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The Making of Human Rights Polities

Contentious Governance and the Uneven Implementation of Human Rights

The Case of Irregular Migrants' Unequal Access to Healthcare in Spain after Royal Decree Law 16/2012

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FOREWORD

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• Venner, Kayin Joëll, *The Making of Human Rights Polities: Contentious Governance and the Uneven Implementation of Human Rights. The Case of Irregular Migrants' Unequal Access to Healthcare in Spain after Royal Decree Law 16/2012*, Supervisor: Gorka Urrutia Asua, University of Deusto, Bilbao

The selected theses demonstrate the richness and diversity of the EMA programme and the outstanding quality of the work performed by its students. On behalf of the Governing Bodies of EMA and of all participating universities, we congratulate the authors.

Prof. Manfred NOWAK
Global Campus Secretary General

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Prof. George ULRICH
EMA Programme Director

This publication includes the thesis *The Making of Human Rights Polities: Contentious Governance and the Uneven Implementation of Human Rights. The Case of Irregular Migrants' Unequal Access to Healthcare in Spain after Royal Decree Law 16/2012*, written by Kayin Venner and supervised by Gorka Urrutia Asua, University of Deusto, Bilbao.

BIOGRAPHY

Kayin Venner is a recent graduate of the European Inter-University Centre for Human Rights and Democratisation (EIUC, Venice, Italy). Before completing his studies in human rights and democratisation in September 2018, he obtained a master's degree in Public Policy and Governance at the University of Amsterdam (2017), and a bachelor's degree at Wageningen University in International Development Studies (2016).

ABSTRACT

The emergence of 'new nationalism' undermines the principle of universality and threatens the realisation of human rights of irregular migrants. Within this context, and that of an economic crisis, Royal Decree-Law (RDL) 16/2012 encroached upon irregular migrants' right to health in Spain. Despite its enactment at national level, several autonomous communities refused to implement the law, among other things in the name of the (human) right to health. The latter depicts the emergence of 'human rights polities'; political entities at local, regional or supranational levels, less subject to new nationalism, that develop policies in contestation to existing hierarchies to uphold human rights. This process constitutes a process of contentious governance, which can be analysed through the concepts of political opportunity structures, the formation of collective actors and contentious performances. In the context of RDL 16/2012, autonomous communities within Spain have contributed to pressure from the bottom-up to implement human rights standards at regional and national level. Among other things, the gap in the implementation of RDL 16/2012 can be attributed to a divergence in competencies, political colour and interests between the national state and the autonomous communities, as well as diverse political opportunity structures and fragmented social pressure. The more inclusive nature of regional governments, I argue, is an argument in favour of the 'democratisation of human rights instruments', especially given the recent upsurge of new nationalism.

ACKWNOWLEDGEMENTS

TABLE OF ABBREVIATIONS

ACs	Autonomous communities
CESCR	Committee on Economic, Social and Cultural Rights
CSOs	Civil society organisations
ICESCR	International Covenant on Economic, Social and Cultural Rights
PP	Partido Popular
RDL	Real Decreto-Ley (Royal Decree-Law)
UDHR	Universal Declaration of Human Rights
UN	United Nations

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INTRODUCTION

Like many other countries, Spain has been roaming in the dark pertaining to the ways in which to accommodate irregular migrants within its society whilst upholding human rights. Due to irregular migrants' migratory status and the restrictive nature of national legislation, irregular migrants are regularly in a vulnerable position and do not enjoy full access to economic, social and cultural rights.[1] It is a well-known phenomenon that economic, social and cultural rights are frequently revoked during times of economic crises, despite the fact that they are subject to progressive realisation. Within this context, following the economic crisis of 2008, the Spanish government enacted Royal Decree-Law (RDL) 16/2012 to ban irregular migrants from primary health services, with the exception of minors and pregnant women.[2] Interestingly, however, RDL 16/2012 was not implemented evenly across the country. Despite the reality of restrictive national legislation, some lower levels of government designed health policies of a more inclusive nature, effectively granting irregular migrants access to healthcare services.[3] In so doing, autonomous communities (ACs) played (and still play) a crucial role in providing access to health and ensuring the universality of the human right to health, which makes it an important unit of analyses – too frequently overlooked – in the governance of migration and the realisation of human rights.

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[1] Blanca Garcés-Mascareñas and Sébastien Chauvin, '6. Undocumented Immigrants' [2017] Urban Europe 51.

[2] Nuria Sangüesa Ruiz, 'El Derecho a La Salud de Los Extranjeros Residentes En Situación Irregular: Sobre La Legitimidad Constitucional Del RD-Ley 16/2012' [2015] Revista electrónica del Departamento de Derecho de la Universidad de La Rioja, REDUR 233.

[3] Marta Cimas and others, 'Healthcare Coverage for Undocumented Migrants in Spain: Regional Differences after Royal Decree Law 16/2012' (2016) 120 Health Policy 384.

Although political landscapes differ across the regions, these cannot possibly explain the differentiated implementation solely. Cimas and others found that 'political party coincidence in the regional and national governments does not fully account for the differences in the implementation of the RDL 16/2012'.[4] At least 5 of the 17 ACs that designed more inclusive health policies and thus turned their back on RDL 16/2012 had a Partido Popular (PP) ruling majority in government, so politically matching the national level.[5] Despite the corresponding political landscape, these regions implemented the RDL in different ways and, more interestingly, actively challenged it. In other words, other factors than solely political colour must play a role; factors which may potentially be influenced by human rights advocates and defenders on the ground, as opposed to intangible political sentiments on higher levels that are difficult to steer. It is important to understand both the political and non-political factors that led to the implementation gap in order to grasp how the realisation of the human right to health can be improved.

Why then did some regions act in accordance with the universality of the human right to health, whilst others followed the regressive national legislation? In other words, what factors influenced ACs in providing access to health and how come some regions went further than others? Did ACs disobey the national legislation out of a belief in the universality of human rights? Or did they do so for other reasons, such as public (health) safety, political mobilisation from below, path dependency and so forth? In order to answer these and other questions, I aim to analyse what reasons and factors underlie the implementation gap of restrictive national legislation that excluded irregular migrants in Spain from the (primary) healthcare system. I will do so by means of a case study and hope it will lead to a better understanding of the challenges and the opportunities that exist with regard to the (regional and local) implementation and realisation of the human right to health.

This brings me to the societal relevance of this thesis. Primarily, for any firm believer in the universality of human rights, it is vital to grasp how and why irregular migrants are excluded from health services in order to come up with strategies to include them. The latter is a necessity, not

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[4] Marta Cimas and others (n 3) 386.
[5] ibid.

only to respect their human dignity and rights, but also since excluding irregular migrants from social services like health may contribute to further stigmatisation of migrants and overall racism toward this group.[6] Moreover, since 'restricting access to social services for undocumented migrants can … undermine policy objectives in the areas of social cohesion, labour market, public health, and education strategies, and risk downgrading Europe's labour conditions',[7] understanding the factors that influence inclusion of irregular migrants on a regional level may ultimately contribute to a variety of positive social, economic and cultural impacts for society as a whole.

Academically, scholars have paid insufficient attention to the critical comparison of regions within countries that unevenly implement human rights, for example in terms of the enactment of progressive versus restrictive policies in the area of health. So far, and especially in relation to non-federal states, the academic and policy emphasis has been on the national level on the one hand, and (more recently) the local, city level on the other,[8] subsequently throwing the regional level on one heap with the local level or ignoring the regional level altogether, whereas they too have competencies relevant in the realisation of human rights. It remains questionable why some regional levels of governments become defenders of human rights, while others do not. Instead of presuming the progressive nature of lower levels of government and/ or ignoring regions that show regressive signs,[9] I aim to critically compare them. I expect there is much to learn with regard to the precise factors determining successful implementation of human rights at the regional versus the national level in the context of irregular migration. Theories on contentious governance, polities, social movements and path dependency will be analysed to shed light on the (non-political) factors that influence the successful implementation of the human right to health.

[6] Kadri Soova and Michele LeVoy, 'PICUM Position Paper on Undocumented Migrants and the Europe 2020 Strategy: Making Social Inclusion a Reality for All Migrants in Europe' 10 < http://picum.org/wp-content/uploads/2017/11/UndocumentedMigrantsandEurope2020Strategy_EN.pdf >. Accessed 13 April 2019
[7] ibid.
[8] Maurizio Ambrosini, '"We Are against a Multi-Ethnic Society": Policies of Exclusion at the Urban Level in Italy' (2013) 36 Ethnic and Racial Studies 136
[9] ibid.

Now that the case has been briefly introduced and the societal and academic relevance has been elaborated upon, a theoretical approach will follow, which will form the framework of my research analysis. After the theoretical approach, the formulation of a research question will be outlined. Then, in the methodology, I will shed light on how the research question will be answered. Subsequently, a case analysis will follow in which I will incorporate, in a critical way, the theories discussed in the theoretical framework. After the case analysis, I will discuss the conclusions and elaborate on the limitations and potential impact of my research within and outside academia, eg with regard to policy makers and human rights defenders.

1.

THEORETICAL FOUNDATIONS UNDERLYING IRREGULAR MIGRANTS' RIGHT TO HEALTH IN RELATION TO THE EMERGENCE OF HUMAN RIGHTS POLITIES

The theoretical framework will comprise of four parts. I will firstly elaborate upon my conceptualisation of human rights and the human right to health, by positioning this work in the human rights field, using Dembour's four-school approach.[10] Subsequently, the term 'irregular migrants' will be elaborated upon, among other things, in connection to theories on citizenship and (new) nationalism. Thereafter, I will relate all this to theories that may account for policy divergence among regions and the state, such as competing ideas of citizenship, path-dependency and contentious governance, touching upon important concepts that will play a central element in the case analysis such as contentious performances, political opportunity structures and the emergence of the human rights polity.

1.1 HUMAN RIGHTS AND THE HUMAN RIGHT TO HEALTH

Both irregular migration and the human right to health – human rights in general, for that matter – can be interpreted in different ways. Depending on how one makes sense of human rights, among other things, one may evaluate different situations as constituting a violation of human rights. By positioning this work in a heuristic human rights model, based on the scholarly work of Dembour, my understanding of human rights, and the human right to health in specific, will be elucidated upon; an obvious necessity before

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[10] Marie-Bénédicte Dembour, 'What Are Human Rights-Four Schools of Thought' (2010) 32 Hum Rts Q 1.

elaborating upon the relationship between irregular migrants and the human right to health. Moreover, by elaborating upon the heuristic human rights model, I aim to shed light on how we can account for peoples' (including judges') diverse evaluation of whether excluding irregular migrants from health services constitutes a breach of a human right.

According to Dembour, the human rights field can be subdivided into four schools of thought – the natural, the deliberative, the protest and the discourse school – and each of them encompasses a specific understanding of human rights.[11] Whereas each of the four different schools of thought differs in their understanding of human rights, they should be seen as 'overlapping orientations rather than clear-cut quarters'.[12] In other words, these different orientations may interact with one another so that it may well be possible for one scholar to belong to different schools of thought. Importantly, limitations of Dembour's model are recognised in her own work: 'The model is thus offered as a heuristic device which does not attempt to reflect the complexity of arguments made about human rights'.[13] Having said this, I will shortly elaborate upon the different schools of thought, before positioning this work and myself in the model.

Scholars belonging to the natural school will think of human rights as 'those rights one possesses simply by being a human being'.[14] A central concept in this school is the concept of human dignity, which is a term reflected in many treaties and declarations. Not surprisingly, therefore, it is one of the most dominant schools of thought. Human rights, according to this school, derive their meaning from 'nature', which can be understood as something transcendental; for some this may be God, for others this may be reason, the universe, etc.[15] According to this school, the recognition of human rights by people and or states is not a prerequisite for the existence of them, although

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[11] Dembour (n 10).
[12] Marie-Bénédicte Dembour and Tobias Kelly, *Are Human Rights for Migrants?: Critical Reflections on the Status of Irregular Migrants in Europe and the United States* (Routledge 2011) 12.
[13] ibid.
[14] Dembour (n 10) 3.
[15] ibid.

they do acknowledge that recognition in treaties and declarations is desirable. Lastly, scholars belonging to this school are generally optimistic about the potential of human rights law to prevent human rights violations from happening.[16]

In contrast, scholars belonging to the deliberative school conceive of human rights as those rights that have been agreed upon between societies. By extension, the deliberative school challenges the naturalistic view of the natural school and focuses on that which has been written down in law.[17] Consequently, this school emphasises the limitations of human rights; there is not more to it than that which has been agreed upon.[18] In other words, human rights are created through a deliberative process, and they do not exist beyond that.

The protest school puts human rights central in the fight against oppression and the pursuit of social justice.[19] Scholars belonging to this school conceive of human rights as claims that the oppressed can deploy in combatting injustice, although they acknowledge that there are more human rights in existence than just those that have been enshrined in laws. The latter derives from the belief that human rights law is ultimately in the hands of an elite, which may have contradicting interests compared to the oppressed.[20] Scholars belonging to this school of thought are more concerned with the economic and political systems creating marginalisation and human rights violations, and are therefore less optimistic about the potential of human rights law.

Finally, scholars belonging to the discourse school do not conceive of human rights in the natural sense, but in the discursive sense. That is to say, although they do not belief in the human rights idea, they do acknowledge that their existence in political discourses can make them powerful tools. Within this school of thought, given their lack of a belief in human rights, scholars often call for the need of an alternative movement of emancipation.[21]
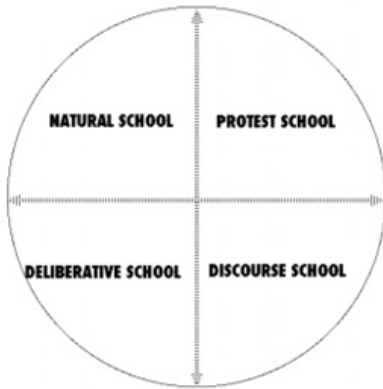
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[16] Dembour and Kelly (n 12) 18-19.
[17] Dembour and Kelly (n 12) 19.
[18] Dembour (n 10) 3.
[19] ibid.
[20] ibid.
[21] ibid 4.

Figure 1: The human rights field[22]

I would position myself, and by extension this thesis, somewhere in between the natural school and the protest school. In other words, this work regards human dignity as central to human rights and finds affiliation with those scholars who argue that everyone is entitled by nature to certain basic rights, which ultimately derives from our common humanity. At the same time, however, this work acknowledges that protest and political struggle are essential elements in the realisation of these rights, given skewed economic and political systems underlying human rights violations. Furthermore, in line with the protest school, it should be acknowledged that a slight suspicion to human rights law is imperative, as it is incomplete at best, among other things because the human rights regime is currently not well suited for the protection of those who lack legal recognition/lack citizenship. Moreover, this work finds agreement with the argument that there are more human rights than those that are protected by law, such as the right to global freedom of movement and/or the right to sexuality/sexual orientation.

Having been explicit about my position and by extension that of this thesis in the human rights field, it is critical to zoom into the human right to health to elaborate on what it exactly entails and encompasses. In a legal sense, the human right to health is an economic, social and cultural

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[22] Dembour (n 10) 5.

right and enshrined in various treaties such as the Universal Declaration of Human Rights (article 25) and the International Covenant on Economic, Social and Cultural Rights (ICESCR) (article 12).[23] Because 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health' falls under economic, social and cultural rights, national governments are subject to progressive realisation using the maximum number of resources that are available to them.[24]

The right to health encompasses, among others things, access to health services, but can even be interpreted as including access to housing and sufficient and adequate food.[25] Given the scope of my thesis, I will leave open the question of whether the right to health also constitutes certain obligations of states to provide adequate food or access to housing. In this thesis, therefore, I will refer to the right to health in a narrow sense, with reference to the right for everyone to have access to healthcare services, including both primary and emergency care.

Relating the right to health to irregular migrants, it must be remarked that the need of healthcare among irregular migrants is frequently high, given that they constitute a particularly vulnerable group. Firstly, the (traumatic) process of illegal immigration frequently has consequences for one's physical and mental health, and secondly, lacking forms of social protection, irregular migrants often live and work in bad conditions, which furthermore negatively impacts their health.[26] In practice, however, it can be observed, among other things because access to primary healthcare is not guaranteed throughout Europe, that irregular migrants in Europe make less use of primary healthcare than the average person or regular migrant.[27]

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[23] Sylvie Da Lomba, 'Irregular Migrants and the Human Right to Health Care: A Case-Study of Health-Care Provision for Irregular Migrants in France and the UK' (2011) 7 International Journal of Law in Context 357; Universal Declaration of Human Rights (adopted 10 December 1948) UNGA Res 217 A(III) (UDHR) art 25; International Covenant on Civil and Political Rights (adopted 16 December 1966, entered into force 23 March 1976) 999 UNTS 171 (ICCPR) art 12.

[24] ibid 360.

[25] John Tobin, *The Right to Health in International Law* (OUP 2012).

[26] Marta Cimas and others, 'Healthcare Coverage for Undocumented Migrants in Spain: Regional Differences after Royal Decree Law 16/2012' (2016) 120 Health Policy 384.

[27] Marjolein Winters and others, 'A Systematic Review on the Use of Healthcare Services by Undocumented Migrants in Europe' (2018) 18 BMC Health Services Research 30.

1.2 Irregular migration and citizenship

Although everyone is entitled to rights, in (legal) practice it can be observed that certain groups are frequently excluded from the enjoyment of human rights. Among these are irregular migrants. To make sense of why this is the case, I will define the group 'irregular migrants', and link this to theories on citizenship and nationalism.

An important observation that can be derived from the literature is that a proper term to define the category of migrants who are living in a country in which they do not enjoy legal authorisation, does not exist. Rather, many terms are currently used by scholars to define the same category of migrants, for example by referring to them as 'undocumented', 'irregular' or even 'illegal'.[28] Given that the vulnerability of this category of migrants is subject to the volatility of their status, which is ultimately a 'social, political and legal construction', it can change over time depending on, among other things, political circumstances.[29] Because the word 'irregular' emphasises the precariousness of their legal status (which is not fixed, but irregular and volatile; their status can be temporarily legal, then change to illegality and back again), I have decided to adopt the term 'irregular migrants', as opposed to undocumented, which is a more static interpretation.

