Publicly Funded Abortion and Marginalised People's Experiences in Catalunya

A Longitudinal, Comparative Study

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Abstract: Abortion law reforms enacted in Spain in 2010 and extended to Catalunya expanded access to abortion. Simultaneously, the autonomous region was affected by economic crisis and austerity, affecting access to care for migrant and marginalised populations. Mixed-method ethnographic data were collected in relation to low-income and immigrant women seeking abortion in two phases: (1) 2012–2013 and (2) early 2016. Data sources included surveys, interviews and participant observation. Data analysis combined descriptive statistics, modified Grounded Theory, thematic analysis and constant comparative methods. Despite public funding of care in a system ostensibly available to all, marginalised people seeking abortion reported reduced access and more barriers to access. Participant experiences with legal, publicly funded abortion revealed bureaucratic difficulties and delays as well as inconsistent and inadequate information. Data on marginalised people's experiences demonstrate that even where abortion is legal and ostensibly available, politico-economic contexts and trends affect their access to abortion and public health care.

Keywords: abortion, Catalunya, health care, immigrants, migrants, public health, Spain

Worldwide, about half of pregnancies are unplanned or mistimed (Darroch et al. 2011); more than half of these end in abortion (Singh et al. 2018). Abortion rates are simultaneously higher and more often associated with complications where the procedure is more restricted and more stigmatised (Ostrach 2016; Ostrach and AbiSamra 2017; Sedgh et al. 2012). It is important to note the wide diversity of settings in which people seek and obtain abortion care. These are shaped by varying politico-economic and socio-cultural factors, which are all influenced by and in turn influence policy. Such factors – including legal restrictions, availability of funding, degree of abortion-related stigma in a given community, location of and time needed to reach high-quality providers, and awareness of abortion care options – each and together ultimately determine access to and quality of abortion care (Barot 2011; Boonstra 2007; Ostrach 2014a, 2016). The global public health burden resulting from unsafe abortion can be reduced by improving access to high-quality, non-stigmatised care (Billings et al. 2002; Jones and Weitz 2009; Ostrach 2016).

Abortion Liberalisation & Implementation in the Health System

Access to safe and legal abortion in Spain and Catalunya changed dramatically as of mid-2010 under reforms to sexual and reproductive health laws (Guttmacher Institute 2010; Ostrach 2017, 2018a). Implemented in publicly funded health systems, the abortion reforms had specific and unique effects in Catalunya, where migrants have greater access to

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public health care (Ostrach 2017). The 2010 reforms expanded abortion rights for any reason in the first trimester (up to 14 weeks from the last menstrual period, by this law's definition) and under qualifying circumstances in the second trimester (from 14 to 22 weeks from the last menstrual period, by the 2010 law). It also mandated comprehensive sexual education in public schools and greater access to contraception (Ostrach 2017).

Anyone residing in Catalunya may seek healthcare through the public health system. All residents *empadronados* (registered) at their local town hall may obtain a health card and use public health services. Following the 2010 liberalisation of abortion laws, any person with a health system card person seeking a publicly funded abortion must go to their assigned neighbourhood clinic; complete a pregnancy test; state that they want an abortion; and obtain a paper referral form and voucher for a contracted clinic (there is an alternate centre for youth).

According to the 2010 law and the policy under which it was implemented in the health system, this can and should ostensibly happen on the spot, without an appointment, on a walk-in, same-day basis. No element of the abortion law or health system policy specifies that someone must schedule a time to request a voucher, that they must make more than one visit to obtain it, or that they must wait any specified amount of time for the voucher. All neighbourhood clinics are expected to have staff on-site that can complete the voucher paperwork.

The Catalan Context

Catalunya has long been viewed as part of Spain. Historically, politically and culturally autonomous, this region bordering north-eastern Spain has had an increasingly contested relationship with its larger neighbour, which now formally occupies it (Bel 2013; Castro 2013; Crow 1985; Ostrach 2018b; Tremlett 2008). As of November 2017, Spain forcibly occupied Catalunya under an invocation of Spanish Constitutional Article 155 – a process considered by many to be a political and military *coup d'état* (Ostrach 2018b). Many in the region have also long supported self-determination referenda on full separation from Spain (BBC 2014; *El Mundo* 2012; Frayer 2015), including migrant residents, who, in Catalunya, have had arguably greater access to many social services, including the health system, than in other autonomous regions of Spain (*Nous Catalans* 2013; Ostrach 2013).

