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Migration and Healthcare Reformsin Spain.Symbolic Politics, Converging Outputs and Oppositions from the Field

Migrants' entitlement to social protection has increasingly become a conflictive issue in the political battlefield, with research pointing towards the determinant role of party politics in reforming migrants' welfare entitlements. Focusing on the 2012 healthcare reform and 2018 counter-reform adopted in Spain by a right-wing and left-wing government respectively and drawing on qualitative analysis of parties' discourses and policy measures, our findings suggest that ideological differences along the healthcare-migration nexus were overemphasised to play symbolic politics. Partisan competitionhad less impact onactual policy outputs, while path-dependent practices and opposition from multiple venuesplayed a central role in the policymaking process.

Keywords: migration; healthcare reform; PP; PSOE; partisan discourse; path-dependency; advocacy coalition

Introduction

The right of migrants with irregular status (hereafter: MIS) to access the healthcare systems of EU countries has longbeen a controversial issue for policymakers, pitting international humanrights and public health imperatives against issues of national sovereignty and border control (Ambrosini& van der Leun 2015). When dealing with this dilemma, policy responses have systematically leaned towards limiting healthcare entitlements (IOM 2016), wherebyMIS (undocumented non-EU migrants, mobile EU citizens who do not comply with legal residency requirements, rejected asylum seekers) are seen as undeserving beneficiaries.

Until recently, Spain had formed an exception as it had undergone a relatively stable trajectory of extending healthcare entitlements to everyone living within its national borders (Moreno Fuentes 2015). Following the introduction of the Spanish Healthcare Act in 1986, Spain's healthcare system gradually extended its coverage

untilit became a universalist system. The Foreigners Act 4/2000 entitled foreign residents to full healthcare coverage regardless of their legal status, making the Spanish healthcare system the most inclusive in Europe (Scuto 2011).

However, this came to an abrupt end in 2012, when theright-wing government of Mariano Rajoy, president of the PP (Partido Popular – Popular Party), suddenly excluded MIS from public healthcare, justifying this turnby saying that it was necessary to cut public expenditure and put an end to abuses in times of crisis. This government was succeeded by a left-winggovernmentled by Pedro Sanchez, president of the PSOE (PartidoSocialistaObreroEspañol- Spanish Socialist Workers' Party), which fiercely opposed this measure and promised to restore universal access. One of the PSOE's first actions upon gaining power in 2018 was to undo this policy reform. Asthis paper will show, however, universalism does not seem to have been restored for MIS.

Partisan explanations of policy restrictivenessfeature heavily in scholarly debates on migration. Immigration has long been a strikingly divisive issue in the political arena (Akkerman2012; Green-Pedersen &Odmalm2008), and research often supports the enduring relevance of left-wing versus right-wing governing parties in explaining reforms onimmigration policies and migrants' social rights (Bale 2008; Hampshire &Bale 2015; Lutz 2019; Piccoli2019; Yılmaz2012; Natter, Czaika& de Haas 2020). Not surprisingly, this perspective in migration research hasstronglyre-emergedin current times of permanent austerity and migration crises, in which radical and centre-right parties increasingly – and often successfully – exploit the 'immigration-as-a-threat-to-the-welfare-state' card in electoral struggles.

Without questioning the existence of this dynamic, our contribution challenges this 'partisan turn' in thedebate on migration and welfare politics. By focusing on the Spanish 2012 reform and 2018 counter-reform regulating healthcare access for MIS, we

address the interplay between partisan discourseand policy measures, pre-existing institutional structures and advocacy coalitions when it comes to determining policy reform outputs. In doing so, we also aim tocontribute to a broader understanding of welfare retrenchment dynamics by addressing the healthcare domain, which is often assumed to be the most 'partisan-neutral' of social policy areas. At the same time we will focus on changes to healthcare entitlements for a specific target group– MIS– which, although does not belong to parties' constituency as it lacks any political rights,nevertheless represents a 'partisan-salient' issue in contemporary Europe.

First of all, we will present the theoretical framework and research methods guiding this research. We will then reconstruct the 2012 reform and 2018 counter-reform policymaking processes, focusing on the PP's exclusionary discourses and measures during its term in power, the strategies developed by field actors in reaction to policy change, and the PSOE's discourses and the policy measures it adopted to (supposedly) restore universalism. Our analysis suggests that partisandifferences in framing the issue (particularly concerning whether or notMIS are deserving ofhealthcare)were overstressed to play symbolic politicsat the national level, while they mattered less for policy outputs, which seem to converge when it comes to actual content. In contrast to this, the path-dependence of pre-existing healthcare structures at the regional level and opposition 'from below, inside, and outside' played a central role in the policymaking process, limiting the expectedeffects of the PP's 2012 reform while opening the path for the 2018 counter-reform.

Theoretical framework

The analysis of welfare reforms constitutes a key topic in social policy research, attracting a great deal of scholarly attention and confronting advocates of 'old' and 'new' welfare politics since Pierson's (1996) work on the politics of retrenchment.From

his perspective, European welfare states have expanded to an extent where they are seen as part of the status quo, creating commitments, expectations and interests that make any significant retreat unlikely. In addition to opposition from veto players, reform processes are also path-dependent, shaped by policy legacies and pre-existing welfare structures that operate as institutional veto points hindering retrenchment. In the changed political context surrounding social policy, politicians try to circumvent the electoral consequences of launching unpopular, radical and highly visible cuts, attempting to achieve retrenchment while engaging in the 'politics of blame avoidance' (Pierson 1996, p. 179).

