CENTRO STUDI SUL FEDERALISMO
PERSPECTIVES ON FEDERALISM

ISSN: 2036-5438

Constitutional bases in the federal conflict over access to health care of undocumented immigrants in Spain

by

Irene Sobrino Guijarro*

Perspectives on Federalism, Vol. 6, issue 2, 2014

Abstract

In Spain, over the last thirty years, the powers of "Autonomous Communities" to guarantee welfare and social rights have witnessed exponential proliferation. Such expansion has occurred within the wider processes governing the transfer of powers from the central level and the consolidation of the political autonomy of "Autonomous Communities." For instance, the vast majority of legislative powers in the social sphere are allocated to different levels of government according to a shared pattern, whereby the central level establishes framework legislation to be complemented and implemented by each of the "Autonomous Communities". However, the practical difficulties of determining the scope of legislative competences within such a shared logic are a permanent source of intergovernmental and constitutional conflict in Spain.

This paper seeks to analyse some of the constitutional coordinates that frame the federal tensions that have arisen from the last national legal reform, which have drastically curtailed the right to free health care for undocumented immigrants in Spain. The Spanish case illustrates the efforts of the Constitutional Court to conciliate unity and diversity in the legal design of health care, and highlights the crucial constitutional role of the subnational levels of government in preserving social inclusion policies in a context of general welfare retrenchment.

Key-words

Federalism, "Autonomous Communities", right to health care protection, irregular immigrants, human rights

1. Introduction

The "social" orientation of the Spanish State is configured as a constitutional goal whose fulfilment is not only binding upon the central level of government, but, very importantly, it also entails a constitutional responsibility for each of the seventeen "Autonomous Communities" comprising the Spanish asymmetrical federalism. In this regard, the "welfare state" principle involves legislative commitments at both levels of government in accordance with the constitutional allocation of powers. At the subnational level of government, the competences on welfare and social rights have witnessed an exponential proliferation within the wider processes of transfer of powers from the central level and the consolidation of the political autonomy over the last thirty years. In particular, the vast majority of competences on the social sphere is allocated according to a shared or concurrent pattern between the two levels of government. The practical difficulties to determine the scope of legislative competences on each subject and, specifically, the complaints of the "Autonomous Communities" (hereinafter, *AA.CC.*) over the interference of the central level in their own sphere of legislative power, have constituted a permanent source of intergovernmental constitutional conflict.

This paper seeks to analyse some of the constitutional coordinates that frame the federal tensions over the last national legal reform that drastically curtailed the right to free health care for undocumented immigrants in Spain. Specifically, the Spanish case illustrates both the complexities and the recent constitutional dialogue between the levels of government and the Constitutional Court on the federal conciliation of unity and diversity on welfare, where subnational entities share legislative powers to co-define how social policies should be fulfilled in their own territories. **Part I** provides an overview of the legal amendments on the access to health care for undocumented immigrants in Spain. In **Parts II** and **III** the constitutional parameters defining the content and scope of the right of undocumented immigrants to receive health care attention in Spain are identified. To this end, firstly, it is carried out an analysis of how the International and European instruments of human rights protection that have been ratified by Spain articulate this question. Secondly, the Spanish constitutional case-law on the rights' of foreigners and on the allocation of shared competences on health care are examined and explained. In **Part IV**

the main parameters at issue (i.e. rights and competences) are contextualized within the specific terms that have channelled the constitutional conflicts between the central Government and some of the *AA.CC.*, paying particular attention to the Basque Country case and the upholding of the Constitutional Court of its measures addressed to keep on granting health care to irregular immigrants.

2. Summary of the legal reform

On April 2012, a structural reform of the Spanish National Health Care system was enacted. The reform was introduced by *Royal Decree-Law* 16/2012 of 20 April 2012, *concerning urgent measures to guarantee the sustainability of the National Health System and to improve the quality and safety of its services* (hereinafter, *RDL 16/2012*)[I]. On its Preamble, the *RDL* justified the amendments as required measures for a stricter health spending control, in order to increase the sustainability of the system and the efficiency in its management. Fundamentally, the changes to regulations on the provision of health care were applied on the three following areas: (1) the concept of insured persons entitled to health care and that of the beneficiaries of those persons, (2) the portfolio of health services provided by the National Health Care system, which got divided according to different categories, and (3) the financial contributions to be made by the insured person and their beneficiaries to pharmaceutical services (by introducing the so-called "co-payment").

One of the changes introduced by the *RDL* is the requirement of legal residence to non-EU migrants in order to have access to free health care, limiting such access for irregular migrants to emergency, maternity and childcare. This has entailed a deep transformation of the legislative framework existing so far in Spain, taking into account that from 2000 and until 2012 migrants without a legal residence were fully entitled to health care in the same conditions as Spaniards, provided they were registered with their local census (*Padrón Municial de Habitantes*).[II] This former regulation, which did not link health provision to legal residence, represented the start of a process towards the universalization of health protection in compliance with the constitutional design of health care as a public and universal service (Article 43 SC).

According to an earlier legislative scenario on the subject (since 1986), foreigners enjoying legal residence in the Spanish territory were entitled to health care assistance,

while the non-resident would only be entitled to this right insofar and in the extent provided by legislation and international covenants[III]. The Organic Law 4/2000 on foreigners in Spain conducted a radical change for these to have access to health care, since it replaced the requirement of legal residence with that of mere registration on the local population census[IV]. On the grounds that the registration on the aforementioned local census did not require the legal residence in the country, but just a permanent home address, the right to health care got decoupled from the requirement of legal residence and, therefore, irregular immigrants could be included within the personal scope of the right to health care. Until 2012 this was, in a nutshell, the articulation of the basic regulatory framework that allowed foreigners to have access to health care in the same conditions as Spaniards, provided the requirement of registration in the local census was fulfilled.