Migrants' Access to Abortion

As early as 1981, Catalunya was amongst the first autonomous regions in Europe to begin administering its own health system, which includes coverage for migrants (Lizana 2012). Medical anthropology and other social science studies in migrant health find that migrants consistently face more obstacles and delays when seeking care – particularly when it comes to reproductive services (Kennedy and Murphy-Lawless 2003; Laroche 2000; Medda et al. 2002; Ostrach 2013; Willen 2005). Where migrants who can become pregnant are covered by public systems, the coverage is often ethnically tiered (Willen 2005), limited to pregnancy (Ostrach 2013), or has built-in waiting periods (Carrasco-Garrido et al. 2007; Ostrach, 2013). In some cases, only certain migrants are covered (Carrasco-Garrido et al. 2007; Willen 2005) based either on labour status or country of birth, creating categories of citizenship and societally 'valuing' certain (reproductive) labour differently. At the time of the 2010 reforms, and as Catalunya became one of the only places in the world where anyone, *regardless of immigration status*, could obtain health system coverage, the region represented a 'best case scenario' for access to safe abortion – a recognised public health priority worldwide (Adler et al. 2012; Barot 2011; Berer 2004). Globally, migrant and other marginalised populations lack access to health systems as readily as do locally born women, especially for reproductive health care. And this is especially the case for abortion (Carrasco-Garrido et al. 2007; Ostrach 2013). Migrants tend to be less aware of the legal status and availability of abortion and other reproductive health services in countries to which they migrate (Carrasco-Garrido et al. 2007).

Within this landscape, the practical situation of abortion legality and access in Catalunya, particularly for migrants and marginalised people such as those in poverty, continually shifted following the 2010 abortion law, the global economic crisis, and the Eurozone-imposed austerity measures that took effect in late 2012 (Murcía López 2013; Raventós and Wark 2012). The Spanish government rapidly and disproportionately passed austerity measures on to Catalunya: sweeping budget cuts, locally referred to as *recortes* and levied heavily on the health system, contributed to an ongoing paradox of expanded legal access to abortion yet with constrained practical access. With these *recortes*, the inclusion of abortion services in a health system available to all, including, unlike other autonomous regions, unregistered

migrants (Ostrach 2013), became subject to greater funding cuts and political threats. As a result, migrants' access to health care and expanded legal abortion was particularly threatened.

Baseline Study Approach and Findings

In an earlier phase of research (2012–2013) presented in greater detail elsewhere (Ostrach 2017, 2018a), I first examined the implementation of the expanded abortion liberalisation within a Catalan health system heavily affected by austerity measures through surveys and interviews with women obtaining publicly funded abortions; with providers and staff at a clinic contracted with the Catalan health system; with other key informants in the sexual and reproductive health NGO sector; and through participant observation. Just over a quarter of the women surveyed in 2012–2013 (28 per cent of a total sample of 350) waited longer to receive the health system referral voucher required to obtain a publicly funded abortion than law and policy at the time dictated. They should have been able to obtain a voucher in one visit to their neighbourhood health system clinic – upon request, without scheduling an appointment. Just over a quarter of the women surveyed (27 per cent) had to make more than one visit. Such delays complicated their ability to obtain legal, safe abortions.

Migrants, who represented half of the women interviewed in the 2012–2013 phase of my fieldwork, and many of those seen in the clinic during participant observation, were more affected by such delays and obstacles than were participants originally from Catalunya. Migrant women were typically two weeks later in gestation by the time they succeeded in obtaining the health system voucher that enabled them to go to the publicly contracted clinic for an abortion – a voucher they should have received the day they requested it. Migrant women who participated in interviews arrived at the contracted clinic after having made one to two more visits to their neighbourhood health centres to request or wait for a voucher, on average, than their locally born counterparts. Compared to locally born women, migrants were more often delayed into the second trimester while seeking a referral voucher despite having requested it in the first trimester.