Since Pierson's work, a great deal has been written about the 'how' of welfare retrenchment given political and institutional constraints(Green-Pedersen &Haverland 2002; Starke 2006),detailing the different blame avoidance strategies governments employ in order to implementunpopular policy reforms. These include:i) 'manipulating procedures',by relying on institutional opportunities to avoid or reduce blame (such as delegating decision-making power to other bodies); ii) 'manipulating payoffs', byredistributing the incidence of gains and losses among those affected by a reform (such as imposing losses on groups that are politically weak); and iii) 'manipulating perceptions', that is, changing the perceptions of those affected by the reform (such as convincing voters that a reform is needed and just) (for a recent review, see: Vis 2016).

Questioning the idea that retrenchment always implies punishment from voters whilefocusing on'when' blame avoidance strategies are necessary, recent studies find that the need for governments to employ themvaries amongsocial policy areas (Jensen 2012; Green-Pedersen &Jensen 2019). Specifically,life courserelated policies – and healthcareprogrammes in particular–have been found to enjoy a high level of public supportregardless of income distribution, making their retrenchment unlikelyand

reducing issue competition between left-wing and right-wing governments:as a result, vetopoints in the healthcare domainare supposed to be less relevantthanlabour market-related policy reforms, for which veto players still play a significant role in hindering retrenchment.

In answer to the question of 'who' needsblame avoidance strategies when pursuing welfare reforms, another stream of researchcontends that right-wing parties rely onsuch strategiesto a lesser extent than left-wing parties, as retrenchment constituteslittle electoral risk for the former whilethe latter may be harshly punished by their constituents for implementing cutbacks (Giger & Nelson 2011). This perspectiverecalls the'traditional partisan politics' approach in the debate on welfare reforms, which derives policy outputs from governing parties and assumes that the latterexpress clear ideological stances for social-democratic or conservative welfare policies (Korpi 1989; Korpi&Palme 2003; Allan &Scrugg 2004). On the contrary,the 'new school' ofpartisan politicspoints out how these actors operate in more subtle or unexpected ways than in times of welfare expansion (for a review, see: Häuserman, Picot &Geering 2013).Accordingly, and in line with early contributions by Levy (1999) and Ross (2000),researchindicates that left-wing governmentsmay retrench more successfully than their right-wing counterpart: as they are usually associated with defendingthe welfare state, they have more leeway for retrenchment,and can even claim credit for it (Elmelund-Præstekær&BaggesenKlitgaard 2012).

As it clearly emerges, the debate onwelfare reform dynamicsand retrenchment in Europe is set to continue, with institutionalistscholarsandadvocates of partisan politics on opposite sides. From this perspective, the dominance of traditional partisanship explanations in the understanding of welfare-migration politics appears quite surprising. As outlined above, the vast majority of existing scholarship strongly supports the

enduring relevance of left-wing versus right-wing governing parties in explainingpolicy inclusiveness/restrictiveness in Europe (Bale 2008; Hampshire & Bale 2015; Lutz 2019; Piccoli 2019; Yılmaz 2012).In contrast to the analysis of admission policies, where pro-immigration and anti-immigrationpositions cut across the political spectrum, these studies converge on the 'parties matter' thesis when it comes to migrants'social protection: left-wing parties are more likely to adopt policies that grant labour and welfare rights to migrants(including MIS), while right-wing parties usually oppose such measures(Natter, Czaika& de Haas 2020).

Engaging with thiswelfare-migration politics debate, we contend that the relationship between party political discourseson the entitlement of MIS to healthcare and the actual outputs of the policy reforms that these parties propose – and eventually adopt – may be far from linear. Although they compete with each other when framing the issue at the discourse level,right-wing and left-wing governments mayactually convergewhen it comes to their envisaged policy outcomes. The main difference between them relies on the types of strategies adopted and on the level of opposition they are confronted with when retrenching migrants' welfare entitlements.

In addressing this topic, we also aim to contribute to the wider debate on the institutional and political determinants of welfare reform. We do so by addressing the most distinct lifecycle-related welfare domain,healthcare(assumed to be 'partisan-neutral'), while focusing onchangestothe healthcare entitlementsofa target group (MIS) that does not coincide with parties' target group (voters) but which nevertheless constitutes a 'partisan-salient' issue in contemporary Europe.

Methods

This contribution aims to explore the mechanisms behind the Spanish reform and counter-reform regulating healthcareentitlement for MIS in the period 2012-2019,

focusing on the interplay between partisan discourse, institutional structures and advocacy coalitions toexplainpolicy outputs, namely the changes in levels of and eligibility criteriafor healthcare entitlement for MIS.

Spain presented a particularly appropriate case for our research purpose, asits steady pattern of extendingMIS' healthcare entitlements was suddenly challenged by exclusionary reformmeasures implemented by the right-wing party PPin 2012, followed by acounter reform introduced by the left-wing PSOE in 2018.

In conducting the study, we combined document analysis of policy measures adopted by national and regional governments in the period 2012-2019 with an analysis of the political parties' discourses. For the first, we relied on relevant legislative texts and policy documents, and on specific regulations and administrative instructions issued in the period 2012-2019 at the national and regional levels.

The focus on both governmental levels derives from the decentralised structure of the Spanish healthcare system (Sistema Nacional de Salud, SNS), which implies a complex articulation of responsibilities and competences between the national government and the 17 Autonomous Communities.In the migration-healthcare domain, the central government is responsible for immigration policies, defining migrants' entitlement to healthcare (eligibility conditions and minimum extent of coverage), and basic healthcare legislation, andeach Autonomous Community's regional healthcare department (*ServiciosRegionales de Salud*) is responsible for organising and providing healthcare services.Regions can extend the package of healthcare coverage for its population, to supplement the minimum servicesprovided forat the national level.[1] Therefore, we considered it essential to focus on both levels of the Spanish systemin order to understand policy reform dynamicsand blame avoidance strategies in a system characterised by a high degree of decentralisation (Bonoli 2001; Mortensen 2013).