Undoubtedly, the recent reform, by conditioning access to free health care to the fulfilment of legal residence, has implied a substantive regression on such a process of universalization. Specifically, since 2012, the concept of "insured" persons entitled to health care refers to employees, to those who receive any type of periodic social security benefit, and to people whose unemployment benefits have run out. Additionally, the new legislation defines a residual entitlement on health care for those who cannot be considered "insured" according to those parameters and, provided they reside legally in Spain, have an annual income below a certain economic threshold[V]. Consequently, it has been supressed the previous legal possibility to access health care for migrants that were registered at a local census and provided evidence of insufficient economic capacity.

Exceptionally, the new regulation allows for undocumented migrants to gain access to health care should they be in any of the following "special situations": (a) in case of urgency because of a serious illness or accident; (b) assistance to pregnancy, childbirth and postpartum and, finally, (c) full access to free health care will be provided to those migrants who have not attained eighteen years of age.

Additionally, in the event that the conditions to be considered "insured" or "beneficiary" entitled to health were not met, health services could alternatively be provided through the payment of the actual cost of the health service, or through the payment of a subscription fee within the framework of any of the "special agreements" established by the health reform. As a prerequisite allowing for the subscription of the agreement, it is necessary to have enjoyed a prior one-full year inscription on the local

census, thus irregular immigrants could theoretically fit into this option. The subscription of any of the "special agreements" would grant access to the basic common portfolio of health services provided by the National Health system. Besides, the "Autonomous Communities", in accordance with the decentralized provision of health care, may complement the national basic range of health services with additional services and benefits.

Some social organizations have criticized the restrictive character of the protection channelled by these agreements. Among other questions, it is underlined that they would not allow the subscribers to access either the additional or the common portfolio of accessory health services, which therefore should be defrayed by the immigrant[VI]. At the same time, the legal requirement of sustaining a continuous payment of certainly high fees would entail a further hurdle for social groups particularly prone to suffer severe economic and labour precariousness[VII]. Furthermore, the fees legally established have a basic or minimum nature for the whole country, which implies that these could be eventually raised in the territory of any given "Autonomous Community". The absence of either standardized fees for the whole country, or a maximum ceiling for the fees that could be required by Health Administrations of the *AA.CC*, further deepens on the weakened legal protection and material obstacles to access health care by one of the most vulnerable groups in society[VIII].

3. Human rights law and health protection of irregular immigrants

The aim of the following section is to identify the core of binding elements in the area of access to health care for undocumented immigrants, arising from some of the International and European conventions to which Spain is a party. The relevance of these instruments as binding interpretative tools is certainly prominent since, according to Article 10.2 SC, the fundamental rights recognised by the Constitution must be interpreted in conformity with the international treaties of human rights protection ratified by Spain.

3.1. International human rights instruments

Numerous international instruments recognize the right to health care, with independence of the individual legal status or nationality. The Universal Declaration of

Human Rights enshrines that "everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services" (Article 25)[IX]. In a more specific way, the International Covenant on Economic, Social and Cultural rights adopted by the United Nations in 1966 and that has been ratified by all Member States of the European Union, establishes in its Article 12 "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health". The interpretation that the Committee on Economic, Social and Cultural Rights (CESCR) has applied to this Article departs from the assessment of health as "a fundamental human right indispensable for the exercise of other human rights"[X]. According to the Committee, the content of the right to health would entail the right to enjoy a series of services and necessary conditions to attain the highest possible level of health. Specifically, the States parties must guarantee that the provision of health care contains the essential elements of availability, accessibility, acceptability and quality[XI]. The specific content of the concept of accessibility, which is divided into four dimensions, is particularly interesting: (a) non-discrimination, health facilities and services must be accessible to all, especially to the most vulnerable or marginalized sections of the population; (b) physical accessibility; (c) economic accessibility (affordability) of health services for all, including socially disadvantaged groups, in a way that the poorer households should not be disproportionately burdened with health expenses as compared to richer households; (d) information accessibility to questions related to health issues. Very importantly, the CESCR establishes the specific legal obligation for States to respect the right to health by refraining from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum seekers and illegal immigrants, to preventive, curative and palliative health services[XII]. Therefore, the Committee defines a content of the right to health in which the collective of irregular immigrants is included. Also, the minimum content of the right to health includes a more complete range of health services, going beyond the mere emergency attention.

The "International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families"[XIII] is an important instrument of international human rights protection that specifically deals with the protection of the needs of migrant workers, either with a regular or irregular status. Its Article 28 recognizes the right of migrant workers to receive any urgent medical care that shall not be refused by reason of any

irregularity with regard to stay or employment. According to literature, the most important aspect of this Article is the prohibition of States parties to refuse urgent health care to undocumented migrants. However, two questions should be emphasized. In the first place, medical assistance is limited to the emergency one, thus either the medical follow up or the preventive health care would not be included here (Bell 2010: 156-157; Cholewinski 2005: 48; Da Lomba 2004: 379). In the second place, it must be underlined as well that this Treaty has not been ratified yet by any of the main immigrant-receiving countries in Europe or by North America. One of the reasons justifying the lack of ratification in the EU may lie in the fact that the individual ratification by any of the Member States could potentially enter into conflict with the nucleus of policies related to the control of immigration in the Union (Bell 2010: 157).

3.2. European human rights instruments

1. European Convention of Human Rights

In contrast with the numerous complaints existing on the subject of social security, very scarcely the European Court of Human Rights has had the chance to deliver decisions over complaints where the applicant has claimed the right to health care services on the grounds of the State's direct or indirect responsibility causing any illness or worsening of health conditions (Clements and Simmons 2008: 417). In particular, Decisions regarding the scope of the right to health of irregular immigrants have been very few, since most of the cases were circumscribed to residence rights, typically when the immigrant was contesting a national decision to be removed to a third country (Bell 2010:159). However, out of the existing decisions, it is possible to identify some jurisprudential body with relevant interpretative criteria for the area of health assistance of undocumented migrants.