An important consideration, in line with the protest school, is that it is questionable to what extent the migratory status is the only problem underlying irregular migrants' inaccessibility to human rights. Rather, it is likely that their migratory status intersects with other characteristics that often define this group, which ultimately leads to a state's aversion to realise their human rights, whether consciously or unconsciously. In the words of Dembour and Kelly:

> If the access of migrants to human rights is problematic, it may not be so much because the people we are talking about are migrants, but because they are predominantly poor and black, linked to a long history of political and economic exploitation. These migrants are denied rights, not so much because they have crossed an international border some time in their lifetime (many of us in the cosmopolitan 'elite' do this regularly without any consequent problem), but because they are politically and socially marginalized.[30]

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[28] Alice Bloch and Sonia McKay, *Living on the Margins: Undocumented Migrants in a Global City* (Policy Press 2016) 6.
[29] ibid.
[30] Dembour and Kelly (n 12) 9.

Despite this marginalisation, it is important to acknowledge that irregular migrants have agency and should not solely be seen as 'victims'. Although legal and political circumstances often shape their lives in a negative way, they themselves have the power to change their lives and circumstances too. According to Bloch and McKay this individual agency and power is essential to take into account in academic analyses on irregular migrants.[31] Having said that, irregular migrants often do not mobilise out of fear to draw attention to their irregular status. Moreover, in line with this, '… immigrants face particular problems in political organisation. The particular conditions in which the most marginalised migrants live mean that they lack the moral, political and economic resources for this struggle'.[32] Given this context of marginalization, it is likely that in those places with inclusive health policies, irregular immigrants interests' have been strengthened by CSOs and other political agents, who may have politically mobilised in their name or alongside them.

Having further clarified the group of migrants that will be focused on in this thesis, I will now link the above to theories on citizenship and nationalism. To understand the situation and vulnerability in which irregular migrants live, the connection between human rights and citizenship (nationalism) is of key significance. The reason for this being that in practice human rights are too often merely protected by states in relation to possession of particular citizenship (namely citizenship of the particular country).[33] The latter is why the principle of universality is relevant in relation to irregular migration, given that this notion goes beyond the pathological connection between human rights protection and citizenship. In order for one to grasp these linkages, we must engage with, among other things, the history of state building and the evolution of our understanding of citizenship and nationalism.

Ever since its conceptualisation in Roman times, and before that during the time of the ancient Greeks, citizenship encompassed an element of exclusion. After all, in ancient Athens, for example, only a certain segment of the population was granted citizenship, the non-citizens being the women, slaves and children.[34] Up until medieval times, citizenship was still conceived of as a relationship some entitled individuals had to cities,

[31] Bloch and McKay (n 28) 7.
[32] Dembour and Kelly (n 12) 9.
[33] Laura Thompson, 'Protection of Migrants' Rights and State Sovereignty' (2013) 1 UN Chronicle (online).
[34] Gerard Delanty, *Citizenship in a Global Age* (McGraw-Hill Education (UK) 2000) 11.

and importantly not to nation states. In other words, the word did not yet refer to nationality in any way.[35] However, over the centuries a shift can be observed in the way people have come to understand citizenship and the political community to which it belongs.

Whereas the term citizenship initially signified membership of a city (-state) with specific rights as well as corresponding duties, the process of state building from the 16th century onwards drastically changed our conceptualization of citizenship.[36] At this time, the increasing power of the state challenged the urban relationships that people had attained over the centuries. According to Delanty, this process of state building led to the assimilation of difference and the effective naturalisation of those who were deemed (culturally) different (assimilating those whom are different to create loyalty with the state). Delanty refers to the type of nationalism that accompanied this process of state building as 'old nationalism', which according to him was based on patriotism.[37] During this period, the emphasis was placed on the principle of equality (eg the principle of *egalité* in the French revolution), since it proved instrumental to state building.

In contrast to this, over time citizenship has moved toward the recognition of difference and away from the principle of equality.[38] According to Delanty and Castells, this is because nationalism has lost its connection to state building.[39] In recent times, a new kind of nationalism has evolved, coined 'new nationalism' by Delanty, a type of nationalism that is less inclusive than the old kind of nationalism because it has replaced the idea of equality with the idea of difference.[40] The above is in line with Manuel Castells' observation that nationalism is increasingly reactive instead of pro-active; it is increasingly about defending cultural institutions, rather than about state building.[41] In other words, it is primarily becoming a cultural and ethnic kind of nationalism, rather than a political kind of nationalism.[42] Arguably, Delanty states that new nationalism is an expression of social discontent, rather than of a patriotic sentiment.[43]

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[35] Delanty (n 34) 12.
[36] ibid.
[37] ibid 97.
[38] ibid 10.
[39] Manuel Castells and Cambridge Blackwell, *The Information Age: Economy, Society and Culture. Volume 1: The Rise of the Network Society* (Citeseer 1997); Delanty (n 34).
[40] Delanty (n 34) 97.
[41] Castells and Blackwell (n 39) 31; Natalie Sabanadze, *Globalization and Nationalism: The Cases of Georgia and the Basque Country* (Central European UP 2010) 25.
[42] Sabanadze (n 41).
[43] Delanty (n 34) 95.

One of the ways in which this is reflected is through feelings of extreme hatred toward immigrants. Whereas the old nationalism tried to assimilate otherness, new nationalism defines itself by denouncing difference without the assimilating effort. In Delanty's words, 'It [new nationalism] is more a matter of xenophobia than of jingoism … Nationalism today no longer appeals to ideology but to identity and material interests'.[44]

In a context of new nationalism, two prevailing understandings of citizenship can be identified: a classic understanding of citizenship connected to both the market and the state and encompassing a legal status (which is therefore more exclusionary), versus an understanding of citizenship that is defined more substantively (and thus less formally) through participation in a political community.[45] At this point, looking at the relationship between rights and citizenship, it should be noted that the rights attached to citizenship are bound to the political community to which it belongs. In other words, citizenship rights are much more particularistic, whereas human rights are more universalistic.[46] Over time, the rights of individuals as human beings and the rights of citizens have diverged,[47] and it is this divergence that is paramount to our understanding of the inhumane situation of the irregular migrant.

In her famous work *The Origins of Totalitarianism*, Arendt – one of the most renowned political philosophers of the 20th century – criticises human rights for its lack of enforcement potential and for its protection mechanisms ultimately depending upon the will of nation states.[48] Securing rights, she argued, only truly happens through membership of a political community, through citizenship. At this point, she argued that the inadequacy of human rights is reflected by the non-realisation of irregular migrants' human rights.[49] She emphasised the fact that those irregular migrants whom are stateless are effectively without protection of the political community. After stressing the gravity of the extent of marginalisation of stateless people by arguing that even slaves had a place within the community, albeit it was one of extreme exploitation and marginalisation, Arendt argues:

[44] Delanty (n 34) 97.
[45] ibid 9.
[46] ibid 69.
[47] ibid 68.
[48] Hannah Arendt, *The Origins of Totalitarianism* (vol 244, Houghton Mifflin Harcourt 1973).
[49] ibid.

Not the loss of specific rights, then, but the loss of a community willing and able to guarantee any rights whatsoever, has been the calamity which has befallen ever-increasing numbers of people. Man, it turns out, can lose all so-called Rights of Man without losing his essential quality as man, his human dignity. Only the loss of a polity itself expels him from humanity.[50]

Although not all irregular migrants are stateless, they too often lose their polity, albeit in a more substantive sense by being physically apart from their country of origin that is unable or unwilling to protect them in the country where they reside. Despite the negative evaluation of Hannah Arendt dating back to the first publication of her book in 1951, it should be remarked that novel mechanisms of protection have arisen that move beyond the nation state system (treaties, novel monitoring bodies and systems, regional human rights mechanisms), so that one could argue that a certain form of protection is nowadays also guaranteed for irregular migrants. Stronger still, human rights are one of the only sources of protection for irregular migrants in our current societies as they are frequently socially, politically and economically marginalised by the host societies.[51] However, at the same time, the human rights regime does not suffice in effectively realising human rights on the ground.

I would argue that the contention that surrounds the classic understanding of citizenship might open up spaces for alternative expressions of citizenship and democracy (such as the human rights polity, which will be introduced shortly). By extension, the second kind of citizenship, the less formal one, allows for more local notions of citizenship, since residing and participating in a political community can be substantively exercised and realised at lower levels, irrespective of a particular legal or formal status. Ultimately, however, the problem remains that the effective realisation of human rights is still very much dependent on the Westphalian world order, as stressed by Arendt. Those who do not have a place within this world order, being de-facto stateless or undocumented, are the 'wasted lives' of our time, to borrow a telling term by Zygmunt Bauman.[52] They are a testament to the need of better human rights protection, and their marginalisation is a thorn in the eye for those with a belief in human dignity.

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[50] Arendt (n 48) 297.
[51] Bloch and McKay (n 28).
[52] Zygmunt Bauman, *Wasted Lives: Modernity and Its Outcasts* (John Wiley & Sons 2013).

1.3 Contentious governance and the making of human rights polities

Perhaps it is this thorn that has resulted in protest from lower levels of government, and the opening up of spaces for alternative expressions of citizenship and democracy. Garcés-Mascareñas and Chauvin emphasise that with regard to irregular migrants the local level of government is of vital importance since this is where irregular migrants can still be included in societies that uphold overall exclusionary policies.[53] The increased attention to the local level as a beacon of hope fits within the more general shift within academia to stop disregarding space as non-influential on the social, economic and cultural. This on-going spatial turn signifies the increased attention of the relationship between space and society within academia.

Unmistakably, it is at the local level where interaction takes place between and among citizens and non-citizens, where one is closer to everyday realities and where irregular migrants come into contact with support networks of civil society and street level bureaucrats.[54] It has been argued that these street level bureaucrats, motivated by humanitarian and professional concerns, play an essential role in the incorporation of irregular migrants.[55] In other words, street-level bureaucracy has been put to the fore as one of the reasons why irregular migrants have been granted access to public services, including health care (eg professionals such as doctors unwilling to ignore their professional ethical codes).

Perhaps not surprisingly, reality on the local level is more complex than this, as it turns out that it is not merely 'sunshine' on the local level either. As Ambrosini has shown by means of a case study in Italy, local authorities sometimes also enact more rigid and exclusive policies that effectively exclude migrants from economic, social and cultural life.[56] Whereas scholars have given ample attention to the inclusive nature of local levels of government, they have largely ignored the restrictive nature that sometimes also germinates from the local level.[57] Moreover, in line with this, they have also ignored the divergence among local (regional) levels in terms of inclusive versus exclusive policies. Despite the attention

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[53] Blanca Garcés-Mascareñas and Sébastien Chauvin, '6. Undocumented Immigrants' [2017] Urban Europe 51.
[54] ibid 52.
[55] ibid.
[56] Maurizio Ambrosini, '"We Are against a Multi-Ethnic Society": Policies of Exclusion at the Urban Level in Italy' (2013) 36 Ethnic and Racial Studies 136
[57] ibid.

on the local and national level, it is still unclear what factors underlie the uneven realisation of progressive versus regressive policies on regional levels in a comparative sense. It is the latter that this thesis tries to shed light on.

It is not just street level bureaucrats that may challenge exclusionary laws. As has been outlined in the introduction, various regional and local governments actively challenged RDL 16/2012, which restricted access to healthcare services for irregular migrants. In order to make sense of this contestation between governmental players, the concept of 'contentious governance' can provide insights. First and foremost, the concept recognises that the government – or the state for that matter – is not a unified actor or entity; different governmental actors and levels of government may have different and competing interests and competencies. This is in line with the principle-agent theory/problem,[58] which argues that agents – in this case the ACs – may diverge from decisions taken by the principle (the Spanish state) due to the agency that the agents have and the idea that the decisions taken by the principal do not always coincide with the interests of the agent. It is therefore better to think of the state as composed of a myriad of actors who compete for power on a variety of issues, among which immigration policies and health policies. This is illustrated by the emphasis on 'governance', as opposed to government. The relatively recent emphasis on governance in political science has been broadly documented starting from the 1990s.[59] The increased autonomy of governmental actors as a consequence of, among other things, decentralisation, and the role of networks of self-organising civil society in designing policies are exemplary of the shift from government to governance.[60]

In line with this shift toward governance, Hajer has argued that policies are increasingly being developed without the presence of a clear-cut polity.[61] Policy is increasingly being developed beyond and

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[58] Francisco Javier Moreno Fuentes, 'El Puzzle de La Exclusión Sanitaria de Los Inmigrantes Indocumentados En España' [2015] Anuario CIDOB de la Inmigración 277, 290.

[59] Roderick Arthur William Rhodes, 'The New Governance: Governing without Government' (1996) 44 Political Studies 652.

[60] ibid 666; I Verhoeven and C Bröer, *Contentious Governance: Local Governmental Players as Social Movement Actors* (Amsterdam UP 2015) 4 <https://dare.uva.nl/search?identifier=8ee15a55-6686-4249-9f5e-0adbec29be91> accessed 10 November 2018.

[61] Maarten Hajer, 'Policy without Polity? Policy Analysis and the Institutional Void' (2003) 36 Policy Sciences 175.

within traditional polities that define the nation state. Issues like climate change are being deliberated upon in an institutional void, Hajer argues, a space in which we lack the established institutions, rules and norms to properly deal with an issue.[62] The term institutional void does not merely relate to policies that are designed in unconventional spaces of governmental players, it also relates to the involvement of other actors in designing policies, such as companies and CSOs. In other words, given the myriad of competing actors at hand, the polity has lost its stability and should currently be conceived of as something discursive. As such, it has become an interesting unit of analysis.[63]

In line with the idea of polities as something discursive, I argue that we are witnessing, among other things, the emergence of novel polities, including 'human rights polities'. According to Corry:

> polity-structure exists when a group of units become oriented towards the governance of a common 'governance-object'. The latter can be defined as an object that is constructed as real, distinct, malleable and subject to political action, for example, constructs such as 'France' or 'the climate'.[64]

Given my positioning in the human rights field, I would argue that human rights are real constructs; they exist. They are enshrined in declarations and treaties that are tangible, and beyond that the human rights idea is, I believe, just as much a reality as the idea of the state, with reference to Corry's example, the idea or construct of 'France'. Moreover, human rights are not only real, they are malleable, since political agents can shape their realisation and/or non-realisation, just as much as the climate can be influenced by unsustainable behaviour, making both conditional on political action.

By extension, I will define human rights polities as those political entities (eg cities and regions) that uphold human rights in contestation to existing hierarchies; it is not just the presence of human rights policies that results in the creation of the human rights polities within (and beyond) the nation state, but the active defiance of hierarchy, a process

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[62] Hajer (n 61).
[63] ibid 176.
[64] Olaf Corry, 'What Is a (Global) Polity?' (2010) 36 Review of International Studies 157, 159.

of intra-governmental disobedience if you will, that was required for these policies to be enacted, making them a distinct group of units oriented towards a common governance object. Contention is a vital component of a human rights polity, depicting the true commitment of the group of units to human rights protection. In other words 'the polity is constructed, dynamically, through contestation in the political process, with occasional involvement by courts'.[65]

Since the state is not the obvious polity anymore,[66] it could also be argued that the state is not always the appropriate unit of analysis anymore in relation to human rights realisation. After all, some areas (regions or cities) within a state may realise rights, whereas others may not. This reflects the idea of human rights polities; islands of a politics of human dignity within (and perhaps beyond) nation states that offer a countermovement to the convulsing politics of a new type of nationalism that seems increasingly xenophobic.

Table 1: Overview of different political systems[67]

	Political systems (sets of units that interact enough to have to take each other's actions into account)		
	Hierarchy	Anarchy	Polity
Constitutive feature	Existence of a sovereign	Absence of sovereign power and absence of common governance-object	Existence of a common governance-object
Ordering principle	Super – and subordination between subjects	Coordination between subjects	Orientation towards common governance-objects
Organisation of political space	Vertical	Polar	Concentric
Principle of memebership	Centralised inclusion/exclusion	Systemic mutual recognition	Decentealised identification
Variable dimensions	Centralisation/ Decentralisation of power	Unipolar/multipolar	Dense/dispersed

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[65] Cristina M Rodríguez, 'Noncitizen Voting and the Extraconstitutional Construction of the Polity' (2010) 8 International Journal of Constitutional Law 30, 31.

[66] Hajer (n 61).

[67] Corry (n 64) 174.

The emergence of human rights polities goes beyond the development and emergence of 'human rights cities', a phenomenon that has been increasingly explored in academia over the past few years.[68] In other words, it should be remarked that although human rights cities may constitute a human rights polity, not every human rights city would necessarily constitute a human rights polity, since one can only talk about a distinct polity when in its efforts to protect human rights it acts in contestation with state policies and/or laws. In that sense, a human rights polity is relational to existing hierarchies. Moreover, human rights polities can be local (cities), but also regional (or supranational), which makes it a relevant term in relation to provinces and or states within (federal) countries.

Within the debate around human rights cities, the role of local levels of government in the realisation of human rights on the ground has been extensively recognised.[69] In Europe, although some scholars mention 'regional authorities' on one heap with local authorities,[70] the academic focus has primarily been on cities and municipalities, as opposed to regions such as provinces or states within countries. This is somewhat in contrast to scholarly work in the United States and Canada, where for example federalism has been more extensively analysed in relation to human rights implementation.[71] Importantly, it is essential to stress that it is relevant to distinguish between the local and regional levels of government, and thus to not throw them on one heap, given that their competencies may vastly differ and their efforts to protect human rights may be distinct.

