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Policy implementation analysis on access to healthcare among undocumented immigrants in seven autonomous communities of Spain, 2012–2018

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ABSTRACT

Background In 2012, the Government of Spain enacted Royal Decree-Law (RDL) 16/2012 and Royal Decree (RD) 1192/2012 excluding undocumented immigrants from publicly funded healthcare services. We conducted a policy implementation analysis to describe and evaluate the legal and regulatory actions taken at the autonomous community (AC) level after enactment of 2012 RDL and RD and their impact on access to general healthcare and HIV services among undocumented immigrants.

Methods We reviewed documents published by the governments of seven ACs (Andalucía, Aragón, Euskadi (Basque Country), Castilla-La Mancha, Galicia, Madrid, Valencia) from April 2012 to July 2018, describing circumstances under which undocumented immigrants would be able to access free healthcare services. We developed indicators according to the main systemic barriers presented in official documents to analyse access to free healthcare across the participating ACs. ACs were grouped under five access categories: high, medium-high, medium, medium-low and low.

Results Andalucía provided the highest access to free healthcare for undocumented immigrants in both general care and HIV treatment. Medium-high access was provided by Euskadi and medium access by Aragón, Madrid and Valencia. Castilla-La Mancha provided medium-low access. Galicia had low access. Only Madrid and Galicia provided different and higher level of access to undocumented migrants in HIV care compared with general healthcare.

Conclusions Implementation of 2012 RDL and RD across the ACs varied significantly, in part due to the decentralisation of the Spanish healthcare system. The challenge of healthcare access among undocumented immigrants included persistent systemic restrictions, frequent and unclear rule changes, and the need to navigate differences across ACs of Spain.

Strengths and limitations of this study

- ► This policy study adds to the literature on healthcare access among undocumented immigrants, an underserved population of increasing importance in the European context.
- ► The policy implementation analysis contained data extracted from rich primary resources and data.
- ► The study included data from 7 out of 17 autonomous communities in Spain; thus, the results might not be generalisable to all of Spain.

INTRODUCTION

In recent years, Spain implemented multiple austerity measures as a result of the 2008 financial crisis.[1–3] As part of this cost-saving effort, the Spanish government enacted Royal Decree-Law (RDL, carrying the force of law issued by the government in exceptional cases without need of preliminary approval by the parliament) 16/2012 and Royal Decree (RD, carrying the force of regulation with parliamentary approval to indicate certain norms on a matter requiring specific guidance) 1192/2012, which made changes to the previously practiced universal healthcare system and predominantly excluded undocumented immigrants by linking the right to access free healthcare to the legal and employment status of an individual.[1 2 4–6]

Of 31 European Union (EU)/European Free Trade Association (EFTA) member countries, 22 (71%) identify immigrants as an especially vulnerable population to the HIV.[7] HIV is an especially important area of concern in Spain, as it has one of the highest incidences of infection among EU countries (39 352 new cases from 2006 to 2015, ranking fourth in EU/EFTA).[8] No precise data are available on the number of HIV-positive undocumented immigrants in Spain. However, according to a 2015 report from the Spanish Ministry of Health, Social Services and Equality (*Ministerio de Sanidad, Servicios Sociales e Igualdad* or MSSSI), a total of 3366 newly diagnosed HIV cases (7.2 cases per 100 000) were registered

nationwide in 2014, and 32% of those cases were among immigrants.[2]

Various social, economic, cultural and legal factors increase vulnerability to HIV infection in immigrant populations.[9–15] Social and economic difficulties encountered in the host country often result in inconsistent condom use, multiple sexual partners, high alcohol consumption, drug injection,[16–19] sexual exploitation[20] and prioritisation of food and housing over health.[9] Barriers to healthcare access also increase the vulnerability of immigrants to HIV, chief among them laws and regulations that prevent immigrants from accessing services.[9 10 21 22] RDL 16/2012 excluded approximately 500 000 undocumented immigrants from the national health system.[2] This posed a risk to the health of undocumented immigrants, which in turn may threaten the health of the general population.[1 23] For example, studies have shown that HIV-positive undocumented immigrants tend to delay accessing necessary healthcare.[1 9] Even though undocumented immigrants in Spain can purchase health insurance, the premiums are generally unaffordable,[24] especially as 40% of documented immigrants are unemployed.[25]