Firstly, the Court of Strasbourg has held that the denial of medical treatment under circumstances of urgency may constitute a breach of the obligation of the State to protect the right to life enshrined in Article 2 of the European Convention of Human Rights. However, the identification by the Court of positive obligations from public powers with regard to the provision of health care ("when there is a real an effective threat to life")[XIV], has remained on a theoretical level since the Court did not infer the existence of a violation of Article 2 in the submitted complaints so far[XV].

Secondly, the Court has held that the suffering caused by an illness, physical or mental,

may be included within the protective scope of Article 3 (prohibition of torture, inhuman or degrading treatment of punishment) when it is, or risks being, exacerbated as a result of conditions of detention, expulsion or any other measure for which the authorities can be held responsible[XVI]. Therefore, under certain circumstances, the refusal to provide health care to an immigrant has entailed a violation of Article 3 from the State [XVII]. However, more recent cases show that Decisions considering the violation of Article 3 within the context of decisions of expulsion affecting individuals with aggravated health conditions have been applied very strictly and therefore, have an exceptional nature[XVIII].

Finally, the Court has also held that the decision to remove from the country a immigrant with a serious pre-existing mental illness could constitute a violation of the right to private life (Article 8 of the Convention), on the grounds of the adverse consequences that the administrative decision may have on the mental stability, considered by the Court as an element of the moral integrity protected by Article 8 [XIX].

While these Decisions have held the public power responsibility to grant certain levels of health care for irregular immigrants, it has to be noted that the factual contexts in which the Court has identified violations of Articles 1, 3 and 8 have in common the existence of extreme seriousness of the medical conditions of the immigrants. It thus shows that the threshold set by the Court to affirm the public power responsibility on the health circumstances is certainly very high (Clements and Simmons 2008: 419; Da Lomba 2004: 385).

2. The European Social Charter

The European Social Charter, adopted in 1961 and revised in 1996[XX] is an instrument of human rights protection that complements the European Convention of Human Rights by recognizing a catalogue of social and economic rights. Specifically, Articles 11 and 13 of the Revised European Social Charter enshrine the right to health[XXI]. One of the hurdles for its application to irregular immigrants lies in its personal scope of application, which is restricted to foreigners who are nationals of other Contracting Parties and who are lawfully resident or working regularly within the territory of the Party concerned[XXII]. Therefore, the rights contained in the Charter are not extensive to third countries nationals.

In the case *International Federation of Human Rights Leagues (FIDH) v. France* (2003)[XXIII], the complaint questioned whether a legal reform in France limiting the health assistance of

irregular immigrants was contrary to the European Social Charter. According to the new regulation, any person without lawful residence who had stayed in France for less than three months would only receive medical treatment in case of emergency where there was a life threat. In those cases where the residence in France was longer than three months, medical assistance would be applicable, but the expenses would be covered by the patient: a flat-rate charge would be payable in respect of non-hospital treatment and a daily charge for hospital stays.

FIDH claimed that France had violated the right to medical assistance (Article 13) by ending the exemption for illegal immigrants from charges for medical and hospital treatment. Additionally, the complainant alleged that the rights of children and young persons to protection (Article 17) were contravened by the legal reform that restricted access to medical services on children of illegal immigrants.

While Charter rights do not extend to undocumented immigrants, the European Committee of Social Rights emphasized that the Charter must be interpreted in a manner that is consistent with the principles of individual human dignity and that any restrictions should consequently be read narrowly. Regarding the personal scope restriction, the Committee departs from the premise that it has a differentiated impact on each of the social rights and, under the circumstances of the case, it affirmed that it "treads on a right [right to health care] of fundamental importance to the individual since it is connected to the right to life itself and goes to the very dignity of the human being"[XXIV]. By considering that "health care is a prerequisite for the preservation of human dignity", the Committee held that any legislation that "denies entitlement to medical assistance to foreign nationals, within the territory of a State Party, even if they are there illegally, is contrary to the Charter" [XXV]. In particular, the Committe found no violation of Article 13, on the grounds that illegal immigrants could access some forms of medical assistance after three months of residence, while, in the rest of the cases, illegal immigrants could at any time obtain treatment for emergencies and life threatening conditions. However, the Committee did find a violation of Article 17, since the fact that children shared similar restricted conditions to access health care as adults according to the legal reform, meant an infringement on the general and reinforced protection that the Revised Charter granted to children and young persons, including minors, to care and assistance [XXVI].

Although this Decision held the possibility of extending the rights of the Charter to

illegal immigrants, it has been to date the only case in which the Committee has applied an extensive interpretation of the personal scope. Therefore, it has been pointed out that, arguably, the application of this principle may be limited to those rights that are intimately linked to protecting fundamental human dignity (Bell 2010: 159).

4. Immigrant's fundamental rights and competences on health care: constitutional case-law

4.1. Constitutional case-law on the rights of foreigners in Spain

Article 13.1 of the Spanish Constitution establishes that "*Foreigners in Spain shall enjoy the public freedoms guaranteed by the present Title, under the terms to be laid down by treaties and the law*". The Spanish Constitutional Court has interpreted this provision, setting up a threefold classification of the aliens' rights[XXVII]. According to the Constitutional Court, Article 13.1 SC grants the legislator a remarkable freedom to regulate the rights of foreigners in Spain, by enabling the establishment of specific conditions for their exercise. However, the scope of legislative manoeuvre would be shaped by three basic parameters: a regulation of this type should take into account, firstly, the degree of connection of certain rights with the guarantee of human dignity (Art. 10.1 SC); secondly, the compulsory content of the right when it is recognised that foreigners are directly entitled to it according to the Constitution, and thirdly, in any case, the content defined for the right by the Constitution and international treaties (Art. 10.2 SC). Finally, the conditions for the exercise of the rights provided by the law should lead to the preservation of other rights, property or interests which are constitutionally protected, and are suitably proportionate to the final purpose.