In relation to the realisation of human rights 'on the ground' or in practice, scholars have stressed the need to 'localise' human rights;

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[68] Barbara Oomen and Moritz Baumgärtel, 'Human Rights Cities' [2014] The Sage Handbook of Human Rights 709; Barbara Oomen, 'Rights and the City: Does the Localization of Human Rights Contribute to Equality?' (2015) In Marjolein van den Brink et al (eds), *Equality and human rights: nothing but trouble?, Liber amicorum Titia Loenen*, SIM Special no 38, SIM 407; Esther van den Berg and Barbara Oomen, 'Towards a Decentralization of Human Rights: The Rise of Human Rights Cities' (2014) In The Future of Human Rights in an Urban World: Exploring Opportunities, Threats and Challenges, edited by Van Lindert T and Lettinga D, 11-16; Cynthia Soohoo, 'Human Rights Cities: Challenges and Possibilities' (2015). Global Urban Justice: The Rise of Human Rights Cities, Barbara Oomen, Martha F. Davis, Michele Grigolo, eds. (Cambridge University Press 2016).
[69] ibid.
[70] ibid.
[71] Jamie Cameron, 'Federalism, Treaties and International Human Rights under the Canadian Constitution' (2002) 48 Wayne L Rev 1.

local experiences and understandings of human rights (violations) must feed into global human rights regimes.[72] By extension, and in addition to the localisation of human rights, there is a case to be made for the institutional makeup of our societies to be better reflected in human rights regimes. Currently, human rights treaties and instruments are very state centric and do not reflect the complexities of the institutional makeup of our societies that have moved away from 'government' to 'governance', from centralised hierarchy toward decentralisation, federalism and the involvement of CSOs.

In line with this, I believe it to be relevant to explore an idea I would like to coin 'the democratisation of human rights instruments'. That is to say, to formally and informally increase the active participation of lower levels of government (regional and local political entities with certain competencies and thus responsibilities in the realisation of human rights) in human rights mechanisms, for example by allowing them to join human rights instruments and mechanisms and co-sign treaties (eg grant them treaty making capacity). Although democratising human rights instruments may lead to fragmentation of human rights implementation within states, it may also lead to more positive developments such as the localisation of human rights and (more institutionalised) pressure from below to take human rights more seriously at national levels; thus challenging the idea of human rights as international impositions on state sovereignty.[73] Although beyond the scope of my thesis as further research on this topic is needed, it should be remarked that in order to combat fragmentation the democratisation of human rights instruments should not substitute state protection, but complement it. More concretely, elements of 'co-operative federalism', which has allowed provinces in Canada to participate in the making and implementation of treaties, as well as in the reporting of compliance,[74] could for example be expanded, and adapted to fit non-federal, yet highly decentralised states (like Spain).

Importantly, given the scope of this thesis, I will not be able to argue with full certitude that human rights polities exist by merely looking at

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[72] Koen De Feyter, 'Localising Human Rights' in Wolfgang Benedek and Fabrizio Marrella (eds), *Economic Globalisation and Human Rights* (Cambridge UP 2007) <www.cambridge.org/core/product/identifier/CBO9780511493935A015/type/book_part> accessed 10 November 2018.

[73] Oomen (n 68) 407.

[74] Cameron (n 71) 49.

the human right to health, nor that there is a need to democratise human rights instruments without any further (future) research on the topic in terms of advantages and disadvantages. However, given its contention, looking at the human right to health does allow me to shed light on the making of a human rights polity (and the potential of democratising human rights instruments); so even if human rights polities do not exist in the most encompassing way with reference to all rights, I may argue that they are emerging.

At this point, in order to make sense of human rights polities, it is necessary to understand the formation of policies. In order to do so, one needs to understand both the processes behind policy change and policy persistence. Within policy and governance studies, it is the concept of path-dependency that relates to the persistence of policies over time and the difficulty of creating change. To understand how health policies moved in different directions, and how human rights polities are being made and unmade, it is necessary to look into both the static and dynamic processes underlying policy formation, including contention.

But how can one analyse these processes? Given the shift to governance, it is not hard to grasp that contention can take place within and among governmental actors themselves. In general, 'contention is commonly understood to be a process of claims making by non-state actors in which the state is either the target of or a third party to claims'.[75] However, Verhoeven and Bröer have shown that governmental actors, such as political parties or local levels of government, can also be the 'initiators of claims' in order to bring about changes in policies and laws.[76] In some cases, lower levels of governments can even demonstrate social movement like behaviour, eg when facilitating social mobilisation against a national law or decision.[77] In order to analyse contentious governance, three dimensions of contentious governance can be identified; contentious performances, the formation of collective actors and political opportunity structures.[78]

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[75] Verhoeven and Bröer (n 60) 3.
[76] ibid.
[77] Verhoeven and Bröer (n 60) 2.
[78] Doug McAdam, Sidney Tarrow and Charles Tilly, 'Comparative Perspectives on Contentious Politics' [2009] Comparative Politics: Rationality, Culture, and Structure 260.

The concept of contentious performances, as defined by Tilly and Tarrow, is related to the broader concept of claims-making between political actors and it encompasses the 'relatively familiar and standardized ways in which one set of political actors makes collective claims on some other set of political actors'.[79] In contrast, a contentious 'repertoire' is the specific collections of contentious performances that a particular political actor or set of actors uses and knows.[80] In other words, contentious performances make up a repertoire.

Social interaction and narratives may underlie these contentious performances. According to scholars, social interaction is an essential element influencing why people join collective action.[81] That is to say, in relation to the formation of collective actors, social interaction is of importance. According to Passy, 'scholars stress that social interactions shape people's cognitive map continuously which in turn facilitate (or not) their commitment to contentious politics'.[82] However, it is not just social interaction that defines contentious politics. Rather, it is the combination of narratives and social interaction that contribute to collective action.[83] Interactions that make up social action are both improvised and routinised. That is to say, it entails a certain element of agency and a trial and error process, but the existence of social scripts and shared knowledge and understanding also leads to reproduction and routines.[84]

As I have stated, besides these contentious performances, other dimensions of contention are also worthy of analysis, among these are political opportunity structures. Political opportunity structures are the properties of a regime that may affect the extent to which contentious performances are successful.[85] In other words, they are the institutional and political openings that are available to social movement actors to influence decision-making. Although scholars have interpreted political opportunity structures in many ways, they include, amongst other things:

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[79] Charles Tilly and Sidney G Tarrow, *Contentious Politics* (OUP 2015) 14.
[80] Tilly and Tarrow (n 79) 14-15.
[81] Florence Passy, 'Charles Tilly's Understanding of Contentious Politics: A Social Interactive Perspective for Social Science' (2009) 15 Swiss Political Science Review 351.
[82] ibid 356.
[83] ibid.
[84] Passy (n 81) 356-357.
[85] McAdam, Tarrow and Tilly (n 78) 263.

the multiplicity of independent centers of power within the regime, the regime's openness to new actors, the instability of current political alignments, the availability of influential allies or supporters for challengers, the extent to which the regime represses or facilitates collective claim making [and the changes in these factors].[86]

When analysing contention, not only the performances must be looked into, but also the structures within which these performances enfold, as these may determine the success of claims making performances.

In addition to political opportunity structures, another dimension worthy of analysis is the formation of collective actors. By looking into the formation of collective actors, which is more relational in nature, one may shed light on the dynamics of the contention at hand, as opposed to looking solely at the structures on the one hand and performances on the other.

In relation to the analyses of contentious politics, different methodological tools and theoretical traditions are of importance. There are three main theoretical traditions underpinning the analysis of contentious politics, namely the political process approach (structural), the rational choice perspective (mobilisation of resources), and the constructivist perspective (framing).[87] McAdam, Tarrow and Tilly make a strong case for a synthesis among and between these perspectives in order to properly be able to analyse contentious politics. In so doing, they propose an approach that they entitle 'the mechanism-and-process approach',[88] which can be linked to the three dimensions of contention that have already been touched upon. Elements of this approach will be incorporated in my case analysis, which I will methodologically work out in the next chapter. In relation to performances, political opportunity structures and the formation of collective actors, some mechanisms can be identified that are reflected in all processes of contention.[89] By looking into these mechanisms and by analysing them, one may unpick the process of contention and move beyond epistemological myopia.

According to McAdam, Tarrow and Tilly contentious processes encompass at least five major mechanisms.[90] One of these is 'brokerage',

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[86] McAdam, Tarrow and Tilly (n 78) 263.
[87] ibid 265.
[88] ibid 266.
[89] McAdam, Tarrow and Tilly (n 78).
[90] ibid.

which they define as the creation of new connections among groups or parties that weren't (well) connected before.[91] Since in any campaign diffusion of ideas requires social movement actors to connect with previously unconnected groups, and since brokerage facilitates coordination and reduces communication costs, it is a well-known phenomenon in contentious politics. Besides brokerage, contentious politics also encompasses a process called 'identity shift'. This refers to the way in which people with different identities and social roles create and adopt a distinct and common identity, albeit temporarily.[92] Within this process, 'boundary formation' is of importance, which signifies the 'the creation of an us–them distinction between two political actors'.[93]

Another process of contention involves the inclusion and exclusion of actors. Whenever a less powerful actor is drawn toward the centre of power through a process of contentious politics and is thus included, as opposed to excluded, we can speak of a process of 'co-optation'.[94] Lastly, among other things to gain support, social movement actors frequently aim to spread their ideas through different media outlets, including social media. Contentious performances and ideas often spread from one place to another, turning local contentious issues into regional, national or international ones. The process depicting this dispersion of contention is called 'diffusion'.[95]

1.4 CONCLUSION

Irregular migrants are a vulnerable group of people that often do not enjoy access to human rights, including the human right to health. The rise of a new kind of nationalism has aggravated the realisation of human rights for irregular migrants at a national level given its xenophobic character. The principle of universality is under pressure due to a strong linkage between citizenship, nationalism and human rights protection; those without appropriate citizenship risk being stripped of their rights by nationalist forces. However, within this development, a

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[91] McAdam, Tarrow and Tilly (n 78) 266.
[92] ibid.
[93] ibid.
[94] ibid.
[95] ibid.

contrary development may be identified, in line with the shift away from 'government' to governance, which is the rise of 'human rights polities'.

The emergence of human rights polities goes beyond the development and emergence of human rights cities, given the latter's exclusive focus on the local level and the fact that contention does not presubscribe it. Human rights polities are local, regional or supranational political entities (less subject to chauvinistic, new nationalism) that develop policies and/or laws that oppose the state's policies, rules or regulations in the name of human rights. This process constitutes a process of contentious politics, which can be analysed through the concepts of political opportunity structures, the formation of collective actors and contentious performances. Within these dimensions of contentious governance, mechanisms can be identified which may shed light on the dynamics of contention.

Now that the theoretical framework has been provided, the methodology will be elaborated upon, which will be followed by the case analysis.

2.

RESEARCH METHODOLOGY

2.1 RESEARCH QUESTION

In order to make sense of the factors underlying non-compliance of certain ACs in relation to RDL 16/2012, and based on the theoretical framework, I believe it to be relevant to look into political opportunity structures, the formation of collective actors and contentious performances.

To answer the more generic question of why some ACs act in accordance with the universality of the human right to health, whilst others follow the discriminatory national legislation implemented in 2012, I have formulated, in relation to the theories and concepts outlined in the theoretical framework, the following research question:

> How do political opportunity structures, the formation of collective actors and contentious performances by regional governments and civil society organisations enable and/or restrict the provision of healthcare to undocumented migrants in Spain, and how does this relate to the idea of emerging human rights polities?

To answer the research question at hand, this thesis will be informed by a range of data collection methods and methods of analysis. These will be outlined accordingly.

2.2 METHODS OF DATA COLLECTION

In terms of the methods of data collection, it should be noted that this thesis encompasses literature research and a case study. In the literature research part, I engaged with academic literature from public policy and human rights related fields, whereas in the second part of the thesis, besides literature research, a qualitative content analysis has been conducted to analyse the political opportunity structures, contentious performances and the formation of collective actors.

In relation to qualitative content analyses, data can be derived from a variety of sources. That is to say, 'text data might be in verbal, print, or electronic form and might have been obtained from narrative responses, open-ended survey questions, interviews, focus groups, observations, or print media such as articles, books, or manuals'.[96] To understand why some regions adhere to the human right to health more than others, the claims made by the different governments were analysed in light of political colour, political opportunity structures, the formation of collective actors and contentious performances. The main part of the qualitative content analysis encompasses an analysis of all the main claims (for defying RDL 16/2012) made in publically accessible legislative and administrative documents of regional governments in the period 2012 to 2015, and 2015 to 2018 (two distinct governmental cycles).

In total 34 relevant legislative and administrative documents were analysed, differing in their degree of authority (see annex 1). The legislative and administrative documents have been obtained using the matrix containing all the norms and laws defying RDL 16/2012 drafted by the civil society platform 'Yo SÍ, Sanidad Universal', and the accuracy of this matrix has been verified by comparing it with the norms and laws found by Cimas and others.[97] In addition to this, the websites of the regional health ministries were consulted and scrutinised for the presence of norms and laws extending RDL 16/2012 using the combining search terms '*la asistencia sanitaria*' and '*inmigrantes sin papeles*' or '*inmigrantes irregular*' (eg the existence of the announcement of more inclusive healthcare in Murcia was retrieved in this way).

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[96] Hsiu-Fang Hsieh and Sarah E Shannon, 'Three Approaches to Qualitative Content Analysis' (2005) 15 Qualitative Health Research 1277, 1278.
[97] Marta Cimas and others, 'Healthcare Coverage for Undocumented Migrants in Spain: Regional Differences after Royal Decree Law 16/2012' (2016) 120 Health Policy 384.

The resolution drafted in Castilla y Leon on 12 June 2018 found in this way has not been analysed since it has been drafted after the recent governmental change at national level.[98]

Importantly, ACs have issued documents with a different degree of (legislative) authority. Laws have been implemented in five ACs, 'orders' have been created by three ACs, resolutions by one and instructions by ten ACs (for an overview, see annex 1). The differences between 'orders', 'resolutions' and 'instructions' lies in the degree of authority (the order being most authoritative (after laws), followed by resolutions and lastly instructions),[99] although all are norms which have led to the inclusion of irregular migrants to the healthcare system. Instructions are documents that tend to be complementary to normative positions and often clarify points of the regulations to which they refer.[100] For the period until 2015, health inclusiveness has been based on Cimas and others, whereas for the period following 2015, for which no health inclusiveness scores exist, I estimated the health inclusiveness based on the requirements and the coverage established in the norms and laws, comparing these to the requirements and coverage of the norms and laws from the preceding period and the health inclusiveness attributed to it by Cimas and others (for more information, see footnote n. 182).[101]

I have complemented the analysis of legislative and administrative documents with personal accounts of policy makers and other involved actors through conducting interviews. This constitutes the other part of the qualitative content analysis. Given the limited scope of my thesis, I had to select which regions to focus on, and in so doing upheld a combination of two different case selection techniques, namely the 'deviant' and 'diverse' case selection methods as elaborated upon by Seawright and Gerring.[102] In order to arrive to the most meaningful

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[98] Gerencia Regional de Salud (SACyL), 'Programa Asistencial de Carácter Social Para La Población Extranjera En Situación Administrativa Irregular Residente En La Comunidad de Castilla y León y Con Recursos Económicos Insuficientes' <https://gobiernoabierto.jcyl.es/web/jcyl/GobiernoAbierto/es/Plantilla100DetalleFeed/1284216489702/Programa/1284810924563/Comunicacion> Accessed 13 April 2019.

[99] Maite Sanz, 'Conceptos de normativa. Parte 3. Normas jurídicas. Definiciones' (*Blog de normativa*, 24 January 2012) <https://normativainfo.wordpress.com/2012/01/24/conceptos-de-normativa-parte-3-normas-juridicas-definiciones/> accessed 10 June 2017.

[100] ibid.

[101] Cimas and others (n 97).

[102] Jason Seawright and John Gerring, 'Case Selection Techniques in Case Study Research: A Menu of Qualitative and Quantitative Options' (2008) 61 Political Research Quarterly 294, 300.

conclusions, I believed it to be necessary to focus on those regions that had a political landscape similar to that of the national context in one of the periods under scrutiny. In other words, political colour functioned as my control variable. Moreover, to make any meaningful comparison, I believed it to be relevant to select regions that differed in health inclusiveness in terms of irregular migrants' access to healthcare (so regions that deviate from RDL 16/2012 and those that do not).

Figure 2: Scores of regional health care policies after RDL 16/2012 (until 2015)[103]

Based on the scores attributed to the regions in terms of health inclusiveness toward irregular migrants, I decided to focus on the ACs of Navarra and Cantabria. Navarra was by far the most inclusive AC in the period 2012-2015 since it scores 100% in health inclusiveness as calculated by Cimas and others.[104] In other words, it deviates most from RDL 16/2012. Moreover, before 2015, a political party ruled the region with a similar political colour than that of the PP, namely the Unión del Pueblo Navarro (UPN), which until 2008 actually represented the PP in the region.[105] In terms of regions ruled by the PP, Cantabria was

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[103] Cimas and others (n 97) 390.
[104] Cimas and others (n 97).
[105] Miguel Ángel Artola, 'PP-UPN, Divorcio a La Navarra' [2008] Cambio 16 18.

among those that deviated most in terms of health inclusiveness in relation to other regions ruled by the PP, given that it scored 68.5% in health inclusiveness in 2012-2015 as opposed to the 35% average in a PP region.[106] I aimed to also interview the government of La Rioja or Castilla-La Mancha, since these regions were ruled by the PP and scored 0% in health inclusiveness, making them most compliant with RDL 16/2012. Unfortunately, despite various emails and phone calls, I did not gain access to government officials in these regions. In the end, semi-structured interviews were conducted with a health director in the regional government of Cantabria and a legal advisor of the health department of the regional government of Navarra (see annex 4). Both worked on the implementation of RDL 16/2012 at a regional level. In relation to these two interviews, I received support from two translators. In addition to the interviews with the two regional governments, I conducted an interview with the advocacy officer of the CSO that led the fight against RDL 16/2012, Medicos del Mundo. Thus, in total, three interviews were conducted in Spanish and English with informants, lasting around 1.15 hours each, all of which were recorded with the interviewees' permission. Whereas I transcribed one interview myself, the Spanish interviews were transcribed and or translated by a translator, a former journalist and current human rights and policy student, Maria Clara Calle. The methodological impact of translation and language limitations will be touched upon in the discussion section of my thesis. Naturally, the ACs in Spain are very different in various respects, so I acknowledge that there are some shortcomings by having only interviewed two regional health ministries; it will be difficult to generalise any claims made by the government officials interviewed. However, in combination with the qualitative content analysis of the 34 legislative and administrative documents, the interviews provided me with insights. The limitations on the interview and case selection are discussed in the 'discussion' section of my thesis.

