEMFYC); Doctors of the World; Observatorio del Derecho Universal a la Salud de la Comunitat Valenciana (Observatory on the Universal Right to Healthcare of the Valencian Community, ODUSALUD); Andalucía Acoge (Andalusia Welcomes); Plataforma Salud Universal Aragón (Universal Healthcare Platform of Aragon); Plataforma per una Atenció Sanitària Universal a Catalunya (Platform for Universal Healthcare of Catalonia, PASUCAT); Sociedad Española de Salud Pública y Administración Sanitaria (Spanish Society for Public Health and Healthcare Administration, SESPAS), Federación de Asociaciones por la Sanidad Pública (Federation of Associations for Public Health, FDASP); Asociación de Refugiados e Inmigrantes de Perú (Association of Refugees and Immigrants from Peru, ARI-PERÚ) and Red Transacional de Mujeres (NetworkWoman).

Organizations or individuals can join REDER through its website, adhering to the foundational Manifesto that stated the mission, vision and objectives of the network. For more information go to: http://www.reder162012.org/index.php?option=com_k2&view=item&layout=item&id=207&Itemid=424

Previous to REDER, Doctors of the World launched a message to the social and health care professionals, administration and management staff of the NHS, encouraging them to join the movement of conscientious objection regarding the application of the RDL. They also encourage all citizens to support the mobilizations against the RDL driven by many social organizations.

The movement of conscientious objection was a first step to REDER. From the very beginning, Doctors of the World together with SEMFYC have played a leading role in REDER although the network is opened to everybody who shares its objectives. They organized periodical meetings to coordinate efforts and particularly to guarantee a good quality of the information included in the register of cases. In fact, this registry is at the core of the initiative and is where the adhering organizations report the cases of "exclusion". For reporting cases a protocol (available here: http://reder162012.org/reder-Descripci%C3%B3n-de-los-Protocolos-de-Funcionamiento.pdf) must be used and there are strict validation procedures. There is a commitment to a high quality of reporting, because low quality information in the reported cases can undermine the whole effort.

As REDER initiatives and actions were adapted to local context and legislation, we exemplified their efforts with the work at headquarters in Madrid were the SIAD team was launched since 2012, SIAD meaning: Information Service, Monitoring and Reporting. That is, they inform people seeking solutions to their health situations, accompany them if necessary to solve their problems in health centers or hospitals and denounce cases of people that health care is denied even having the right to it according to the RDL. Moreover, they prepare and train their own staff regarding the issues that affected all those people who were expelled from the National Public Health System. The beginnings were not easy because there was a lot of confusion, but throughout 2013-2014 SIAD team was consolidated in a more systematic and effective manner. There are two volunteer groups that serve people who visit them: the group Monday afternoon, consisting of 9 people, and the Tuesday morning, with 7. They coordinate two technical groups: mobilization and social intervention. Both groups met jointly with the technicians once a month in order to determine strategies and analyze the different actions. The number of people assisted also increasing. All cases are recorded in two databases, in addition to filling another file with the testimonies of people who visit their facilities. Apart from this direct intervention informative workshops are regularly conducted in hospitals, health centers, universities and associations, both in Madrid and in other cities of the Region.

4. Pluralism

REDER is a participative movement with great diversity including stakeholders from different areas, such as NGOs-voluntary organizations, scientific societies, observatories, platforms, immigrant organizations, etc. The 300 organizations and individuals integrating REDER seek to join their voices with all those others calling for the urgent need to reform the RDL and the subsequent Royal Decree 1192/2013, which establishes the people who are to be considered insured and beneficiary of the National Healthcare System, excluding undocumented immigrants from such categories. In this regard, REDER rejects the creation of any parallel system for access to public healthcare other than the individual public healthcare card now in use. Likewise, discrimination free care is being considered to be offered to the affected people, no matter what their profiles are, so they are properly looked after since it is a key factor to overcome the vulnerable groups' exclusion.

5. Transparency

We have confirmed through interviews and site-visits that there is plenty of information about forms, guides, and the services provided by REDER and Doctors of the World. Nearly all of the information on REDER is available through its website, including periodic reports (with versions in English)

In financing terms, REDER is being supported by the organizations that are part of the network and by a contribution of the Open Society Foundation. Regarding the main coordinating organizations, Doctors of the World is financed by membership contributions, grants for projects aswell as the work of volunteers. SEMFYC is a scientific society of family physicians financed by membership fees and a broad number of scientific and dissemination activities.

6. Impact

6.1 Social Impact

Since the creation of REDER, the network has gathered more than 2,000 cases of individuals whose human right to health had been violated as a result of the exclusion of undocumented immigrants from the public healthcare system. These cases are those of people who have been able to turn to one of the social organisations or collectives that are part of REDER to receive support, advice or medical care thanks to engaged professionals. These 2,000 cases are a small but

representative sample in terms of portraying the suffering and the impact on human lives caused by the RDL.