Furthermore, this distinction enabled us to focus onthe ways in which national and regional governments may participate in migration-healthcare reformprocesses: either by introducing changes to MIS' healthcare entitlements and eligibility criteria (a national competence) or to the package of servicesthatMIS are granted access to (where the Autonomous Communities have more room for manoeuvre).

We also analysed documents produced by professional associations (e.g. SEMFYC, Spanish Medical College) and civil society organisations (e.g. REDER, Yo Si Sanidad Universal, Médicos del Mundo) concerned with the issue of MIS'access tohealthcare, in order to address the positioning and role played by theseactors in the 2012 and 2018 reform processes.

In addition to official documents, the analysis of parties'discoursesrelied on press articles from national newspapers and paid particularattention to statements from both the PP and PSOE as these parties had led the national governments responsible for the 2012 reform and 2018 counter-reform respectively. With the aid of Nexis Lexis, we selected articles from the national newspaper *El Pais*on 'healthcare' and 'immigrants' at three points in time: 2012 (PP reform); 2015 (when the PP appeared to change its position) and 2018 (PSOE counter-reform). This selection was further refined by selectingarticles on political parties' discourses and practices vis-à-vis healthcare access for MIS. As Spain's newspapers are characterized by strong partisan identities and *El País* leans towards the left, we complemented the selection with articles from newspapers which lean towards the right, particularly *El Mundo*. Where possible, the resulting sample of over 70 *El País* articles was matched with articles covering the same news in other national newspapers (*El Mundo*, *ABC*) and professional journals (*RedacciónMedica*, *Acta Sanitaria*) using general internet search tools.

After data collection, we chronologically reconstructed and compared parties' discourses, changes in positioning and policy measures vis-à-vis MIS' healthcare access. In conducting the analysis, we used manual coding and focused on the following dimensions of partisan discourse: *i)* problem-formulation and policy goal; *ii*) general vision of healthcare; *iii*) policy categories (particularly, target groups); *iv*) arguments and general rhetoric (including elements such as metaphors or emphasis); and *v*) proposed policy measures (including symbolic ones). Then, we compared such dimensions with the actual policy measures addressing healthcare access for MIS adopted in the framework of the 2012 reform and 2018 counter-reform.

The 2012 Healthcare Reform: Reversing a Trend of Gradual Inclusion

Until the turn of the millennium, Spain paid little attention to the issue of healthcare for MIS. Although Spain experienced a migration turnaroundin the late 1980s (Author A) that coincided with the shift from a categorical to a universalistic healthcare system (the 1986 Healthcare Act entitled almost all of the resident population to the SNS), healthcare access for MIS was limited to pregnancy, emergency care and the treatment of infectious diseases.

During the late 1990s, however, efforts to changethis policy gained momentum. Bottom-up mobilisations from health and voluntary organisations, in concomitance with political debates on the need to define a coherent law on immigration, opened a window of opportunity which made it possible to grantMISaccess to unconditional public healthcare coverage(Moreno Fuentes 2015). The Foreigners Law 4/2000 gave every person with habitual residence in the country entitlement to healthcare on equal grounds with Spanish nationals. Through the mechanism of *empadronamiento*, access to healthcare was established regardless of an individual's legal status and formalised through issuance of a healthcare card (tarjeta sanitaria).[2] Overall, this policy framework

strongly contributed to the definition of a healthcare citizenship inspired by the principles of social justice and solidarity, aimed at overcoming social inequalities and paying particular attention to vulnerable groups, such as poor people, MIS, and the homeless(Cantero Martínez &Garrido Cuenca 2014, p. 97).

The last step towards universalism took place in January 2012, with the adoption of the General Public Healthcare Law 33/2011, which removed the last barriers for groups that were still excluded from the SNS (i.e. Spanish citizens who did not contribute to the social security system and who had incomes above a certain threshold). With this step, the SNS became a fully universalist system, which enjoyed a high level of public support (Rico 1996). According to the 2012 national health survey (CIS 2012), 70.6 per cent of the population believed that the SNS functioned 'well' or 'very well'.

Just a few months later, however, this path was suddenly reversed by a Real Decreto-Ley (RDL) 16/2012 on 'urgent measures to guarantee the sustainability of the SNS', which was adopted by the central government led by the PP.

As the name of the reform suggests, the harsh economic and fiscal crisis affecting Spain and ensuing austerity measures were cited to justify cuts to public healthcare spending, thealleged 'urgency' of which was used to pass the reform without parliamentary debate.[3] In the introduction to the decree, retrenchment was justified using arguments of economic efficiency, contending that the 'lack of rigour and emphasis on the system efficiency has led the SNS to a situation of severe economic difficulty' (RDL 16/2012, p. 3).Cost-containment to reverse this 'unsustainable public deficit' was deemed necessary in order to sustain the SNS in the long term.

Furthermore, the sustainability argument was invoked to introduce a radical shiftin the process of healthcare universalisation in terms of both entitlement and coverage.RDL 16/2012 transformed the ethos and underlying philosophy of the system

from a universalistic system to an insurance-based one, thereby changingthe basis for entitlement from habitual residence to contribution to the social security system. Although financing continued to be tax-based, the reform re-introduced the categories of 'insured persons' (workers, pensioners, unemployed receiving benefits and job seekers) and 'beneficiaries' (dependent relatives of insured persons under the age of 26) to define the groups entitled to the complete package of healthcare services provided by the SNS. This excluded non-insured persons and theirdependent relatives, turning healthcare into a contribution-basedright and unveiling a new rhetoric of health-related deservingness: '[healthcare must be]for the ones who truly work like us and pay their taxes*'* (Ana Mato, PP Health Minister, El País, 20 April 2012).