In the first place, the Constitutional Court has identified a group of rights that corresponds to foreigners through constitutional mandate and where any legislative treatment other than the one accorded to Spaniards would not possible. The entitlement to exercise such rights belongs to the person as such and not as citizens, since they are essential to ensure human dignity. This group would include the right to life, physical and moral integrity, ideological freedom, but also the right to effective judicial protection, the right to free legal aid and the right not to be discriminated against on grounds of birth, race, sex, religion or any other personal or social condition or circumstance.

The second group refers to those rights directly recognized by the Constitution for foreigners (specifically with respect to the rights to assembly and association). According to the Constitutional Court, this implies that the law cannot deny such rights to foreigners, although it can establish "additional conditioning factors" with respect to the exercise of those rights by foreigners. However, in all cases constitutional prescriptions should be observed, as the legislator cannot freely configure the content of the right when this has been directly recognised by the Constitution as a right of foreigners.

The Constitutional Court has identified a third category of rights to which foreigners are entitled to the extent and in the conditions established in treaties and laws. These rights are not directly attributed by the Constitution to foreigners but the legislator may extend to non-nationals "although not necessarily in identical terms to those described for Spaniards". In regulating such rights lawmakers enjoy wider freedom, as they would be able to modulate the conditions of their exercise "based on the nationality". This would be the case of the right to work, the right to health and the right to receive unemployment benefits. However, it is important to underline that, according to the Constitutional Court, the possibility for the legislator to establish "restrictions and limitations" is not unconditional, since those measures cannot affect the rights that are essential to ensure human dignity (Art. 10.1 SC), or the content defined for the right by the Constitution or international treaties to which Spain is party. Moreover, the legislative freedom is also restricted in that the conditions for exercising these rights and freedoms of foreigners will only be constitutionally valid if they are designed to preserve other rights, property or interests which are constitutionally protected and which are proportionate to the intended purposes.

4.2. Constitutional case-law concerning the allocation of powers on health care

The Spanish Constitution enshrines the "social" character of the State in its Preliminary Title: "*Spain is hereby established as a social and democratic State subject to the rule of law, and advocating as higher values of its legal order, liberty, justice, equality and political pluralism"* (Art. 1.1). The constitutional commitment with a social state refers to the entire political organization and, therefore, it is equally addressed to both the central political level and to the subnational political levels in Spain.

The social nature of the political organization as a whole is configured as a transversal fundamental goal that is shaped through different constitutional clauses throughout the entire text. In this regard, it should be underlined Article 9.2, which imposes upon all public powers the obligation to promote the conditions ensuring that the freedom and equality of individuals and of the groups to which they belong, may be real and effective. Additionally, the respect and protection of the "*Governing Principles of Economic and Social policy*", which include most of the social and economic rights, are addressed to public authorities in general.

In congruence with this framework, the constitutional regulatory frames of the *AA.CC.* (the so-called "Statutes of Autonomy") do enshrine the social and democratic character of their political organizations. One of the most remarkable characteristics of the last wave of reforms of the Statutes of Autonomy -starting in 2006- has consisted on the incorporation of wide bills of social rights as mandates for positive actions by the public powers, although only exceptionally they do also entail proclamations of subjective rights in the stricter sense[XXVIII].

From the viewpoint of the allocation of powers between the two political levels, the centre of gravity regarding the implementation of social policies lies in the subnational level of government. However, the central state is constitutionally granted a reinforced legislative position with regard to the design of the nuclear questions of social competences, which are structured according to a generic "shared logic": either through the "*concurrent*" or the "*shared*" powers. Under the "concurrent" competences both levels exercise their legislative powers on the same subject, but focusing on diverse aspects of its regulation. The issue is thus shared, dividing it into functional spheres (competence on the "legal bases" for the central state/ competence on the legislative development and administrative implementation for the *AA.CC.*). In general terms, this is the case for education (Art. 149.1.30 SC), health care (Art. 149.1.16 SC) and social security (Art. 149.1.17 SC). In the case of the "shared competences", the State exercises its legislative powers on the subject while the *AA.CC.* exercise their executive powers on it. This pattern is applied, for instance, on labour legislation (Art. 149.1.7 SC), and on the external health measures and legislation on pharmaceutical products (Art. 149.1.16 SC). In addition, the national level has very often resorted to the so-called *transversal* or *horizontal* powers, aimed to guarantee either a certain degree of equivalence or uniformity in the basic conditions of

exercise of rights in the whole country (Art. 149.1.1. SC), or the possibility of a regulatory intervention in questions that have an impact on the general economic policy (Art. 149.1.13 SC).

This synthetic description of the coordinates along which the legislative definition and implementation of social policies take place, already suggests an intertwined constitutional scenario prone to generate conflicts over competences between the two political levels of government. In this context, the interpretative role of the Constitutional Court has been decisive in order to determine the actual scope and limits of both the national level and the *AA.CC.* in the joint exercise of the shared powers. The right to health protection is recognized in Article 43.1 of the Spanish Constitution. The second paragraph of this provision adds that it is incumbent upon the public authorities to organise and safeguard public health by means of preventive measures and the necessary benefits and services. In addition, public authorities will promote health education, physical education and sports, as well as the proper use of leisure time. Health is, therefore, recognized as a constitutional value that should be protected by the legislation, both in its individual dimension (right to health protection), and in its collective one (public health protection).