The data has been provided by the Network's organizations from all over Spain. They include cases of cancer, cardiovascular disease, cases of diabetes, cases of degenerative muscle disease, potentially-mortal cases if not treated properly and cases involving individuals with serious mental health problems.

Most of the reported cases have been solved, either providing the needed care (around 90% of cases), solving administrative issues or giving guidance and information.

However, this positive impact has to be counterbalanced with the fact that the original cause the RDL on urgent measures to ensure the sustainability of the NHS is still in vigour.

Therefore, Doctors of the World recommends to the Spanish Government to restore the health model in line with the principle of Universality of healthcare. Meanwhile, each Autonomous Region, until the NHS recovers its universality, should temporarily put actions in place to make effective the full compliance and respect to the right to health in its territory:

- immediately put an end to billing practices for emergency care to immigrants without health card ;
- effectively guarantee health care for minors and pregnant women ;
- ensure access to health services and pharmaceutical services for immigrants excluded from the National Health System
- disseminate widely and properly the measures designed and enforce them to all the personnel working in the regional health system.

The success on the previous aims is mixed depending on the legislation of each Region.

6.2 Political Impact

This legislative measure, which lacks general agreement from the Parliament or the society, violates the Right to Health of the individuals who are excluded from the system. Since the Spanish political system is a decentralized one, each Autonomous Community (Region) is responsible for managing its own healthcare. The application at regional level of this RDL has forced the implementation, often in a rushed and improvised way, of various measures as a response to the problems caused by this central government RDL.

In general, they are measures aimed at addressing public health issues or cases which may receive some media attention because of their specific relevance. The measures taken by the Autonomous Communities are heterogeneous, thus causing significant disparities and inequalities in the health of the population within Spain.

It can be observed, that the only thing that is constant and uniform in the application of this RDL at regional level, is the lack of coordination and the misinformation. For example, the administrative units of each health care centers do not give homogeneous information to the healthcare users, even within the same Autonomous Community or Health Area. Lack of coordination and misinformation are the norm, regardless of the zeal with which the professionals of the health system perform their work.

People who are suffering health exclusion are in a situation of great distress, not only because they do not receive medical care when they need it , but also because they are not being properly informed of their rights and of the different alternatives that the Autonomous Communities launch to alleviate the negative impact of the Royal Decree- Law .

Cases of health care denial to children and pregnant women continue to take place when in fact, it is mandatory. In addition cases of billings for healthcare services in emergencies when it should be free and universal, and numerous cases of breaching of the rules and procedures which the Autonomous Communities have put in place themselves, in order to minimize the adverse effects of the above mentioned legislative changes .

There is another side effect of this RDL which is especially offensive and can't be overlooked: the loss of opportunities to detect cases in the health system of gender violence cases. The exclusion from the health system of immigrant women without residence permits prevents them from benefiting from the opportunity of detection of gender violence cases by the healthcare system.

The urgency for the structural reform of the health system was justified by its unsustainability. Four years later, the society is not aware of its impact assessment. The effectiveness of these changes in the healthcare model must be evaluated carefully, but at the scientific evidence shows that ensuring broad primary care coverage and strengthening prevention and early detection is more efficient that providing care through emergency services.

The way the various regional governments are developing rules to regulate the application of the Royal Decree-Law provides a melting pot of situations that bring out the limbo that has created the Central State regulation. This asymmetric application of the law increases the climate of lack of coordination between different levels of management and, consequently, the barriers to access health

care faced by immigrants. It should be noted the fear expressed by many of them, that inhibits them to go to health centers or manage the renewal or application for their health card, even in cases covered by the law.

Although the situations denounced by are known by political parties and governments, both regional and national, the influence is limited at least at central government and there is no a clear scenario of reversing to the situation previous to the RDL.

We extract a paragraph from one REDER report (2015) that acknowledge the complexity of legislations at regional level: "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 RDL".

As one interviewee said "just imagine the enormous complexity to navigate this system for an immigrant who changes his residency from a region to another", enough said.

7. Recognition

Although people interviewed consider the movement as having credibility and respect, they think it is not well known by most citizens, nor the social media.

8. Scalability

The core elements of REDER have been scaled up at national (Spain) level, but due to the heterogeneous legislation at regional (Autonomous Communities) level some actions are focused at local level. The lessons learnt and the main actions carried out are scalable to other countries where eventually the rights to access healthcare are reduced. Initiatives like the European Network to reduce vulnerabilities in health can help in scalability efforts (more information at: http://mdmeuroblog.wordpress.com/resources/publications/).

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