Just over half of the women surveyed in the earlier study arrived at the clinic unaware that the health system voucher would cover the cost of their abortion – this, after having met in person with health system staff to complete the paperwork required to obtain the voucher for a publicly funded abortion at a contracted clinic and having discussed information about the procedure and their rights under the 2010 law, including the right to coverage under the public health system. At least 175 women in just four months walked out of public health system centres in Catalunya with a voucher in hand still thinking they would need to pay cash for an abortion. For women in poverty, the burden of expecting to pay cash for an abortion, when all other public health services are provided free, is suggestive of and could compound other experiences of marginalisation.

Study Focus

Therefore, to examine whether obstacles to abortion continued to affect marginalised people, including migrants, even years after law and policy changes should have improved access, in this article I present an account of migrant and low-income women's experiences with publicly funded abortion offered through the public health system in Catalunya amidst an economic crisis and following legal reforms years after an initial study. Comparing the analysis of various sources of mixed-method data collected over time, through this longitudinal ethnographic comparison I ague that even where abortion is legal, publicly funded, and ostensibly available to all, larger politico-economic contexts and the realities of implementation often mean that practical access remains subject to the vagaries of policy execution and bureaucratic accountability.

From 2012 through 2016, abortion continued to be officially legal and publicly funded for all. However, both abortion legality and the public funding of health care were under continual threat. Most recently, the Spanish conservative party in power from 2011 and into 2018 (many of whose policies applied to Catalunya), the Partido Popular, succeeded in changing a major legal framework governing abortion access for teens. By late 2015, women ages 16–17 were required to seek parental or guardian permission for abortion in all circumstances (Associated Press 2015). The passage of this amendment to the 2010 abortion law liberalisations represented an unprecedented (if long-threatened) roll-back of abortion access gained earlier. Other such roll-backs were frequently threatened, and the potential loss of access loomed at all times while marginalised groups sought care.

Methods

Research Site and Sampling

I recruited voluntary participants from amongst all patients seeking abortions and amongst staff at a clinic under contract with the Catalan public health system in Barcelona.

The fieldwork clinic was at the time of the earlier study one of only two clinics under contract with the health system to accept the public health system vouchers for the provision of instrumental (surgical) abortion. Soon after the abortion law reforms, it was the only clinic providing second-trimester abortion care; women travelled from all over Catalunya to be seen for any publicly funded abortions between 14–22 weeks' gestation. By the time of the early 2016 study, the ability of various clinics to accept vouchers varied widely at any given time, depending on contracts and quotas granted, renewed, increased or decreased by the health system with little notice or transparency – according to my key informants.

Data Collection

Participants in both studies described here included many registered and unregistered (documented and undocumented) migrants, and a significant proportion of low-income residents. They represented a diversity of ethnic and racial groups, and wide age range.

To allow for ethnographic comparison between data from the earlier study period and women's experiences several years later, I conducted a rapid ethnographic assessment (REA) (Utarini et al. 2001) at the same contracted clinic throughout January 2016, engaging in participant-observation four to five days per week. At the time of the REA, it was one of several clinics under contract with the Catalan health system but still one of the only (and at times the only) clinic offering late-second-trimester care. The intent of the subsequent study was to determine whether and how access to abortion in the public system might have changed and to evaluate the (then-) current state of abortion care in the public health system. All women coming to this clinic for publicly funded abortions received study announcement flyers inviting them to participate in an optional, informal interview to take place in a private room in the clinic following their discharge from care. Twenty-eight women participated in these informal same-day interviews ($n = 28$); 13 were migrant women from 10 different countries. All women receiving abortion care during the study period were informed about the ongoing research and my participant observation; all consented to have my observations of their experiences in the clinic included in the study.

Data Analysis

The analysis of the earlier study is described elsewhere (Ostrach 2017). I analysed similar data from the 2016 REA, including brief interviews with people seeking publicly funded abortions and participant-observation field notes from daily clinic visits, using thematic analysis (Ando et al. 2014) and constant comparative methods (Glaser 1965) to identify, evaluate and compare themes as they emerged. Further thematic analysis of interviews and field notes occurred following the completion of fieldwork in order to identify and evaluate relationships between and the significance of key ideas and themes.