The right to health care belongs to the constitutional category of the "*Governing principles of economic and social policy*" (Arts. 39-52 SC), which must be recognized, respected and protected by the substantive legislation, judicial practice and actions of the public authorities, of both the central level and the "Autonomous Communities". However, the binding effect of these principles is downgraded since they may only be invoked in the ordinary courts in the context of the legal provisions by which they are developed (Art. 53.3 SC).

In addition, the individual appeal for protection to the Constitutional Court ("*recurso de amparo*") is restricted as a constitutional procedural guarantee for the so-called "*fundamental rights and public liberties*" (Arts. 14-30 SC). Nevertheless, in light of the constitutional case-law, some of the social rights have enjoyed this protection on the grounds of their connection to different fundamental rights, as it is the case with the right not to be discriminated of Article 14, the fundamental right to the effective judicial protection of Article 24, and various fundamental civil and political rights (Díaz Crego 2012).

As it was mentioned above, according to the constitutional case-law on the constitutional rights of foreigners in Spain, the right to health care is framed within one of

the categories where the legislator enjoys a wider margin to determine the conditions for their exercise. In this regard, the legal reform on health has amended the conditions for non-EU migrants to enjoy the right to health care, by replacing the requirement to be registered in the local census by that of legal residency. Additionally, the access to health care on the grounds of insufficient economic capacity has become equally subjected to the legal residency.

From the viewpoint of the allocation of powers on health, the political and constitutional praxis of the "concurrent" logic on this matter has turned out to be particularly complex and has generated a high quantity of conflicts of competence between the two political levels of government. One of the origins of this complexity is due to the high degree of vagueness with which the Spanish constituent designed the model of distribution of competences. Questions such as the content, the scope or the intensity of the concept of the basic or framework competence, were left almost completely undefined, leaving the problem opened to a further concretion by the Constitutional case-law.

Another cause of the high degree of confrontation lies in the own logic of this mechanism: the determination of the space of intervention of one of the legislators directly conditions the space of intervention of the other one. It thus implies a situation of reciprocal dependence where the theoretical scope attributed to the notion of "legislative or legal bases" constitutes a fundamental parameter, as it is going to determine the space of intervention of both legislators.

The Spanish Constitutional Court has adopted from an early case-law a concept of "legal bases" in which a "material" and a "formal" dimension coexist: the scope of the regulation must be oriented and limited by certain principles (*material* dimension of bases), and at the same time these must be legislated by the country's Parliament (*formal* dimension).

The Constitutional Court's case-law regarding the basic competence on health care has been particularly relevant, since it has had an impact beyond this concrete subject and has contributed to the shaping of a general doctrine on "legal bases" focused on a greater intensification of its formal elements[XXIX]. However, with regard to the material component of the "legal bases", the subject of health care has not been subtracted to the recurrent problems that arise from the criteria used by the Court in order to identify the *material* scope of the "basic legislation".

Particularly, the constitutional case-law has identified the basic legislation on health care with the "minimum regulation" that can guarantee the "equality of all citizens in the exercise of the right to health"; or with the one that provides "unity" to the health system, or "establishes a common denominator in the subject". Certainly, these criteria do project imprecise and too wide definitions concerning what should be considered as the content of the "basic legislation". The application of these parameters has also been regarded as highly unsystematic and casuistic, making it difficult to infer a conceptual scheme that may act as an effective guarantee for the *AA.CC.* to legislate on the concurrent powers.

Logically, there is a complex set of problems associated to the goal of achieving certain objective and abstract definitions of the scope of the "basic legislation". Unanimously, the doctrine acknowledges the impossibility for the constitutional case-law to configure a strict and detailed determination of what the "basic legislation" is. Fundamentally, that is due to two reasons. In the one hand, the formulation of what is "basic" on a certain subject is likely to be altered by the changing reality and needs regarding a specific sector (García Morillo 1996: 127). But the question that hinders in a greater extent the establishment of objective definitions of the "basic legislation" lies in the intrinsic risks of *aprioristic* determinations of the legislative margin left for both the central state and the regional lawmakers[xxx].

In light of this context, some scholars have put forward possible solutions aiming to reduce the negative impact that the inherent characteristics of the basic legislation have had on the safeguard of legal certainty for *AA.CC (*Alberti Rovira 1991: 333-334; García Morillo 1996: 134). In a nutshell, part of the literature holds that the case-law should establish certain constitutional parameters with objective and reasonable stability, resulting from a process of clarification and systematization of the rules that the constitutional case-law has been applying within the framework of the conflicts of competence.

Another sector of the literature deems necessary the use of a "principle-oriented conception" to define the scope of central state power on "basic legislation" (De Otto 1988: 233; Viver i Pi-Sunyer 1990: 77). According to this viewpoint, the bases should be "norms of principles" addressed to the *AA.CC.*, containing the general principles, the guidelines or criteria of any given activity that should guide the regulation of a certain subject and would therefore channel its implementation: "*its definition must be based, not on the*

material elements needing of a standard regulation, but on the statement of the principles that the AA.CC. should respect when establishing the legislative development (…)" (Viver i Pi-Sunyer 1990: 97).

5. Constitutional appeals: the Basque Country case and the response of the Constitutional Court

Numerous *AA.CC.* lodged appeals of unconstitutionality against some of the most significant modifications carried out by the *RDL 16/2012, 29 of April* on the health care system[XXXI]. The claims against the legislative restricted interpretation of the conditions to access health care are present in all of them. On this specific question, there are fundamentally two main legal arguments in the appeals to sustain the lack of conformity with the Constitution of the health care amendment. In the first place, it is argued that the exclusion from free health care of certain social groups, as it is the case of undocumented migrants, entails an infringement of the "*Governing principle*" of Article 43 SC (that recognizes the right to health protection) interpreted together with Article 15 SC (right to life) and Article 14 SC (non- discrimination). In the second place, it is claimed that the centralized definition of the insured and the conditions of access to health care are too exhaustive and leave scarce legislative room for the *AA.CC.* to complement such a "legislative framework" of the central level.