Almost a year after the 2012 health reform was implemented, the central government of Spain addressed the issue of immigrant access to free healthcare in case of infectious diseases. Specifically, in December 2013, in an effort to tighten epidemiological surveillance of diseases, MSSSI implemented RD 576/2013, resulting in a regulatory change for 'Healthcare Interventions in Situations of Public Health Risk', as approved by the inter-territorial council of the national health system. This new RD declared that all individuals, including undocumented immigrants, were once again entitled to free healthcare whenever an identified infectious disease, such as HIV/AIDS, was subject to epidemiological control.[26] In theory, this change should have allowed HIV-infected undocumented immigrants to regain access to necessary free treatment and care. However, there was much confusion around the legal entitlements created under the new regulation. This was not unique to Spain. In many European countries, access to healthcare has been denied to immigrants despite their legal entitlement to services.[4] Undocumented immigrants have been denied access to healthcare due to a lack of legal awareness in their communities, provider ignorance of laws regarding immigrants' protection and an unwillingness to treat among medical professionals due to deep-seated discrimination and racism.[27 28] Thus, it was unclear the extent to which RD 576/2013 translated into actual access to services among undocumented immigrants across the autonomous communities (ACs) of Spain.

Given the highly decentralised health system in Spain, the aim of this study was to provide a comparative policy implementation analysis on access to free general healthcare services and HIV care among undocumented immigrants in different ACs, from the implementation of RDL 16/2012 until the enactment of RDL 7/2018, which was intended to reinstate universal health coverage.[29]

METHODS

Document review

We reached out to public health specialists and non-governmental organisations (NGOs) dedicated to immigrant access to care or access to HIV care in all ACs of Spain. We aimed to obtain all possible internal and official instructions published by each AC that related to entitlements granted to undocumented immigrants for free general healthcare services and/or HIV care in the ACs of Spain. We received responses from seven ACs, specifically Andalucía, Aragón, Euskadi (Basque Country), Castilla-La Mancha, Galicia, Madrid and Valencia. We reviewed all policies and regulations available online and on governmental websites as well as internal documents received from these ACs. Due to the context of the study, internal documents were considered an important part of the review, without which the analysis would not be complete. Reviewed governmental documents issued by the seven ACs were published between 20 April 2012 and 30 July 2018 in both Spanish and Galician. Upon initial review of the governmental documents, a summary of the findings was created for each AC in Spanish and sent back to the public health specialists and NGOs for confirmation or comment.

According to the main systemic barriers presented across official documents, we identified two access level indicators: proof of identification and proof of residency in an AC. We developed a model (see figure 1) using these two indicators to assess the severity of the limitation on free general healthcare access among undocumented immigrants. Five categories of access to free general healthcare services were as follows: low access, medium-low access, medium access, medium-high access and high access. Specific access indicators developed per level were based on the percentage of the study time frame during which access to free general healthcare services was granted to all undocumented immigrants (without categorisation, eg, women, minors, human trafficking victims and asylum seekers). They were also based on the number of months of proven residency required (during the same percentage of the study time frame) by an AC, and if any type of identification was required. The term 'free general healthcare' refers to services granted free of charge for all health needs of undocumented immigrants (aside from HIV care). The term 'free healthcare access' refers both to general care services and HIV care (see table 1).

The percentage of the study time frame that access to free general healthcare was granted to all undocumented immigrants was calculated according to the following information: (1) Total study time frame was calculated in months from 20 April 2012 to 30 July 2018—a total of 75 months; (2) It was assumed that all undocumented immigrants were still provided free general healthcare coverage during the time between the enactment of 2012 RDL (20 April 2012) and the first instruction issued in an AC to implement the RDL and RD; (3) Months were calculated from the first instruction of an AC (date differed for each