Among those excluded, MISmade up the most targeted group, both in symbolic and practical terms. Like other non-insured persons, they were excluded from public healthcare (with the exception of emergency, maternal and primary childcare), and their healthcare cards were withdrawn. However, presenting MIS as abusers of scarce healthcare resources was a key tool used to legitimate the 2012 reform process.

Justifications of the reform focused on abuses by non-Spanish citizens as a critical dimension of the problem. However, the analysis reveals discrepancies between the arguments used in the legislative text and those put forward by PP politicians in their general communication strategy. On the one hand, the introduction of the legislative text did not explicitly mention MIS. Citing a document issued by the Spanish Court of Audits in 2012, RDL 16/2012 referred to 'some situations of healthcare assistance' that were 'weakening the sustainability of the SNSin an alarming wa*y'* (RDL 16/2012, p. 4). Specifically,it stressedthatSpain was providing services for persons who were already covered 'either by their social security institutionsback home or by private insurances', creating a serious problem due to the 'impossibility of

guaranteeing reimbursement for the expenses made through the provision of healthcare services to EU citizens' (RDL 16/2012, p. 5). Hence, inefficiency was associated tointra-EU movers and invoicingproblems caused by the lack of effective coordination among Member States' social security systems.

On the other hand, PP politicians publicly blamedMIS for abusing and misusing the system. Claiming that 'the universalistic healthcare system is not for the whole universe' (Rafael Hernando, PP deputy spokesman in the Congress, El País, 14 August 2012), the economic framing of the problem (financial unsustainability, lack of EU coordination on reimbursement procedures) merged with a vision of the SNS as a closed system, which clearly delineates its members and defines who deserves access tohealthcare.

From this perspective, PP politicians deployed a rhetoric of 'crusade', blaming previous legislation forenabling'fraud with everybody's money', and universalism foracting as a magnet for foreigners willing to (ab)use the Spanish system. Therefore, the ultimate goal of the PP's reform was to put a stop to 'Spain being a country where people enrol in the local register (without residing here), with the sole goal of accessing healthcare and social services, when they don't even have a job' (Rafael Hernando, PP deputy spokesman in the Congress,El País, 14 August 2012). Within this framework, they claimed credit for the 2012 reform as it made it possible to tackle abuses: 'For the first time in history, a government is establishing controls to avoid health tourism and the fraudulent use of health services by foreign citizens.' (Spokesman of the Council of Ministries, La Nueva España, 22 April 2012).

Framing the reform as part of a 'tough approach', PP leaders claimed that it was necessary to place healthcare and social benefits off limits for low-income andofficiallyunemployed foreigners, calling for stricter migration controls and tougher

expulsions. In the words of Feijoo, president of Galicia Region (PP), 'undocumented [migrants] must regularise their legal status or leave' (El País, 14 August 2012).

Overall, PP discourses reveal a key feature of the problem-framing and general justification of the reform: blaming MISfor the system's deficits as a way to legitimate cost-containment measures and, most importantly, implement a radical change to the healthcare paradigm (Hall 1993). By linking the problem (fraud, inefficiency, crisis) to the solution (excluding undeserving migrants), they expected to reach their intended goal (a sustainable health system).

Embedded Universalism and Field Opposition: Opening the Path for the 2018 Counter-Reform

Following the introduction of RDL 16/2012, the PP-led government was confronted with a range of problems caused by excluding MIS from the SNS. The government hesitated when it came to its concrete implementation, first proposing the creation of private health insurance for MIS, then suggesting treating them in the SNS and forwarding the bill to their homecountries(Agustín Rivero, General Director of SNS; El País, 11 August 2012)[4]. Furthermore, it faced opposition from significant field actors, such as the Autonomous Communities, who tried tocircumvent the central government's restrictions; municipalities who launched initiatives to facilitate healthcare access for MIS; and healthcare professionals who continued to treat MIS regardless ofwhether they were officially entitled to care.

Overall, a deeply-embedded universalist logic permeated the system, ultimately frustrating theintended exclusionary effects of the PP's reform.

Path-Dependent Practices of Regional Healthcare Structures

As previous studies suggest (Bonoli 2001; Costa-Font 2010; Mortensen 2013),

retrenchment may be difficult to achieve in welfare systems with a high degree of vertical fragmentation of power, due to the large number of veto players participating in the policymaking process, whose agreement is necessary in order to change the status quo. The 2012 reform met with a great deal of resistancefrom Spain's federal system of *ComunidadesAutonomas*, although initial reactions were sharply heterogeneous[5].

Almost every regiontried to limit or frustrate the reform (Cimas et al. [2016]; Moreno Fuentes [2015]):two regions (Andalusia and Asturias) continued to provide full healthcare accessto MIS; eightregions (Aragon, Cantabria, Canarias, Cataluña, ComunidadValenciana, Extremadura, Galicia and País Vasco) extended state-defined coverage through 'complementaryprogrammes'; and five regions (Baleares, Castilla y Leon, La Rioja, Madrid, and Murcia) implemented the reform but made exceptions for MIS with chronic, mental or infectious diseases.

Remarkably, what initially seemed to be a horizontal clash between regions governed by opposing coalitions turned into a vertical conflict betweenthe national and regional governments.

Resorting to public health and ethical arguments, Navarra (governed by UPN, the region's right-wing nationalist party)and País Vasco (guided by PSE-EE,the Basque socialist party) were among the first regions to enact regional laws against the national reformin order to defend the core values of the universality, equity and quality of the healthcare system (Acta Sanitaria 2016; El Correo 2017), as well as to guarantee MIS' 'right to health and physical integrity' and 'prevent the spread of certain infectious diseases affecting directly the health of the society as a whole' (Público 2012).Although the national government lodged an appealagainst these laws at the Constitutional Court, the Court's verdicts upheld the two regions'responsibility to provide universal healthcare, ruling that the right to healthcare shouldprevail over the economic

benefitthat limiting healthcare may produce. The national government also brought a case against Valencia and Cataluña in the Constitutional Court for issuing universalist healthcare regional laws (Decree 3/2015; Law 9/2017). This time, however, Valencia's decree was annulled on the grounds that itencroached upon national responsibilities.