The Government of the Basque Country, in addition to bringing a constitutional appeal to challenge the recently enacted legislation, took a further measure by passing a new regulatory framework on health care (*Decree 114/2012, 26 of June*, *on the provision of health care services by the National Health Care System in the territory of the Basque Country*). With regard to the personal scope of the right to health care, the goal of the Decree is to react before the recently enacted legislation. Specifically, it extends the scope of personal protection of the central state provisions, by granting access to health care to those people that have been registered in any local census in the Basque Country for at least a year, lack any alternative access to public health protection and provide evidence of insufficient economic capacity (Arts. 2 and 3 of the Basque Decree). As a result, the subnational regulation complements and widens the "basic legislation" on the access to health care, by applying the equivalent parameters on its territory (i.e. mere registration at the local census) that existed at the national level prior to the reform[XXXII].

On the 20 of July, the Government of Spain appealed the constitutionality of the Basque Decree by lodging a conflict of competence before the Constitutional Court. The Government alleged that, by diverging from the State's definition on the entitlement to access the health care provision, the Decree was interfering with the competence of the central level to establish the "basic" regulation on health care. As a consequence of the constitutional procedural privilege that the Government may resort to when contesting a regulation of an "Autonomous Community" (Article 161.2 SC), the effects of the Basque Decree were temporarily suspended.

The Basque Government appealed before the Constitutional Court the suspension of the contested provision. The Court, in light of the arguments put forward by the "Autonomous Community", upheld the Basque request and lifted the suspension of the Basque Decree through the *Order 239/2012, 12 of December*. It is necessary to underline that the Order of the Constitutional Court that upheld the request of the Basque country did not imply a final judgment on the substantive issues regarding the conflict of competence on health care between the central Government and the Basque Country. However, the reasoning of the Court at this point is very relevant insofar as it makes the universal access to health care prevail over the efficiency economic reasons claimed by the Government of the Nation to keep the suspension.

Specifically, the Constitutional Court, in order to assess the Basque Country request to lift the suspension on its Health Care Decree, carries out a balance of the general and particular interests at stake in the case. In this regard, the Court identifies a general interest in the economic benefits linked to the costs savings derived from the national measures restricting the access to health care. At the same time, it is recognized another general interest that lies in the public guarantee of health care, both in a collective dimension (public health) and in the individual right to health[XXXIII]. The Constitutional Court emphasizes the close interrelation between, on the one hand, the "*Governing Principle*" on the right to health protection (Art. 43 SC) and, on the other hand, the fundamental right to life and to physical and moral integrity (Art.15 SC), on the basis of what has been previously stated in its case-law and in the European Court of Human Rights[XXXIV]. The Court argues that "the general and public interests linked to the promotion and guarantee of the right to health care, do constitute interests associated to the protection of constitutional goods which are particularly sensitive". In particular, it reasons that, should

the suspension on the Basque Country Decree be kept, there could be concrete injuries "to the right to health and to physical integrity of the groups affected by the measure [specifically, the undocumented migrants, that would be prevented to keep on receiving free health treatments in the Basque Country], as well as public health risks for the whole society". The Court deems that the "singular importance of the interests at issue cannot be undermined by eventual cost saving arguments on health care that have not been put into concrete terms"[XXXV]. In this regard, the Constitutional Court argues that the lack of further specification from the central Government concerning the alleged economic efficiency of the measure restricting the access to health care, may be likely due to the actual inexistence of any sort of cost-saving deriving from the new legislative framework. The Court puts forward the thesis that restricting access to health care, far from implying a financial saving operation, may arguably just imply a transfer of costs from primary care to emergencies care.

In light of these considerations and carrying out a balance of the interests at issue, the Court claims that the concrete risks that the suspension of the Decree exerts on particularly important constitutional goods are not superseded by some abstract economic benefits that are not specified by the central Government. In coherence with this legal reasoning, the Court upheld the request of the Government of the Basque Country to lift the suspension of its Decree on health care that extended the level of entitlement to free health care granted by the central level.

6. Conclusions

It still remains uncertain what the actual reasoning of the Court will be on the pending conflict of competence between the Government of Spain and the Basque Country, as well as on the appeals of unconstitutionality lodged by numerous *AA.CC.* against the national health care reform. There are, however, certain interpretative patterns that have been implemented by the Constitutional Court and that may allow us to identify some of the constitutional coordinates that channel the federal tension between unity and diversity in the Spanish decentralized fulfilment of welfare state, focusing on the particular area of the articulation of access to health care.

With regard to the impact of the legal reform on the *constitutional fundamental rights*, it is possible to infer some concepts that should determine the material confines for the normative action and that, from the territorial viewpoint, should be respected on a nation-wide basis. As it was pointed out above[XXXVI], according to the constitutional case-law, the limits for the legislator to establish the conditions for the exercise of the right to health protection by foreigners in Spain, would consist of the content defined for the right by the Constitution and human right treaties, but it would also be contingent upon an assessment of proportionality criteria. In our opinion, the consideration of the legal reform in light of these parameters provides solid interpretative tools to sustain its unconstitutionality.