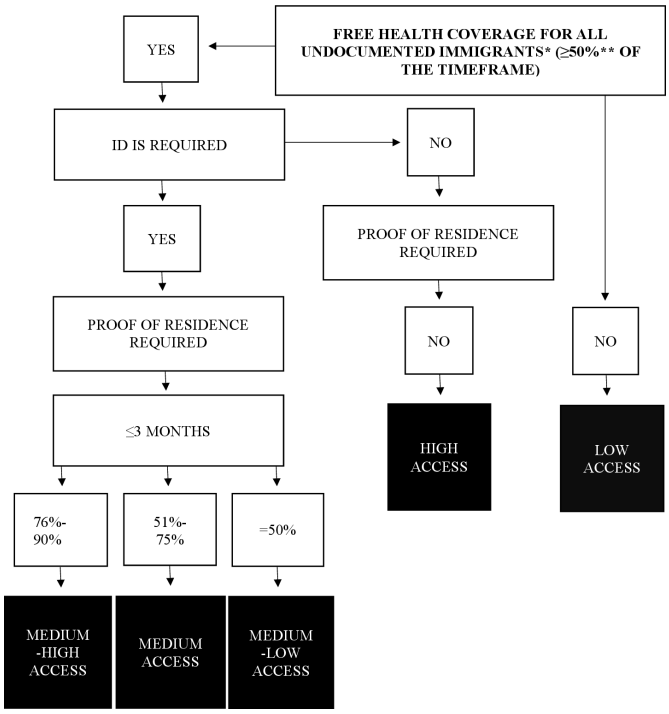

Figure 1 Level of access to free general healthcare services for undocumented immigrants.
*'All undocumented immigrants' refers to providing free general healthcare coverage to every undocumented immigrant and not just to a special population within the group. 'Special population' refers to immigrants who are pregnant, minors, human trafficking victims, asylum seekers and cases of accidents or other serious illness.
**≥50% (≥37 months) refers to the initial cut-off point to differentiate between low access and high/medium-high/medium/medium-low access.

AC) granting free general healthcare coverage specifically to all undocumented immigrants in an AC until the end of the study time frame (30 July 2018); (4) Months calculated from points 2 and 3 were added, thus determining total time free general healthcare coverage was provided to all undocumented immigrants in any respective AC; (5) To determine the percentage of time each AC provided free general healthcare coverage to all undocumented immigrants, total months calculated in point 3 were divided by the total study time frame (75 months) and multiplied by 100; (6) All calculations were made to ±10 days to round up to a month, if needed.

There was no need to develop a separate model to analyse level of access to HIV care for undocumented immigrants, because granting full access to free general healthcare services (the same as those available to citizens) includes HIV treatment. Thus, the model described in figure 1 was applied to analyse the level of access to HIV care.

Coding assumptions

For the purpose of this study, the following assumptions were made while coding selected indicators to determine level of access granted to free healthcare services to undocumented immigrants: (1) If requirement to present an identification was not specifically indicated by governmental instructions, it was assumed that a patient needed to show proof of identity during registration for healthcare coverage as most services in Spain routinely require such identification; (2) If a governmental instruction stated that a patient must meet a specific requirement (ie, proof of residence, legal identification) but did not explain how it should be proven, it was assumed that documentary proof would have to be provided and verbal declaration would not suffice; (3) In case of the need for 'Identification' and a 'Proof of Residency Certificate', it was assumed that a patient had to provide these documents; (4) If free full coverage was provided to undocumented immigrants, it was assumed that HIV care was included in the plan (unless otherwise stated); and (5) It was assumed that HIV care was provided when a governmental instruction referred to coverage of diseases under epidemiological surveillance, infectious illnesses, diseases of obligatory declaration, diseases impacting public health or diseases creating a social emergency.

Coding of access provided to undocumented immigrants in each AC was based only on the information written in the governmental documents, not on verbal testaments by any contacted public health officials or NGO representative of the seven ACs.

Patient and public partnerships

No patient or individuals from the public was involved in this study.

RESULTS

Level of administrative barriers to accessing free general and HIV healthcare services among undocumented immigrants

According to the 2012 RDL and RD, undocumented immigrants were to be denied access to free healthcare services if certain requirements were not met.[1 2 4–6] However, due to the decentralised nature of the Spanish health system, the implementation of this national policy depended on the interpretation by each AC. The results below describe the governmental instructions developed by each AC from April 2012 to July 2018. We assessed level of access to free healthcare granted to undocumented immigrants by each AC according to the restrictions the instructions entailed. In total, 22 documents issued by the seven ACs were identified. Fifteen were governmental instructions (one was an internal document), three were new programme documents (one was an internal document), two were decrees and two were orders. Out of 22 instructions across the seven ACs, 12 (55%) required minimum months of proven residency in the AC to have access to free general healthcare services. All ACs aside from Andalucía required some type of identification. All ACs aside from Galicia enacted at least one instruction that granted access to free general healthcare to all undocumented immigrants at one point during the study time frame. Table 2 provides a summary of the policy actions

Table 1 Indicators of level of free access for general healthcare in each AC

Level of access	Access level indicators	
	Instructions on undocumented immigrants' right to free general healthcare coverage	Identification and proof of residency requirement
High	Instructions highlighted the right of all undocumented immigrants (without categorisation) to free general healthcare services.	Instructions stated that identification and proof of residency in the AC were not required during the whole study time frame.
Medium-high	Instructions highlighted the right of all undocumented immigrants (without categorisation) to free general healthcare services during 76%–90% of the study time frame.	1. During 76%–90% of the study time frame required proven residency in a respective AC between 0–3 months; 2. Any type of identification document.
Medium	Instructions highlighted the right of all undocumented immigrants (without categorisation) to free general healthcare services during 51%–75% of the study time frame.	1. During 51%–75% of the study time frame required proven residency in a respective AC between 0–3 months; 2. Any type of identification document.
Medium-low	Instructions highlighted right of all undocumented immigrants (without categorisation) to free general healthcare services during 50% of the study time frame.	1. During 50% of the study time frame required proven residency in a respective AC between 0–3 months; 2. Any type of identification document.
Low	No published instruction highlighted the rights of all undocumented immigrants (without categorisation) to free general healthcare services.	N/A.