Lastly, a relevant note to make is that the writing of the theoretical framework has been subject to an iterative process; I have been sensitive to different and/or new ideas depending on the findings of the interviews and the qualitative content analysis. In a way the theoretical framework has been partly informed by the case analysis, although pre-existing ideas based solely on literature research have shaped most of it.

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[106] Cimas and others (n 97).

2.3 METHODS OF ANALYSIS

At this point, given that I have argued that polities are discursively constructed and that social interaction and narratives are of importance in relation to contentious performances and the formation of collective actors, I am first and foremost interested in the production of meaning, which belongs to the constructivist paradigm. On the other hand, given that I recognise that performances and group formation takes place within certain established structures, I am also interested in identifying and analysing the political opportunity structures, as described by McAdam, Tarrow and Tilly. In contrast to analysing performances, which belongs the constructivist paradigm, analysing the political opportunity structures would coincide more with a political process approach. Importantly, therefore, it is relevant to point out here that this thesis will be upholding both a meaning production approach (performances) and a political process approach (political opportunity structures). These belong to different epistemological and ontological traditions, namely an interpretivist versus a more positivist paradigm.

Although some may believe that both approaches cannot be combined, I believe they can be complementary, among other things with reference to McAdam, Tarrow and Tilly who have specifically called for the need to combine epistemological traditions to understand contentious governance.[107] These authors proposed the mechanism-and-process approach precisely to try and find a synthesis between different epistemological traditions. I believe that neither the constructivist nor the political process models have the sole answers in understanding processes of contention. Rather, new insights can be acquired when different epistemological traditions are combined. By being explicit and acknowledging that I'm mixing different research traditions, and by following elements of the approach designed by McAdam, Tarrow and Tilly, I aim to resolve the tensions related to mixing different philosophical underpinnings of research.

Despite the fact that McAdam, Tarrow and Tilly advocate for the importance of analysing mechanisms of contention, they have not really worked it out in a methodological way. Although they mention ethnographic, quantitative and naturalist experiments as

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[107] Doug McAdam, Sidney Tarrow and Charles Tilly, 'Comparative Perspectives on Contentious Politics' [2009] Comparative Politics: Rationality, Culture, and Structure 260.

potential methodological tools to analyse contention, they state other methodologies can also be used to analyse contentious governance.[108] After careful consideration, I decided to analyse contentious performances, political opportunity structures and the formation of collective actors in relation to mechanisms by means of a qualitative content analysis, as outlined by Bengtsson, and Hsieh and Shannon.[109] A qualitative content analysis can be described as 'a research method for the subjective interpretation of the content of text data through the systematic classification process of coding and identifying themes or patterns'.[110] I have decided to opt for a qualitative content analysis, in contrast to for example framing theory which is traditionally used to analyse contentious performances, because I believe the general and broad nature of a qualitative content analysis enables me to use it for different purposes, so both for identifying political opportunity structures and analysing performances and the formation of collective actors. Given the scope of this thesis, I will not pay attention to the resource mobilisation approach, although I acknowledge that resources are of importance in any process of contention.

In relation to the qualitative content analysis, and using the coding software MAXQDA12, four different steps were followed which can be summarised as 'decontextualisation, recontextualisation, categorisation, and compilation'.[111] In what Bengtsson has coined the decontextualisation phase, I have read the transcribed interview data and the policy documents under scrutiny very carefully and formulated 'meaning units', which relate to the pieces of text that contain insights. In a process of (semi) open coding I have subsequently attached (sub) 'codes' to each meaning unit. These (sub) codes were the themes or concepts that were identified when breaking down the meaning unit into its essence; this is why this phase of the research has been coined 'decontextualisation'.[112] Codes were derived from the transcribed interviews and policy documents semi-inductively. The reason that I relate to this latter process as semi (!) inductive/open coding is because of the theoretical framework and literature research that presubscribed

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[108] McAdam, Tarrow and Tilly (n 107) 287-289.
[109] Hsieh and Shannon (n 96); Mariette Bengtsson, 'How to Plan and Perform a Qualitative Study Using Content Analysis' (2016) 2 NursingPlus Open 8.
[110] Hsieh and Shannon (n 96) 1278.
[111] Bengtsson (n 109) 11.
[112] ibid.

the coding process and which may have shaped and influenced what I looked for; it will therefore not be fully inductive. I think it is important to recognise the implicit deductive phase that may have influenced the coding process since it may have biased what I looked for; the 'researcher must take into consideration his or her "pre-understanding", both in the planning process as well as during the analyzing process, in order to minimize any bias of his/her own influence'.[113]

In the recontextualisation phase, and in line with the necessity to repeat the coding process multiple times due to the possibility for inductive codes to change as one's interpretations may evolve,[114] I re-read the (transcribed) texts to identify whether any important information was left unlabelled or wrongly labelled. Then, I either included the leftover pieces of text by linking them to a meaning unit and (sub-) code, or discarded them whenever I considered the information not relevant for my research question. In the categorisation phase, I grouped the meaning units and their (sub-)codes into certain categories or themes by further condensing the information.[115] These then became my 'main codes'. Lastly, in the compilation phase, I analysed these categories or 'main codes' in relation to their meaning units and (sub-) codes. I did so in a manifest way. In contrast to a latent analysis, I aimed to 'stay closer to the meaning and contexts',[116] and used the interviewees' explicit words and statements, as opposed to looking for implicit meanings of their statements. Whilst doing so, I have paid special attention to the mechanisms identified by McAdam, Tarrow and Tilly.[117] To facilitate the compilation phase I created tables, using the coding software MAXQDA, so that I got an overview of the meaning units, (sub) codes and categories (main codes) and was able to analyse these in an easier way. In the table below, the column 'condensed meaning unit' illustrates the kind of reduction I made by myself, although this is not reflected in the MAXQDA tables.

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[113] Bengtsson (n 109) 8.
[114] ibid 12.
[115] ibid.
[116] ibid.
[117] McAdam, Tarrow and Tilly (n 107).

An example of this would be the following:

MEANING UNIT	CONDENSED MEANING UNIT	(Sub-) CODE	CATEGORY (Main Code)
In 2012, at different regional levels several platforms were created and the project REDER that I am coordinating is saying precisely to gather all those regional initiatives under one big umbrella	REDER created as the umbrella organization of regional platforms that originated in response to RDL 16/2012	Uniting social movement actors	Role of CSO
We tried to articulate at a regional level alternatives working with regional governments but also … working with regional governments and advocating at regional governments to ask them to change the regional norms that provide access to the people	Medicos del Mundo cooperates with regional governments and advocates changing laws and developing alternatives to increase access	Political advocacy at regional level	Role of CSO
… also working at regional level within our offices to provide migrants with information because one of the main offence that happened because of this change of law was that no-one was informed about what were the real consequences, what were the rights that the people were still maintaining despite RDL. There was a whole confusion and Medicos Del Mundo tried to fill that gap by providing information to the people	Regional offices of MDM provide information to migrants about their rights	Provide information	Role of CSO
Not just information, but also health, because as we were talking the implementation of RDL has not been adequate and even the exceptions of RDL were breached, as in most cases, and so the role of Medicos del Mundo was also, and also other organisations, but Medicos del Mundo did it, was accompanying; going with the people … if a pregnant woman was rejected at the hospital then Medicos del Mundo would go with that pregnant woman to the hospital and say that according to the law this woman has a right to healthcare so you have to treat her	Regional offices accompany migrants to ensure access to health	Access to healthcare	Role of CSO

Twelve main codes were identified during the (semi-) inductive coding process of the legislative and administrative documents, namely: principle of universality and equality, principle of efficiency/effectiveness, principle of (economic) costs, (breach of) competencies, (constitutional) right to health, human rights treaties and international declarations, national health laws, regional laws, public/collective health (risk), health irregular migrant, practical reality, and lastly, social programme.

The codes identified during the coding process of the three interviews were slightly different. In line with the previous process, twelve main codes were identified during the (semi-) inductive coding process of the three interviews, namely: role of CSO, RDL 16/2012, mobilisation of collective actors, principle of (economic) costs, right to health, political colour, public health, competing interests, (breach of) competencies, ACs' contentious performance, healthcare provision in practice, and lastly, political opportunity structure. The latter code depicts the deductive element in the coding process, as the theoretical framework informs it.

The overall analysis of the coded documents and interviews has been placed in a context of the theoretical framework; the human right to health, irregular migration and citizenship, new-nationalism and the emergence of discursive (human rights) polities.

3.

CASE ANALYSIS OF IRREGULAR MIGRANTS' UNEVEN ACCESS TO HEALTHCARE AFTER ROYAL DECREE LAW 16/2012

I have divided the case analysis into four parts: context and historical background of RDL 16/2012, political opportunity structures, contentious performances by ACs and, lastly, the formation of collective actors.

3.1 Cᴏɴᴛᴇxᴛ ᴀɴᴅ ʜɪsᴛᴏʀɪᴄᴀʟ ʙᴀᴄᴋɢʀᴏᴜɴᴅ ᴏꜰ RDL 16/2012

In the last two decades of the 20th century, after Spain's dictator Franco died in the 1970s and the country underwent a process of democratization, Spain gradually evolved into a welfare state.[118] This process was accompanied by, among other things, the adoption of certain laws relating to entitlements to education, healthcare and social welfare protection. Back in 1986, through the Ley General de Sanidad, Spain created the Spanish National Health System or SNHS.[119] Healthcare became funded through general taxation and healthcare coverage expanded incrementally to all those residing in Spain, specifically through laws enacted in 1989, 2000 and 2011.[120] Especially the law passed in 2000 (Ley 4/2000) proved decisive for migrants in an irregular situation as they were granted, regardless of their precarious legal status,

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[118] Eloisa Del Pino and Emmanuele Pavolini, 'Decentralisation at a Time of Harsh Austerity: Multilevel Governance and the Welfare State in Spain and Italy Facing the Crisis' (2015) 17 European Journal of Social Security 246, 247.

[119] Marta Cimas and others, 'Healthcare Coverage for Undocumented Migrants in Spain: Regional Differences after Royal Decree Law 16/2012' (2016) 120 Health Policy 385.

[120] María Luisa Vázquez and others, 'Are Migrants Health Policies Aimed at Improving Access to Quality Healthcare? An Analysis of Spanish Policies' (2013) 113 Health Policy 236, 239; Cimas and others (n 119) 385.

the same healthcare and education entitlements as Spaniards, under the condition that they were registered at a municipal level.[121] This meant that by 2011, a system of (free) universal coverage existed.

This progressive realisation of health rights over the last decades ended in April 2012 as a consequence of RDL 16/2012 enacted by the PP government in the context of the supposed need of austerity measures in the economic crisis that hit Spain in 2008.[122] According to the new government led by the PP, the healthcare system needed to be fundamentally altered in order to 'guarantee the sustainability of the National Health System'.[123] Defending its legislation, the PP argued for the need to end 'health tourism', despite the fact that this represented a different issue than the 'problem' of including irregular migrants in the system, rhetorically it proved important.[124] The RDL was introduced at a time when the healthcare sector was already undergoing significant budget cuts at a regional level following an alleged need to cut government spending (cuts of around 5% in 2012 in comparison to 2010).[125] Despite the significant impact RDL 16/2012 would have on the healthcare system, which will be illustrated shortly, RDL 16/2012 did not entail nor require a consultation processes with relevant stakeholders such as healthcare professionals and CSOs.[126]

By enacting RDL 16/2012, the PP government introduced a healthcare system that moved away from universality toward a system in which some were stripped away from their access to healthcare, whereas others would remain entitled to receive healthcare, namely Spaniards in employment and their beneficiaries (eg children under 26).[127] Irregular migrants constituted a significant group that lost its access to healthcare; around 150,000 of the 873,000 non-residents that lost their access to primary healthcare were irregular migrants.[128]

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[121] Cimas and others (n 119) 385.

[122] Francisco Javier Moreno Fuentes, 'El Puzzle de La Exclusión Sanitaria de Los Inmigrantes Indocumentados En España' [2015] Anuario CIDOB de la Inmigración 277, 290.

[123] Pedro Gallo and Joan Gené-Badia, 'Cuts Drive Health System Reforms in Spain' (2013) 113 Health Policy 1, 2.

[124] Fuentes (n 122).

[125] Gallo and Gené-Badia (n 123) 2.

[126] Interview with MDM Advocacy Officer (23 May 2018); Gallo and Gené-Badia (n 123).

[127] Julio Heras-Mosteiro, Belén Sanz-Barbero and Laura Otero-Garcia, 'Health Care Austerity Measures in Times of Crisis: The Perspectives of Primary Health Care Physicians in Madrid, Spain' (2016) 46 International Journal of Health Services 283.

[128] Fuentes (n 122) 289; Heras-Mosteiro, Sanz-Barbero and Otero-Garcia (n 127).

Through the RDL healthcare coverage became dependent on social security entitlement.[129] From this point onwards, irregular migrants were solely entitled to receive emergency healthcare, with the exception of minors under 18 and pregnant women.[130] Besides excluding irregular migrants from primary care, RDL 16/2012 also revoked certain previously free services or products for Spaniards; it established a system in which people had to co-pay for medication.[131] Curiously, whereas healthcare provision is paid through general taxes, meaning irregular migrants actually contribute to the system through consumption, they are not entitled to reap the benefits of it.[132]

Unsurprisingly, civil society and health professionals criticised the enactment of RDL 16/2012, not only because people lost the right to health whereas Spain has ratified the ICESCR[133] including the Optional Protocol,[134] but also because the promised savings could not be scientifically underpinned or proven.[135] In contrast, evidence shows that providing primary care to irregular migrants is less expensive than excluding them from it and forcing them to ultimately make use of emergency care (a more costly type of care).[136] Not long after RDL 16/2012 got implemented, a campaign was set up by health professionals (eg Yo SÍ, Sanidad Universal and SemFYC, the Spanish Society of Family and Community Medicine) who called upon others to 'conscientiously object' to RDL 16/2012 in the name of their Hippocratic oath.[137] The campaign entailed the provision of information on how to become a conscientious objector and what its consequences could be for health professionals legally speaking; the campaign team encompassed legal advisors who could assist health professionals attending irregular migrants from facing legal issues.[138]

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[129] Cimas and others (n 119) 385.

[130] Fuentes (n 122).

[131] Heras-Mosteiro, Sanz-Barbero and Otero-Garcia (n 127) 284.

[132] Gallo and Gené-Badia (n 123) 3.

[133] International Covenant on Economic, Social and Cultural Rights (adopted 16 December 1966, entered into force 3 January 1976) 993 UNTS 3 (ICESCR).

[134] Optional Protocol to the International Covenant on Economic, Social and Cultural Rights (adopted 10 December 2008, entered into force 5 May 2013) A/RES/63/117.

[135] Fuentes (n 122).

[136] European Union Agency for Fundamental Rights, 'Cost of Exclusion from Healthcare: The Case of Migrants in an Irregular Situation.' (Publications Office of the European Union 2015)

[137] Gallo and Gené-Badia (n 123) 4.

[138] Yolanda García Ruiz, 'The Withdrawal of Health Care from Irregular Immigrants and Medical Conscientious Objection' Oñati Socio-legal Series [online], 6 (5), 1088. Available from: <https://ssrn.com/abstract=2888868> accessed 13 April 2019

The response by civil society actors subsequently led to a government proposal to allow irregular migrants to privately cover themselves, which came into effect from October 2012 onwards, but since the costs ranged from 710 to 1864 (65>) euro per month depending on the irregular migrant's age, it proved inaccessible to most.[139] Over the years, an advocacy platform, which also documented violations of the right to health, was set up to unify CSOs efforts against RDL 16/2012, entitled REDER, which was/is coordinated by Medicos del Mundo.[140]

A qualitative study conducted in 2016 confirmed the critique among health professionals.[141] Apart from the critical response by CSOs, lower levels of government were also not keen on implementing the law. Many ACs openly rebelled against the state by not implementing the law or by devising ways to circumvent the 'harsh' edges of it.[142] Only a few ACs implemented RDL 16/2012 fully (eg Castilla-La Mancha in the period 2012-2015).[143] Importantly, regional elections in 2015 led to the victory of parties opposing RDL 16/2012 in many ACs, which led even more regional governments to draft laws and norms defying RDL 16/2012. The response by regional governments will be elaborated upon in the section on contentious performances. Notably, while conducting my research project, the new socialist government of Spain announced on 15 June 2018 that it would restore the previous health system based on universality, which will grant irregular migrants access to healthcare services.[144] CSOs will be involved in the process of drafting and monitoring the new health policy bringing back universality to the healthcare system.[145]

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[139] Gallo and Gené-Badia (n 123) 4; Fuentes (n 122) 284.
[140] Interview with MDM Advocacy Officer (n 126).
[141] Heras-Mosteiro, Sanz-Barbero and Otero-Garcia (n 127) 283.
[142] Fuentes (n 122); Cimas and others (n 119).
[143] Fuentes (n 122) 292; Cimas and others (n 119) 389.
[144] Luis Ángel Sanz, 'El Gobierno de Pedro Sánchez Recupera La Sanidad Universal Para Los Inmigrantes 'sin Papeles' *El Mundo* (Madrid, 15 June 2018) <www.elmundo.es/esp ana/2018/06/15/5b23a40946163ff8108b4586.html> accessed 20 June 2018.
[145] 'La Plataforma REDER Pide Recuperar La Noción de La Salud Como Un "Derecho Inalienable de Todas Las Personas"' (22 June 2018) <http://medicosypacientes.com/ articulo/la-plataforma-reder-pide-recuperar-la-nocion-de-la-salud-como-un-derecho-inalienable-de> Accessed 13 April 2019.

3.2 The institutional and political setting; political opportunity structures

In relation to analysing political opportunity structures, a critique has been the use of diverse variables among scholars.[146] Although I have decided to look into the six variables identified in the theoretical framework, the scope of my thesis does not allow me to touch upon all political opportunity structures in depth. Moreover, I do not pretend to do justice to the complexity of the many variables that could be looked into in relation to political opportunity structures. Despite this, I believe it to be important to analyse and use the concept as to highlight how the Spanish institutional and political context influenced the successfulness of social and political mobilisation against RDL 16/2012.

