



COUNTRY REPORT

SPAIN

MIPEX

HEALTH STRAND



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MIGRANT INTEGRATION POLICY INDEX *HEALTH STRAND*

Country Report Spain

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READER'S GUIDE TO THE REPORT

This report was produced within the framework of the IOM's EQUI-HEALTH project, in collaboration with Cost Action IS1103 ADAPT and the Migrant Policy Group (MPG). Full details of the research and its methodology are contained in Sections I and II of the Summary Report, which can be downloaded from the IOM website at <http://bit.ly/2g0GIRd>. It is recommended to consult this report for clarification of the exact meaning of the concepts used.

Sections 5–8 are based on data from the MIPEX Health strand questionnaire, which covers 23 topics, in 10 of which multiple indicators are averaged. Each indicator is rated on a 3-point Likert scale as follows:

- 0 no policies to achieve equity
- 50 policies at a specified intermediate level of equity
- 100 equitable or near-equitable policies.

'Equity' between migrants and nationals means that migrants are not disadvantaged with respect to nationals. This usually requires equal treatment, but where migrants have different needs it means that special measures should be taken for them. Scores relate to policies adopted (though not necessarily implemented) by 31st December 2014. However, some later developments may be mentioned in the text.

To generate the symbols indicating a country's ranking within the whole sample, the countries were first ranked and then divided into five roughly equal groups (low score – below average – average – above average – high). It should be remembered that these are relative, not absolute scores.

The background information in sections 1-4 was compiled with the help of the following sources. Where additional sources have been used, they are mentioned in footnotes or references. It should be noted that the information in WHO and Eurostat databases is subject to revision from time to time, and may also differ slightly from that given by national sources.

Section	Key indicators	Text
1. Country data	Eurostat	CIA World Factbooks, BBC News (http://news.bbc.co.uk), national sources
2. Migration background	Eurostat, Eurobarometer (http://bit.ly/2grTjIF)	Eurostat, national sources
3. Health system	WHO Global Health Expenditure Database ¹ (http://bit.ly/1zZWnuN)	Health in Transition (HiT) country reports (http://bit.ly/2ePh3VJ), WHO Global Health Expenditure database
4. Use of detention		National sources, Global Detention Project (http://bit.ly/29IXgf0), Asylum Information Database (http://bit.ly/1EpevVN)

These reports are being written for the 34 countries in the EQUI-HEALTH sample, i.e. all EU28 countries, the European Free Trade Area (EFTA) countries Iceland, Norway and Switzerland, and three 'neighbour' countries – Bosnia-Herzegovina, FYR Macedonia and Turkey.

All internet links were working at the time of publication.

¹ For the definition of these indicators please see p. 21 of the WHO document *General statistical procedures* at <http://bit.ly/2lXd8JS>

1. COUNTRY DATA

KEY INDICATORS		RANKING
Population (2014)	46.512.199	●●●●●
GDP per capita (2014) [EU mean = 100]	93	●●●○○
Accession to the European Union	1986	

Geography: Spain is the second largest country in the European Union and the fourth largest country in Europe. It borders the Mediterranean Sea, France and Portugal. The country also includes two archipelagos: the Balearic Islands (in the Mediterranean Sea) and the Canary Islands (in the Atlantic Ocean off the African coast). Additionally, Spain has two exclaves in Northern Africa: Ceuta and Melilla. Its official languages are Spanish, Catalan, Basque, and Galician. The terrain is flat, separated plateaus surrounded by rugged hills; in the North lie the Pyrenees Mountains. The largest city is the capital, Madrid, with 3,14 million inhabitants, followed by Barcelona with 1,60 million. Over three-quarters of the population (79,6%) live in urban settings.

Historical background: Spain suffered a devastating civil war (1936-39) followed by 40 years of fascist dictatorship. After the death of the dictator Francisco Franco in 1975, Spain underwent a peaceful transition to democracy. This transition allowed – within the European welfare framework – the consolidation of the economic modernization undertaken during the 1960's.

Political background: Spain, an EU member since 1986, is a multi-party democracy organized in the form of a parliamentary government under a constitutional monarchy. Its constitution embodies the emphasis on equity and inclusiveness that characterises other 'new democracies' arising out of dictatorships, such as Portugal or Italy. Spain is administratively divided into 17 Autonomous Regions and two Autonomous Cities located on the African continent (Ceuta and Melilla).

Economic background: Spain's industrial sector contributes about 27% of the nation's GDP, while the service sector accounts for 70% of its total production. Since 2008 Spain has been undergoing a deep economic crisis. This is reflected in its economic collapse, rising public discontent with the political system and the welfare state, massive job losses and an increase in the number of people living below the poverty line. A dramatic symptom of this is its unemployment rate (24% overall in 2014, but rising to 51% for people under 25).² Eurostat data show that in 2013, Spain had the seventh highest level of inequality in Europe (Gini coefficient: 33,7). Nevertheless, in 2013 Spain's economy began to improve, and the economic recovery is projected to continue in 2017 and 2018.³

² <http://countryeconomy.com/unemployment/spain>

³ OECD, Spain Economic Forecast Summary November 2016

<http://www.oecd.org/economy/spain-economic-forecast-summary.htm>

2. MIGRATION BACKGROUND

KEY INDICATORS (2014)		RANKING
Foreign-born population as percentage of total population	12,8	●●●●○
Percentage non-EU/EFTA migrants among foreign-born population	65	●●●●○
Foreigners as percentage of total population	10,1	●●●●○
Non-EU/EFTA citizens as percentage of non-national population	57	●●●○○
Inhabitants per asylum applicant (more = lower ranking)	8.284	●○○○○
Percentage of positive asylum decisions at first instance	44	●●●○○
Positive attitude towards immigration of people from outside the EU (Question QA11.2, Eurobarometer)	51	●●●●●
Average MIPEX Score for other strands (MIPEX, 2015)	61	●●●●○

During the 1970's immigration to Spain started to exceed emigration,⁴ and this trend has continued to the point where the country has become one of the most important migration destinations in Europe. Especially after the closing years of the 20th century, vigorous economic growth combined with the demands of an increasingly fragmented labour market and a rapidly ageing population have made Spain an attractive destination for migrants from all over the world, in particular from Morocco, Romania and Latin America (see Figure 1 below).

In terms of country of birth, migrants born outside the EU/EFTA are in the majority, whereas they form only half of those with foreign nationality. Acquiring Spanish nationality is easier for migrants coming from countries with traditional ties to Spain, especially Morocco and Latin American countries. The main destination regions are Catalonia, Madrid, Andalusia and Valencia. Concerning the age of foreigners living in Spain, more than 55% are between 25 and 44 years old (i.e. of working age). The current economic crisis has resulted in high unemployment rates among them. In the last trimester of 2012, 1,2 million foreigners were unemployed – a doubling since 2007.⁵

There is much concern in Spain regarding irregular migration, especially unauthorised entry along its southern borders (referred to as the Western Mediterranean and Western African routes⁶). Whereas such entries on the mainland and the Canary Islands have decreased in recent years, Ceuta and Melilla registered a 49% increase (to 4.235 entries) between 2012 and 2013. This reflected the changing routes of irregular migration. In addition, the political upheavals following the so-called Arab Spring, as well as wars, drought and disease in the Sahel Belt, have led to massive and unprecedented exoduses.

⁴ Romero Valiente, J.M. (2003). Migraciones. In Andrés Arroyo Pérez (ed.), *Tendencias demográficas durante el siglo XX en España*. Madrid: Instituto Nacional de Estadística. <http://bit.ly/2hQ1tWp>

⁵ Anuario de Estadísticas del Ministerio de Empleo y la Seguridad Social (2012). <http://www.empleo.gob.es/es/estadisticas/contenidos/anuario>

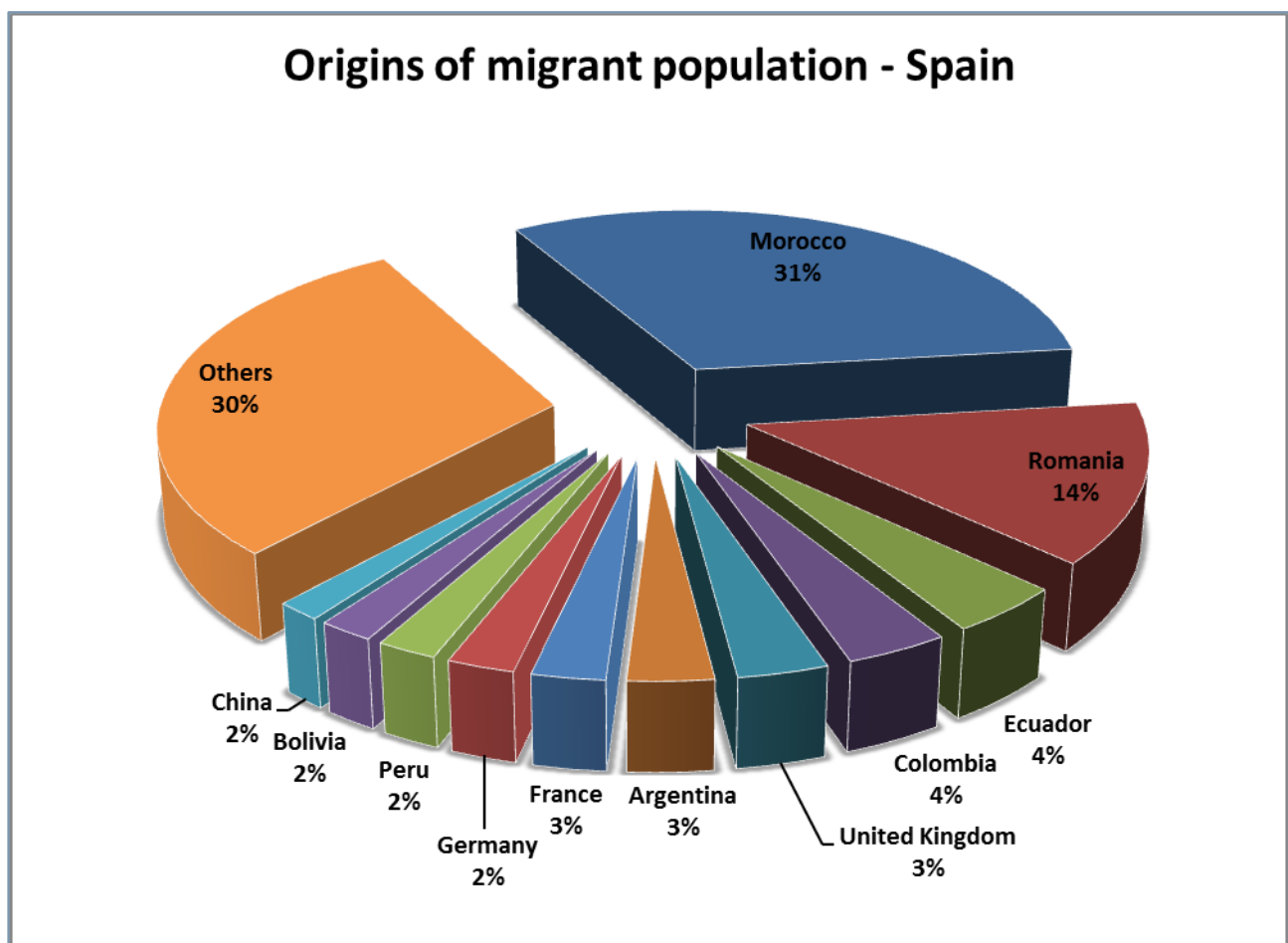
⁶ <https://www.iom.int/news/migrant-arrivals-europe-mediterranean-top-210000-2016-deaths-2859>