AC, autonomous community.

taken in each AC during the study time frame (total of 75 months), as well as level of access granted to free general healthcare among undocumented immigrants calculated according to the model in figure 1. Variations in access to HIV care were also noted in table 2. Description of the documents are presented in more detail in online supplemental table 1.

High access

Access level indicators: Governmental instructions of an AC highlighted the right of all undocumented immigrants (without categorisation, eg, pregnant women, minors, refugees, asylum seekers, cases of accidents or serious illness) to free general healthcare services and specifically stated that any type of identification and proof of residence in the AC was not required during the study time frame.

Andalucía

Among the seven ACs, Andalucía provided the highest access to free general healthcare services for undocumented immigrants, with the fewest systemic barriers (based on issued governmental instruction). Andalucía issued only one governmental instruction between April 2012 and July 2018. An official governmental instruction was issued on 6 June 2013 by the Ministry of Social Welfare (*Consejería de Salud y Bienestar Social*) of the AC providing temporary general healthcare assistance as part of the Public Health System of Andalucía, specifically for undocumented immigrants who earned a minimum wage or who were not covered by any other health insurance.[30] No proof of residency in the AC or identification card was required. While the instruction was developed to provide 'temporary free assistance' to undocumented immigrants, it was not replaced with any other official document. Andalucía continued providing free general healthcare assistance to undocumented immigrants under the instruction of 2013 document throughout the study period.

Medium-high access

Access level indicators: Governmental instructions of an AC highlighted the right of all undocumented immigrants (without categorisation) to free general healthcare services and required proven residency of 0–3 months during 76%–90% of the study time frame; and required any type of identification.

Euskadi (Basque Country)

Euskadi provided medium-high access to free general healthcare services for undocumented immigrants (based on issued governmental instruction). The AC issued three governmental instructions, one decree and one order between April 2012 and July 2018 in order to provide access to free general healthcare services to everyone in the AC. On 26 June 2012, Euskadi issued Decree 114/2012[31] to provide free general healthcare services to people who were no longer insured by any other public healthcare services and met the requirements set by the AC. The decree did not mention entitlements granted

Table 2 Summary of level of barriers to accessing free healthcare services and/or HIV care for undocumented immigrants in seven ACs of Spain

	Governmental document(s) issued after 2012 health reform on undocumented immigrants' access to free care by each AC (N)	Granted access to free healthcare coverage to all undocumented immigrants (% of study time frame)	Required identification (yes/no)	Required proof of residence (% of study time frame)	Required proof of residence (months)	Full coverage provided or separate instructions on infectious diseases such as HIV (% of study time frame)	Level of access
Andalucía	1	100	No	No (100)	0	Full coverage (100)	High
Aragón	4	64	Yes	Yes (64)	0–3	Full coverage (64); separate instruction (69)	Medium
Castilla-La Mancha	2	50	Yes	Yes (100)	0*	Full coverage (50)	Medium-low
Euskadi	5	81	Yes	Yes (76–90)†	0–3	Full coverage (81)	Medium-high
Galicia	4	6‡	Yes	Yes	N/A	Separate instruction (92)	Low§
Madrid	2	63	Yes	Yes (100)	0	Full coverage (100)¶	Medium
Valencia	4	51	Yes	Yes (51)	3	Full coverage (51)	Medium