Learning from that experience, other regions chose a different strategy to pursue the same goal, i.e. 'continue providing healthcare, while avoiding the risk of a State appeal against the regional decision' (Andalucía, Instrucción 6 Junio 2013).Accordingly, most regions decided to indirectly facilitate universal healthcare access for MIS by resorting to administrative instructions, orders or regulations rather than regional laws (Table 1).

Importantly, the arguments put forward by regional governments to justify these measures revealed a deep rooting of universalismin the minds of the institutional actors working in the SNS.As the General Secretary of the Andalusian Health Department clearly affirmed, 'It is possible that our decision to keep providing healthcare has been used in the political debate against the central government. However, we [in Andalusia] have always guaranteed healthcare for all. Regardless of political competition, it is what we have always done, this is what our Statute of Autonomy affirms, that anyone living in Andalusia has a right to healthcare. And this is well before the political debate.'

Significantly, similar path-dependency arguments were mobilised by PP-run regions that continuedto provide healthcare for MIS. The General Director of the Healthcare Department of ComunidadValenciana,then governed by PP, stated'the truth is that you cannot change the way of looking at universalism and healthcare. There is an obligation, an ethic of healthcare professionals and of the entire healthcare system to provide care to those in need. You cannot change this.'

In a clear converging pathtowards reinstating healthcare coverage for MIS (Table 1)(Sevillano&Silió 2015),by the beginning of 2018, almost all regions wererelying on their margins for autonomy to circumvent the national lawby means of procedural and administrative tools, appealing to their institutional responsibilityfor providing healthcare.

[Table 1 near here]

Opposition from Pro-Universalism Advocacy Coalition

In addition to path-dependent practicesat the regional level, bottom-up opposition from other actors played a central role in frustratingthe 2012 reform. Immediately after its approval, a wide-ranging social movement emerged, bringing together a broad array of non-governmental actors who opposed the application of the decree and called for the reinstatement of universalism (Suess et al. 2014). This advocacy coalition included professional associations, patients' organisations, trade unions, NGOs, migrants' associations, grassroots movements created in response to the RDL 16/2012 (particularly, Yo SÍ Sanidad Universal and REDER – Red de Denuncia y Resistencia al RDL 16/2012), and the Ombudsman at national and regional levels.

Although these actors demanded the reintroduction of free and universal healthcare in general, a specific demand concerned the right to healthcare for MIS, who were seen as the most vulnerable group among those excluded from the SNS by the RDL 16/2012. Indeed, access to healthcare for MIS became a highly symbolic demand that embodied the struggle for 'healthcare for all'.

Pursuing this common goal, these actors developed distinct initiatives at different levels and venues, ranging from public opinion (opposition 'from below') to healthcare services and professionals (opposition 'from inside'), and the judicial arena (opposition 'from outside'). Concerning the first, campaigns and demonstrations

targeting public opinion tried to raise awareness of thenegativeeffects of the 2012 reform bypresenting evidence-based counterarguments and launching observatories to monitor healthcare exclusion and inequalityat the national and regional levels[6].

Simultaneously, opposition was originating 'from inside', that is, from health professionals whocontinued to provide free and full treatment to MIS, justifying their practicesin ethical and deontological terms. As Serafin Romero, General Secretary of the Medical College put it, 'it is [our] deontological duty to treat any citizen'*;* likewise, the President of the Spanish Association of Family and Community Medicine (SEMFYC) declared that'I treat people, not insured persons' (El País, 10 August 2019).[7]This 'opposition from inside' was soon supported by NGOs and professional organisations, such as Médicos del Mundo and Yo Si Sanidad Universal, which presented an argument for professionals' conscientious objection to the 2012 reform by launching a campaign named 'Right to Care'.While this venue became redundant in regions that reinstated healthcare coveragesoon afterthe 2012 reform, it representeda fundamental tool to minimisethe exclusionary effects of RDL 16/2012 in regions that had delayed reacting to it or initially implemented it to the letter.

Finally, opposition to the 2012 reform acted 'from outside', by judicialising politics at the regional, national and international levels. Denouncements by the national and regional Ombudsmen were crucial in this respect, aswas the endorsement by several international bodies of the pro-universalist coalition and its struggle to restore universalism.[8]Through this channel, cases of exclusion that were reported and compiled by the aforementioned observatories were used as a 'lever' in the judicial struggle. As explained by a representative of Red Acoge, a national network of pro-immigrant organisations,the judicial strategy was to choose a case and ensure it was prosecuted until a national court challenged the legal basis of RDL 16/2012,referring to the lack of

constitutional validity of the norm, or, as a final step, to lodge an appeal against the 2012 decreein the European Court of Justice.

The Path towards the 2018 Counter-Reform

Confronted with such widespread opposition, the PP began to show some willingness to modify its position in 2015. On March 2015, the Health Minister Alonso announced thegovernment's intention to grant MIS access to primary care, justifying this proposal on the grounds of 'public health reasons' and because 'it is more practical' to avoid crowding emergency rooms. At the same time, however, he emphasised that MISwouldnot be giventheir healthcare card back, as that would grant them '*a* right that they do not have elsewhere in Europe' (ABC 2015).

Although this promise did not lead to concrete measures, and was mere political spin in the run-up to the regional elections in May 2015, it demonstrated the salience of this issue in Spanish political debate. It was also at this point thatthe PP started to emphasisethe similarity betweenits vision on healthcare and that of one of its main competitors, the PSOE, in an attempt to avert criticism. The General Secretary of the PP claimed in Parliament, 'they[PSOE] know that the government wants them[MIS] to have access not only to emergency care but also to primary care' (La Vanguardia 2015).