Apart from unauthorised entrants, many irregular migrants in Spain are ‘overstayers’ who remain in the country after their visitors’ visas or residence permits have expired. Some irregular migrants who were legalised in the regularisation campaigns of 1995-2005 actually became *deregularised* as a result of becoming unemployed, especially following the economic crisis.

Like most of the EU, Spain has recently experienced an increase in the number of asylum applications, from 2.565 in 2012 to 14.595 in 2015. The acceptance rate for asylum applications is about average, but as the above table shows, Spain attracts relatively few asylum seekers relative to the size of its population.

Spain also obtains an average score on the measure of acceptance of non-EU/EFTA migrants. Although large-scale immigration is a relatively new phenomenon, the country has a colonial past and a long history of migration to other parts of the world; diversity is thus a familiar phenomenon for Spaniards.

Figure 1. Foreign-born population in 2014 by country of origin (Eurostat)



3. HEALTH SYSTEM

KEY INDICATORS (2013)		RANKING
Total health expenditure per person (adjusted for purchasing power, in euros)	2.074	●●●○○
Health expenditure as percentage of GDP	9,1	●●●○○
Percentage of health financing from government National health system (NHS) / social health insurance (SHI)	67	NHS
Percentage of health financing from out-of-pocket payments (higher percentage = lower ranking)	23	●●○○○
Score on Euro Health Consumer Index (ECHI, 2014)	670	●●●○○
Overall score on MIPEX Health strand (2015)	53	●●●●○

The Spanish Public Healthcare System (SPHS) has a set of peculiarities attributable to the division of formal responsibilities between the central government and the Autonomous Regions. This section describes the organization and structure of the SPHS as well as its characteristics. In keeping with usual MIPEX practice in countries with a degree of regional autonomy, data for the MIPEX Health strand questionnaire were drawn from two regions with a high percentage of migrants, in this case Andalusia and Catalonia. Scores for Spain were arrived at by aggregating these data.

General overview: The 1978 Spanish Constitution stipulates the legal model of the SPHS; Article 43 establishes the right to health protection and healthcare for all citizens, while Article 149 establishes national and regional competences regarding social security and healthcare.⁷ The General Health Law 14/1986 constituted an essential milestone in shaping the SPHS, embodying a progressive model of universal healthcare.⁸ Its pillars are: (1) health promotion and disease prevention; (2) the effective equality of all people in accessing healthcare and benefits; (3) overcoming territorial and social imbalances; and (4) the principle of equality between men and women in policies, strategies and health programs.

In 2014, total healthcare expenditure in Spain was in the middle of the range for European countries. Between 2009 and 2013, however, there had been a gradual decline in spending on health (amounting to a 7% cut) as a result of austerity policies. Most of this was due to a reduction in government financing, which declined from 76% to 71% of the total costs.⁹

Regarding the structure of the SPHS, we highlight three key characteristics: (a) funding of health provision is organized through the general state budget in accordance with the regional financing model; (b) management is decentralized through the health services of the regions; and (c) there exist general, supplementary, and auxiliary health services established by national government, as well as

⁷ Constitución Española de 1978 https://www.boe.es/diario_boe/txt.php?id=BOE-A-1978-31229

⁸ Ley 14/1986, de 25 de abril, General de Sanidad <https://www.boe.es/buscar/act.php?id=BOE-A-1986-10499>

⁹ WHO, Global Health Expenditure Database, <http://apps.who.int/nha/database>

complementary health services belonging to the regions. This model shapes the SPHS as an integrated healthcare system, understood as a set of organizations that provide, directly or through subcontracting, a series of services to a target population, and it is responsible for the costs and health outcomes of the population (detailed in Table 1). It is structured into two healthcare levels. First, primary care provides basic healthcare services within the community to guarantee maximum accessibility. Second, specialist care is provided in hospitals and dedicated medical centres due to its complexity.

Regarding pharmaceutical services, there are different levels of co-payment for medicinal products and/or medical devices funded by the SPNS: (a) medicines dispensed in hospitals are not subject to co-payment from users; and (b) outpatient pharmaceutical services are subject to co-payment from users at the time of dispensing – based on criteria related to income, age and medical diagnosis.

Table 1. The SPHS decentralization structural framework

Central Government	<ul style="list-style-type: none"> • Basic legislation and coordination • Minimum package funded through SPHS • Pharmaceutical policy • International health policy • Educational requirements
Regional Governments	<ul style="list-style-type: none"> • Health planning • Subsidiary legislation • Organizational structure of the Health System • Accreditation • Subcontracting and service provision • Public health / Agency Public Health • Quality evaluation / Agency for Quality
Local Councils	<ul style="list-style-type: none"> • Health and hygiene • Cooperation in the management of public services

Catalan Healthcare System: The Autonomous Region of Catalonia, with a population of roughly 7,5 million as of 1 January 2015 (14% or 1.025.812 being foreigners¹⁰), has had since 1971 full competence in health service provision as part of the decentralized SPHS, based on the common principles of universality, equity, and free provision.¹¹

The Catalan Healthcare System is characterised by a provider-purchaser split. The provision of services is the responsibility of a number of contracted providers, principally the Catalan Health Institute (*Institut Català de la Salut*), a public company owned by the regional government. But there are also public consortia (in which Catalan as well as municipal governments and other public entities participate), public and private foundations.¹²

The Department of Health (DH) is responsible for determining health policies, ensuring the sustainability of the system and quality control. On the other hand, *CatSalut* (the Catalan Health Service) is

¹⁰ National Statistical Institute (INE). <http://www.ine.es/jaxi/tabla.do>

¹¹ Ley Orgánica 4/1979, de 18 de diciembre, de Estatuto de Autonomía de Cataluña.

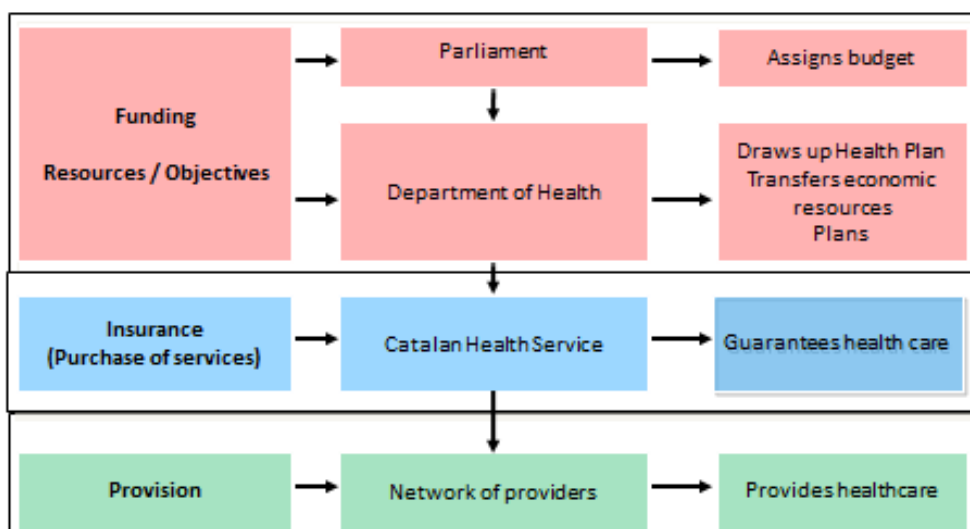
<https://www.boe.es/buscar/doc.php?id=BOE-A-1979-30178>

¹² Decret 196/2010 de 14 de desembre, del sistema sanitari integrald'utilització pública de Catalunya (SISCAT). 16-12-2010. Diari Oficial de la Generalitat de Catalunya (DOGC), N° 5776.

responsible for establishing service policies in accordance with the health policies of the DH, determining the system of health provisions and subcontracting services, as well as carrying out results assessment. Finally, the service providers are the organizations that CatSalut subcontracts. Figure 2 shows the structure of the Catalan healthcare model.

Figure 2. Functions of the Catalan Healthcare system

Source: <http://bit.ly/2iDlz8k>



Andalusian Healthcare System: Andalusia is another of the largest regions in Spain. It is located in the south and at the beginning of 2015 had a total population of 8.401.567, of which 633.957 (8%) were foreigners.¹³ Andalusia is the region with the lowest health expenditure per capita in Spain.¹⁴

The Andalusian Government (*Junta de Andalucía*) has had full responsibility for health services since the enactment of the Statute of Autonomy in 1981.¹⁵ The Andalusian healthcare model was developed according to Law 2/1998,¹⁶ which had as its objective the regulation of activities that allow implementing the right of protection of health for all citizens under the principles of equity, universality, coordination, public finance, efficiency and free provision.

Currently, the Andalusian Ministry of Health (formerly the Ministry of Equality, Health and Social Policy) is the Andalusian government agency responsible for standards of equality, health and social policies. It is also accountable for the management of agencies directly associated with the provision and management of social and health services. Figure 3 illustrates this model.