*Castilla-La Mancha required proof of residence in the AC but without a minimum time requirement during 100% of the study time frame. However, all undocumented immigrants (without categorisation) were granted access to general healthcare services only during 50% of the study time frame; thus, the AC was considered medium-low access.
†Euskadi in the start required 1 year proof of residence in the AC (68% of the time study time frame), however free care could still be received through emergency room. The requirement was changed to 'proof of residence in the AC but without a minimum time requirement' during 11% of the study time frame.
‡Referred to the period between the enactment of 2012 RDL (20 April 2012) and the first instruction issued by the AC (31 August 2012). No instruction issued afterwards had granted access to all undocumented immigrants (without categorisation), which explains 'N/A' in the proof of residence requirement column.
§Galicia created separate instructions on infectious diseases, granting healthcare access to everyone in such cases, but if only the following requirements were met: if patients provided proof of residency, any type of identification and proof of not being covered by any other insurance. Compared with other ACs, the time and level of free general healthcare services granted to undocumented immigrants were different than those granted for HIV care. Specifically, in Galicia, access level for free general care was considered low whereas access level for HIV care was considered medium-high, according to the model in figure 1. As the instruction required presentation of proof of residency and any type of identification, access to HIV care was not considered high even though the calculated percentage of time coverage was 92%.
¶Madrid had a separate section on infectious diseases in its first instruction issued August 2012 stating that everyone should be provided access to HIV care. However, the same instruction did not grant access to free general healthcare services to all undocumented immigrants (eg, those not HIV-positive); thus, the level of access to free general healthcare was not in the same category as access to HIV care. For simple visual presentation, details on the level of HIV care in Madrid were provided in the same section of table 2 and online supplemental table.
AC, autonomous community.

specifically to undocumented immigrants, nor did it mention cases of uninsured patients with communicable diseases, including HIV.

Decree 114/2012 was partially suspended on 24 July 2012, by the constitutional tribunal. The suspension was partially lifted on 12 December 2012, with the copayment of medications removed and the rest left for consideration. However, the decree was again almost fully suspended on 20 December 2017 because it was considered to be outside of the competencies of the AC to give free healthcare services to all people otherwise not covered by 2012 RDL and RD.[32] An order with no legislative power was issued on 4 July 2013, with almost identical governmental instructions as Decree 114/2012.[33] Two subsequent governmental instructions issued on 22 August 2013[34] and 30 September 2013[35] were specifically dedicated to providing access to free general healthcare services to undocumented immigrants who were no longer insured by any other public healthcare services and who earned a minimum wage. Both governmental documents highlighted their right to access general free healthcare services regardless of whether they met the

pre-established 1-year residency requirement, especially the individuals seeking care who fell under the special categories of pregnant women, minors and in cases of accidents, serious illness, or infectious diseases.

Under the AC's instruction issued on 30 September 2013,[35] the undocumented immigrants who did not meet the 1-year residency requirement were assigned family doctors until discharge or until they complied with the requirements of the AC to receive a public insurance card. In 25 January 2018, a separate governmental instruction[36] was issued by the AC to decrease the magnitude of the requirements set by their previous governmental instructions. This instruction cancelled those of 22 August 2013 and 30 September 2013 and highlighted the entitlement of undocumented immigrants to free healthcare services without a minimum time of residency requirement; however, it did not specifically state language about access to HIV care or communicable diseases.

Medium access

Access level indicators: Governmental instructions of an AC highlighted the right of all undocumented immigrants (without categorisation) to free general healthcare services and required proven residency of 0–3 months during 51%–75% of the study time frame; and required any type of identification.

Aragón

Aragón issued four governmental instructions between April 2012 and July 2018. From 30 April 2013 to 9 August 2015, free general healthcare services were provided under AC's governmental instruction, which created the Program of Aragón for Social and Public Health Protection.[37] The programme did not specifically name undocumented immigrants as beneficiaries but referred to providing free general healthcare services to all people living in Aragón who were not covered by any other health insurance. This governmental document was cancelled on 9 August 2015 by a new governmental instruction, which specifically indicated the provision of free general healthcare services to undocumented immigrants and decreased the number of years required to be registered in the AC in order to access free care.[38]

Aragón also created two different governmental instructions specifically on diseases that required mandatory reporting or epidemic outbreak (part of epidemiological surveillance), including HIV. The AC's first instruction was created in 9 April 2014[39] and the second was published on 23 May 2017[40] cancelling the earlier round of governmental documents. Neither of the governmental instructions referred to undocumented immigrants specifically, but covered everyone who was not covered under any other health insurance and had a disease that was on the list of 'special cases'.[39 40]

Madrid

Madrid issued one official governmental instruction and one internal governmental instruction between April 2012 and July 2018. Both governmental instructions referred specifically to undocumented immigrants. According to the governmental instruction of 27 August 2012 HIV-positive undocumented immigrants could access relevant healthcare services free of charge because HIV was an 'Infection of Obligatory Declaration' and/or was on the 'List of Pathologies Included for Healthcare Purposes in Public Health Cases'.[41] All patients who received treatment before 31 August 2012 would continue receiving needed treatment without interruption, even if they were no longer eligible for public health insurance. Access to free general healthcare services for undocumented immigrants was provided only in cases of: (1) emergency due to serious illness or an accident; (2) pregnancy; (3) minor status; (4) asylum seekers; and (5) human trafficking victims. This was amended by the ACs internal governmental instruction of 2015 that granted access to free general healthcare services to all types of immigrants, including those without residence permits or health insurance.[42]

Valencia

Valencia issued three governmental instructions and one decree law between April 2012 and July 2018. First, official governmental instruction was published on 29 June 2012.[43] The governmental instruction mentioned undocumented immigrants as among the beneficiaries of the free coverage. However, access to free general healthcare services to undocumented immigrants was provided only in cases of: (1) emergency due to serious illness or an accident; (2) pregnancy; (3) minor status; (4) asylum seekers; and 5) human trafficking victims.