A key political opportunity structure in the context of healthcare is the 'multiplicity of independent centers of power within the regime'.[147] The regime being the Spanish state, this dimension is important given that many competencies have been devolved to regional governments over the years, among which are health and education. Whereas some ACs were given the competency of health in the 1980s, others were granted responsibilities in the 2000s.[148] The extent of decentralisation goes so far that one can identify 'elements of both dual and cooperative federal systems' in Spain.[149] Certain competencies are allocated between state and regional governments, although most competencies are shared in one way or another, which results in a continuous process of contestation on competencies, eg in the area of health.

Interestingly, after the economic crisis struck Spain this gradual movement toward decentralisation has been increasingly contested. Following the economic crisis in Spain, the power of ACs weakened in favour of the central state who was given a 'political opportunity window' to intervene in regional competencies in the name of austerity measures, as well as in the context of corruption scandals on regional levels.[150] The

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[146] Marco Giugni, 'Political Opportunities: From Tilly to Tilly' (2009) 15 Swiss Political Science Review 361, 363.

[147] Doug McAdam, Sidney Tarrow and Charles Tilly, 'Comparative Perspectives on Contentious Politics' [2009] Comparative Politics: Rationality, Culture, and Structure 260. 263.

[148] Del Pino and Pavolini (n 118) 248.

[149] ibid.

[150] Del Pino and Pavolini (n 118) 253.

loss of power of the ACs can additionally be explained by the fact that the central government expenditure rose, whereas the expenditure of ACs decreased, thus effectively altering the power positions in favour of the central government. The contestation on competencies is especially evident in recent years where the state government has tried to intervene in the competencies of regional governments through appealing certain decisions in front of the constitutional court of Spain. It is important to acknowledge the role the constitutional court plays in settling disputes between the central governments and the 'rebelling' ACs.[151] In the context of health, the Spanish PP government has put several cases in front of the constitutional court. Some of the more recent judgments have been in favour of state intervention, effectively weakening the power position of the regional governments.[152]

Since the healthcare system is decentralised, one can speak of a multiplicity of independent centres of power in the context of health. Although the ACs have certain competencies independent from the state, they do also have to remain within certain conditions set by the nation state.[153] In the words of the health director of Cantabria:

> The AC has exclusive health competencies. That is to say, health competencies have been transferred away from the national government, although it reserves certain situations of setting strategies, limits and regulations. The [regional health] ministries … also have the mission of, in relation to the [national] government, claiming certain competences, to protest certain intrusions in their competencies or to negotiate those limits that the state reserves to unify a little the national health system. … However, the right to health care, which is a right that is set by legislation, is the norm of the state. The AC can make some changes within its powers but has to abide by the general rule.[154]

In other words, their relative autonomy gives them freedom to defy national legislation and enables them to challenge rules that they find to be not in their interest, something which will be elaborated upon in the section about contentious performances.[155] Importantly, '… all Autonomous Communities enjoy the same degree of political autonomy

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[151] Del Pino and Pavolini (n 118).
[152] Interview with MDM Advocacy Officer (n 126); Interview with Legal Advisor, Health Ministry, Navarra (1 June 2018).
[153] Interview with Legal Advisor, Health Ministry, Navarra (n 152).
[154] Interview with Health Director, Cantabria (30 May 2018).
[155] ibid; Interview with Legal Advisor, Health Ministry, Navarra (n 152).

and the differences between the exercise of their powers is rather low … The only exception is the specific financial system of the Basque Country and Navarra'.[156] The latter is important to take into account as it may give these regions slightly more power to challenge national legislation, given that they levy and collect their own taxes and can argue to be fiscally independent from Spain. However, given the above, overall, the extent of autonomy enjoyed by the 17 different ACs is comparable.

The 'openness' of the Spanish state is shaped by the extent to which it is decentralised territorially and functionally; the more decentralised a state, the lower the capacity of individual actors and the more difficult it is for any one actor to act unilaterally.[157] Moreover, '… decentralization implies a multiplication of state actors, and, therefore, of points of access and decision-making'.[158] These multiple points of access function as a political opportunity structure for mobilising actors against RDL 16/2012 as it simply widens their possibilities to influence decision making and weakens the power of the central government to implement RDL 16/2012 effectively. This has been illustrated by the advocacy officer of Medicos del Mundo:

> once we saw that at a national level there was a huge difficulty in convincing the government to move backwards and to change what they had done, we tried to articulate at a regional level alternatives … working with regional governments and advocating at regional governments to ask them to change the regional norms.[159]

In other words, in their pursuit to combat [the effects of] RDL 16/2012, the institutional makeup of the Spanish state allowed the mobilising actors to navigate the various points of access into the decisio-making process.

It can be derived from the literature that the relative 'instability' of political arrangements represents another political opportunity structure. During the elections in 2011, the PP gained an absolute majority (the second biggest in Spanish democratic history).[160]

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[156] European Committee of the Regions, 'Division of Powers' (2012) <https://portal.cor.europa.eu/divisionpowers/countries/MembersLP/Spain/Pages/default.aspx> Accessed 13 April 2019.

[157] Hanspeter Kriesi, 'Political Context and Opportunity' [2004] The Blackwell Companion to Social Movements 67, 70.

[158] ibid.

[159] Interview with MDM Advocacy Officer (n 126).

[160] Irene Martín and Ignacio Urquizu-Sancho, 'The 2011 General Election in Spain: The Collapse of the Socialist Party' (2012) 17 South European Society and Politics 347.

This generated a situation in which opposition parties lacked the political 'power' to effectively challenge RDL 16/2012, as they were restricted in passing alternative legislation through parliament. In other words, a situation of relative political stability existed. In the general elections of 2015 and 2016 respectively, the PP lost its absolute majority, although it remained in power.[161] This limited the government's capacity to act and increased the access points for social movement actors to influence decision-making. In the end, the lack of an absolute majority, and therefore the relative instability of the government, allowed the opposition party Partido Socialista Obrero Español (PSOE) to take over power in government in light of corruption scandals among PP politicians through a vote of no confidence by opposition parties.[162] Subsequently, two weeks after the new (socialist) government was installed they announced they would implement legislation to return to a universal healthcare system, meaning that irregular migrants will once again regain access to healthcare.[163]

Moreover, in relation to political alignments and the access for mobilising actors to influence the decision-making process, the level of democratisation and the electoral system are of importance. It is relevant to look into the level of democratisation as this may tell us something about the state's willingness to engage and listen to other (new) actors. The level of democratisation also reflects the number of access points social movement actors have at their disposal to influence the decision making process.[164] According to the Economist Intelligence Unit's Democracy Index, Spain constituted a full democracy throughout the years following 2012.[165] The fact that the Spanish electoral system is based on proportional representation means mobilising actors have more points of access to influence decision-making, since, in contrast to majoritarian or plurality electoral systems, proportionality means

[161] Pablo Simón, 'The Challenges of the New Spanish Multipartism: Government Formation Failure and the 2016 General Election' (2016) 21 South European Society and Politics 493.

[162] Raphael Minder, 'Spain's Prime Minister, Mariano Rajoy, Is Ousted in No-Confidence Vote' *The New York Times* (New York, 1 June 2018) <https://www.nytimes.com/2018/06/01/world/europe/spain-mariano-rajoy-no-confidence.html>. Accessed 13 April 2019

[163] Ángel Sanz, (n 144)

[164] Kriesi (n 157).

[165] The Economist Intelligence Unit's Democracy Index*, '*EIU Democracy Index 2017' <https://infographics.economist.com/2018/DemocracyIndex/> accessed 10 June 2018.

actors can more easily access the political arena.[166] Likewise, 'the more proportional an electoral system, the greater usually the number of parties, which again increases the possibilities of access'.[167] This point is reflected by a comment of the advocacy officer of Medicos del Mundo:

> So even if we were approaching the socialist party in, let's say, Valencia, we were also approaching the socialist party in Madrid at a national level, so it was both ways. In this sense, we reached an important outcome in 2015 right before the general elections, in March 2015. We reached an agreement with all the political parties from the opposition, so except Partido Popular and Ciudadanes … in which they all committed that should they govern at any regional level after the elections they would pass laws to provide for universality. And in fact, that was fulfilled.[168]

Similarly, on a regional level the 'instability' of political arrangements is also of importance. For example, in 2012 the UPN in Navarra designed a social programme to assist those who were excluded from receiving healthcare after RDL 16/2012, but 'especially the political opposition of Navarra, considered it was not enough … given that it was a type of social welfare assistance, as opposed to an intention that every citizen should have the right to health'.[169] The moment the opposition in Navarra achieved a parliamentary majority they proposed Statutory Law 8 / 2013, with which they brought back the universal right to healthcare to any resident of Navarra, irrespective of a precarious legal status.[170] The loss of a parliamentary majority of the centre right party thus led to the adoption of the most inclusive law in all of Spain, despite the fact that the centre right UPN kept in power until 2015.

In terms of the availability of influential allies or supporters for challengers, the notion of 'nested political opportunity structures',[171] is of significance as it sheds light on the complexity of available actors to influence decision-making. Since the Spanish state has made agreements internationally with other states and international bodies, these agreements can be used to hold the Spanish government accountable. Examples include signed human rights treaties. At this

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[166] Kriesi (n 157) 70.
[167] ibid.
[168] Interview with MDM Advocacy Officer (n 126).
[169] Interview with Legal Advisor, Health Ministry, Navarra (n 152).
[170] ibid.
[171] Jackie Smith, 'Transnational Processes and Movements' [2004] The Blackwell Companion to Social Movements 311, 317.

juncture, it can be stated that 'local political opportunity structures are embedded in national political opportunity structures, which are in turn embedded in international political opportunity structures'.[172] The latter creates 'possibilities for complex patterns of relations among actors seeking political influence'.[173] As the analysis of legislative and administrative documents will show, influential allies or supporters for challengers include the World Health Organization, el Defensor del Pueblo (Ombudsperson), as well as human rights instruments, such as international treaties and United Nations bodies. In the concluding observations of the Committee on Economic, Social and Cultural Rights, Spain was urged to adopt the necessary policies and laws to grant access to healthcare to irregular migrants, in line with articles 2 and 12 of the ICESCR.[174]

Moreover, apart from the above allies, and in line with proportional representation, a significant number of political parties existed (in the opposition) that turned its back against RDL 16/2012 from the very beginning, with the exception of Ciudadanos. The existence of these parties and actors has been important for CSOs to mobilise against RDL 16/2012, eg with reference to the agreement made in 2015 just before the regional elections.[175]

Given Spain's level of democracy and in light of the extent to which the regime represses or facilitates collective claim making, it can be concluded that in the area of health, state repression does not occur in the explicit, violent sense. The state government obstructs collective claims making in other ways, eg through constitutional appeals by challenging regional laws (eg in Catalunya, Valencia, Navarra, Pais Vasco, Cantabria etc).[176] By constitutionally challenging the regional governments, turning a political question into a legal one, the central government has used its powers to limit collective claim making.

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[172] Franklin Rothman and Pamela Oliver, 'From Local to Global: The Anti-Dam Movement in Southern Brazil, 1979-1992' (1999) 4 Mobilization: An International Quarterly 41, 43.

[173] Smith (n 171).

[174] UN Committee on Economic, Social and Cultural Rights, 'Consejo Económico y Social. Observaciones Finales Sobre El Sexto Informe Periódico de España. E/C.12/ESP/CO/6. < https://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symboln o=E%2fC.12%2fESP%2fCO%2f6&Lang=en> Accessed 13 April 2019.

[175] Interview with MDM Advocacy Officer (n 126).

[176] ibid.

Importantly, certain constitutional rights the central government enjoys have obstructed the process of claims making by opposition parties and CSOs. Despite the fact that a window of opportunity established itself after the general elections of 2016, when the opposition parties reached a parliamentary majority and alternatives could be proposed in the parliament, RDL 16/2012 was not reformed. The possibility of the government to veto parliamentary initiatives, regardless of their own minority position, led to a situation where any parliamentary initiative regarding healthcare for irregular migrants was blocked. Despite the constitutional court ruling that the PP government was abusing its right to veto parliamentary initiatives, the PP government continued to do so.[177]

Moreover, apart from this, and looking at the legislation at hand, the legislative instrument of a RDL allows a government to pass legislation without consultation with other actors, since 'royal decrees are considered and used as government emergency pieces of legislation that requires on no previous parliamentary nor consensus with other parties'.[178] The existence of this form of legislation in the Spanish constitution – enshrined in article 86.1 – in itself somewhat restricts the process of collective claim making, although it can only be used if an urgent and an extraordinary need can be proven.[179]

Lastly, in light of the changes in institutional factors, as was touched upon before, it can be stated that the elections – both nationally and regionally – have proven fundamental in the facilitation of collective claims making against RDL 16/2012. After the regional defeat of the PP, many parties opposing RDL 16/2012 came to power, which were subsequently able to more publicly denounce the national legislation than the PP regional governments (not bound to party loyalty). Moreover, in light with institutional changes, key to challenging RDL 16/2012, as the qualitative analysis will show in the next section, was the presence of preceding legislation that had a universal character. This therefore constituted a political opportunity structure; related to the notion of path dependency, these preceding laws and agreements provided the regional governments and CSOs with the ability to (legally) challenge RDL 16/2012.

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[177] Interview with MDM Advocacy Officer (n 126).
[178] Gallo and Gené-Badia (n 123) 2.
[179] Thomas Beukers, Bruno de Witte and Claire Kilpatrick, *Constitutional Change Through Euro-Crisis Law* (CUP 2017) 205.

Overall, political opportunity structures as well as a lack of opportunity structures can be identified, both of which have influenced the political and social mobilisation against RDL 16/2012. In certain ways, there has been a lack of political opportunity structures from the perspective of CSOs and regional governments. After the crisis hit Spain in 2008, the power of ACs weakened in favour of the central state that was able to intervene in regional competencies in the name of austerity measures and in the context of corruption scandals on regional levels. Moreover, certain constitutional competencies of the government in the context of the economic crises, such as the unilateral enactment of legislation in the form of RDLs and the veto power have restricted successful claims making against RDL 16/2012.

On the other side, important factors shaping success of social mobilisation were the multiplicity of independent centres of power and the 'openness' of the regime, a result of Spain's decentralised competencies in health and the democratic nature of the Spanish state. The decentralised nature of the Spanish state and the presence of influential allies among opposition parties and at a national and international level reduced the central governments' capacity to act unilaterally in implementing RDL 16/2012 and allowed CSOs to navigate the various points of access into the decision-making process to challenge RDL 16/2012. The 'instability' of political arrangements in relation to an electoral system based on proportionality, which allowed for institutional and political shifts to take place (at different levels), furthermore positively impacted the success of social and political mobilisation against RDL 16/2012. The instability of political arrangements at regional levels (eg Navarra) and at the national level following the loss of PP's absolute majority in 2015/2016, constituted a crucial political opportunity structure, eg in relation to the adoption of more inclusive regional norms. All the above-mentioned political opportunity structures have contributed to (the differentiation and) the realisation of the human right to health within Spain. Ultimately, a change in government, a consequence of a vote of no confidence over a corruption scandal within the PP, led to the withdrawal of RDL 16/2012 (announced in June 2018).

3.3 CONTENTIOUS PERFORMANCES BY AUTONOMOUS COMMUNITIES

In relation to contentious performances opposing RDL 16/2012, I have limited myself to those formalised into laws and norms and subsequently analysed the claims that have been put to the fore by different regional governments. In relation to defying RDL 16/2012, autonomous governments have developed instructions, norms, directives and laws so as to extend healthcare provision to irregular migrants. In these legislative and governmental documents certain claims can be identified; arguments in favour of extending healthcare coverage to irregular migrants and opposing RDL 16/2012. After qualitatively analysing the legislative and administrative documents, I have summarised the main arguments defying RDL 16/12 in the tables below. I have ordered them according to the political party in power and the governmental cycle, effectively creating four different tables. In addition, I have created a table depicting the abbreviation and full name of the political parties and their political colour (see table 5).

Table 1: Overview of main claims to extend healthcare provision by regional PP governments (2012-2015)

Autonomous community	Political party 2012-2015 (2016)	Health inclusiveness	Arguments to extend healthcare beyond RDL
Cantabria	PP	Moderate	• Maintain and improve the level of collective health • Reduce the risk of disease transmission • Avoid the deterioration of health problems in patients • Preventative healthcare is more effective, cheaper and more efficient than emergency care
Valencia	PP	Moderate	• Health promotion • Prevention of diseases and provision of healthcare • Prevention and treatment of reportable diseases, infectious diseases and mental illnesses

Autonomous community	Political party 2012-2015 (2016)	Health inclusiveness	Arguments to extend healthcare beyond RDL
Galicia	PP (until 2016)	Moderate	• Maintain and improve the level of collective health • Reduce the risk of disease transmission • Avoid the deterioration of health problems in patients • Preventative healthcare is more effective, cheaper and more efficient than emergency care • Context of current globalisation
Aragon	PP	Moderate	• Maintain and improve the level of collective health • Reduce the risk of disease transmission • Avoid the deterioration of health problems in patients • Practical reality ('we cannot ignore') • Reportable diseases laid down in EU Regulations
Extremadura	PP	Moderate	• RDL 16/2012 discourages seeking medical assistance which can affect the health of the population • Protect public health • Reduce the risk of disease transmission • Avoid the deterioration of health problems in patients
Madrid	PP	Low	• Public health
Balearic Islands	PP	Low	• Public health
Murcia	PP	Low	• Effectiveness of RDL 16/2012 • Emergency care is understood as integral and continuous care • Preserve the health not only of the patient but also of the community
Castile-La Mancha	PP	N/A	N/A
La Rioja	PP	N/A	N/A
Castilla y León	PP	N/A	N/A

Source: Own elaboration based on qualitative analysis of governmental documents. Health inclusiveness derived from Cimas and others.[180]

[180] Cimas and others (n 119).