¹³ National Statistical Institute (INE). <http://ine.es/jaxi/tabla.do>

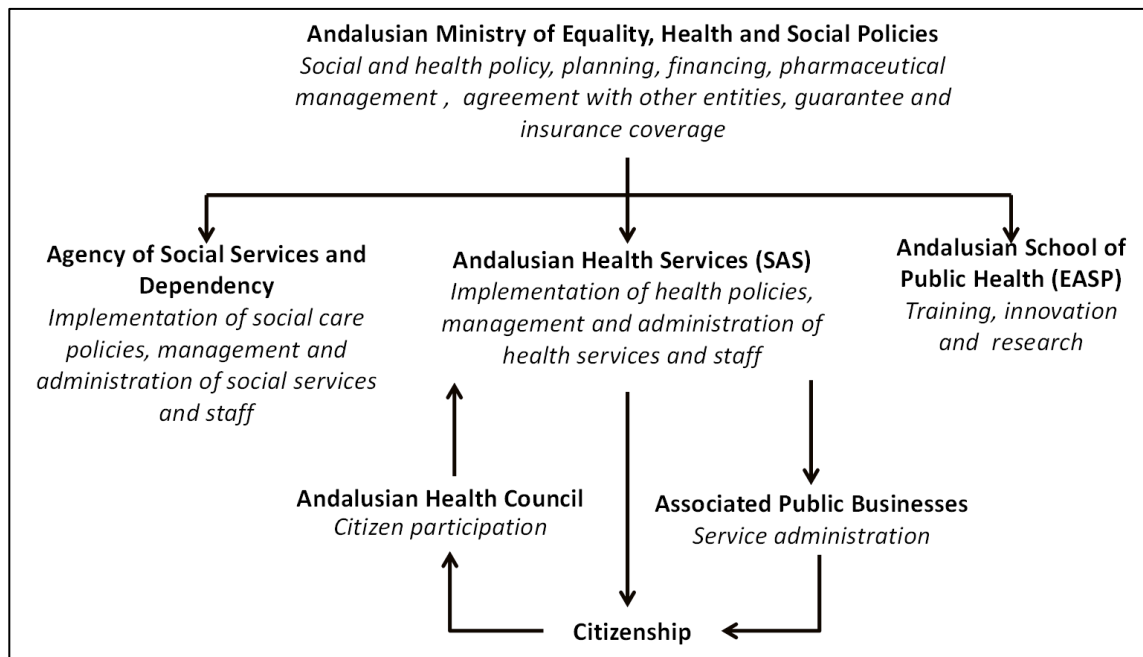
¹⁴ <https://www.msssi.gob.es/estadEstudios/estadisticas/docs/EGSP2008/egspPrincipalesResultados.pdf>

¹⁵ Ley Orgánica 6/1981, de 30 de diciembre, de Estatuto de Autonomía para Andalucía.

<https://www.boe.es/buscar/doc.php?id=BOE-A-1982-63>

¹⁶ Ley 2/1998, de 15 de junio, de Salud de Andalucía. <http://www.juntadeandalucia.es/boja/1998/74/1>

Figure 3. Structure of the Andalusian Healthcare model



4. USE OF DETENTION

In this section we describe the use of detention for migrants entering Spain in an administratively irregular way, setting aside its use in other situations related to criminal activities. Unless they have urgent medical needs, migrants intercepted on land, at sea, on the coast, or at airports are transferred directly to the nearest *Policía Nacional* station (National Police), where registration and nationality assessments are carried out. After this, in accordance with Organic Law 4/2000,¹⁷ the transfer process reassigns migrants to different centres: (a) Reception Centres, (b) Refugee Assistance Centres (CARs), and (c) Detention Centres (CIEs). Unaccompanied minors are transferred directly to Minor Protection Centres, which should not be considered as migrant reception centres since they are the same facilities as for national population.

a. Reception Centres

In Spain, reception centres include two CETIs (*Centro de Estancia Temporal de Inmigrantes / Centres of Temporary Stay for Immigrants*) in the Autonomous Cities on the African continent, and other centres managed by civil society organizations (CSOs) on the mainland.

Migrants entering irregularly through Ceuta and Melilla are sent to CETIs. These are managed by the Spanish Ministry of Employment and Social Services. From a legal perspective, migrants in these centres are not ‘detained,’ but temporarily ‘sheltered.’ CETIs are characterised as providing adequate assistance,¹⁸ but they are usually badly overcrowded, which worsens migrants’ living conditions and the quality of care they receive. For instance, in December 2014, the CETI in Melilla admitted 1.300 people (nearly three times its official capacity), of whom about 800 were Syrians.¹⁹

Once there, migrants are provided with an identity card. This card grants them freedom of movement throughout Melilla or Ceuta and entitles them to healthcare assistance. Initial medical assistance is provided at the CETI; in emergency cases, migrants are taken to a public hospital. The length of stay in CETIs is currently not limited by law.

One critical issue is the transfer from the CETIs in Melilla and Ceuta to mainland Spain, which is usually protracted and arbitrary.²⁰ Usually through agreements between the government and CSOs, migrants are transferred by the government to the mainland, where they are housed in centres managed by CSOs until they find their own accommodation through their personal contacts and networks.²¹

The CSOs that usually manage these reception centres are Red Cross, CEAR, ACCEM and CEPAIM.²² Migrants in these centres are generally newcomers who arrived at the coast or come from either the CIEs or the CETIs. These centres offers emergency shelter and humanitarian aid in two kinds of situations: firstly, they take care of homeless, indigent migrants expelled from CIEs. In CSO centres, they are provided with lodging, food and other basic resources for a period of 15 days. In addition, these

¹⁷ Ley Orgánica 4/2000, de 11 de enero, sobre derechos y libertades de los extranjeros en España y su integración social <https://www.boe.es/buscar/act.php?id=BOE-A-2000-544>

¹⁸ APDHA (2009). Derechos Humanos en la Frontera Sur. 2008. <http://www.apdha.org/media/fronterasur2008.pdf>

¹⁹ El confidencial: El CETI de Melilla acoge a 1.300 inmigrantes, 800 de ellos de origen sirio. http://www.elconfidencial.com/ultima-hora-en-vivo/2014-12-26/el-ceti-de-melilla-acoge-a-1-300-inmigrantes-800-de-ellos-de-origen-sirio_454720/

²⁰ UNHCR (2014). Asylum trends. First half 2014. Available from: <http://www.unhcr.org/5423f9699.html>

²¹ APDHA (2008). Centros de Retención e Internamiento en España. <http://www.apdha.org/media/CIEsoctubre.pdf>

²² García-Ramírez, M., Luque-Ribelles, V., Albar, M-J., Paloma, V., & Garrido, R. (2015). *Irregular migrations and occupational wellbeing of guardias civiles at the Southern Spanish borders*. Technical report. CESPYD: Universidad de Sevilla.

centres help them get in touch and meet their families or their Spanish contacts. Secondly, CSO centres also help migrants in need of protection, such as families or women with children coming from CETIs. They generally stay there between three and six months, although they can apply for an extension of up to eight months to the Ministry of Health, Social Services and Equality.

b. Refugee Assistance Centres (CARs)

CARs (*Centros de Atención a Refugiados*) are centres where asylum seekers and refugees are given room and board, urgent and primary medical care, as well as psychosocial assistance. Their objective is to provide support to asylum seekers and refugees who have no economic resources to cover their basic needs.

CARs are managed by the Ministry of Employment and Social Security together with different CSOs (e.g. RC, ACCEM, CEAR). Currently there are only four CARs in Spain, which are not enough in the present situation.

To be admitted to a CAR, migrants must have asked for international protection and have no economic resources. Generally, asylum is applied for either at the border once asylum seekers have crossed over to Spain or in Policía Nacional stations, although the application can also be made afterwards.

Stays in CARs are generally for six months, which can be extended to a maximum of 12-18 months if it is justified by the manager of the CAR and the person in question. In case of refusal, a legal document is handed out to the person, who must return to his/her country within 15 days. Asylum applicants may lodge an official appeal by judicial means.

c. Migrant Detention Centres (CIEs)

According to the Order of 22 February 1999 on the standards of practice and internal regulations of migrant detention centres,²³ the Ministry of Home Affairs is in charge of managing, inspecting, coordinating and monitoring CIEs (*Centros de Internamiento de Extranjeros*). This is done through the General Police Directorate, which is also in charge of the safety and security of the centres.

CIEs are non-penitentiary detention centres designed for the precautionary custody of foreigners in order to guarantee their deportation, expulsion or return under the terms and conditions established by Spanish immigration legislation.²⁴ Internment cannot last for longer than 60 days and takes place while disciplinary proceedings are carried out. Migrants transferred to these centres are those who have finished their conviction time and must be deported, as well as those whose administrative situation requires a deportation process.

As of early 2013, Spain operated a network of seven CIEs.²⁵ In 2013, a total of 9.002 people were held in CIEs, of whom only 4.726 were ultimately deported.

In CIEs migrants are entitled to access legal, social, cultural, and health services. Article 16 of RDL 162/2014²⁶ establishes the rights of interned foreigners: (a) to be informed about their legal situation; (b) to physical integrity; (c) to receive adequate medical assistance; (d) to be assisted by the centre's

²³ Orden de 22 de febrero de 1999 sobre normas de funcionamiento y régimen interior de los centros de internamiento de extranjeros. <https://www.boe.es/buscar/doc.php?id=BOE-A-1999-4528>

²⁴ Real Decreto 162/2014, de 14 de marzo, por el que se aprueba el reglamento de funcionamiento y régimen interior de los centros de internamiento de extranjeros. https://www.boe.es/diario_boe/txt.php?id=BOE-A-2014-2749

²⁵ Global detention project. <http://www.globaldetentionproject.org/countries/europe/spain/introduction.html>

social services; and (e) to receive legal assistance. At the same time, they are entitled to communicate with the outside world.