Both the Constitutional Court and the ECHR have stressed the close bond between, on the one hand, the right to health and, on the other hand, the fundamental right to life and physical integrity[XXXVII]. In particular, this singular connection would underlie the generalist formulation of the right to health in the Spanish Constitution ("*the right to health protection is recognized*", Art. 43 SC), which seems to recall the universalist terminology applied by human rights international treaties with regard to personal scope to health care protection. In a striking contrast with this approach, the legislative restriction of access to health care for undocumented migrants would not project any kind of integrative notion of health care provision. Actually, the new legislative conditions of access to health care do not just imply an increase of the *degree* or *level* of restriction for undocumented migrants. Instead, they entail a *substantial* change of the entitlement to access free and public health care, while projecting a real risk of exclusion over a whole social group whose legal status is actually defined by its irregular presence in the territory. Furthermore, the requirement to pay certainly high fees in order to subscribe the special agreements could contravene the "economic accessibility" as a essential part of the material scope of the right of everyone to health (Art. 12, International Covenant of Economic, Social and Cultural rights) as interpreted by the CESCR.

In addition, the new request of legal residency to access health care raises doubts about its constitutional validity from the viewpoint of the proportionality of such a reform with regard to its purpose. In this context, and given the instrumental connection between the protection of health and the right to life, it is highly questionable that the economic benefits portrayed as part of the general interests that the new measure may bring, can prevail over the damage to essential constitutional values and fundamental rights at issue.

Analysing the questions at issue from the viewpoint of the *allocation of shared competences* (i.e. legal bases from the State/legal implementation by the *AA.CC*), the Constitutional Court has stated that the determination of the conditions that entitle the persons to have access to health care, together with the definition of the common portfolio of health care services, belong to the conceptual sphere of the "bases", since these are addressed at establishing a "common legal ground that guarantees a uniform and equal access to health care for all citizens regardless of their place of residence within the country"[XXXVIII]. The constitutional role of the central level to establish the standardized or minimum conditions of access to fundamental rights for the whole territory is a common feature in current welfare states. The complexities of this question arise when the national legislation has to be contextualized within the natural dynamics of a federal system, where subnational levels of government share legislative powers to co-define how welfare state should be fulfilled in their own territories.

With regard to the allocation of competences on immigration, the Constitutional Court in its Decision on the Statute of Autonomy of Catalonia (31/2010, 28th of June) addresed for the first time the scope of the national level powers on immigration (Art. 149.1.2 SC). The Court declared the constitutional compatibility between the exclusive power on immigration reserved for the central level, and the *AA.CC*'s exercise of their exclusive and shared powers on social areas (e.g. on health, education, social assistance, housing and culture) to promote the social integration of the immigrant population[XXXIX]. Yet, regarding the specific delimitation of the social shared competences, the Spanish case lacks a clear constitutional or univocal doctrinal definition of the scope of "legal bases", which is one of the major sources of conflicts between levels of government, as it as been brought to light in the case of health care.

In this respect, should "legal bases" (i.e. the persons entitled to public and free health care) be interpreted as a national "minimum common denominator" that could be extended, enhanced or supplemented by the subnational political levels that are also in charge of fulfilling the constitutional right on health care (Art. 43 SC)? Or, on the contrary, are "legal bases" in this case a uniform and fundamental set of rules that does not allow for any decentralized legislative improvement by the *AA.CC*.?.

In our opinion, the role of the central state to uniformly guarantee a minimum and equal access to health care is in any case granted by its legislative power to define those

who, in any event and in a nation-wide scale, should be granted health care and which the common health services should be. Nevertheless, the subnational levels of government, on the grounds of the political autonomy constitutionally guaranteed, should be allowed to enhance or complement that minimum or standard level in their own territory, in conformity with the mandates to enforce a real and effective equality enshrined in the Constitution and in the Statutes of Autonomy.

As it has been analysed in detail, the Basque Country's initiative to complement the national protection regarding the access to health care has been temporarily endorsed by the Constitutional Court on the grounds of the extraordinary significance of the right to health care in the constitutional system of values. Debates of this nature show the complexities of a territorially decentralized fulfilment of the welfare state but, more importantly, they highlight the crucial constitutional role of the subnational levels of government to preserve social inclusion policies in a context of general welfare retrenchment.

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[*] Irene Sobrino Guijarro is an Assistant Professor of Constitutional Law at the University of Seville (Spain).

[I] This *Royal Decree-Law* was partially instituted by *Royal Decree 1192/2012 of 3 August 2012 regulating the status of insured persons and beneficiaries for the purpose of receiving publicly funded health care in Spain through the National Health Service*, which entered into force on 4 August.

[II] Article 12 of the *Organic Law 4/2000 of 11 January, on the rights, freedoms and social integration of foreigners in Spain.*

[III] *General Health Law* 14/1986, Article 1, paras. 2 and 3.

[IV] Article 12, Organic Law 4/2000. In some cases, irregular immigrants would be exempted from the requirement to be registered in a local census (cases of urgencies, accidents or serious illness; minors and pregnant women. For a detailed explanation of the legal conditions attached to the local census registration, see García Vázquez 2007: 166-170.

[V] Specifically, below one hundred thousand euros, *Royal Decree-Law 1192/2012 of 3 August 2012.*

[VI] Therefore, among others, the following services would be covered by the health care "special agreements": activities involving the prevention, diagnosis, treatment and rehabilitation carried out in medical centres. However, fundamental questions such as the needed medication to treat chronic illnesses (e.g. VIH or cancer) or any pharmacological treatment that should be followed once left the medical centre should be entirely defrayed by the patient (Article 8 of the Law 16/2003). See "Foro para la Integración Social de los inmigrantes", 2012a, 3.

[VII] The monthly fees set for the "special agreements" on health care provision are 157 euros/month for those older than 65, and 60 euros for the rest. See, *inter alia*, "Foro para la Integración Social de los Inmigrantes" 2012b: 19-21, 37.