Table 2: Overview of main claims to extend healthcare provision by non-PP regional governments (2012-2015)

Autonomous community	Political party	Health inclusiveness	Arguments to extend healthcare beyond RDL
Navarra	UPN	High	• Right to (free and universal) healthcare • Principle of universality • Legal insecurity created by RDL 16/2012 • Breach of AC competencies; competent to independently develop health policies • Preceding regional laws in favour of free and universal healthcare • The will of the Parliament of Navarra
Andalucía	PSOE	High	• Constitutional right to health (article 43) • Principle of universality • Principle of equality • Collaboration agreement with CSOs • Breach of Autonomous Statute of Andalucía recognizing right to universal health • Preceding regional laws in favour of universality and equality • Principle of efficiency (homogenise)
Asturias	PSOE	High	• Constitutional right to health (articles 43 and 10) • Promotion of health and prevention of diseases • Principle of equality • Principle of universality • Protection of public and individual health • Preceding laws (Ley 33/2011 and Ley 14/1986) • Human dignity • The UN Declaration of Human Rights • International treaties ratified by Spain • European Charter of Fundamental Rights (article 35)
Canarias	CC	Moderate	• Promotion of health and prevention of diseases • Principle of effectiveness • Practical reality in era of globalisation • Competent to design own policies to protect health (Ley 11/1994, articles 42 and 43) • The right of vulnerable groups (eg those with chronic and invalidating diseases) to special and preferential health policies (Ley 11/1994, article 9)

Autonomous community	Political party	Health inclusiveness	Arguments to extend healthcare beyond RDL
Catalunya	CIU with support of ERC	Moderate	• Resolution of the Ombudsman (20 June 2012) • European Charter of Fundamental Rights (article 35) • European Convention on Human Rights • Declaration of Alma-Ata (1978) • Resolution of the European Parliament of 8 March 2011 • General Comment No. 14 of CESCR • Article 12 of the ICESCR (including Optional Protocol) • Constitution of the World Health Organization • Avoid the deterioration of health problems in patients • Avoid liability on behalf of Spain of breaching treaties • Principle of proportionality; economic savings versus damages • Protect public health • Necessary condition for the effective realisation of the other rights • Competencies Catalan Health Service
Euskadi	PSE-EE with PP support	Moderate	• Constitutional right to health (article 43) • Preceding laws that established universality • Principle of universality • Principle of equality • Principle of effectiveness • The economic crisis is the least opportune moment to restrict healthcare coverage • Autonomous Statute (articles 9 and 18) • Competent to establish own policies to protect health • Guarantee of financial sufficiency and budgetary stability

Source: Own elaboration based on qualitative analysis of governmental documents. Health inclusiveness derived from Cimas and others.[181]

[181] Cimas and others (n 119).

Table 3: Overview of main claims to extend healthcare provision by non-PP regional governments (2015-2018)

Autonomous community	Political party 2015 - 2018	Estimation health inclusiveness	Arguments to extend healthcare beyond RDL
Extremadura	PSOE	High	• Constitutional right to health (article 43) • Principle of universality • Protect public health through preventive measures • Combat social exclusion • Preceding national and regional laws establishing universality (Ley 10/2001, Ley 16/2003, Decreto 31/2004 and Ley 33/2011) • Principles of social justice and equality • Human dignity • Avoid the deterioration of health problems in patients • Competencies in matters of public health correspond to ACs • Principle of effectiveness and efficiency
Valencia	PSPV-PSOE and Compromis with support Podemos	High	• Principle of universality • Universal and fundamental right to health • Avoid the deterioration of health problems in patients • Principle of equality • Constitutional right to health (article 43) • Preceding national and regional laws (Ley 16/2003, Ley 33/2011 and Ley 10/2014) • Competencies in matters of public health correspond to ACs • Preserve public health • Human dignity • Principle of efficiency and effectiveness • Collaboration with CSOs

Autonomous community	Political party 2015 - 2018	Estimation health inclusiveness	Arguments to extend healthcare beyond RDL
Catalunya	JxS (CiU, ERC) with support CUP	High	• Resolution of the Ombudsperson (20 June 2012) • European Charter of Fundamental Rights (article 35) • European Convention on Human Rights • UDHR (article 25.1) • Declaration of Alma-Ata (1978) • Resolution of the European Parliament of 8 March 2011 • Article 12 of the ICESCR (including Optional Protocol) • Urgent call of CESCR in May 2012 and General Comment No. 14 of CESCR • Constitution of the World Health Organization • Avoid the deterioration of health problems in patients • Avoid liability on behalf of Spain of breaching treaties • Principle of proportionality; economic savings versus damages • Protect public health • Necessary condition for the effective realisation of the other rights • Autonomous Statute establishing right to equal access to healthcare • Competencies Catalan Health Service • Preceding national and regional laws establishing universality (Ley 14/1986 and Ley 21/2010

Autonomous community	Political party 2015 - 2018	Estimation health inclusiveness	Arguments to extend healthcare beyond RDL
Castilla la Mancha	PSOE with support Podemos	High	• Critique from civil society (eg associations of healthcare professionals) and the ombudsperson on RDL 16/2012 • Principle of proportionality and suitability; other less burdensome alternative policies could have been drafted to cut healthcare costs • Protect public health • Exclusive competencies established in Autonomous Statute of social assistance and social services • Principle of equality • Principle of universality
Cantabria	PRC and PSC-PSOE	High	• Constitutional right to health (article 43) • Preceding national and regional laws (Ley 14/1986 and Ley de Cantabria 7/2002) • Competency to develop health policies lies at the level of ACs • Intensify and reinforce the principle of universality • Right of health as right of citizenship • Protect public health • Principle of effectiveness and efficiency • Principle of equality
Baleares	PSOE and Més per Mallorca, with support from Podemos and Més por Menorca	High	• Constitutional right to health (article 43) • Preceding national and regional laws (Ley 14/1986 and Ley 5/2003) • Competency to develop health policies for irregular migrants without resources (Decreto 39/2006) • Autonomous Statute establishing universality (article 25.1) • Principle of universality • Principle of equality • Principle of efficiency or effectiveness

Autonomous community	Political party 2015 - 2018	Estimation health inclusiveness	Arguments to extend healthcare beyond RDL
Aragon	PSOE with support from Podemos, CHA and IU	High	• Constitutional right to health (article 43) • Principle of universality • Preceding national and regional laws (Ley 14/1986 and Ley 6/2002) • Autonomous Statute establishing universality (article 14.2) • Principle of equality • Principle of efficiency or effectiveness (homogenise)
Euskadi	EAJ-PNV and PSE-EE (from 2016)	High	• UDHR (articles 22 and 25) • European Commission guidelines • World Health Organization guidelines and advice • Constitutional right to health (article 43) • Preserve and protect the individual health of persons • To protect the public from public health risks • Competent to independently develop health policies, eg in relation to the Autonomous Statute (article 18) • Preceding regional laws establishing universality (Ley 8/1997 and Decreto 147/2015) • Principle of universality • Principle of equality and solidarity • Principle of efficiency or effectiveness
Canarias	CC	High	• Improve health of irregular migrants • Principle of effectiveness (simplify the procedure) • Reduce the risk of disease transmission

Source: Own elaboration based on qualitative analysis of governmental documents. Health inclusiveness derived from criteria and health coverage established in laws and norms, following approach of Cimas and others. [182]

[182] To estimate the health inclusiveness scores for the period following 2015, for which no scores exist, I looked at the requirements and the coverage established in the norms and laws and compared them to the requirements and coverage of the norms and laws from the preceding period and the health inclusiveness attributed to it by Cimas and others (n 119).

Table 4: Overview of main claims to extend healthcare provision by PP regional governments (2015-2018)

Autonomous community	Political party 2015-2018	Estimation health inclusiveness	Arguments to extend healthcare beyond RDL
Murcia	PP	High	• Right to health and physical integrity of the person • Protect public health • Principle of efficiency and effectiveness (eg to prevent a collapse of services providing emergency care) • Reduce the risk of disease transmission • Humanitarian reason and social protection
La Rioja	PP	Low to Moderate	• Principle of effectiveness • To avoid territorial differences among ACs
Madrid	PP	Low	• Absence of an inter-territorial standard • To avoid territorial differences between ACs

Source: Own elaboration based on qualitative analysis of governmental documents. Health inclusiveness derived from criteria and health coverage established in laws and norms, following approach of Cimas and others.

Table 5: Overview of (regional) political parties and political orientation

Political party or political alliance	Name	Party position relative to other parties	Progressive or Conservative
PP	**Partido Popular**	Centre-right to right	Conservative
PSOE **In Euskadi: PSE-EE** **In Valencia: PSPV-PSOE** **In Catalunya: PSC-PSOE**	**Partido Socialista Obrero Español**	Centre-left	Relatively progressive
Podemos	**Podemos**	Left	Progressive

Specifically, I compared and looked at 1) the presence of a formal definition of alternative procedures for access to healthcare, 2) the administrative requirements (number of documents and months of residency needed to qualify), 3) extent of healthcare coverage in comparison to general public and 4) whether all undocumented migrants were covered or only those with limited resources. Given the scope of my thesis I could not look into all 11 variables that are looked into by Cimas and others, but since I am not interested in the meticulous score but an overall estimation of the health inclusiveness (into roughly three groups; low, medium, high), I deemed the above factors informative enough.

Political party or political alliance	Name	Party position relative to other parties	Progressive or Conservative
Cs	Ciudadanos	Centre	Relatively conservative
EAJ-PNV	Partido Nacionalista Vasco	Centre-right	Relatively Conservative
UPN	Unión del Pueblo Navarro	Centre-right	Relatively Conservative
CC	Coalición Canaria	Centre-right	Relatively conservative
CIU	Convergence and Union (encompasses Democratic Convergence of Catalunya)	Centre-right	Conservative
ERC	Esquerra Republicana de Catalunya	Centre-left	Relatively progressive
Compromis	Coalició Compromís (affiliated with 'Valencian Style')	Left	Progressive
JxS [CiU, ERC]	Juntos por el Sí	N/A (Left and Right united)	N/A (Catalan independence)
CUP	Candidatura d'Unitat Popular	Left	N/A (Catalan independence)
PRC	Partido Regionalista de Cantabria	Centre	Progressive
Més	Més per Mallorca y Més per Menorca	Left	Progressive
CHA	Chunta Aragonesista	Left	N/A (Aragonese nationalism)
IU	Izquierda Unida (national affiliation with Unidos Podemos)	Left to Far left	Progressive

Source: Own elaboration based on data from The Manifesto Project.[183] See annex 2 for party positions and ideologies in plot. In relation to the few regional parties that were not included in the dataset (CUP, PRC, Més and CHA), I visited the party's websites and derived their position and ideology from there.

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[183] A Volkens and others, 'The Manifesto Data Collection' (Wissenschaftszentrum Berlin fur Sozialforschung/WZB 2017) Manifesto project (MRG/CMP/MARPOR) Version 2017b <https://visuals.manifesto-project.wzb.eu/mpdb-shiny/cmp_dashboard_selectable/>. Accessed 13 April 2019

The analysis of the legal documents affirms our understanding of lower levels of governments as initiators of claims in a process of contentious governance, as emphasised by Verhoeven and Broer.[184] The arguments and claims identified to extend healthcare beyond RDL are multifaceted. The qualitative content analysis and the tables illustrate that enacting policies in accordance with human rights does not always occur in the name of human rights laws or norms. Rather, other more practical arguments that may seem secondary to human rights advocates may be deemed more important by a regional government. Although many legislative and administrative documents contain a reference to a right to health, eg in relation to the constitution, the principle of universality or even human dignity, only a few explicitly relate it to international human rights treaties, namely Euskadi, Catalunya (in a very elaborate way) and Asturias (which merely touches upon the UDHR). At the time, different left wing and centre right parties ruled these regions, thus moving beyond political colour as the explanatory factor determining human rights references.

Intriguingly, it can be observed that, although many PP governments have extended healthcare beyond RDL 16/2012, they do not refer to a 'right' to health, with the exception of the AC of Murcia (from 2015 onwards). Given the overall lower health inclusiveness among PP governments, it is not surprising that PP governments do not talk about a right to health. Looking at the documents at hand, this is reflected by the fact that many PP governments created 'social programmes', which can be seen as a type of welfare assistance which one can access under certain conditions, but does not grant all people access to health.

According to the advocacy officer of Medicos del Mundo, a possible explanation for the rights language in Murcia can be found in the strong social pressure in Murcia and the overall inclusive trend observed in other communities to provide universal healthcare.[185] The respective health directives of Cantabria and Navarra also confirmed the role of social pressure in contributing to more health inclusiveness in some

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[184] I Verhoeven and C Bröer, *Contentious Governance: Local Governmental Players as Social Movement Actors* (Amsterdam UP 2015) 3 <https://dare.uva.nl/search?identifier=8ee15a55-6686-4249-9f5e-0adbec29be91> accessed 10 November 2018.
[185] Interview with MDM Advocacy Officer (n 126).

regions, remarking that social movement action was diffused unevenly over the country.[186] Another explanation could be the high number of irregular migrants in Murcia, due to the agricultural sector in which a lot of undocumented people work, and therefore the greater necessity to provide health as to reduce the risk of disease transmission.[187] Although an instinctive explanation for the more inclusive healthcare policies in certain regions, no connection between the numbers of migrants versus the inclusiveness of health policies was found in research by Cimas and others.[188] In all likelihood, without any conclusive answer, a combination of all these factors played a role in determining the rights language in Murcia.

The documents analysed reveal that the overall health inclusiveness improved after the elections of 2015; many ACs established less rigid criteria to access healthcare, eg in relation to the minimum time of registration needed in the AC (eg in the Canarias from one year to three months). In relation to the more inclusive trend observed after 2015, the AC of Madrid passed an internal order re-introducing the provision of healthcare to irregular migrants to avoid territorial differences in the healthcare system in the context of an absence of an 'inter-territorial standard'. In the words of the advocacy officer of Medicos del Mundo, 'you could really see that it was the reaction to the fact that almost every AC after 2015 started approving laws to provide universality'.[189] I would say that the standard of near universality created by other ACs following 2015 functioned as a political opportunity structure; it provided social movement actors and regional governmental actors with influential allies and functioned as support to challenge RDL 16/2012 in regions where health inclusiveness was still lower. In line with this, pressure from the regional governments to change RDL 16/2012 increased following the 2015 elections,[190] something that is also reflected in table 3 by the many new norms implemented.

Whatever the arguments used, the inclusive norms adopted by PP governments depicted in table 1 affirm that the creation of inclusive health policies goes beyond the left-right dichotomy. As can be derived

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[186] Interview with Health Director, Cantabria (n 154); Interview with Legal Advisor, Health Ministry, Navarra (n 152).
[187] Interview with MDM Advocacy Officer (n 126).
[188] Cimas and others (n 119).
[189] Interview with MDM Advocacy Officer (n 126).
[190] ibid; Interview with Legal Advisor, Health Ministry, Navarra (n 152).

from the tables, many PP governments developed more inclusive norms, although they do not use the language of human rights, nor very strong language. This could be a reflection of party loyalty on the one hand, and competing interest on the other. In the words of the health director of Cantabria:

> And their own allies of other ACs surely cannot and do not want to confront their own party, but that is the double language of politics: on the one hand, I say one thing, but on the other hand I have to say something else. It [the language of inclusiveness] is a compulsory language when you are close to the citizen. When you are close to the problems, you can say that you do not see them, but they put them in front of you![191]

In line with a similar argument that is often put forward as to why local levels of government are frequently more inclusive,[192] the last sentence of this quote demonstrates the closer gap between policymakers/politicians and the needs of people. By extension, all the interviews depicted a clear clash of interest between the state and the ACs. This is also reflected in the analysis of legislative documents, eg from implicit sentences like 'we cannot ignore' to explicit references of 'globalisation' and practical reality. As the legal advisor from Navarra stressed, the state and ACs have different interests, among other things because they have different competencies. 'There is a total disconnection between the interests in Madrid, I mean the State, and the interests of each of the ACs. In fact, none of the ACs is happy with this system. Everyone has made its little tricks to include them (migrants), even the ones (communities) from PP. It is not an ideological reason, as it is an interests question.'[193]

Whereas the state has the competency over migration, he argued, the ACs are responsible for healthcare provision. In line with the principle-agent problem touched upon in the theoretical framework,[194] the government official in Navarra argued that these two competencies clash since RDL 16/2012 was drafted from a migration perspective as opposed to a health perspective. In other words, RDL 16/2012:

> … signified a policy, a punishment, from a migration perspective, to deter them [migrants] from coming, to try and make sure they go away.

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[191] Interview with Health Director, Cantabria (n 154).
[192] Oomen (n 68) 403.
[193] Interview with Legal Advisor, Health Ministry, Navarra (n 152).
[194] Fuentes (n 122).