A second governmental instruction on 31 July 2013 initiated the 'Valencian Program to Protect Public Health', which aimed to provide free general healthcare services to all who were not covered by any other public health insurance (it did not single out undocumented immigrants).[44] Coverage was provided if a patient could provide all the documents listed in online supplemental table 1 or if a patient had an infectious disease of mandatory reporting. A third governmental instruction was published on 21 July 2015[45] and cancelled the governmental instruction of 31 July 2013.[44] The new governmental instruction named undocumented immigrants as a specific beneficiary of the free coverage and also decreased some requirements they had to meet compared with the prior governmental instruction.[45] The fourth governmental document was issued as a decree law on 24 July 2015[46] and was created to give procedural guidance to the implementation of governmental instruction of 21 July 2015.[45] The decree law was temporarily suspended in November 2015[47] and permanently so in December 2017[48] by the Constitutional Tribunal because it was considered to be outside of the jurisprudence of the AC to provide free healthcare services to all people otherwise not covered by 2012 RDL and RD.

Medium-low access

Access level indicators: Governmental instructions of an AC highlighted the right of all undocumented immigrants (without categorisation) to free general healthcare

services and required proven residency of 0–3 months during 50% of the study time frame; and required any type of identification.

Castilla-La Mancha

Castilla-La Mancha issued one order and established one govermental project between April 2012 and July 2018. The initial internal governmental instruction for the project was published in January 2013[49] and provided undocumented immigrants with access to free general healthcare services only to pregnant women and minors. On 23 February 2016, an order was published providing free general healthcare services to all undocumented immigrants.[50] Relevant free healthcare in those with communicable diseases was provided by redirecting an undocumented immigrant to the Department of Infectious Diseases. No specific governmental instructions were provided on how undocumented immigrants could access the care after contacting the department.

Low access

Access level indicators: No governmental instructions of an AC highlighted the rights of all undocumented immigrants (without categorisation) to free general healthcare services during the study time frame.

Galicia

Galicia had the lowest access to free general healthcare services among undocumented immigrants. Galicia issued three governmental instructions and established one governmental programme between April 2012 and July 2018 regarding access to free general healthcare services in the AC. The first governmental instruction was published on 31 August 2012 and aimed to provide access to free general healthcare services to everyone in the AC who was no longer covered by any public insurance.[51] Access to free general healthcare services to undocumented immigrants was provided only in cases of: (1) emergency due to serious illness or an accident; (2) pregnancy; (3) minor status; (4) asylum seekers; and (5) human trafficking victims. No specific requirements were set in this governmental instruction.

The second governmental instruction issued on 21 September 2012 established the Galician Program for Social Protection of Public Health (Programa Galego de Proteccion Social de Saude Publica, or PGPSSP),[52] providing the same coverage to undocumented immigrants as the previous governmental document. However, this second instruction clearly stated the specific requirements (among which were 183 days of proof of residency in the AC and a type of identification) a person had to meet in order to be granted access to free general healthcare services.

A third governmental instruction was published on 9 November 2012 specifically aiming to provide free healthcare services to patients with communicable diseases (including HIV).[53] This governmental instruction did not specifically name undocumented immigrants as beneficiaries, nor did it provide exemptions, in case the documents requested could not be provided by the patients trying to access care. A programme was created by the AC on 7 March 2013 to provide governmental guidance to employees of healthcare centres on who and how to enrol in PGPSSP.[54]

Level of access to HIV care

Five of the seven ACs (aside from Galicia and Madrid) fell under coding assumption number four described in the methods section; specifically, 'when all undocumented immigrants were granted access to free healthcare coverage it was assumed that access to HIV care was also granted during the same time'. As in the case of free general healthcare access, Andalucía provided high access to free HIV care to all undocumented immigrants; Euskadi provided medium-high access; Aragón and Valencia provided medium access; and Castilla-La Mancha provided medium-low access to all HIV-positive undocumented immigrants according to the time the ACs granted free general healthcare access to all undocumented immigrants.