Triangulation

During data collection, I integrated the different analytical approaches through ongoing comparison of data sources and triangulation in the moment (Bernard 2011; Creswell 2007; Ostrach and Cheyney 2014) in particular with participant observation field notes and through discussion with clinic staff – key informants who could speak to the congruence or dissonance of what was reported in interviews by study participants in relation to what larger numbers of patients reported across many more appointment intakes. Moreover, once the early 2016 data collection phase was complete, I analysed interviews and field notes triangulating key themes and concepts across both time points. This cross-comparison between multiple qualitative data sources – and in comparison to earlier findings (Ostrach 2017) – facilitated the identification of similar and diverging trends between what participants directly said in interviews and what was apparent in daily interactions with clinic staff and the researcher. It also facilitated the identification of similar and diverging trends between the latter and what had been occurring three to five years earlier.

Theoretical Framework

I analysed data for this longitudinal comparative analysis of practical access to legal abortion theoretically through a critical medical anthropology (CMA) framework (Ostrach 2014b; Singer 1986, 1995). A CMA perspective closely examines power relationships in health-care settings and systems, and draws attention to how dynamics of class, gender, race/

ethnicity, national governments and other structures of inequality shape access to health care and lived experiences with health and illness. This theoretical approach is particularly apt for evaluating the accessibility of health systems and bureaucracies to migrants and other marginalised groups, as these systems and structures often reproduce larger inequalities in capitalist societies (Baer et al. 2003; Singer and Castro 2004). Migrant and precarious labour is vital to capitalist, service-based, tourist economies, and it is too often exploited; yet migrant workers' health is rarely valued – making the Catalan health system's accessibility to even unregistered migrants a rare departure from the norm. Examining *how* accessible legal, publicly funded abortion truly was for migrants, over time, represented a crucial rationale to apply CMA to both a public health system and to migrant health and rights in a setting otherwise seen as widely progressive.

Findings

Demographics

Participant demographics in 2016 were similar to the earlier study. Of the 28 women interviewed in early 2016, ages ranged from 20 to 38; the average age was 30. Of the migrant participants, the average time they had been living in Catalunya was 12 years, though one had been in the area for just under a year. Though in the rapid phase of research in 2016 the study design did not allow for collecting surveys with specific questions about income and family size, many participants talked in detail about young children and precarious employment/income situations as factors in their decisions to terminate a new pregnancy. The majority of women interviewed spoke explicitly about their economic marginalisation years after the global economic crisis but while Catalunya was still affected by ongoing austerity measures imposed by both Spain and the European Union. As in 2012–2013, this often took the form of women framing their abortion-seeking in terms of an economic need to care for children they already had, rather than in terms of the increasing financial pressures that adding another child would have on their families: 'So, me, already supporting two children . . . having another? No' (Kati,[1] a 23-year-old Ecuadorian migrant who had been living in Catalunya since 2007). This was a common narrative – both interview participants, and other patients with whom I interacted during participant observation – largely talked about their abortion need in relation to economic demands and difficulties.

Awareness of Health System Funding of Abortion

Echoing the earlier study, participants in 2016 were appreciative of the opportunity to have their abortions paid for by the health system – once they understood that would be the case. Six years after the abortion law reforms that resulted in abortions being covered by the health system, Nika, a 27-year-old Catalan who had not initially been aware her abortion would be paid for by the public health system said:

> If you don't have money to come get an abortion, not even the €300 that it will cost you (sic), how will you have the money to care for a child? I see it as a very good thing what they've done now, the [health] system . . . the laws . . . Also [people don't know] how the abortion laws are – [Spanish lawmakers] want to prohibit so that it can't be [legal], they want to put [restrictions]. They can't obligate anyone to have a child when we don't even have [enough] to eat.