However, according to several reports, these rights are not respected by CIE management.²⁶ In these cases, CIEs become de facto penitentiaries, yet without the basic guarantees and resources of the latter. CIEs have been described as unconstitutional, since people are detained for what they are rather than for what they have done.²⁷

When the deportation process from CIEs cannot be completed, migrants are released and abandoned to their fate, living in social and legal limbo. They are released into the community and become part of the large irregular migrant population living in Spain.²⁹ There are no provisions for migrants in this situation, as they cannot legally work and have only limited access to healthcare services (see next section) and social protection. In order to survive, many of them look for shelter in migrant settlements with deplorable living conditions and a total lack of healthcare and social services. This creates an enormous risk for migrant and public health, due to the difficulty in monitoring the health status of migrants released from CIEs.²⁹

²⁶ APDHA (2008). Centros de Retención e Internamiento en España. <http://www.apdha.org/media/CIEsoctubre.pdf>

²⁷ García-Ramírez, M., Luque-Ribelles, V., Albar, M-J., Paloma, V., & Garrido, R. (2015). *Irregular migrations and occupational wellbeing of guardias civiles at the Southern Spanish borders*. Technical report. CESPYPD: Universidad de Sevilla.

5. ENTITLEMENT TO HEALTH SERVICES

Score 50 Ranking ●●○○○

A. Legal Migrants

Inclusion in health system and services covered

In Spain, legal migrants are covered by the same system as national citizens. Due to the recent dismantling of universal health coverage through the Royal Decree Law 16/2012, entitlement is now based on insurance, i.e. affiliation to the Social Security System.²⁸ Insured status is granted if at least one of the following requirements is met:²⁹

- Being employed or self-employed and affiliated to the Social Security System, paying all necessary contributions.
- Being a pensioner within the Social Security System.
- Being the recipient of any periodic benefit of the Social Security System, including unemployment benefits and subsidies.
- Having used all unemployment benefits and subsidies, being registered with an employment office.
- Living in Spain and able to demonstrate one of the following: being a descendant of a Social Security affiliate under the age of 26 or with more than 65% disability; being in charge of a Social Security affiliate; or being the partner or ex-partner of a Social Security System affiliate.

If none of these criteria are met, Spanish citizens, people from EU/EFTA member states and foreigners authorized to live in Spain are granted entitlement as long as they demonstrate that their income is below 100.000 Euros per year. Finally, people who are neither insured nor beneficiaries of the Social Security System are entitled to receive medical assistance subject to payment by signing a special agreement.³⁰

Special exemptions

According to the RDL 16/2012,³¹ specific migrant groups deemed to be especially vulnerable and in need of support are exempt from restrictions on entitlement. These groups are:

²⁸ Real Decreto-ley 16/2012, de 20 de abril, de medidas urgentes para garantizar la sostenibilidad del Sistema Nacional de Salud y mejorar la calidad y seguridad de sus prestaciones https://www.boe.es/diario_boe/txt.php?id=BOE-A-2012-5403

²⁹ Real Decreto 1192/2012, de 3 de agosto, por el que se regula la condición de asegurado y de beneficiario a efectos de la asistencia sanitaria en España, con cargo a fondos públicos, a través del Sistema Nacional de Salud. <https://www.boe.es/buscar/doc.php?id=BOE-A-2012-10477>

³⁰ Real Decreto 576/2013, de 26 de julio, por el que se establecen los requisitos básicos del convenio especial de prestación de asistencia sanitaria a personas que no tengan la condición de aseguradas ni de beneficiarias del Sistema Nacional de Salud y se modifica el Real Decreto 1192/2012, de 3 de agosto, por el que se regula la condición de asegurado y de beneficiario a efectos de la asistencia sanitaria en España, con cargo a fondos públicos, a través del Sistema Nacional de Salud. https://www.boe.es/diario_boe/txt.php?id=BOE-A-2013-8190

³¹ Real Decreto-ley 16/2012, de 20 de abril, de medidas urgentes para garantizar la sostenibilidad del Sistema Nacional de Salud y mejorar la calidad y seguridad de sus prestaciones https://www.boe.es/diario_boe/txt.php?id=BOE-A-2012-5403

- pregnant women and minors under 18 (applicable to all persons who do not have medical insurance)
- victims of torture, rape, psychological trauma, or sexual violence including victims of genital mutilation,
- under-age victims of any kinds of violence, abuse or exploitation
- victims of human trafficking
- individuals diagnosed with infectious diseases that endanger public health (e.g. TB, HIV/AIDS)

Barriers to obtaining entitlement

The economic crisis has had a greater impact on migrants than on the general population. In sum, imposing the current requirements for entitlement on migrants and nationals may create barriers and inequities for migrants.³² One example is the fact that in order to be entitled to healthcare, a migrant must apply for an Individual Healthcare Card (the document that identifies every citizen as a healthcare user). The administrative processes to obtain healthcare entail various procedures and requirements that are frequently difficult to meet for particular groups of migrants such as the Roma coming from Romania and Bulgaria. For example, they have to go to their consulates to ask for a document that certifies that they are not covered by the healthcare system in their countries of origin. For that, sometimes they are often ignored or charged. In other cases, the local council creates artificial barriers to allowing these migrants to register at the local census, for example, by asking a legal address.³³

B. Asylum Seekers

Inclusion in health system and services covered

Asylum seekers have full access to the SPHS. They are not required to be insured by the Social Security System and receive a 'health certificate' (instead of an Individual Healthcare Card). This certificate grants them access to the SPHS and enjoyment of the same rights as any other citizen. Alongside the regular health system, agencies such as the United Nations High Commissioner for Refugees (UNHCR)³⁴ or the Centro Español de Ayuda al Refugiado (CEAR)³⁵ offer health services to refugees and asylum seekers.

Additionally, victims of human trafficking on an authorized temporary stay in Spain are entitled to healthcare and are offered the basic SPHS services stipulated in Article 8 of Law 16/2003³⁶ and RDL 576/2013.³⁷

³² Vázquez, M.L., Vargas, I. & Aller, M-B. (2014). Reflexiones sobre el impacto de la crisis en la salud y la atención sanitaria de la población inmigrante. Informe SESPAS 2014. *Gaceta sanitaria*, 28(S1), 142-146.

³³ García-Ramírez, M. Escobar-Ballesta, M., & Lizana, T. (2015). *Implementation of the National Roma Integration Strategy and Other National Commitments in the Field of Health in Spain*. International Organization for Migration.

³⁴ Office of the United Nations High Commissioner for Refugees (UNHCR). <http://www.acnur.org/t3/que-hace/asistencia/salud>

³⁵ Comision Española de Ayuda al Refugiado (CEAR). <http://www.cear.es/quienes-somos/presentacion>

³⁶ Ley 16/2003, de 28 de mayo, de cohesión y calidad del Sistema Nacional de Salud. <https://www.boe.es/buscar/act.php?id=BOE-A-2003-10715>

³⁷ Real Decreto 576/2013, de 26 de julio, por el que se establecen los requisitos básicos del convenio especial de prestación de asistencia sanitaria a personas que no tengan la condición de aseguradas ni de beneficiarias del Sistema Nacional de Salud y se modifica el Real Decreto 1192/2012, de 3 de agosto, por el que se regula la condición de asegurado y de beneficiario a efectos de la asistencia sanitaria en España, con cargo a fondos públicos, a través del Sistema Nacional de Salud. https://www.boe.es/diario_boe/txt.php?id=BOE-A-2013-8190

Special exemptions

Not applicable.

Barriers to obtaining entitlement

There are some problems with documentation and status of asylum seekers, mainly related to a lack of awareness on the part of administration staff in healthcare centres – which represent the point of entry into the system. Staff are sometimes incorrectly informed about the requirements for entitlement, which can impair healthcare access for these vulnerable groups. There is a clear need for additional training of administrative staff concerning the different legal statuses of migrants, asylum seekers, refugees, and beneficiaries of subsidiary protection.

C. Undocumented Migrants

Inclusion in health system and services covered

Undocumented migrants who do not live in centres are not entitled to healthcare according to RDL 16/2012,³⁸ except in the case of medical emergencies for serious illnesses or injuries, until they are discharged from hospital. This has increased their vulnerability, as they do not reside legally in the country and cannot therefore obtain employment which would afford them access to the Social Security System. Practitioners and experts draw attention to the complexity of situations in which migrants suffering from chronic illness cannot be treated as emergencies, since services offer no treatment or follow-up.

Special exemptions

There are some cases where healthcare is nonetheless available to undocumented migrants: (a) minors; (b) women during pregnancy, childbirth, and postpartum; and (c) victims of human trafficking with special needs.³⁹

Barriers to obtaining entitlement

Undocumented migrants living in centres often have problems accessing the SPHS, as they do not have Individual Healthcare Cards. This impedes their access to diagnostic procedures and specialized care in hospitals and other centres – even in cases of communicable diseases.

It is important to note that the situations described above began occurring after RDL 16/2012 was passed.⁴⁰ This RDL has given rise to several legal contradictions and additional access barriers since the Organic Law 2/2009 has not been repealed.^{41,42} Some regions have implemented alternative policies so

³⁸ Real Decreto-ley 16/2012, de 20 de abril, de medidas urgentes para garantizar la sostenibilidad del Sistema Nacional de Salud y mejorar la calidad y seguridad de sus prestaciones https://www.boe.es/diario_boe/txt.php?id=BOE-A-2012-5403

³⁹ Real Decreto 576/2013, de 26 de julio, por el que se establecen los requisitos básicos del convenio especial de prestación de asistencia sanitaria a personas que no tengan la condición de aseguradas ni de beneficiarias del Sistema Nacional de Salud y se modifica el Real Decreto 1192/2012, de 3 de agosto, por el que se regula la condición de asegurado y de beneficiario a efectos de la asistencia sanitaria en España, con cargo a fondos públicos, a través del Sistema Nacional de Salud. https://www.boe.es/diario_boe/txt.php?id=BOE-A-2013-8190