Only Aragón and Galicia issued separate instructions dedicated to providing free healthcare coverage to everyone who had an infectious disease controlled under epidemiological surveillance. Despite separate instruction for providing care to everyone with infectious diseases,[39] Aragón still fell into medium access category, as the total time free general healthcare coverage was provided to all undocumented immigrants did not exceed 75% of the study time frame. In contrast, although Galicia was considered an AC that provided low access to free general healthcare coverage to all undocumented immigrants according to the developed model (see figure 1), in the case of access to HIV care, it fell under medium-high access. Because a separate instruction on infectious diseases[53] was issued on 9 November 2012 HIV care was provided to everyone during 92% of the study time frame. However, according to the instruction,[53] proof of residency (without a minimum time requirement) and any type of identification were still required, and HIV care could not be considered as high access even though the percentage of time frame coverage exceeded 90%. Madrid provided a high level of access to HIV care to all undocumented immigrants due to its first instruction issued in August 2012,[41] which singled out infectious diseases and granted free access to everyone with such illnesses. In table 2 and online supplemental table 1, Galicia is indicated as low access and Madrid as medium access due to the level of free general healthcare services provided to all undocumented immigrants.

DISCUSSION

This study extended prior research by Cimas *et al*[55] and Pérez-Molina and Pulido[56] with a focus on systemic barriers to free general and HIV-specific healthcare encountered by undocumented immigrants during the 6 years after

universal healthcare for undocumented immigrants was rolled back (2012–2018). We found the actual implementation of the restrictive national policy across ACs to be highly variable, but most studied ACs included some restrictions to free healthcare for undocumented immigrants. A key goal of this study is to draw attention to the systemic barriers faced by undocumented immigrants in accessing healthcare in Spain—and in Europe in general. Our study also points to the heterogeneity of the healthcare system in Spain which makes access to care difficult to navigate particularly among vulnerable populations.

The confluence of social, economic and political factors might have led Spain to enact the 2012 reform. The financial crisis of 2008 significantly affected Spain.[2 3] The impact of the crisis was evident through decreased economic growth, an increased ratio of public deficit to gross domestic product (GDP) compared with the average of EU countries (9.4% in 2011 compared with 4.4% of EU-27),[1] an increase in the percentage of the total population living below the poverty line (21% by 2012),[2] and skyrocketing unemployment rates.[2 3] Specifically, in 2013, 24.4% of all Spanish citizens (vs 8% in 2006) were unemployed, 30.3% (vs 9.4%) were unemployed among documented immigrants from EU countries and 40.4% (vs 12.1%) were unemployed among documented immigrants from countries outside of the EU. Specific data are not available for undocumented immigrants in Spain due to the lack of administrative status for this population. However, undocumented immigrants are usually worse off than documented immigrants.

In addition to the economic factors, social and political factors related to the increasing number of immigrants in Spain since 1998 might have also been in play.[57] The government in charge of the healthcare reform was led by the Popular Party, which newly swept into power in 2012. While this party traditionally represented the center–right wing of the political spectrum, nationalism and protectionism were rising fast in the face of the economic fallout from the 2008 financial crisis. The 2012 health reform targeting undocumented immigrants specifically could, thus, be seen as a strategy to cater to the more conservative base in the country.

Undocumented immigrants have found difficulties in accessing free healthcare in other European countries as well. Barriers vary from general discrimination to specific policies that restrict their access to free healthcare services. This phenomenon occurs despite the presence of conventions obliging EU member states to defend the human right to health.[58] Nevertheless, similar to the case of Spain, regional governments and/or local representatives of civil society across Europe have been working to fill in the gaps and create pathways for undocumented immigrants to access free care.[58]

The highly decentralised structure of healthcare in Spain is one reason for the differential implementation of 2012 RDL and RD in the seven ACs. In addition, we examined further the hypothesis by Cimas *et al*[55] that different governing political parties might also explain the variability in policy implementation. Because of the longer time frame of this study, many more changes in the political parties in the ACs were noted. Specifically, in Aragón, Castilla-La Mancha and Valencia, political parties in power changed from right-wing (governing in 2012) to left-wing (governing after 2015). The new governments of the ACs issued official instructions to lower the structural barriers set for undocumented immigrants to access free healthcare services. Andalucía provided the highest access to free healthcare services for undocumented immigrants and, notably, it was governed consistently by the left-wing political party during the course of the study. Galicia provided the lowest access and had a right-wing political party in power throughout the study time frame. Less drastic changes were present in the barriers set by governmental documents in Madrid (medium access; right-wing government) and Euskadi (medium-high access; coalition of right-wing and left-wing coordinated government), where shifts in political parties did not occur during the study time frame.