As observed in the earlier study, in 2016 migrant and low-income women who participated in interviews were less likely to understand accurately the process by which they could obtain a fully funded abortion through the public health system, and were more likely to report that health system staff had not explained it fully or had given them the wrong information. During participant observation, many people arriving at the clinic, though perhaps unaware that the public health system voucher they had already made multiple visits to their neighbourhood health centre to obtain would cover the cost of their abortion, were nevertheless aware of the oft-threatened restrictions on abortion discussed in the news by conservative legislators. As hinted at in Nika's quote, this awareness was also held in tension with concerns about the economic situation.

Health System Delays and Multiple Visits Necessary to Obtain Vouchers

Of 28 women I interviewed in 2016, only 11 received the health system voucher to which they were entitled in one visit, as should have occurred. Six participants had to make more than two visits to obtain the voucher that should have been provided on the spot; four of these were migrant women. Nine of the 13 migrant women interviewed had to either make more visits and/or wait longer than they should have in order to receive a voucher for their publicly funded abortion, as compared to locally born women. Of 12 Catalans, five had to make more than one visit; while

four had to wait longer than they should have. Four women total had to wait two or more weeks for a voucher: an Argentinian migrant who had to make four visits to health system centres – resulting in a three-week wait; a Catalan who made two visits and waited three weeks; a Bolivian migrant who made three visits and waited two weeks; and a Peruvian migrant who made two visits and waited two weeks. Overall, most participants waited a week or less than a week for the voucher. Twelve participants reported receiving the voucher the day they requested it, as is supposed to occur; seven of these were Catalan and one was Spanish.

So, a Peruvian migrant woman who had been living in Catalunya for 16 years and who was familiar with the public health system, described her experience of being sent from one health system centre to another. She was first scheduled to see a physician and then, after that, the health system midwife who actually filled out the voucher to pay for her abortion at the contracted clinic:

> Well, for me it was a little complicated because first I went with the doctor [at her neighbourhood health centre], who made me do the pregnancy test, from there they gave me an appointment for more than a week later with another, the midwife [at a different health system centre, where many migrants are seen].

What So likely did not know was that, under the abortion law and health system policy up to that point, there was no need or reason for her to have been scheduled to see a gynaecologist at her neighbourhood centre, or to have been made to wait to see the midwife at a different centre, who ultimately filled out her voucher. Health system staff at her own neighbourhood centre could have confirmed her pregnancy and filled out the voucher the same day, upon request and without appointments. Ultimately, So reported two visits to different public health system centres and waiting more than two weeks to be able to schedule a publicly funded abortion appointment at the contracted clinic. Such unnecessary delays and perceived run-arounds were commonly reported both to me and to clinic staff while I observed – especially by migrant women. Melani, a 36-year-old Peruvian migrant who had been living in Catalunya for 13 years at the time of our interview, stated that the process to obtain her voucher was 'very fast', but then described being obliged to go through steps not required by law or policy, which likely delayed the eventual receipt of her voucher.

In her interview, Melani told me she first went to the gynaecology unit at her neighbourhood health centre (in a relatively small town outside of Barcelona) and requested a same-day appointment, which she got, and in which her pregnancy was confirmed. Melani knew she was about nine-weeks pregnant, but said she was then referred to a larger town with a bigger public health centre for a sonogram. Pregnancy confirmation by sonogram is not required, by policy, prior to issuing the voucher for a publicly funded abortion – a sonogram will be done as the first step of an appointment at the contracted clinic. Nevertheless, Melani was not given a voucher until after the sonogram and another meeting with a health professional. Though she succeeded in obtaining a voucher in less than a week, she had to go to two different centres and talk with multiple health system staff in order to do so. Because she was not told, upfront, what the process was supposed to be, she did not understand this to be a series of unnecessary and unfair delays. This was common amongst people attending the clinic.

In contrast, one of the Catalan women, Sofia-Morena, who was 38 years old, reported that she received a voucher on the spot at her local health centre when she requested it, as is supposed to happen:

> So, when I went and said 'I'm sure, I want to do [the abortion],' automatically they gave me the [voucher] and I called [the contracted clinic]. Everything in that moment, no problem.

Nonetheless, such accounts of smooth, by-the-book experiences obtaining vouchers were the exception.