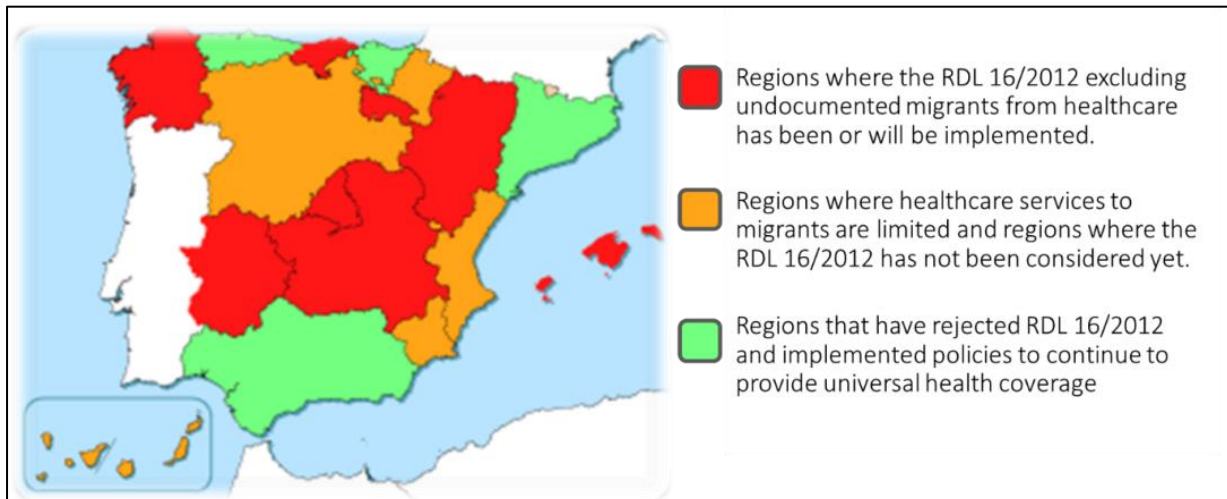
⁴⁰ Real Decreto-ley 16/2012, de 20 de abril, de medidas urgentes para garantizar la sostenibilidad del Sistema Nacional de Salud y mejorar la calidad y seguridad de sus prestaciones https://www.boe.es/diario_boe/txt.php?id=BOE-A-2012-5403

⁴¹ Ley Orgánica 2/2009, de 11 de diciembre, de reforma de la Ley Orgánica 4/2000, de 11 de enero, sobre derechos y libertades de los extranjeros en España y su integración social. https://www.boe.es/diario_boe/txt.php?id=BOE-A-2009-19949

⁴² López-Fernández et al., (2012). Is the universal coverage of our National Health System in danger? *Gaceta Sanitaria*, 26(4), 298-300.

that healthcare remains universal and free for everybody, including undocumented migrants: these are regions that have gained important health competencies that allow them to bypass the application of RDL 16/2012.⁴² This situation has resulted in a variety of contradictory health entitlement models in Spain (see Figure 4). In some regions, such as Catalonia⁴³ and Andalusia,⁴⁴ undocumented migrants are still entitled to free and universal healthcare. This contrasts with the case of Ceuta and Melilla, where, in spite of their high immigration rates, RDL 16/2012 has been applied rigorously.

Figure 4. Status of Health Reform by Region⁴⁵



⁴³ CatSalut. Instrucció 10/2012 Accés a l'assistència sanitària de cobertura pública del CatSalut als ciutadans estrangers empadronats a Catalunya que no tenen la condició d'assegurats o beneficiaris del Sistema Nacional de Salut http://scientiasalut.gencat.cat/bitstream/handle/11351/1319/catsalut_instruccio_10_2012.pdf?sequence=1

⁴⁴ Instrucciones de la Dirección General de Asistencia Sanitaria y Resultados en Salud del Servicio Andaluz de Salud sobre el reconocimiento del derecho a la asistencia sanitaria en centros del Sistema Sanitario Público de Andalucía a personas extranjeras en situación irregular y sin recursos <http://www.defensordelpuebloandaluz.es/sites/default/files/20131205125641980.pdf>

⁴⁵ www.derechoacurar.implicare.org/las-comunidades-autonomas-ante-la-exclusion-de-las-personas-migrantes-sin-permiso-de-residencia-de-la-atencion-sanitaria

6. POLICIES TO FACILITATE ACCESS

Score 67 Ranking ●●●●○

Information for service providers about migrants' entitlements

Many of the negative effects of RDL 16/2012⁴⁶ are related to both providers' and users' lack of information about healthcare entitlements.⁴⁷ The absence of clear information has led to multiple interpretations of the current legislation by SPHS workers, with negative consequences for migrants' access. Although information is supposed to be provided speedily through instructions that managers pass on to their employees, it generally takes time for the information to reach all employees, if it does at all. The situation is worsened by the fact that many users – especially undocumented migrants or foreign Roma – are also unaware of their rights. To overcome this deficiency, NGOs (often receiving public funding) play an important role, ensuring that administrative staff and healthcare providers are informed about and comply with the relevant regulations.

Information for migrants concerning entitlements and use of health services

There is no active institutional information program for migrants. Nevertheless, there are some regional plans (i.e. *III Plan Integral para la Inmigración in Andalusia*⁴⁸ and *Pla Director d'Inmigració en l'Àmbit de la Salut* in Catalonia⁴⁹) to achieve this. As a result of these plans, some intercultural mediation programmes provide information to migrants about using health services. In addition, dissemination of information is generally carried out by voluntary associations and NGOs. Although the methods of dissemination are usually adapted so that the information can reach migrants and enable them to exercise their rights, content is often poorly adapted.

Migrants can be informed through websites, telephone services, documents, posters and staff (such as cultural mediators) at the healthcare centres. Sometimes the information published is translated into more than two languages.

Health education and health promotion for migrants

Most health education and health promotion campaigns in Spain are carried out by NGOs which receive financial support from the government (although funding is quite limited). These campaigns are open to anyone but focus above all on vulnerable groups. Materials are frequently available in different languages (e.g. English, French, Arabic, Russian, Romanian, Chinese, Polish and Portuguese).

Provision of 'cultural mediators' or 'patient navigators' to facilitate access for migrants

Mediators exist in Spain but are not recognized professionally. This poses a major problem, since mediation is not explicitly encouraged by existing laws or by health institutions. Nevertheless, social workers and staff of NGOs often act as cultural mediators. Moreover, in major migrant areas, mediators

⁴⁶ Real Decreto-ley 16/2012, de 20 de abril, de medidas urgentes para garantizar la sostenibilidad del Sistema Nacional de Salud y mejorar la calidad y seguridad de sus prestaciones https://www.boe.es/diario_boe/txt.php?id=BOE-A-2012-5403

⁴⁸ III Plan Integral para la Inmigración en Andalucía http://www.juntadeandalucia.es/export/drupaljda/PIPIA_III.pdf

⁴⁹ Pla Director d'Immigració en l'Àmbit de la Salut

http://www.bcn.cat/novaciudadania/pdf/ca/salut/plans/PladirectorImmiiSalut2006_ca.pdf

are sometimes hired by city councils and intercultural mediation programs are developed. When cultural mediators are available, they assist all migrant users free of charge.

Some examples of good practices are: (a) the program '*Mediación intercultural en el ámbito de salud*,' carried out by the NGO CODENAF;⁵⁰ and (b) the '*Pla Director de Inmigración*,' (now Immigration and Health program of the Catalan Agency of Public Health)⁵¹ carried out by the Catalan government, which developed an intercultural mediation model with private funding that trained and hired intercultural mediators for the Catalan health services.

Is there an obligation to report undocumented migrants?

There is no obligation to report undocumented migrants in Spain, unless the person is under judicial investigation and the information is explicitly required by court order.⁵²

Are there any sanctions against helping undocumented migrants?

There are no legal sanctions or other pressures on professionals to stop them from helping undocumented migrants.^{53,54}

⁵⁰ <http://www.codenaf.org/codenaf-facilita-el-acceso-de-sus-usuarios-a-los-servicios-sanitarios-de-sevilla/>

⁵¹ Pla Director d'Immigració en l'Àmbit de la Salut

http://www.bcn.cat/novaciudadania/pdf/ca/salut/plans/PladirectorImmiiSalut2006_ca.pdf

⁵² Ley Orgánica 15/1999, de 13 de diciembre, de Protección de Datos de Carácter Personal.

<https://www.boe.es/buscar/doc.php?id=BOE-A-1999-23750>

⁵³ Ley Orgánica 4/2000, de 11 de enero, sobre derechos y libertades de los extranjeros en España y su integración social

<https://www.boe.es/buscar/act.php?id=BOE-A-2000-544>

⁵⁴ Ley Orgánica 2/2009, de 11 de diciembre, de reforma de la Ley Orgánica 4/2000, de 11 de enero, sobre derechos y libertades de los extranjeros en España y su integración social. https://www.boe.es/diario_boe/txt.php?id=BOE-A-2009-19949

7. RESPONSIVE HEALTH SERVICES

Score 38 Ranking ●●●○○○

Interpretation services

Interpretation services are the main strategy used by the SPHS to tackle communication barriers between migrants and healthcare professionals. However, these are not always available in healthcare organizations, due to the fact that they are not mandatory. When available (especially in local communities with high cultural diversity) they are free of charge for all users.

The most used methods are telephone interpretation (e.g. “*Salud Responde*” in Andalusia and “*CatSalut Respon*” in Catalonia, providing information in more than 100 different languages and dialects) and the use of apps. Moreover, in some regions, there are credentialled volunteers who act as interpreters.

Requirement for 'culturally competent' or 'diversity-sensitive' services

In Spain there are no specific requirements of this kind. For instance, training or experience in this field is not among the criteria needed to work in the SPHS.

Training and education of health service staff

Training in cultural competence is not a compulsory part of basic professional training or in-service professional development. However, there are relevant initiatives, some examples being the following:

- Masters programs related to migration and health in some universities (e.g. University of Seville, Deusto University)
- Manuals and training programs offered by Andalusian Ministry of Health⁵⁵
- Spain participates in the Culturally Competent Teachers and Medical Education (C2ME) project⁵⁶ and the MEM-TP project lead by the Andalusian School of Public Health (EASP).⁵⁷

The main problem is that these initiatives seem to appeal mainly to professionals who are already committed to this cause.

Involvement of migrants

Migrant involvement in Spain is low. In fact, Spain’s citizenry is not usually involved in contributing to research, evaluation, planning or the design of SPHS services; top-down procedures are the rule. However, migrant participation is lower than that of nationals. When there is involvement, it takes place through ad hoc initiatives. Migrants mostly participate in public health through NGOs. These carry out all sorts of tasks: mainly, information dissemination, research on migrant health and service provision (through cultural mediation). Also, in most public health institutions there are committees in which citizens may participate to assess the services; migrants can take part in these just as any other citizens.