It was no surprise, then, that one of first actions of the PSOE government upon gaining power in 2018was to repeal RDL 16/2012 and to re-include MIS as beneficiaries of public healthcare . However, there is a huge difference between words and deeds.

The 2018 Counter-Reform: Universalism at the Front Door, Selective Inclusion at the BackDoor

When RDL 16/2012 was introduced, the PSOE strongly criticized the reform, putting forward a rights-based frame. In opposition to the PP's economic-based argument, it

called for the restoration of universal healthcare on ethical/humanitarian grounds, to protect public health, and on the basis of national and international legal antecedents. Contrary to the PP, which interpreted healthcare as a conditional right linked to social security contributions, the PSOE framed it as a citizens' fundamental right –yet to beextended to any person living in Spanish territory–, and which therefore should be guaranteed by the State. Shortly after the 2012 reform was approved, Encarna Linares, PSOE spokespersonon healthcare issues in the Senate, asked the PP government to withdraw RDL 16/2012 as it was 'unjust, immoral and cruel' (RedacciónMédica, 5 June 2013). From a public health perspective, PSOE SenatorJoséMartínez Olmos warned that 'Diseases such as diabetes will be insufficiently covered; the same applies to infectious diseases, which become a public threat when leftuntreated' (El País, 8 August 2012).This framing of healthcare as a fundamental right of all individuals was alsoexpressedinthe PSOE's electoral programme for the 2015 municipal and regional elections: in its health section, entitled 'To treat healthcare as a right and not as a commodity', healthcare was defined as a 'fundamental andinalienable right', which 'is not for sale' (PSOE 2015).

Between 2012 and 2018, therefore, PSOE repeatedlypromised to 'shield' public funding for a public, free and universalistic healthcare system and to re-include those who had been excluded by the 2012 reform, MIS first and foremost (El País, 7 August 2012). Alfredo Pérez Rubalcaba,PSOE leader between 2012 and 2014,requested PP Prime Minister Mariano Rajoy 'to give healthcare back to immigrants' because'no decent society can support any of these two measures: withdrawing healthcare and charging for hospital medications' (El País, 9 October 2013). In line with his predecessor, the new PSOE leader Pedro Sánchez declared in 2015that, if elected, hisgovernment 'would allow immigrants in an irregular situation [who are in Spain] to

be treated in our public healthcare system' (EUROPA Press, 4 May 2015), a promise symbolised by his commitment to reissuing MIS with a healthcare card. In doing so, he targeted a wide share of potential voters. According to the results of the 2016 national health survey (CIS 2016), 64.8 per cent of respondents believed that MIS should receive the same SNS healthcare treatments as Spanish citizens.[9]

Hence, when in opposition, the PSOE struggled not only to frame the healthcare-irregular migration issue in a way that opposed the PP, but also to 'own' it more widely(Petrocik 1996). By invoking humanrights, ethical and public health arguments, and undermining the PP's cost-containment justifications for the 2012 reform by pointing to the negligible fiscal impact of providing healthcare services to MIS, it presented itself as the guarantor of social rights in Spain.

After bringing down Rajoy's government in June 2018,one of PSOE's first actions was to repeal RDL 16/2012. The new RDL 7/2018 'on universal access to the SNS' introduced important changes to the 2012 reform, particularly with regard to healthcare entitlements ('every person who resides in the Spanish state') and the policy goal ('access to the SNS in conditions of equity and universality'). In the new text, the right to healthcare was understood as a human right ('inherent to every human being'), and the equality of every person in the eyes of the SNS as a condition to be guaranteed (people were to have access to healthcare'without any discrimination, neither general nor targeted ones'). Dismantling the contributory-based logic behind the 2012 reform, the 2018 counter-reform decoupled healthcare entitlements from insurance status while reconnectingit toresidence in Spain.

Against such framing, however, a deeper look atthe entitlement criteria and procedures regulating healthcare for MIS reveals a convergence between the 2012 reform and 2018 counter-reform. Even though the new law established universalist

ownership of the right to healthcare (residence-based and regardless of nationality or legal status), it included conditions for exercising this right, indirectly distinguishing between 'rightful' and 'conditional owners' of healthcare entitlements. According to Article 3 of RDL 7/2018, to access free healthcare in Spain, a person must:

- have Spanish nationality and reside habitually in Spanish territory; or
- if Spain is not their usual place of residence, they must have a recognised entitlement to such right, as long as no other institution is obliged to cover her/his healthcare expenses; or
- be foreign-born with legal and habitual residence in Spain, and not under the obligation to show that they have any other sickness coverage.

More specifically, RDL 7/2018 and the Ministerial guidelines issued on June 2019 affirm that MIS are entitled to free healthcare on equal grounds to Spanish nationals, provided that:

(1) they are not obliged to demonstrate that they havehealthcare coverage in another Member State, according to EU law[10];
(2) they cannot export their healthcare rights from their country of origin/previous country of residence;
(3) there is not a third person liable for payment.

Therefore, although MISwere readmitted to the SNS, the 2018 counter-reform set significant eligibility and procedural restrictions. In order to exercise the right to healthcare, MIShave to demonstrate that they are not coveredby health insurance in another country, a bureaucratic obligation that could be extremely difficult to comply with, given the difficulties that this group faces with movement due to their legal status.This also applies to uninsured EU citizens, who must demonstrate that they do not

have health insurance in their home country within ten days after applying for healthcare in Spain. Importantly, this new criterion requires the person to providean 'official certificate of lack of coverage', which must beissued by the competent insurance body in their home country (Health Ministry, 2019 guidelines).