Health System Staff and Provision of Information

Fifteen of 28 women interviewed reported being told by health system staff their abortions would be publicly funded with the referral voucher. Of these, ten were migrants (from the overall 13 migrant women interviewed). However, even six years after the passage of the abortion law reforms many participants still described a lack of information shared with them by health system staff. As Tuty, a 20-year-old Catalan woman who sought a voucher for a publicly funded abortion as soon as she missed a menstrual period, said:

> In general, they didn't explain anything . . . arriving at the [neighbourhood health] centre, what happened was [they said]: 'There are these [abortion] methods. This, this, or this (sic)'. So I said: 'But can you tell me a little what these are, or advise me?' 'No we can't tell you anything'. They gave me the

> voucher, directly, but without telling me anything, and [just said:] 'There, do what you want'.

Most of the women interviewed reported some confusion about what health system staff told them – if not about the voucher, then about some other aspect of their visit. It is worth noting, however, that many seemed unperturbed by this. Based on what I observed during clinic patients' intake sessions with clinic staff in 2016, in this time period following austerity-related *recortes* sub-standard attention to public services seemed to be becoming normalised. For the most part, participants, particularly migrants, unflinchingly recounted delays, misinformation, and what seemed (to those of us familiar with the policies and procedures that should have been followed) to have been run-arounds.

Discussion

As predicted soon after the passage of the landmark 2010 abortion law (Ostrach 2013), migrant and other marginalised women in Catalunya initially encountered, and continued to experience, obstacles to legal and publicly funded abortion. As was found soon after the abortion law reforms, this comparative study revealed that marginalised women, including migrants, still encountered obstacles while accessing legal, publicly funded abortion through the Catalan health system. The continuing experiences of abortion inaccessibility in the public system so many years after implementation of liberalised abortion laws are troubling.

Migrant women reported having to make more visits and wait longer for public funding vouchers as compared to locally born women, in violation of the policies and procedures long in place. Those most familiar with the health system seemed the most dismayed or surprised by delays – Catalans and migrants who had been in the country longest reported not previously having to request vouchers for other forms of care at contracted centres. Yet belying an explanation I heard multiple times during participant observation, that people with more experience with the health system might have greater ease navigating it, were the migrant participants who had lived in Catalunya for many years or even decades and who yet reported delays greater than those experienced by their Catalan-born counterparts. More of the participants who reported getting a voucher more rapidly and with fewer difficulties were Catalan, or had lived in the region longer and were less likely to be perceived as migrants by health system staff. That a health system ostensibly accessible to migrants (unlike so many others) began to reveal inequalities following austerity cuts in a period of and after economic crisis demonstrates the limits of publicly funded health care when it remains subject to health bureaucracies also affected by larger policies and structures.

The number of low-income women and migrants told by health system staff in 2016 that the voucher they obtained would fund their abortion represented only a tiny improvement over three to four years earlier. Half of those I interviewed nearly six years after a legislative and policy change intended to make abortion more accessible nevertheless had to make more than the single visit that should have been required; and disproportionately more migrant women (nearly a third) had to. These disparities in access demonstrate that even a publicly funded health system continued to be not equally accessible to all.

Considered longitudinally, this data demonstrates that, despite policy improvements enacted on paper, the differential power relationships embodied within institutionalised health bureaucracies in Spain and Catalunya continue to reproduce health inequality in Catalunya, particularly for low-income and migrant pregnant women. As seen in other CMA analyses of health policy and health bureaucracy (Mulligan and Castañeda 2017; Singer and Castro 2004; Willen 2005), delays and denials of such legal, publicly funded care to which migrants in Catalunya otherwise have had almost uniquely broad access (compared to other public health systems) in fact appear not to have improved greatly over time since abortion liberalisation, but rather to have persisted in the post-reform period. Based on accounts from those who should have benefitted most from expanded legal access to abortion; and its inclusion in services funded by the public health system accessible to migrants, the level of access and ease with which care could be obtained only slightly improved over time since the passage and implementation of the 2010 abortion reform law. In CMA terms, this is a predictable outcome of *systems-correcting praxis*, or non-reformist reform.