⁵⁵

http://www.juntadeandalucia.es/salud/sites/csalud/galerias/documentos/p_4_p_2_promocion_de_la_salud/materiales_publicados_inmigrantes/manualatencioninmigrantes.pdf

⁵⁶ Culturally Competent in Medical Education. <https://www.amc.nl/web/Research/Overview/Major-projects-and-collaborations/Culturally-Competent-in-Medical-Education/Culturally-Competent-in-Medical-Education/Project-C2ME.htm>

⁵⁷ <http://www.mem-tp.org/>

Encouraging diversity in the health service workforce

In this regard, the SPHS recruitment system is usually based on merits, yet none of these are related to training in diversity and migration (e.g. ACT 176/2006 which regulates recruitment methods in the public health system in Andalusia, Art. 6⁵⁸). Ethnic minorities and migrants are underrepresented in the faculties where future healthcare providers are trained and there are no specific measures to foster diversity.

Development of capacity and methods

Adaptation of diagnostic procedures and treatment methods is tolerated to a limited extent, but not encouraged. Socio-cultural background is taken into account more frequently in diagnostic procedures than in treatments. This is done mostly by social workers and nurses.

⁵⁸ DECRETO 176/2006, de 10 de octubre, por el que se modifica el Decreto 136/2001, de 12 de junio, que regula los sistemas de selección del personal estatutario y de provisión de plazas básicas en los centros sanitarios del Servicio Andaluz de Salud <http://www.juntadeandalucia.es/boja/2006/209/6>

8. MEASURES TO ACHIEVE CHANGE

Score 58 Ranking ●●●●●

Data collection

Health and demographic databases rarely include information related to migrant status, country of origin, ethnicity, etc. Additionally, there is no unified system that the services and institutions of the different autonomous regions can share in order to compile, use, and assess information about migrants' health in Spain. Nor do the different regions share their users' data with other regions, due to personal data protection legislation.⁵⁹ This situation leads to multiple problems, such as difficulties in monitoring treatments when a user moves to a different region and the expenses arising from repeated diagnoses. In fact, systematic monitoring of migrants' health is only done in cases of infectious diseases, which are systematically reported to the Ministry of Health, Social Services and Equality.

Support for research

The scientific and social challenges of research on migrant health are registered in the Innovation, Technology and Science National Strategy 2013-2020,⁶⁰ whose objectives are part of the European research framework "Horizon 2020" for the period 2014-2020. Nevertheless, there is no explicit official policy encouraging research on migrant health.

The Catalan Ministry of Health has funded some research projects in order to develop and evaluate policies to improve the access of migrants to health services.⁶¹ With the current budgets cuts, however, no more public money is being earmarked at the ministerial level for research in migration and health. Academics consider that it is important to research this field and consequently they have carried out the majority of migrant health research and have been financially supported by governmental institutions (i.e. Programa Estatal de I+D+i, The Spanish Centre of Epidemiology of the Health Institute Carlos III, the Ministry of Economy and Competition, Catalan Health Ministry).

"Health in all policies" approach

In Spain, there is a national strategy regarding health equity.⁶² In October 2008, the Directorate General of Public and External Health created a national commission to reduce social inequalities in health. In May 2010, the commission finished a report featuring all the recommendations on strategic policies to be developed from different areas and at all the different levels of the Public Administration in order to reduce those inequalities. Although this law was approved, it is not currently being applied.

⁵⁹ Ley Orgánica 15/1999, de 13 de diciembre, de Protección de Datos de Carácter Personal.

<https://www.boe.es/buscar/doc.php?id=BOE-A-1999-23750>

⁶⁰ Plan estatal de investigación científica y técnica y de innovación 2013-2016, Gobierno de España.

http://www.idi.mineco.gob.es/stfls/MICINN/Investigacion/FICHEROS/Plan_Estatal_Inves_cientifica_tecnica_innovacion.pdf

⁶¹ Immigració i salut. http://canalsalut.gencat.cat/ca/home_professionals/temes_de_salut/immigracio_i_salut

⁶²Estrategia Nacional de Equidad en Salud, Gobierno de España.

<http://www.msssi.gob.es/profesionales/saludPublica/prevPromocion/promocion/desigualdadSalud/EstrategiaNacEquidadSalud.htm>

In Catalonia, the government has approved an Inter-Ministerial Public Health Plan (PINSAP) to mobilise various government sectors and make them responsible for the health impact of their policies, improving actions on their main determinants, both structural and those related to lifestyle.⁶³

In addition, there are numerous policies in Spain that are not related to health whose implementation may have helped to reduce health inequalities (e.g. *III Plan Integral para la inmigración en Andalucía Horizonte 2016*;⁶⁴ Citizen and Migration plan: Horizon 2026 of the Catalan Government).⁶⁵ However, the impact of this type of policies has not been sufficiently assessed.⁶⁶ In fact, the majority of national policies have been developed in theory only because the RDL 16/2012 disregarded any commitment to health equity.

Whole organisation approach

In Spain, there is not a unique whole organization approach, but there are many organizations committed to provide equitable healthcare for migrants and ethnic minorities that are present in most departments and services.

Many of the health organizations in Spain have offered intercultural mediation services since the beginning of the immigration phenomena and have paid for these from their own budgets. The organizations understood quickly that the participation of mediators in the healthcare sector was fundamental in order to offer a comprehensive quality care service and to allow the exchange of knowledge between the newly arrived and the healthcare professionals, thus overcoming linguistic and cultural barriers.

Some Spanish hospitals belong to the WHO Network on Health Promoting Hospitals and participated in the Migrant Friendly Hospitals Task Force.⁶⁷ This consortium has developed a set of standards aimed at monitoring and measuring equity in healthcare for migrants and other vulnerable groups. It offers an opportunity for staff and services to question what they do, why they do it, and how it can be done better.⁶⁸

Leadership by government

At the national level, the Strategic Plan of Citizenship and Integration 2011-2014 of the National Department of Immigration and Emigration has a specific blueprint on health intervention, which is the continuation of the Strategic Plan 2007-2010.⁶⁹ The new plan aims to integrate the “different perspectives when approaching health promotion, community health and disease prevention, and to incorporate tools and instruments of social intervention focused on the needs and problems of the community. Examples of these are health mediation programs, the identification of agents in

⁶³ http://salutpublica.gencat.cat/web/.content/minisite/aspcat/sobre_lagencia/pinsap/pinsap-en.pdf

⁶⁴ *III Plan Integral para la inmigración en Andalucía Horizonte 2016*.

http://www.juntadeandalucia.es/export/drupaljda/PIPIA_III.pdf

⁶⁵ Citizenship and Migration Plan: Horizon 2016. Generalitat de Catalunya

http://benestar.gencat.cat/web/.content/03ambits_tematics/05immigracio/03politiquesplansactuacio/pla_ciudadania_immigracio/PCM_2013-2016-ING.pdf

⁶⁶ *Avanzando hacia la equidad: Propuesta de políticas e intervenciones para reducir las desigualdades sociales en salud en España, 2015*. Ministerio de Sanidad, Servicios Sociales e Igualdad. Gobierno de España.

http://www.mspsi.gob.es/profesionales/saludPublica/prevPromocion/promocion/desigualdadSalud/docs/Propuesta_Politicas_Reducir_Desigualdades.pdf

⁶⁷ <http://www.mfh-eu.net/public/home.htm>

⁶⁸ http://hphnet.org/attachments/article/291/Equity%20Standards%20SAT%202014_Light.pdf

⁶⁹ Strategic Plan of Citizenship and Integration 2011-2014. <http://www.gfmd.org/pfp/ppd/434>

community health programs, diversity management in health, and intercultural competence training for healthcare professionals” (p. 140).⁷⁰ Additionally, there are other specific plans in different regions.

Involvement of stakeholders

There is no specific policy to involve all stakeholders, but the different government departments of each region coordinate several policies aimed at improving migrant health. For example, in Catalonia, there is an interdepartmental commission which coordinates government policies addressing migrant needs, including health needs. There are also different groups of multidisciplinary work with technicians from each department dealing with issues such as the prohibition of female genital mutilation and health assistance for the Roma community.

Migrants’ contribution to health policymaking

Migrants’ contribution to health policymaking is very low, although migrants sometimes play an important role in implementing policies and disseminating information.

The Forum for Social Integration of Migrant Population is the basic tool for enquiries, information and counselling regarding migrant integration.⁷¹ The forum’s main goal is to promote migrant participation and integration in Spanish society. It is composed of different NGOs and associations of migrants, unions and workers in public administration.

Additionally, there are some examples of collaboration between migrants and government institutions. For example, the governments of Catalonia and Andalusia have developed several general and specific protocols with the participation of migrant groups, NGOs and organizations (e.g. female genital mutilation prevention, sexual and reproductive health advice).⁷²

⁷⁰ See note 68

⁷¹ Foro para la Integración de los Inmigrantes <http://www.foroinmigracion.es>

⁷² http://www.violenciagenero.msssi.gob.es/otrasFormas/mutilacion/protocolos/protocolo/pdf/cataluna_2007.pdf

CONCLUSIONS

As in the rest of Southern Europe, policies for migrants in Spain are a critical issue and the subject of much public debate. On the one hand, the government has a moral and legal obligation to guarantee adequate healthcare coverage for the entire population, including migrants, in keeping with international human rights conventions. But on the other hand, the socio-political crisis gripping Southern European countries has provided governments with an excuse to reduce budgets meant to ensure equity in healthcare and social services equity, instead implementing cutbacks in entitlements and dedicated resources.

Despite the difficult economic climate, Spain has developed many policies that benefit migrants' social integration - for example, migrants' right to reunite with their families or to become long-term residents under certain circumstances.⁷³ Its mean score on other MIPEX strands is above average (see section 2). Regarding healthcare, Spain—together with Portugal—used to be a worldwide reference for providing public healthcare to all migrants regardless of their legal status. This contrasts with the implementation of RDL 16/2012, which is estimated (although the figures are unreliable) to have denied about 900.000 people access to healthcare, triggering an ethical, human and public health problem.⁷⁴ This measure has led to conflicting health entitlement models in Spain's different Autonomous Regions. In some places, the regional government has opposed the RDL, while in others, where the RDL is followed, some health providers and citizen movements have organized opposition to it (e.g. Marea Blanca movement,⁷⁵ Sociedad Española de Medicina Familiar y Comunitaria,⁷⁶ Plataforma Multicultural por una Sanidad Pública en Andalucía⁷⁷).