But the healthcare system is not for making the people leave the country; it is for providing healthcare to people who are in the country … the alleged purpose in Madrid was not regarding healthcare, it was another type of objective, and here in the ACs we faced a healthcare issue. At that time, UPN [center-right] decided from the beginning to attend those people.[195]

Corresponding to the ACs' competencies, the argument most commonly used by regional governments is the protection of public health. This seems to be an argument that crosses left and right wing boundaries, as it is referred to in nearly all norms and laws created, irrespective of party colour, mostly in general terms by referring to the protection, promotion or preservation of 'collective' or 'public health'. Perhaps unsurprisingly, PP governments tend to more elaborately mention the risk of disease transmission. An explicit example of the fear for disease transmission can be found in the AC of Extremadura in 2013 (PP government):

This situation could cause side effects in the [resident] population because they [irregular migrants] can contract diseases and spread them; there are many people in a regular situation who live daily with foreigners in an irregular situation, both in residential buildings, as well as in other areas.[196]

In line with the observation that norms created by PP governments tend to more elaborately mention the risk of disease transmission, CSOs like Medicos del Mundo strategically used the argument of the health risk in advocating health inclusiveness among right wing parties, as they seemed more sensitive to these arguments than to human rights arguments.[197]

In addition, arguments about ACs' competencies to extend healthcare coverage beyond RDL 16/2012 are not referred to by PP governments, whereas they come to fore in nearly all norms and laws created by regional governments not ruled by the PP. This illustrates the decentralised nature of the Spanish state on the on hand and party loyalty (to not explicitly defy their own party) on the other. It can be

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[195] Interview with Legal Advisor Health Ministry, Navarra (n 152).
[196] See annex 1, Extremadura, Instruction of 15/07/2013.
[197] Interview with MDM Advocacy Officer (n 126).

derived from the documents that in legitimising their more inclusive provision of healthcare, the regional governments refer to the existence of opposing laws agreed to in the past. These past laws represent a political opportunity structure for regional governments to challenge RDL 16/2012. The laws referred to are twofold. Firstly, the universality established by preceding laws is referred to. Secondly, the autonomy in the development of healthcare policies is referred to in relation to the ACs' competencies and/or autonomous statutes. Often, these are one and the same law. Based on the many arguments about competency that came to the fore through the qualitative content analysis of the legislative documents, it can be concluded that ACs seem very much aware of their struggle over competency in the field of health. This is furthermore reflected by the following quote, depicting contentious politics in practice:

> By putting our legal services at work, to see what holes the national law has and what competencies we can derive from our statute of autonomy and our operating laws, so that they can tell us in what the State can force us and in what we can escape … We put jurists to work in favor of a universal and free public service idea.[198]

Remarkably, the qualitative analysis showed that many regional governments referred to their intervention as a 'social programme'. By presenting their intervention as such, ACs tried to claim competency in defying RDL 16/2012, without having to do so in a very confronting or explicit way and run the risk of legal action by the state. Especially for PP governments this provided an opportunity to implicitly challenge the state's competency over the matter, without having to explicitly defy their own party at national level in light of competencies. The legal advisor in Navarra argued that (PP) ACs are deliberately labelling the interventions 'social programmes', 'because with that they are trying to derive their competence from social action, instead of health where the competencies between the AC and the state is more contested'.[199]

Nearly all parties other than the PP have interpreted the provision of healthcare as a right to everyone. Various principles underlie the provision of healthcare. Apart from the morality of human rights and or universality, the principle of equality was also often touched upon in

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[198] Interview with Health Director, Cantabria (n 154).
[199] Interview with Legal Advisor, Health Ministry, Navarra (n 152).

the governmental documents. On this point, the health director from Cantabria argued, 'We understand that the health system, in addition to its health function, fulfils a role of equity and cohesion of society because it equates ... because it has nothing to do with income. It is by right, that what unifies the citizens'.[200] The same health director interpreted the right to health as a reflection of citizenship (also reflected in the documents analysed), but her interpretation of citizenship differed from its connection to nationality or a formal or legal status as defined by Delanty in the theoretical framework: 'We understand as a philosophy that healthcare must be a right of citizenship: if you live here, it is a right of citizenship … That is why this order is created, which allows us to provide health care to all the groups residing in Spain'.[201] Her interpretation of citizenship was thus more connected to physically residing in a place, rather than being in possession of the Spanish nationality. It corresponds to the notion of citizenship as something that can be realised substantively, irrespective of legal status.

The availability of (international) influential allies or supporters has also been reflected in the documents, for example in the ways Euskadi, Catalunya and Asturias (the latter to a lesser extent) refer to the World Health Organization, the UDHR, European norms and/or recommendations by the ombudsperson (*el defensor del pueblo*). Moreover, the concluding observations of the Committee on Economic, Social and Cultural Rights (CESCR), as touched upon in the previous section on political opportunity structures, were referred to in Catalunya. A possible explanation for the fact that Euskadi and Catalunya extensively referred to international institutions might be that, given a strong movement of autonomy in these regions, they are used to using a globalising rhetoric to defend their autonomy; they are already aware of the (international) influential allies available to them to defy the nation-state. The latter might therefore be a reflection of path dependency. Globalising rhetoric is a common phenomenon in the struggle for moral authority; it is a strategy to gain legitimacy from outsiders without looking self-centered.[202]

Several ACs (Euskadi, Navarra, Valencia, Catalunya, Cantabria) have

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[200] Interview with Health Director, Cantabria (n 154).
[201] ibid.
[202] James M Jasper, *The Art of Moral Protest: Culture, Biography, and Creativity in Social Movements* (University of Chicago Press 2008) 276.

had to explicitly defend their laws providing access to irregular migrants in front of the constitutional court of Spain. On the topic, a government official in Navarra remarked 'now they all stand up together that RDL has to be removed, because it does not make sense'.[203] The effort by the national government to turn a political issue into a legal issue has proven problematic for the ACs, since 'courts are governed by law and not by the concept of rights. Then, in the end, many of these things [regional laws] fail because the royal decree is a law, like it or not, but it is a law. The courts cannot decide anything that goes against the law'.[204] Despite negative judgments by the constitutional court declaring certain regional laws unconstitutional,[205] regional governments have kept providing healthcare to irregular migrants, making optimal use of their legal advisors.[206]

Overall, it can be concluded that the analysis affirms the emergence of lower level human rights polities for irregular migrants, eg through upholding more substantive notions of citizenship and through publically defying national power hierarchies in the name of a (human) right to health, the principle of universality and human dignity, among other arguments. PP regional governments, although many of which have expanded healthcare provision to irregular migrants, do not use the 'rights' language (possibly a reflection of party loyalty), with the exception of the AC of Murcia following the 2015 elections. The social pressure in this region, the general trend toward universality in many other regions, and lastly the high number of irregular migrants in this region provide a possible explanation for this exception. PP governments focus more on the risk of disease transmission, whereas regional governments not ruled by the PP more explicitly challenge the state in terms of competencies. The struggle over competencies is reflected in the documents explicitly and implicitly, eg explicitly with reference to claims derived from their autonomous statute or implicitly by labelling the instructions 'social programmes' by which they try to circumvent the state and claim competencies to intervene. Following the 2015 elections, more ACs started to provide healthcare to irregular

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[203] Interview with Legal Advisor, Health Ministry, Navarra (n 152).
[204] Interview with Health Director, Cantabria (n 154).
[205] For instance, STC 139/2016, de 21 de julio de 2016 (Navarra) and STC 134/2017, de 16 de noviembre de 2017 (Euskadi)
[206] Interview with Legal Advisor, Health Ministry, Navarra (n 152).

migrants. Although political colour is influential in the degree of healthcare provided to irregular migrants (eg difference between social programme and social welfare assistance or healthcare as a right), the provision of healthcare to irregular migrants and thus the defiance of RDL 16/2012 moves beyond the right-left wing dichotomy.

3.4 Formation of collective actors

The implementation of RDL 16/2012 led to a resistance movement at national, regional and local level. Given that the formation of collective actors is relational in nature, some mechanisms elaborated upon in the theoretical framework can be identified, such as a process of brokerage. The resistance movements encompassed various actors from different spheres; it encompassed societal, political and professional actors. In challenging RDL 16/2012, health professionals, political opposition parties and CSOs joined forces and created new alliances and networks. For example:

in 2012, at different regional levels, several platforms were created and the project REDER … is saying precisely to gather all those regional initiatives under one big umbrella at national level, and also include other organizations at a national level that are also against exclusion.[207]

In other words, previously unconnected groups started building alliances to collectively mobilise in opposition to RDL 16/2012.

The interviewees confirm that the resistance movement contributed to the adoption of more inclusive health policies at a regional level.[208] This is also reflected by many legislative and authoritative documents analysed, for instance, the norm created by Castilla La Mancha (see annex 1, Castilla la Mancha, order of 9/2/2016), touches upon the critique from civil society and health professionals on RDL 16/2012 as an argument for the inclusion of irregular migrants in the healthcare system. Another example is the agreement of cooperation with civil society actors that was touched upon by the health ministry of Andalucía as an argument for the inclusion of irregular migrants (see annex 1,

[207] Interview with MDM Advocacy Officer (n 126).
[208] ibid; Interview with Health Director, Cantabria (n 154); Interview with Legal Advisor, Health Ministry, Navarra (n 152).

Andalucia, Instruction of 06/06/2013).

In line with the above, the health director in Cantabria was 'absolutely convinced' social pressure constituted a major explanation as to why some PP governments adopted more inclusive health policies than their national party designed at national level:

> The social pressure ... That is, the fact that health is transferred to the AC allows it to be closer to the problems of citizens, and the pressure of citizens is ultimately what moves things … So the AC government, even if it wants to respect the national decree because it is its [own] party that does it [at national level], is subject within the AC to pressure from collectives that are demanding an answer ... it [AC] has its own parliament.[209]

The latter comment also relates to the political opportunity structure of decentralisation; regional governments have their own parliament, meaning politicians are not solely held accountable at national level. The presence of strong allies in parliament subsequently provides social movement actors with opportunities to advocate for more health inclusiveness. Another clear example depicting the process of brokerage is the social and political pact that was signed in September 2017:

> by all the parties of the opposition at the national level, but also by the 70 organizations and trade unions and professional organizations from the healthcare sector. They all came together and made a pact for a public and universal health care system in which the parties again committed to pass a national law in order to overthrow the RDL.[210]

Although this pact constituted a major breakthrough, bringing together previously unconnected groups, the effect remained limited given that the PP government kept using its veto powers to nullify any proposal to bring back universality.[211]

Whereas it seems the ACs did not built alliances in the formal sense of the word in response to RDL 16/2012, ACs did work together, using existing and informal channels, to discuss how to respond to RDL 16/2012 and how to challenge it. Firstly, the issue was discussed multiple times in the formal inter-territorial council, the national forum in which proposals

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[209] Interview with Health Director, Cantabria (n 154).
[210] Interview with MDM Advocacy Officer (n 126).
[211] ibid.

of the ministries are discussed, adopted and/or rejected by the ACs.[212] However, since the national ministry also attends these meetings, and given established hierarchies and formal rules in such a forum, the ACs saw themselves limited in their defiance of RDL 16/2012. In contrast, key to the formation of collective action against RDL 16/2012 were the informal channels available to the health ministries of the ACs, thus circumventing the national state actors. About the period following 2012, the government official in Cantabria stated, 'There was permanent contact through phone calls and meetings. We spoke with ACs on the side to ask them how they see it, what they do'.[213] In response to the question of whether formal cooperation without the state ministry existed, the government official in Navarra responded, 'No, but there are a lot of phone calls and e-mails from health ministries [of ACs] who want to include them [irregular migrants] in the National Health System, and they talk and try to create a consensus'.[214]

According to the health director of the government of Cantabria 'there are private forums that are not institutional but that each AC establishes with the others in a private way'.[215] This cooperation moves beyond the occasional phone call, eg it also encompasses meetings and the exchange of documents and strategies that may support the ACs' claims over competencies. For example, the legal advisor of Navarra mentioned that a report drafted by him, which explored the legal ways of how to continue providing healthcare to irregular migrants after the constitutional court's negative judgment was shared by the health ministry of Navarra with other ministries.[216] As a consequence of the report 'the different health ministers of the different ACs started to talk about rebelling against the state' and 'I may tell you, without being pompous, that Navarra is leading this movement'.[217] The words in this quote – 'rebelling' and 'movement' – depict the social movement like behaviour of some ACs, a process that has even been observed among lower levels of governments in more centralised states such as the Netherlands.[218]

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[212] Interview with Health Director, Cantabria (n 154).
[213] Interview with Health Director, Cantabria (n 154)
[214] Interview with Legal Advisor, Health Ministry, Navarra (n 152).
[215] Interview with Health Director, Cantabria (n 154).
[216] Interview with Legal Advisor, Health Ministry, Navarra (n 152).
[217] Interview with Legal Advisor, Health Ministry, Navarra (n 152).
[218] Verhoeven and Bröer (n 184).

The notions of identity shift and boundary formation come to the fore in the way the government officials during interviews talked about their own competencies and interests in relation to the state's competencies and interests, something which is also reflected in the contentious performances derived from the qualitative content analysis.

> The PP … that has its hidden political, economic objectives in this change, chose to create this norm. But the ones who have the problems are the ACs, because a lot of people who had healthcare assistance before lost it … but they are the ACs' patients! … I am not affecting the whole state, I am not putting a person into the National Health System, but in my health service with my money and only to provide assistance here [in Navarra].[219]

In both quotes, a clear boundary is drawn between the national healthcare system and the healthcare system of Navarra. The government official clearly appropriates the patients as being theirs, not the state's. By creating a boundary between Navarra – with its fiscal independency – and the state, he legitimises their competency over healthcare and the law drafted at a regional level in response to RDL 16/2012.

According to the political advocacy officer of Medicos del Mundo, many to most of the laws passed in 2015 encompassed some kind of cooperation with civil society actors, eg through a consultation processes.[220] In the law drafted in Valencia, it is stated that the Health Department has worked together with civil and professional organisations to create a new reality that guarantees a dignified healthcare for every person (see annex 1, Valencia, Law of 24/7/2015). In line with the shift from government to governance, the advocacy officer remarked, 'The regional governments really tried to get in touch with civil society, we also made ourselves present'.[221] A few ACs even moved beyond 'mere' consultations as some laws attributed formal roles to CSOs, eg monitoring the application of a regional law.

The involvement of CSOs at a regional level in monitoring and assessing the implementation of specific regional healthcare policies and laws is a reflection of a mechanism of co-optation. In Valencia CSOs got a formal seat at the table to assess the regional legislation drafted in

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[219] Interview with Legal Advisor, Health Ministry, Navarra (n 152).
[220] Interview with MDM Advocacy Officer (n 126).
[221] ibid.

2015; a commission was set up to monitor and evaluate the application of the regional law, consisting of both governmental officials and CSO representatives (this meets at least twice a year) (see annex 1, Valencia, Law of 24/7/2015). By drawing CSOs towards the centre of power in these regional governments in the context of healthcare policies, CSOs were effectively able to provide the governments with essential information on making the application of the law more effective, and thus to make the healthcare system overall more inclusive. As a consequence of the involvement of CSOs in the evaluation of the law in Valencia, an information campaign was set up to inform health providers and irregular migrants about the rights of irregular migrants.[222]

A similar information campaign was set up in Cantabria through the involvement of CSOs in the policymaking process following the election result and a change of government in 2015. The mechanism of co-optation proved fundamental in this AC as well since the CSOs provided information to the health ministry on how to improve care and how to reach irregular migrants and inform them about their right to health.[223] Due to a process of co-optation, formally expressed through the creation of a commission and follow-up commission, the idea arose to create an information sheet indicating irregular migrants' right to healthcare in different languages, such as Arabic (see annex 3). Importantly, the role of civil society goes beyond the provision of information; in some cases they also acted as intermediaries at healthcare centres, assisting irregular migrants in going to healthcare centres and translating things for those who did not speak Spanish.[224] A very explicit example of co-optation can be found in the AC of La Rioja, where following the elections in 2015, access of irregular migrants to healthcare was channelled through Cruz Roja and Caritas, who signed a special agreement for this arrangement with the ministry of health of La Rioja (see annex 1, La Rioja, announcement of 8/10/2015).

In relation to the diffusion of social movement action against RDL 16/2012, the strength of the social movement actors differed strongly per region, partly reflecting the different legislative context and health inclusiveness in each region. A challenge in mobilising social movement actors following 2015 was the normalisation of the situation and the

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[222] Interview with MDM Advocacy Officer (n 126).
[223] Interview with Health Director, Cantabria (n 154).
[224] ibid; Interview with Advocacy Officer MDM (n 126).

adoption of more inclusive regional norms, lowering local social movement actors' priority in challenging RDL 16/2012. For example, despite RDL 16/2012 being a national issue affecting all regions to some degree, in Navarra and Andalucia civil society did not strongly advocate against RDL 16/2012 because in those regions the regional governments had designed ways to include irregular migrants, which prevented CSOs from adopting it as a major issue.[225] This fragmentation of social movement action, although partly resolved by a process of brokerage and the creation of new alliances and networks of previously unconnected groups, may have negatively impacted the fight against RDL 16/2012 at the national level. In line with this, the health director in Cantabria characterised the social movement against RDL 16/2012 as 'not active enough'; whereas the response of co-payments was fierce, the response of the stripping away of the rights of irregular migrants was less fierce because it did not affect the entire population, nor people in a similar way (given inter-territorial differences in health inclusiveness).[226]

Apart from inter-territorial differences fragmenting social movement actors, the advocacy officer of Medicos del Mundo also identified a process of demobilisation in the years following 2012. Some organisations that were part of REDER had lost their strength once they were already advocating against RDL 16/2012 for years; '… they were very active for a few years but it is very exhausting to maintain a high level of social conflict when you don't achieve change at the same time, so demobilization comes at a consequence.'[227] The new norms implemented in 2015 also facilitated this process of demobilisation, since overall health inclusiveness increased in many regions, despite it being lower than before RDL 16/2012. Although civil society action slightly lessened, contention between regional governments and the national government increased given the changing political landscape and the presence of more inclusive norms in ACs.

All in all, various mechanisms of contentious governance can be identified in relation to irregular migrants' access to healthcare and the formation of collective action. Inter-territorial differences in health inclusiveness meant that social movement action against RDL

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[225] Interview with MDM Advocacy Officer (n 126); Interview with Legal Advisor, Health Ministry, Navarra (n 151).

[226] Interview with Health Director, Cantabria (n 154).

[227] Interview with MDM Advocacy Officer (n 126).

16/2012 was highly uneven. To overcome this fragmentation, a critical mechanism in the formation of collective action against RDL 16/2012 proved to be the process of brokerage, in which societal, political and professional actors joined forces by creating novel alliances. Moreover, key to the formation of collective action from the regional governments' perspective were the informal channels available to the health ministries of the ACs, thus circumventing the national state actors. Especially after 2015, a process of co-optation and the involvement of CSOs in the policymaking process resulted in the improvement of the application of local norms and laws, and overall health inclusiveness. A challenge in mobilising social movement actors following 2015 from the perspective of CSOs was the normalisation of the situation and the adoption of more inclusive regional norms lowering local social movement actors' priority in challenging RDL 16/2012 nationally. However, increased contention between ACs and the state, and overall higher inclusiveness at a regional level, slightly substituted for this demobilisation.

Irregular migrants, a vulnerable group of people in our respective societies, are often faced with a lack of human rights protection, among other rights, expressed by the inaccessibility of the human right to health. The xenophobic character that defines the presence of a new kind of nationalism in Europe has aggravated the realisation of human rights for irregular migrants at national levels. The strong linkages between citizenship, nationalism and human rights protection have resulted in pressure and critique on the principle of universality; those without appropriate citizenship risk being stripped away of their rights by nationalist forces. The implementation of RDL 16/2012, which encroached upon the health rights of irregular migrants in Spain, is a reflection of the latter development in the context of the economic crisis. In contrast to this development, the case analysis has shown that the relative gap or void of human rights protection left behind by new nationalism is being filled by other political entities, among which regional governments.