[VIII] In this respect, see "Foro para la Integración Social de los Inmigrantes", 2012a, 3-4. Furthermore, according to "*Médicos del Mundo*" (*Argumentario. La reforma sanitaria y las personas inmigantes*, 2012), since the health reform entered into force in Spain, one of the most recurring problems have been represented by immigrants who (1) suffered chronic diseases but did not get the periodic controls and/or with interruptions in their treatments, (2) had transmissible pathologies that have not been accompanied by the corresponding protocols (HIV or tuberculosis) or that had (3) mental illnesses without any sort of medical follow up.

[IX] The right to health to everyone is also enshrined in the same terms in various international instruments, among others, in the "International Convention on the Elimination of All Forms of Racial Discrimination", 1965 (Art. 5), in the "Convention on the Elimination of All forms of Discrimination against Woman", 1979 (Arts. 11 and 12), and in the "Convention on the rights of the Child", 1989 (Art. 24).

[x] CESCR General Comment no. 14: "The Right to the Highest Attainable Standard of Health (Art. 12)" E/C.12/2000/4, para 1.
[xi] *Ibid.*, para. 12.
[xii] *Ibid.,* para. 34.
[xiii] Enacted by the United Nations in 1990. It entered into force in 2003.
[xiv] ECHR, *Osman v. United Kingdom* [GC], 28 Oct. 1998, no. 23452/94, para. 116.
[xv] For instance, in the following ECHR decisions on admissibility, the applicants requested their respective States to cover the costs of certain medical treatments under the legal obligation of Article 2 of the European Convention of Human Rights, ECHR *Nitecki v. Poland* (dec.), 21 March 2002, no. 65653/01; ECHR *Scialacqua v. Italy* (dec.), 1 July 1998, no. 34151/96.
[xvi] ECHR, *Pretty v. United Kingdom*, 29 April 2002, no. 2346/02, para. 52.
[xvii] ECHR, *D. v. United Kingdom*, 2 May 1997**,** no. 30240/96.
[xviii] ECHR, *N. v. United Kingdom* [GC], 27 May 2008, no. 26565/05, and ECHR, *Arcila Henao v. The Netherlands,* 24 June 2003, no. 13669/03.
[xix] ECHR, *Bensaid v. United Kingdom,* 6 Febr. 2001, no. 44599/98: paras. 46 and 47.
[xx] Up to date, Spain has not ratified the revised version of the European Social Charter of 1996.
[xxi] Article 11, European Social Charter: "With a view to ensuring the effective exercise of the right to protection of health, the Contracting Parties undertake [ ] to take appropriate measures designed *inter alia*: 1) to **remove** as far as possible the causes of ill-health; 2) to **provide** advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health; 3) to **prevent** as far as possible epidemic, endemic and other diseases".
[xxii] Para. 1, Appendix to the 1996 revised European Social Charter.
[xxiii] ECSR, Complaint no. 14/2003, 8 Sept. 2004.
[xxiv] para. 30.
[xxv] paras. 31 and 32.
[xxvi] The Committee specifies that some provisions of Part I of the Revised Charter also grant protection to children, in addition to the fact that the Charter is directly inspired by the UN Convention on the Rights of the Child, aiming therefore to protect in a general manner the right of children and young persons, paras. 35 and 36.
[xxvii] See *Decisions of the Constitutional Court* 107/1984 (LB 3, 4) and 236/2007 (LB 3, 4).
[xxviii] As an instance of the few social rights that have been configured as subjective claims enforceable in the Courts of Justice, see the *Andalusian Statute of Autonomy,* Article 22.2. on "health care"*,* which states that patients and users of the Andalusian health system have the right to*: "b) The free choice of doctor and health centre"; "h) Avail of a second advisory opinion about their illnesses"; "i) Access to palliative care".* Equally important, on the constitutional nature of the rights provided by the "Statutes of Autonomy", see *Decision of the Constitutional Court 31/2010, LB* 16. See also De la Quadra-Salcedo Janini 2008.
[xxix] See, for instance, the following Constitutional Court decisions regarding conflicts of competence on health care: 32/1983, 69/1988, 80/1988.
[xxx] The Constitutional Court Decision 156/1995 expressly states that such an assessment should be done case by case, and that it would be unfeasible to shape *a priori* theoretical structures that could be meaningful for future cases (3 LB). In a similar respect, see the *Decisions* 141/1993 (5 LB) and 206/1997 (7 LB).
[xxxi] The *RDL* has been appealed by the following *AA.CC.*: Andalusia, Asturias, Canarias, Catalonia, Navarre and the Basque Country. Also, different social and professional organizations, such as the General Council of the Spanish Bar Association, "Médicos del Mundo", and the "Platform of the International Cooperation for Undocumented Migrants" (*PICUM*), have manifested their discrepancy over the restriction of access to health care for irregular migrants in Spain.
[xxxii] The Health Departments of several Autonomous Communities (Catalonia, Asturias and Andalusia) have also adopted instructions in order to grant access to health care for undocumented immigrants.
[xxxiii] *Order of the Constitutional Court 239/2012 (LB 5).*
[xxxiv] *See,* for instance, *Decisions of the Spanish Constitutional Court 53/1985 (LB 11 and 12); 119/2001 (LB 6). ECHR Osman c. United Kingdom (1998); ECHR, Bensaid c. United Kingdom (2001).* For a more detailed explanation, see Part II above.
[xxxv] *Order of the Constitutional Court 239/2012 (LB 5, in fine).*
[xxxvi] See Part III.
[xxxvii] Furthermore, the European Committee of Social Rights in *International Federation of Human Rights*

Leagues v. France stressed the connection between the right to health and the very dignity of the human being. For all, see Part II above.

[XXXVIII] *Decision of the Constitutional Court 136/2012, LB 5*.

[XXXIX] *Decision of the Constitutional Court 31/2010*, *LB* 83, on the interpretation of Article 138.1 of the Catalan Statute of Autonomy.

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