In conclusion, under the austerity regime the reduction of healthcare services for migrants and the modification of entitlement rights has been part of government policy at both national and regional levels. These cuts have had a negative effect on migrant health policies and, consequently, on public health. Nevertheless, our review and other reviews carried out in Spain did not find conspicuously negative results, probably due to the fact that implementation of these policies has been slow and has encountered much resistance.⁷⁸ Therefore, further studies will be needed to evaluate their real impact.⁷⁹

⁷³ MIPEX Spain <http://www.mipex.eu/spain>

⁷⁴ Gimeno, L. A., García, A. & López-Vélez, R. (2014). Salud e Inmigración en el Contexto de Crisis Socioeconómica y de Valores: el Ejemplo de España. *Eu-topias*, 7, 121-1130. <http://eu-topias.org/salud-e-inmigracion-en-el-contexto-de-esta-crisis-economica-y-de-valores/>

⁷⁵ Marea Blanca:

http://translate.google.com/translate?sl=es&tl=en&js=n&prev=t&hl=en&ie=UTF-8&layout=2&eotf=1&u=http://wiki.15m.cc/wiki/Marea_Blanca

⁷⁶ SEMFYC (2012). Atendemos personas, no asegurados. Comunicado ante medidas RD 16/2012. Registro para objeción. http://www.semfyc.es/es/noticias/destacadas/listado/Atendemos_personas_noasegurados_Comunicado_RD_Regsitro_objeci%F3n

⁷⁷ Plataforma para una sanidad universal para todos. <http://www.accionenred-andalucia.org/por-una-sanidad-universal>

⁷⁸ García-Subirats, I. et al. (2014). Changes in Access to Health Services of the Immigrant and Native-Born Population in Spain in the Context of Economic Crisis. *International Journal of Environmental Research and Public Health*, 11, 10182-10201.

⁷⁹ Malmusi, D. & Ortiz-Barreda, G. (2014). Desigualdades sociales en la salud de las poblaciones inmigradas en España. Revisión de la literatura. *Revista Española de Salud Pública*, 88, 687-701.

Finally, regarding the results of this report, experts who participated in our study have proposed the following recommendations:

- Follow Article 35 of the European Charter of Fundamental Rights, where it is stated that “Everyone has the right of access to preventive healthcare under the conditions established by national laws and practices”.⁸⁰
- Health organizations must be provided with sufficient resources in order to adequately assist migrant users – as well as national citizens. Practitioners criticised a lack of facilities and basic resources to do their job.
- Remove the restriction of entitlement to emergency care which the RDL 16/2012 imposed on undocumented migrants.
- Remove other barriers to accessing primary and secondary services. This can be done, for example, by making services easier to reach and by providing migrants with information about the SPHS structure and functioning. Simple and clear procedures should be developed for providing health cards and making sure they are explained to all migrants during the initial reception process.
- Disseminate more and improved information about entitlement for different types of migrants (undocumented, workers, asylum seekers, family members and migrants who live in centres) among healthcare staff, with special focus on administrative personnel.
- Pay special attention to the wellbeing of undocumented migrants in detention centres to guarantee that human rights are respected. It is necessary to improve the living conditions of residents in CIEs and to offer them psychological assistance. The absence of mental health services is one of the most serious limitations, as it would provide an opportunity to empower migrants psychologically, to help them strengthen their social support networks, develop strategies of psychological resilience, manage stress, and eventually become self-sufficient.
- Increase governmental support and recognition for NGOs, which play an important role in the dissemination of information, mediation between providers and users, training users in health education, training providers to be culturally competent, etc.
- Recognize cultural mediation as a professional activity in Spain, regulating its functions and establishing an ethic code.
- Create training programmes in cultural competence for healthcare staff – and administrative personnel – based on social justice principles. These programmes should be aimed at encouraging providers in their work with migrants, to empower them within their organization and to develop competences that allow them to be effective in a culturally diverse context and acting as advocates against injustice.
- Ensure a more diverse cultural background among health providers and policymakers.
- Collect and monitor regularly comprehensive data on migrants’ health in SPHS, reception and detention centres, and through Migration Observatories, e.g. OPAM, reports and the National Migration Survey – which was done by the Spanish Institute of Statistics in 2007 but

⁸⁰ http://www.europarl.europa.eu/charter/pdf/text_en.pdf

not repeated since. Disaggregated data based on migrants' status could be blended and harmonised in a common database in order to anticipate needs and analyse service use.

- Standardize health assessments for health-related data collection in health organizations and services. All systems should use the same coding system, to make it possible to monitor patients who move from one region to another.
- Improve migrant involvement in the research, evaluation, planning and design of SPHS services. This will contribute to a more diversity-sensitive SPHS.
- Promote an overall constructive discourse on migration and public health in the media to foster social integration, while addressing misperceptions in the community. Misinformation fuels unfounded fears of epidemics both among local authorities and the public. To counteract them, the socially responsible collaboration of the media is crucial, as are information campaigns on the positive contribution that migrants make to the community as a whole.

APPENDIX 1. RESEARCH TEAM AND PARTICIPANTS IN THE STUDY

Research team

(in alphabetical order)

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- M^a Luisa Vázquez Navarrete. Consorci de Salut i Social de Catalunya

APPENDIX 2. OUTCOMES FROM THE LITERATURE AND LEGAL REVIEW

PUBLISHED LITERATURE REVIEW (PEER-REVIEWED ARTICLES)

- Delgado-Rodríguez, M. (2014). Immigration and health in Spain. *Revista Española de Salud Pública*, vol. 88 n.6 Madrid Nov./Dec. 2014
- Hernández-Aguadoa, I, Santaolaya, M. & Campos, P. (2012). Las desigualdades sociales en salud y la atención primaria. Informe SESPAS 2012. *Gaceta Sanitaria*, 26 Supl 1:6-13. doi:10.1016/j.gaceta.2011.09.036
- Legido-Quigley, H., Otero, L., La Parra, D., Alvarez-Dardet, C., Martin-Moreno, J.M., & McKee, M. (2013). Will austerity cuts dismantle the Spanish healthcare system? *BMJ*, 346:f2363. doi:10.1136/bmj.f2363
- Legido-Quigley, H., Urdaneta, E., Gonzalez, A., La Parra, D., Muntaner, C., Alvarez-Dardet, C., Martin-Moreno, J.M., & McKee, M. (2013). Erosion of universal health coverage in Spain. *The Lancet*, Volume 382, No. 9909, p1977. doi: 10.1016/S0140-6736(13)62649-5
- Llop-Gironés, A., Vargas, I., Garcia-Subirats, I. , Aller, M.B. & Vázquez, M.L. (2014). Immigrants' access to health care in Spain: a review. *Revista Española de Salud Pública*, vol.88 n.6, 715-734.
- López-Fernández et al. (2012). Is the universal coverage of our national health system in danger? *Gaceta Sanitaria*, 26(4), 298-300. doi: 10.1016/j.gaceta.2012.06.001
- Royo-Bordonada, M. A., Díez-Cornell, M. & Llorente, J. M. (2013). Health-care access for migrants in Europe: the case of Spain. *The Lancet*, Vol. 382, No. 9890, p393–394. doi: 10.1016/S0140-6736(13)61667-0
- Sarmiento, P., Fernández, M., Albar, M.J. & García-Ramírez, M. (2015). Percepción y experiencias en el acceso y el uso los servicios sanitarios en población inmigrante. *Gaceta Sanitaria*, 29:244-51. doi:10.1016/j.gaceta.2015.03.008
- Sobrino, I. (2013). Inmigrantes irregulares y el derecho a la protección de la salud: análisis de la reforma sanitaria en España. *Lex Social: Revista de los derechos sociales*, vol.3(2), 127-158
- Terraza, R., Vargas, I., Rodríguez, D., Lizana, T. & Vázquez, M.L. (2010). Health policies of national and regional level for the immigrant population in Spain. *Gaceta Sanitaria*, vol.24 n.2. doi:10.1590/S0213-91112010000200004
- Van Beek, K. et al. (2013). Comparison of legislation, regulations and national health strategies for palliative care in seven European countries (Results from the Europall Research Group): a descriptive study. *BMC Health Services Research*, 13:27. doi:10.1186/1472-6963-13-275
- Vázquez, M.L., Terraza-Núñez, R., Vargas, I., Rodríguez, D. & Lizana, T. (2011). Health policies for migrant populations in three European countries: England; Italy and Spain. *Health Policy*, 101(1):70-8. doi:10.1016/j.healthpol.2010.08.026

Vázquez, M.L., Vargas, I. & Aller, M.B. (2014). Reflexiones sobre el impacto de la crisis en la salud y la atención sanitaria de la población inmigrante. Informe SEPAS 2014. *Gaceta Sanitaria*, 28 Supl 1:142-6 doi:10.1016/j.gaceta.2014.02.012

GREY LITERATURE REVIEW AND OTHERS (BOOK CHAPTERS, REPORTS, WEBSITES)

Cáritas (2010). La situación social de los inmigrantes acompañados por CARITAS. Observatorio de la Realidad Social CARITAS Española. Retrieved from:

https://www.google.es/url?sa=t&rct=j&q=&esrc=s&source=web&cd=2&ved=0ahUKEwjrw874gLiRAhUFzxQKHTNuCdsQFggsMAE&url=http%3A%2F%2Fwww.caritas.es%2FAdjuntoNoticiaDownload.aspx%3FId%3D147&usq=AFQjCNGauGGEYe41eCIEBvVbxLb7k_vgFg&sig2=pbw003sd1PfrRBrqYSiDBA&cad=rja

Chauvin P, Simonnot N, Vanbiervliet F, Vicart M, Vuillermoz C. (2015). *Access to healthcare for people facing multiple vulnerabilities in health in 26 cities across 11 countries. Report on the social and medical data gathered in 2014 in nine European countries, Turkey and Canada*. Paris: Doctors of the World – Médecins du monde international network. Retrieved from:

<https://mdmeuroblog.files.wordpress.com/2014/05/mdm-intl-network-full-report-11-countries-18th-may-2015.pdf>