Policies were changed to ostensibly improve access to and the affordability of legal abortion, but the overall structures and system that people are required to navigate to obtain it continued to operate with the same power relationships intact, unchallenged and unchanged. This was especially evident not only in continued delays and repeat visits re-

quired to obtain a voucher but also in the most basic reality that people navigating the system to seek publicly funded care were not even *aware* they were experiencing delays and obstacles that should not have been occurring. On the receiving end of unequal power relationships with public health system bureaucracies, as represented by inadequately trained or oppositional health system staff, those with less agency or control in a health-care setting and dependent on the system to receive publicly funded care were generally unaware of being treated unfairly. This is part of how inequality in health bureaucracies continues—and part of why CMA is needed to, as Hahn (1996) put it, 'unmask' it.

This ongoing confluence of legal, policy and healthcare system changes executed within an existing, *unreformed* health bureaucracy represented potentially serious negative implications for public health, for the structuring of migrants' and other marginalised people's access to abortion, and for Catalan and other European health systems under and after austerity as a whole. From the system-wide impact of austerity measures affecting health care that was ostensibly highly accessible to migrants and other marginalised people, to the arbitrary power to cause delays that individual health system staff had over people in need of a voucher for a publicly funded abortion, the degree of civilised oppression (Harvey 1999) evident and wielded as part of and by the structures of the public health system was a stark example of the limits of the systems-correcting praxis in which so many participants engaged, likely unknowingly, by repeatedly returning to the neighbourhood health centres until successfully obtaining a voucher. In the context of austerity and its aftermath, and with differential power relationships built into the health system itself (a system on which, by its very nature, migrants and other marginalised people are reliant), how public and accessible *was* it, truly?

Conclusion

Since the legal reforms of 2010, and the resulting inclusion of abortion in the health system through a voucher referral process, the practical realities of what people must do to obtain abortions in Catalunya do not match either the law, or the public health system's official, positive policies – especially for migrants and other marginalised people. As in other studies of changes in abortion access related to public funding over time (Ostrach, 2014a), health system inconsistencies and delays appear to have persisted from 2012 to early 2016. Marginalised people navigating the health system to obtain legal, publicly funded abortions to which they were entitled encountered ongoing delays. Migrants reported more of them.

The actual state of healthcare provision in the context of a public system that suffers from *recortes* and seemingly inconsistent bureaucratic policies and practices amid an economic crisis and austerity, fails to live up to the ideal that all residents, including migrant and low-income women, can use it. This longitudinal comparative ethnographic research documented disturbing patterns faced by those seeking legal, high-quality abortion in Catalunya, with grave consequences for public healthcare access.

Migrant and other marginalised women in the region continue to be the disproportionate victims of disconnections between health system policies intended to ensure public health by expanding access to legal, safe and high-quality abortion and what is actually available and accessible. Some recipients of public health services suffer from suboptimal provision of care, through a confusing referral process imbued with bureaucratic complications, that is hamstrung (it seems) by budget cuts implemented without a plan for adequate training or consistency.

Likely due to the combination of austerity measures resulting in *recortes*, political pressures and bureaucratic dysfunction, the ability for public health system recipients to fully benefit from legal abortion and public health care remained at the mercy of a health system that continued to reproduce social inequalities in the distribution of public health resources. Even existing policies and health system procedures meant to ensure access to publicly funded abortion were not consistently followed. As multiple participants reported receiving inaccurate or inadequate information from health system staff and/or experiencing delays in receiving vouchers as a result of health system staff not providing a voucher during their first visit, I venture that this could be improved through more communication within the public health system. In the context of crisis-driven austerity cuts, an adequately staffed and funded public health system would likely also allow for better training and accountability to comply with the steps that should be followed to ensure all people seeking abortions receive a voucher the day they request it. Future research should focus on the sources of delays and inconsistent or inaccurate information in the Catalan publicly funded health

system and, more broadly, on persistent and unequal power structures within health systems overall that can undermine policy reforms intended to improve access to care.

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Note

1. All pseudonyms were chosen by the participants themselves.

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