Moreover, RDL 7/2018 introduced an additional administrative barrier tohealthcare access for MIS, by establishing that Autonomous Communities will be in charge of determining the procedure for issuingthe healthcare card to this group.What had been a tangible symbol of the PSOE's struggle to restoreuniversalism when in opposition, has now becomea provision givingthe regionsroom for discretion, a state of affairs that could result in inequalities within the country.

It has become apparent that the PSOE'sexplicit objective of restoring universalismhas been indirectly tempered by the introduction of indirect but significant administrative and procedural barriershinderinghealthcare accessfor MIS. This group hasregained the same healthcare coverage as Spanish citizens –provided that they can manage to obtain access to it.

Symbolic Politics, Converging Outputs and the Embeddedness of Universalism

Since the 1990s, immigration has become an increasingly salient issue in political and public debates. Along the political continuum, parties continue to differ significantly in their discourses and proposed measures on migrants' integration and welfare entitlements, giving the impression of long-standing differences between right-wing and left-wing parties(Hampshire & Bale 2015; Natter, Czaika& de Haas 2020). When we comparepartisan discourses with policy outputs, however, our findingschallengethe idea that left-wing parties are more inclusive towards migrants, and MIS in particular, when it comes to actual policy reforms.While our findings confirm that partisan politics are

not irrelevant, and identify differences in PP and PSOEdiscourses and strategies to legitimate reforms concerning MIS' healthcare entitlements, they also indicate that their effects on policy outputs, that is, on actual entitlements, may be not so clear-cut.

At the discursive level, andin order to win public support, the PP and PSOE clearly competed to framethe issue (the 'why' of reforming healthcare entitlements)and the deservingness (or lack thereof) of the reform's most visible target group (MIS)(Cox 2001; Levy 1999; Slothuus2007).In a context of economic crisis and austerity policies,the PP raised the reform's profileand claimed credit for it, believing that framing healthcare as a right linked to national membership and contribution to the social security system while scapegoating 'illegal and foreign abusers' would secure it support from conservative and anti-immigration voters. Accordingly, retrenchment discourse and policies publicly and openly targetedMIS, a prototype of 'welfare undeservingness' (Willen 2012; Autor B; Reeskens& van der Meer 2019), particularly at times of economic and migration crises. In doing so, it targeted a politically weak group, as MIS are excluded from any political rights,lacking any power to impose sanctions on the government. In other words, in order to justify retrenchment, the PP engaged in a proactive strategy of framing MIS as being undeserving ofhealthcare, expecting political benefits (from conservative and anti-immigration voters) while downsizing its political costs(being protected against electoral punishment from those directly targeted by retrenchment).In order to convince its constituency that excluding MIS from healthcare was not only 'just' but also'necessary', the PP's discourse reveals the active use of two additional typical blame-avoidance strategies, i.e.: i) 're-framing the issue', identifying 'illegal and foreign abusers' – rather than administrative inefficiency – as the main cause of the SNS's fiscal problems; and ii) 'finding a

scapegoat', blaming universalism and left-wing governments for having allowed abuses by non-citizens.

Despite its investment in 'manipulating perceptions' (Vis 2016), the PP was taken by surprise by the widespread oppositionfromacross the field. Path-dependent practices of regional healthcare structures and opposition 'from below, inside and outside' played a central role in the overall policymaking process, ultimately frustrating the intended exclusionaryoutputs of the 2012 reform. If healthcare is not as 'partisan-neutral' as previous studies suggest (Green-Pedersen &Jensen 2019),then veto players are still relevant whenexplaining the success or failure of retrenchment. As our analysis indicates, in fact, existing structures of healthcare provision were strongly anchored in a universalist logic that has progressively and incrementally permeated the SNS and its field actors since the mid-1980s. Such embedded universalist logic was also revealed by healthcare professionals,who kept caring for MIS on a discretional basis, as well as by the wider population, who demonstrated strong support for the SNS and the right of MIS to healthcare across the country. Consequently, and in an attempt to redefine its discursive strategy in the face of upcoming regional elections, the PPwas torn between its policy preferences (retrenchment) and its electoral ambitions (Pierson 1996, p. 146). Itopted to softenits stance in public discourses andsilently allow regional PP governments to re-extend healthcare coverage for MIS.

Once in power, the PSOE used a combination of discursive strategies to reframe MIS' deservingness and to 'own' the issue of universal healthcare, while relying on less visible blame avoidance strategies of 'manipulating procedures'to reduce the visibility of MIS' enduring exclusion from public healthcare.Accordingly, PSOE's framing strategy set out to appeal toits own constituency by conceiving of healthcare as a 'human right for all', invoking ethical principles and public health arguments, and

struggling to ‘own the topic’ of healthcare rights for MIS in party politics. While its policy preferences (universalism) did not seem to present an obstacle to its electoral ambitions, when it took office, the PSOE faced a trade-off between defending universalist principles, as it had steadfastly promised to do when in opposition, and formulating measures to tackle ‘medical tourism’, a move that could be punished by its voters.

Anticipating this possibility, the PSOE government successfully resorted to technical and procedural changes in eligibility requirements – rather than visible changes in healthcare entitlements – to reduce the visibility of the restrictions facingMIS. From this perspective, our findings underpin theories of incremental change, by which welfare reforms often take place by means of an accumulation of piecemeal, gradual and subtle changes over time rather than radical reversals. It also indicates how issue framing (Ross 2000; Cox 2001) matters for the success of policy change, as the relative easiness with which the PSOE government passed its reform was contingent upon its ability to define the problem in a way that was politically and culturally acceptable to mainstream universalist public opinion. By linking pro-universalist discourses recognising MIS as legitimate beneficiaries of public healthcare through subtle changes in entitlement criteria, introducing barriers to exercising this right, the left-wing government succeeded in ‘getting the job done’ with public support where the right-winghadfailed.