Chauvin, P., Parizot, I., & Simonnot, N. (2009). *El acceso a la asistencia sanitaria de las personas inmigrantes sin permiso de residencia y solicitantes de asilo en diez países de la Unión Europea. Legislación y práctica*. Observatorio Europeo del Acceso a la Sanidad de Médicos del Mundo. Retrieved from: <https://www.medicosdelmundo.org/index.php/mod.documentos/mem.descargar/fichero.DOC-115%232E%23pdf>

Foro para la Integración Social de los Inmigrantes (2014). *Informe del foro para la integración social de los inmigrantes en relación con la situación de los flujos migratorios en la frontera sur, ciudades autónomas de Ceuta y Melilla y costas españolas*. Retrieved from:

<http://www.foroinmigracion.es/es/MANDATO-FORO-2010-2013/DocumentosAprobados/Informes/Doc 2 Informe Ceuta y Melilla aprobado 15-12-14.pdf>

García Galán, R. (Coord.). (2007). *Manual de Atención Sanitaria a Inmigrantes*. Sevilla: Junta de Andalucía, Consejería de Salud. Retrieved from:

<http://www.juntadeandalucia.es/salud/sites/csalud/galerias/documentos/p 4 p 2 promocion de la salud/materiales publicados inmigrantes/manualatencioninmigrantes.pdf>

García-Armesto, S., Abadía-Taira, M.B., Durán, A., Hernández-Quevedo, C. & Bernal-Delgado E. (2010). *Spain: Health system review. Health Systems in Transition*. The European Observatory on Health Systems and Policies, WHO. Retrieved from:

http://www.euro.who.int/data/assets/pdf_file/0004/128830/e94549.pdf

García-Ramírez, M., Escobar-Ballesta, M., & Lizana, T. (2015). *Progress Report from a Multi-stakeholder Perspective on the Implementation of the NRIS (National Roma Integration Strategy) and other National Commitments in Spain*. International Organization for Migrations. Retrieved from: http://equi-health.eea.iom.int/images/NRIS_Spain_Final.pdf

International Organization for Migrations (2015). *Assessment Report: Health Situation at EU Southern borders: Migrant Health, Occupational Health, and Public Health in Spain*. International Organization for Migrations. Retrieved from: http://equi-health.eea.iom.int/images/SAR_Spain_Final.pdf

- Jiménez-Martín, S., & Viola, A.A. (2014). *El sistema de salud en España en perspectiva comparada*. Observatorio de la Sanidad Fedea. Retrieved from: <http://sanidad.fedea.net/docs/informe.pdf>
- Kringos, D., Boerma, W., Hutchinson, A. & Saltman, R. (Eds.) (2015). *Building primary care in a changing Europe*. The European Observatory on Health Systems and Policies, World Health Organization. Retrieved from: http://www.euro.who.int/data/assets/pdf_file/0018/271170/BuildingPrimaryCareChangingEurope.pdf
- Lara, R., et al. (2014). *Informe Derechos Humanos en la Frontera Sur 2013*. Seville, Spain: Asociación Pro Derechos Humanos de Andalucía (APDHA). Retrieved from: http://www.apdha.org/media/fronterasur_2013_web.pdf
- Médicos del Mundo (2014). *Dos años de reforma sanitaria: más vidas humanas en riesgo*. Retrieved from: https://www.medicosdelmundo.org/index.php/mod.documentos/mem.descargar/fichero.documentos_Impacto-Reforma-Sanitaria-Medicos-del-Mundo_3ec0bdf9%232E%23pdf
- Ministerio de Sanidad, Servicios Sociales e Igualdad (2015). *Avanzando hacia la equidad Propuesta de Políticas e intervenciones para reducir las desigualdades Sociales en salud en España*. Madrid 2015. Retrieved from: http://www.mspsi.es/profesionales/saludPublica/prevPromocion/promocion/desigualdadSalud/docs/Propuesta_Politiclas_Reducir_Desigualdades.pdf
- Ministry of Health, Social Services and Equality (2012). National Health System of Spain [Internet monograph]. Madrid; 2012 Retrieved from: http://www.msssi.gob.es/en/organizacion/sns/docs/sns2012/SNS012_Ingles.pdf
- Price Waterhouse Coopers (2013). *Diez temas candentes de la Sanidad Española para 2013: Para que la crisis económica no se transforme en una crisis de salud pública*. Retrieved from: <https://www.pwc.es/es/publicaciones/sector-publico/assets/diez-temas-candentes-sanidad-2013.pdf>
- Puig Samper, F. (2013). *El gasto sanitario en España*. Confederación Sindical de Comisiones Obreras. Retrieved from: <http://www2.ccoo.es/comunes/recursos/1/1737174-Cuaderno de Informacion Sindical n 36.pdf>
- Servicio Jesuita a Migrantes España (SJMe) (2015). *CIE y Expulsiones Exprés*. Retrieved from: <http://www.sjme.org/sjme/item/794-cie-y-expulsiones-expres>

MAIN WEBSITES CONSULTED

Entity	Link
Ministerio de Sanidad, Servicios Sociales e Igualdad, Gobierno de España	http://www.msssi.gob.es/sanidad/portada/home.htm
Junta de Andalucía, Consejería de salud	http://www.juntadeandalucia.es/salud/sites/csalandportal/
Generalitat de Catalunya, Departament de	http://salutweb.gencat.cat/ca/

Salut

Ministerio de Interior, Gobierno de España	http://www.mir.es
Observatorio de Desigualdades en Salud	http://www.ods-ciberesp.org/
Observatorio Permanente de la Inmigración. Gobierno de España	http://extranjeros.empleo.gob.es/es/ObservatorioPermanenteInmigracion/

LEGAL REVIEW

(in order of appearance in the text)

Document	Link
Constitución Española de 1978	https://www.boe.es/diario_boe/txt.php?id=BOE-A-1978-31229
Ley 14/1986, de 25 de abril, General de Sanidad	https://www.boe.es/buscar/act.php?id=BOE-A-1986-10499
Ley Orgánica 4/1979, de 18 de diciembre, de Estatuto de Autonomía de Cataluña.	https://www.boe.es/buscar/doc.php?id=BOE-A-1979-30178
Decret 196/2010 de 14 de desembre, del sistema sanitari integrald'utilització pública de Catalunya (SISCAT). 16-12-2010. Diari Oficial de la Generalitat de Catalunya (DOGC), N° 5776.	http://noticias.juridicas.com/base_datos/CCAA/ca-d196-2010.html
Ley Orgánica 6/1981, de 30 de diciembre, de Estatuto de Autonomía para Andalucía.	https://www.boe.es/buscar/doc.php?id=BOE-A-1982-63
Ley 2/1998, de 15 de junio, de Salud de Andalucía.	http://www.juntadeandalucia.es/boja/1998/74/1
Ley Orgánica 4/2000, de 11 de enero, sobre derechos y libertades de los extranjeros en España y su integración social.	https://www.boe.es/buscar/act.php?id=BOE-A-2000-544
Orden de 22 de febrero de 1999 sobre normas de funcionamiento y régimen interior de los centros de internamiento de extranjeros.	https://www.boe.es/buscar/doc.php?id=BOE-A-1999-4528
Real Decreto 162/2014, de 14 de marzo, por el que se aprueba el reglamento de funcionamiento y régimen interior de los centros de internamiento de extranjeros.	https://www.boe.es/diario_boe/txt.php?id=BOE-A-2014-2749
Real Decreto-ley 16/2012, de 20 de abril, de medidas urgentes para garantizar la sostenibilidad del Sistema Nacional de Salud y mejorar la calidad y seguridad de sus	https://www.boe.es/diario_boe/txt.php?id=BOE-A-2012-5403

Document	Link
prestaciones	
Real Decreto 1192/2012, de 3 de agosto, por el que se regula la condición de asegurado y de beneficiario a efectos de la asistencia sanitaria en España, con cargo a fondos públicos, a través del Sistema Nacional de Salud.	https://www.boe.es/buscar/doc.php?id=BOE-A-2012-10477
Real Decreto 576/2013, de 26 de julio, por el que se establecen los requisitos básicos del convenio especial de prestación de asistencia sanitaria a personas que no tengan la condición de aseguradas ni de beneficiarias del Sistema Nacional de Salud y se modifica el Real Decreto 1192/2012, de 3 de agosto, por el que se regula la condición de asegurado y de beneficiario a efectos de la asistencia sanitaria en España, con cargo a fondos públicos, a través del Sistema Nacional de Salud.	https://www.boe.es/diario_boe/txt.php?id=BOE-A-2013-8190
Ley 16/2003, de 28 de mayo, de cohesión y calidad del Sistema Nacional de Salud.	https://www.boe.es/buscar/act.php?id=BOE-A-2003-10715
Ley Orgánica 2/2009, de 11 de diciembre, de reforma de la Ley Orgánica 4/2000, de 11 de enero, sobre derechos y libertades de los extranjeros en España y su integración social.	https://www.boe.es/diario_boe/txt.php?id=BOE-A-2009-19949
CatSalut. Instrucció 10/2012 Accés a l'assistència sanitària de cobertura pública del CatSalut als ciutadans estrangers empadronats a Catalunya que no tenen la condició d'assegurats o beneficiaris del Sistema Nacional de Salut	http://scientiasalut.gencat.cat/bitstream/handle/11351/1319/catsalut_inst_10_2012.pdf?sequence=1
Instrucciones de la Dirección General de Asistencia Sanitaria y Resultados en Salud del Servicio Andaluz de Salud sobre el reconocimiento del derecho a la asistencia sanitaria en centros del Sistema Sanitario Público de Andalucía a personas extranjeras en situación irregular y sin recursos	http://www.defensordelpuebloandaluz.es/sites/default/files/20131205125641980.pdf
Ley Orgánica 15/1999, de 13 de diciembre, de Protección de Datos de Carácter Personal.	https://www.boe.es/buscar/doc.php?id=BOE-A-1999-23750
Decreto 176/2006, de 10 de octubre, por el que se modifica el Decreto 136/2001, de 12 de junio, que regula los sistemas de selección del personal estatutario y de provisión de plazas básicas en los centros sanitarios del Servicio Andaluz de Salud	http://www.juntadeandalucia.es/boja/2006/209/6





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