Though more accessible alternative pathways to free healthcare services for undocumented immigrants may appear to have been created during time periods in which left-wing parties governed an AC, we find that governing political parties may not fully account for differences across the seven ACs. In two ACs, for example, incremental expansion to healthcare access for immigrants was still present in the case of a governing coalition of political parties (Euskadi) or in the case of a right-wing government (Madrid). Euskadi was consistently governed by a collaboration of right-wing and left-wing parties, which could explain the somewhat steady medium-high access. In the case of Madrid, it could be argued that a medium level of access during right-wing governing party rule may be due to the influence of NGO coalitions and civic organisations that are concentrated in the capital.

Another possible explanation for cross-regional differences in the implementation of the national healthcare reform may be seen through a human rights-based lens. The United Nations considers healthcare access to be a human right, and all states have the duty to provide such access to all populations in a non-discriminatory way, taking into account physical accessibility, affordability of the services, access to information needed to seek care and the opportunity to receive or share personal information without fear of a lack of confidentiality.[59] Our review of regional documents showed that four of seven ACs (Andalucía, Aragón, Euskadi and Valencia) indicated the notion that ‘everyone has the right to health protection’ (which is also guaranteed by the Constitution of Spain) as one of the main rationales of the guidelines.,[30 31 36 38 40]

In contrast to a human rights point of view, we also found that the governments of some ACs provided free healthcare services due to the threat of infectious diseases to the general population. This rationale was evident in several governmental instructions published during the time frame of this study in Aragón, Galicia and Valencia.[37 39 44 51 53] This might explain why Galicia

provided low access to free general healthcare services even though it provided medium-high access for all HIV-positive undocumented immigrants. More research is warranted on the general attitudes of the ACs on the motivations behind granting or restricting the right to free healthcare among undocumented immigrants.

While the focus of this study was on the regional implementation of the 2012 Spanish healthcare reform with regard to immigrant access to healthcare, and not on the effect of said policies on actual health outcomes, it is important to note that health budget cuts have been previously found to impact the accessibility and quality of care provided.[24] The decrease in access to free services often impact the poorest populations, among whom undocumented immigrants are included. After 2008, a sharp increase in suicide rates, mental disorders and other causes of death was found across Europe.[24] Economic crises as such have been found to increase the burden of morbidity and mortality, especially among immigrants,[4] as caused by various stressors (eg, unemployment, delay in seeking preventive care or treatment).[24 60 61] In 2010, Spain's total healthcare expenditure was 9.6% of the GDP; of this, 74% was related to public healthcare.[2] The percentage of GDP spent on Spain's healthcare was already below the Organization for Economic Co-operation and Development average for the same year.[1] Nevertheless, the government decided to reduce the budget for health and social services by 13.7% in 2012,[2] and this reduction was swiftly followed by the 2012 RDL and RD.[1]

There are some limitations to this study. First, we included only 7 out of 17 ACs; thus, the results might not be generalisable across Spain. All ACs were contacted; however, only seven responded. One possible reason could be the selected contact method, which was limited only to personal relationships of the investigators. Nevertheless, the study consisted of three (Andalucía, Madrid and Valencia) of the four biggest ACs by population size.[62] In addition, six of seven ACs (Madrid, Andalucía, Valencia, Aragón, Euskadi and Galicia) were among the 10 ACs of Spain with the largest immigrant populations.[62] According to recent statistics, approximately 52% (173 909) of the newly arrived immigrants in Spain (total 333 777) settled in the seven ACs selected for this study.[62] A second limitation of this study is that we cannot extrapolate the findings to actual practices at the clinic level. Further research will be needed to examine policy implementation at a more granular level, given evidence of denial of care even when individuals are entitled to it.[27 28] In addition, more research is also warranted to examine the actual health outcomes of undocumented immigrants in general and as a function of policy changes, considering previously found connection between legal restrictions and health outcomes of immigrants.[1 9 10 21 22]

CONCLUSION

This study shows that 2012 RDL and RD were implemented unevenly across the seven ACs. The results demonstrated that healthcare access was restricted by most ACs for undocumented immigrants in 2012–2018; however, the level of restriction varied across ACs. Discrepancies between national and regional policies, as well as variations across ACs, may be explained by the decentralisation of the Spanish healthcare system, the political atmosphere nationally and in different parts of the country and the varying emphasis of health as a human right versus disease containment perspective in each AC. Over time, almost all of the ACs under study passed governmental policies and instructions that granted significantly more access to free healthcare coverage than the 2012 RDL and RD policies enacted by the central government, though many barriers persisted.

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