In addition, and unlike the PP, the PSOE also enjoyed the institutional opportunities offered by the multi-level structure of the Spanish SNS, relying on a typical blame-avoidance strategy of ‘insulation’that involved shifting decision-making power to another body (Vis 2016).By restricting eligibility criteria at the national level while delegating to each Autonomous Community the responsibility of determining the

procedures for granting healthcare cards to MIS, the central government opted for a 'decentralisation of the healthcare burden',passing the buck of whether to actually include or exclude MIS to regional governments and their healthcare services.

Hence, although both thePP and the PSOE showed discrepancies between general ideological principles and specific policy measures, they resorted to different blame avoidance strategies to introduce restrictions in MIS' healthcare entitlements. While the right-wing government attempted to claim credit for healthcare retrenchmentby activelyand visibly'manipulating perceptions' ('framing undeservingness', 'strategic-reframing' and 'scapegoating'), the left-wing government openly claimed credit for restoring universalism to retain the approval of its voters, while silentlyintroducing retrenchment via less visible strategies of 'manipulating procedures' to avoid potential contestation from field actors. By combining such strategies, the PSOE managed to retrench healthcare rights for MIS without opposition. As a matter of fact, only a few of the field actors who actively engaged against the 2012 reform mobilised against PSOE's counter-reform. Grassroots movements such as REDER and YoSíSanidad Universal declared their concern about the potential exclusionary effects of the new entitlement criteria introduced by the PSOE's regulations on healthcare access for MIS (Seco 2018). Nevertheless, such complaints did not turn into a high-profile, widespread mobilisation of Spanish public opinion. As far as the PSOE's potential voters are concerned, universalism has been restored.

Overall, although our evidence does not refute the claim that parties matter when it comes to (migrants') welfare entitlements,our findings challenge the conventional 'left-right' cleavage in the welfare-migration politics research.Partisan politics are not irrelevant, but their expected differences in terms of policyoutputs may be limited as wellcontingent,as they areinfluencedby pre-existing healthcarelegacies and specific

micro-level, bottom-up mechanisms shaping visiblepolicy reform processes from multiple venues (below, inside, and outside).

Further research is needed to deepen our understanding of the welfare-migration politics nexus. In pursuing this goal, we suggest focusing not only on welfare state generosity (usually assessed in terms of spending) but also on welfare state inclusiveness (assessed in terms of actual entitlements)and to critically test the existence of a linear relation between right-wing parties and restrictions in migrants' welfare entitlements. That partisan differences exist at the level of discourses does not necessarily imply that theymatter for explainingactual retrenchments in welfare entitlements. As the Spanish case demonstrates, left-winggovernments may silently yet successfully lower migrants' entitlements to social protection where right-wingparties fail.

Endnotes

1. The city-enclaves of Ceuta and Melilla are directly run by the Health Ministry.
2. To access free healthcare, migrants with irregular status must enrol in the local population register (*Padron Municipal*), a procedure that does not require any proof of legal status, and attest lack of resources according to the Real Decreto 1088/1989, which extended access to healthcare for all people without sufficient economic resources.
3. In the period 2007-2013, the Spanish GDP growth rate decreased from 3.8% to -1.7%, while unemployment increased from 8.2% to 26.1% (Eurostat 2019). In such a context, also characterised by increasing public debt, EU and international financial institutions called upon Spain to implement fiscal consolidation, leading to the introduction of drastic austerity measures targeting – among others – the healthcare sector. Between 2010 and 2014, healthcare resources decreased by 13%.
4. In 2014, the Ministry of Healthcare formulated a model of health insurance for immigrants, that would be applicable to Ceuta and Melilla, the only two territories whose powers have not been decentralised (De Benito 2014).
5. The PSOE accused the government of '*having created a monster with 17 heads*' (El País, 31 August 2012).

6. Several regions also launched observatories healthcare exclusion and health inequalities, coordinated by NGOs, Universities and health professionals, such as the Odusalud in Valencia or Observatorio de Exclusión Sanitaria in Murcia. Annual reports were issued compiling and documenting cases of refusal of primary care, billing of services, etc. at both the regional and national level (by the country-wide network REDER). Likewise, some NGOs conducted research to identify discriminatory and discretionary practices by professionals (e.g. study by AndalucíaAcoge).
7. However, at the micro level, the picture was more complex, as front-line health service employees used their discretion to restrict access to healthcare. NGOreports documenting exclusionary practices show that they also occurred in those regions whose governments explicitly continued to providefullhealthcare coverage, such as Andalusia.
8. The UN Committee on Economic, Social and Cultural Rights (2012) called upon Spain to review austerity measures that were causing 'disproportionate harm' to the most vulnerable and marginalised groups and individuals, including migrants. In June 2013, the UN Special Rapporteur on contemporary forms of racism, racial discrimination, xenophobia and related intolerance, recommended the revision of the exclusionary measures introduced by the 2012 reform in order to guarantee access to healthcare for migrants, regardless of administrative status (UN Human Rights Council 2013). Likewise, the European Commission against Racism and Discrimination and the Council of Europe reminded Spain that the right to urgent and necessary healthcare services should be guaranteed for all in national law, including migrants with irregular status (ECRI 2018).
9. Unfortunately, the question about migrants' deservingness of public healthcare was only included in the 2016 survey.
10. This clause specifically refers to certain categories of EU migrant citizens, according to Regulation No. 883/2004, Implementing Regulation No 987/2009, and Directive No. 38/2004. Specifically, it concerns EU citizens who require healthcare during a temporary stay in the territory of another Member state (through the European Health Insurance Card, to be issued by the competent authority in the home Member State). It also applies to EU citizens residing in Spain for more than three months but who do not qualify as workers, must demonstrate that they have sufficient resources to avoid placing a burden on Spain's social assistance system, and have comprehensive sickness insurance cover in the host Member State.

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