CONCLUSION

The implementation of the human right to health in Spain has been highly uneven. Following the enactment of RDL 16/2012, regional governments, even those ruled by a party similar to that at national level, rebelled against the state's decision and designed, through a process of contentious governance and in defiance of national legislation, inclusive health policies. A contrary, more inclusive development than new-nationalism can therefore be identified, in line with the shift away from 'government' to governance, namely the emergence of 'human rights polities', a novel concept defined as local, regional or supranational political entities (less subject to new nationalism) that develop policies and/or laws in opposition to the state's policies, rules or regulations in the name of human rights (eg include irregular migrants). The emergence of human rights polities goes beyond the development and emergence of human rights cities, given the latter's exclusive focus on the local level and the fact that contention does not presubscribe it. Importantly, the concept addresses the gap in academic literature in which the regional level has too often been overlooked, or thrown on one heap with local governments, despite distinct and competing competencies and characteristics between them.

Whereas some scholars like Cimas and others identified the influence of political colour in determining the implementation gap of RDL 16/2012,[228] by itself this did not explain the divergence between ACs and the national government, nor did it solely explain the differing health inclusiveness among the regions. In other words, other factors

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[228] Marta Cimas and others, 'Healthcare Coverage for Undocumented Migrants in Spain: Regional Differences after Royal Decree Law 16/2012' (2016) 120 Health Policy 384.

also played a role, but which were these factors and to what extent did they play a role? Although my research has not been able to identify a clear-cut answer to this question, it has nonetheless shed light on the factors that contributed to the implementation gap, eg with reference to the different interests based on the conflicting competencies of migration versus health (a reflection of the principle-agent problem), fragmented social pressure across the country and the different political opportunity structures between the regions and the central government (eg in terms of stability of political alignments at regional/national government).

Overall, political opportunity structures as well as a lack of opportunity structures have been of importance in the political and social mobilisation against RDL 16/2012. The crisis that hit Spain in 2008 weakened the power of ACs in favour of the central state, making it more difficult to challenge RDL 16/2012. Moreover, certain constitutional competencies of the central government in the context of the economic crises, such as the unilateral enactment of legislation in the form of RDLs and the veto power restricted the potential of ACs and CSOs to challenge RDL 16/2012.

In contrast, the multiplicity of independent centres of power, the presence of influential allies and the 'openness' of the regime, a result of Spain's decentralised competencies in health and the democratic nature of the Spanish state, have proven to be critical in realising the human right to health at a regional level, as it reduced the central governments' capacity to act unilaterally in implementing RDL 16/2012 and allowed CSOs to navigate the various points of access into the decision-making process. The elections in combination with the instability of political arrangements at national level (following 2015) contributed to the higher health inclusiveness observed.

Inter-territorial differences in health inclusiveness meant that social movement action against RDL 16/2012 was diffused unevenly over the country. Novel alliances were created through a process of brokerage, a mechanism that proved vital in overcoming social movement fragmentation and demobilisation. In line with the notion of governance, informal channels available to the health ministries of the ACs enabled regional political entities to circumvent the national state. The overall improvement in health inclusiveness following 2015 can be partly attributed to this, as well as to a process of co-optation of CSOs in the policymaking and evaluation process of regional norms and laws.

The analysis has shown that regional governments - faced with different competencies than the national state as well as the practical realities of social, economic and political exclusion of a considerable group of its residents - have rebelled against the state through contentious performances in favour of more inclusive policies, albeit not always in the name of human rights. As the analysis demonstrated, PP governments, arguably faced with party loyalty, focused more on the risk of disease transmission and generally extended the access to health through social programmes, whereas regional governments not ruled by the PP more explicitly challenged the state in terms of competencies and extended the access to health through acknowledgement of the (human) right to health. The latter distinction emphasises the importance for human rights advocates to not merely focus on human rights in persuading (especially right wing) governments in adopting human rights standards; other arguments such as public health, infringement of competencies, practical reality, efficiency, costs and inter-territorial standards may be deemed more important and thus persuasive to these governmental entities.

All in all, the analysis of the political opportunity structures, the contentious performances and the formation of collective actors reflect the emergence of human rights polities in some ACs (in the context of health), namely the ones that adopted the rights language and consciously challenged the national law in the name of the (human) right to health and the principle of universality. Nonetheless, even in the ACs that did not adopt a (human) rights language, healthcare provision has been extended beyond RDL 16/2012. In light of the realisation of human rights, this demonstrates that regional political entities prove more inclusive than the national political entity subject to new nationalism.

DISCUSSION

Within the academic debate about the implementation of human rights, the regional level has too often been overlooked (especially in non-federal countries). Scholarly attention has primarily focused on the nation state on the one hand, and more recently cities, including human rights cities, on the other. My research addresses this gap within existing literature and introduces two relevant concepts within the academic debate about the implementation of human rights; the human rights polity and the democratisation of human rights instruments. Moreover, it explores the underlying reasons why regional governments are more successful in human rights implementation. This thesis has attempted to shed light on the gaps that exist within countries in terms of the realisation of human rights through a case analysis of the human right to health in the context of irregular migration. The approach adopted here, namely analysing political opportunity structures, contentious governance and the formation of collective actors, may provide insights for other researchers that are interested in understanding gaps in human rights implementation. The findings may be especially interesting for researchers interested in (federal) states where competencies, and thus the ultimate responsibility of human rights realisation, is decentralised.

This work is practically concerned and addresses ways in which human rights can be realised through the formation of collective actors, contentious performances and political opportunity structures in a context where a state implemented legislation that denies the human right to health (for irregular migrants). Therefore, besides academics, my research may provide insights for human rights advocacy officers and/or lobbyists, given that my research stresses the importance of taking into account within-country differences in human rights implementation and explores the ways in which one can make sense

of these differences by looking at both structural factors, performances and mobilisation. In other words, this specific understanding of human rights implementation may provide insights for strategies to further the realisation of human rights.

Certain limitations of my research should be acknowledged. My (verbal) fluency in Spanish is modest, which has influenced the way I conducted my research. Especially in relation to the interviews, it was challenging to intervene in Spanish, but this has been partly resolved by making use of a translator. Nevertheless, it should also be acknowledged that the use of a translator accompanies its own limitations, such as problems surrounding interpretation.[229] Overall, given that the main analysis has been written documents (and that I can read Spanish relatively well), I believe language limitations, although influential, have not significantly affected my results; it primarily posed an extra (interesting) challenge for me, which affected me time-wise, more than anything else.

Another limitation has been the limited number of interviewees, and the bias that may exist among them. Despite many emails and phone calls, gaining access to informants in the regional health ministries proved to be a challenge due to unanswered e-mails and/or the bureaucratic and time-consuming way to arrange an interview (eg in the case of La Rioja). The limited access to regional health ministries was partly resolved by slightly changing the focus of my analysis towards legislative and administrative documents. Having interviewed informants in Cantabria and Navarra, it must be noted that at the moment the interviews were conducted, progressive, centre-left wing parties ruled these regions (in contrast to the period before 2015). In other words, they are the progressive ACs that have designed universal healthcare systems and therefore are not representative of PP regions. Especially in Cantabria, where the health director was interviewed (which is a more political figure), as opposed to the legal advisor in Navarra, this may have tainted the kind of answers given. For future research, more interviews should be conducted, especially also in regions ruled by right wing parties, to reduce any bias. Although this may have affected my research, the main analysis has been the 34 legislative documents; which is why I believe

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[229] Bogusia Temple and Alys Young, 'Qualitative Research and Translation Dilemmas' (2004) 4 Qualitative Research 161.

interviewing right wing governments would in all likelihood lead to complementary findings, not necessarily contradicting ones.

Moreover, and among other things, there have been certain methodological implications of looking at legislative and administrative documents that may have influenced my research. Although the documents at hand contain contentious claims, they did not fully encompass the relational aspect of contentious performances and the formation of collective actors. Moreover, inherently, legal claims may differ from political ones, and written claims may differ from verbal ones voiced in regional parliaments, or in the news. Future research could look into these other areas to explore more in depth the relational aspect of contentious governance and the formation of collective actors.

Lastly, in light of limitations, it must be noted that, given the scope of my thesis, socio-historical and political-cultural factors and differences among the regions (which move beyond path dependency) have not been sufficiently taken into account. Given the overall importance of these factors in politics, I suggest these could be more adequately taken into account in future research, building and complementing on the theoretical and practical findings of this thesis, with the aim of trying to understand the uneven implementation of human rights.

Now that limitations have been discussed, and in light of proposing ideas of future research, the solution proposed to democratise human rights instruments in relation to the emergence of new nationalism should be shortly, but critically, discussed. As has been touched upon before, accommodating within-country differentiation into human rights instruments by democratising them would allow lower levels of government, including human rights polities, to participate in human rights instruments and mechanisms and co-sign treaties. Democratising human rights treaties and instruments would create political opportunity structures that could facilitate human rights protection on the ground. However, disadvantages also exist, such as human rights fragmentation. In line with other research that focuses on human rights cities,[230] my research affirms that regional governments are generally more inclusive (in the context of health) than the national government. Therefore, if executed well, the democratisation of human rights could provide

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[230] Barbara Oomen and Moritz Baumgärtel, 'Human Rights Cities' [2014] The Sage Handbook of Human Rights 709

complementary protection, not substitute state protection. Although my research has proven that even without the democratisation of human rights instruments, human rights fragmentation within countries is already a reality, the effect of human rights fragmentation and the democratisation of human rights instruments should be critically researched.

The latter is especially important given its potential and the recent international developments that can be observed. The world is changing. Traditional polities are being challenged and new polities are emerging. These developments ask us to rethink and adapt our human rights instruments to the volatility of everyday global and local politics. Why merely let countries take responsibility for human rights when many tasks are devolved by lower levels of governments who actually carry the ultimate 'responsibilities' to ensure human rights protection? Given the emergence of human rights cities and human rights polities, and in line with the findings of my thesis, democratising human rights instruments may further strengthen bottom up pressure to take human rights obligations more seriously, in addition to curbing chauvinistic nationalism, which not long ago was referred to by the United Nations Human Rights Chief Zeid Ra'ad Al at the opening of #HRC38 as 'the most destructive force to imperil the world …'[231]

Naturally, one may disagree with this more normative position, which one could write a separate thesis on, but in any case, regardless of political feasibility, I believe it to be relevant to look into the possibilities and research and analyse the advantages and disadvantages of the democratisation of human rights in relation to human rights polities, something which could be taken up by those already interested in the development of human rights cities and the localisation of human rights.

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[231] UN Office of the High Commissioner for Human Rights, 'Opening Statement and Global Update of Human Rights Concerns by UN High Commissioner for Human Rights Zeid Ra'ad Al Hussein at 38th Session of the Human Rights Council' (18 June 2018) <https://reliefweb.int/report/world/opening-statement-and-global-update-human-rights-concerns-un-high-commissioner-human> accessed 30 June 2018.

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Aragón
Instrucción de 30 de abril de 2013, de la Dirección General de Calidad y Atención al Usuario, por la que se crea el Programa Aragonés de Protección Social de la Salud Pública
Instrucción de 9 de abril de 2014 de la Dirección General de Salud Pública, para la atención sanitaria y el tratamiento de supuestos especiales por motivos de salud pública
Instrucción de 7 de agosto de 2015, del Consejero de Sanidad, por la que se regula el acceso a la asistencia sanitaria en Aragón para las personas extranjeras sin recursos económicos suficientes ni cobertura de asistencia sanitaria del sistema nacional de salud

Asturias
Instrucciones de 14 de junio de 2012 para el Servicio de Salud del Principado de Asturias sobre la autorización de asistencia sanitaria, con carácter provisional, a las personas extranjeras en situación irregular sin recursos (BOPA N.º 140, de 18 de junio de 2012)
Instrucciones de 30 de agosto de 2012 para el Servicio de Salud del Principado de Asturias sobre la autorización de asistencia sanitaria, con carácter provisional, a las personas extranjeras en situación irregular sin recursos (BOPA N.º 240, de 1 de septiembre de 2012)

Cantabria
Orden SAN/20/2013, de 25 de noviembre, por la que se crea el Programa Cántabro de Protección Social de la Salud Pública y se regula el procedimiento de acceso al mismo (BOC N.º 234, de 5 de diciembre de 2013)
Orden SAN/38/2015, de 7 de agosto, por la que se regula la inclusión en el Sistema Sanitario Público de Cantabria de las personas residentes en la Comunidad Autónoma que no tengan acceso a un sistema de protección sanitaria pública (BOM N.º 157, de 17 de agosto de 2015)

Castilla La Mancha
Orden de 9 de febrero de 2016, de la Consejería de Sanidad, de acceso universal a la atención sanitaria en la Comunidad Autónoma de Castilla-La Mancha (DOCM N.º 36, de 23 de febrero de 2016)

Cataluña
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Ley 9/2017, de 27 de junio, de universalización de la asistencia sanitaria con cargo a fondos públicos mediante el Servicio Catalán de la Salud (DOGC N.º 7401, 29 de junio de 2017)

Extremadura
Instrucción conjunta nº de 15 de julio de 2013 de la Dirección General del SES y de la Dirección General de Planificación, Calidad y Consumo de la Consejería de Salud y Política Social, sobre creación y aplicación del Programa de Atención Sanitaria de Seguimiento en la Comunidad Autónoma de Extremadura (PASCAEX)
Ley 7/2016, de 21 de julio, de medidas extraordinarias contra la exclusión social (DOE N.º 141, de 22 de julio de 2016)

Galicia
RESOLUCIÓN de 31 de agosto de 2012, de la Secretaría General Técnica de la Consellería de Sanidad, por la que se acuerda la publicación de la Instrucción de 31 de agosto de 2012 sobre la prestación de asistencia sanitaria en Galicia a las personas que no tienen la condición de asegurado o de beneficiario reconocida por el Instituto Nacional de la Seguridad Social o, en su caso, por el Instituto Social de la Marina (DOG N.º 175, de 13 de septiembre de 2012)
RESOLUCIÓN de 21 de septiembre de 2012, de la Secretaría General Técnica de la Consellería de Sanidad, por la que se acuerda la publicación de la Instrucción de 21 de septiembre de 2012 de creación del Programa gallego de protección social de la salud public (DOG N.º 193, de 9 de octubre de 2012)

Islas Baleares
Instrucción del director general del Servicio de Salud de 17 de julio de 2015 por la que se establece, con carácter de urgencia, los trámites que se han de llevar a cabo con el objeto de garantizar el derecho al acceso a la asistencia sanitaria de las personas extranjeras sin recursos económicos suficientes, en el ámbito de gestión del Servicio de Salud de las Illes Balears (BOIB N.º 109, de 18 de Julio de 2015)

Islas Canarias
Orden de 14 de diciembre de 2012, por la que se acuerda la puesta en marcha de las actuaciones en materia de promoción de la salud, la prevención de la enfermedad y la prestación de asistencia sanitaria, dirigidas a personas extranjeras no autorizadas ni registradas como residentes en territorio español, que carecen de recursos económicos suficientes (BOC N.º 12, de 18 de enero de 2013)
Orden de 16 de agosto de 2013, por la que se modifica la Orden de 14 de diciembre de 2012, que acuerda la puesta en marcha de las actuaciones en materia de promoción de la salud, prevención de la enfermedad y la prestación de asistencia sanitaria, dirigidas a personas extranjeras no autorizadas ni registradas como residentes en territorio español, que carecen de recursos económicos suficientes (BOC N.º 173. De 9 Septiembre de 2013)
Orden de 10 de diciembre de 2015, por la que se modifican las actuaciones en materia de promoción de la salud, prevención de la enfermedad y la prestación de asistencia sanitaria, para personas extranjeras sin recursos (BOC N.º 241, de 14 diciembre de 2015)

Madrid
Instrucciones de 27 de agosto de 2012 sobre la asistencia sanitaria a prestar por el Servicio Madrileño de Salud a todas aquellas personas que no tengan la condición de asegurado o beneficiario

Murcia
Instrucción n.º 4/2014, de 31 de julio, del Director Gerente del SMS, sobre la prestación de asistencia sanitaria en los centros del SMS, a los extranjeros que se encuentren en las situaciones especiales recogidas en el artículo 3 de la Ley 16/2003, de 28 de mayo, de Cohesión y Calidad del Sistema Nacional de Salud (BORM N.º 203, de 03 de septiembre de 2014)
Resolución de 13 de noviembre de 2015 del Director Gerente del Servicio Murciano de Salud por la que se publica la Instrucción 6/2015, del Director Gerente del Servicio Murciano de Salud, por la que se crea un programa de protección social para la prevención, promoción y atención a la salud de la población extranjera en situación administrativa irregular, residente en la Región de Murcia y con recursos insuficientes (BORM N.º 266, de 17 de noviembre de 2015)
Instrucción n.º 2/2016, de 3 de febrero, del Director Gerente del Servicio Murciano de Salud, por la que se modifica la Instrucción 6/2015, del Director Gerente del Servicio Murciano de Salud, por la que se crea un programa de protección social para la prevención, promoción y atención a la salud de la población extranjera en situación administrativa irregular, residente en la Región de Murcia y con recursos insuficiente (BORM N.º 43, de 22 de febrero de 2016)

Navarra
Ley Foral 8/2013, de 25 de febrero, por la que se reconoce a las personas residentes en Navarra el derecho de acceso a la asistencia sanitaria gratuita del sistema público sanitario de Navarra (BON N.º 43, de 4 de marzo de 2013)

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Instrucción de 25 enero de 2018 de la Dirección de Aseguramiento y Contratación Sanitarias por la que se crea el programa de protección integral de la salud para la prevención de la enfermedad, promoción de la salud, y atención sanitaria de las personas en situación administrativa irregular y que estén empadronadas en un municipio de Euskadi

Valencia
Instrucción de 31 de julio de 2013 de la Secretaría Autonómica de Sanidad, por la que se informa de la puesta en marcha del Programa Valenciano de Protección a la Salud
Decreto-ley 3/2015, de 24 de julio, del Consell, por el que se regula el acceso universal a la atención sanitaria en la Comunitat Valenciana (DOCV N.º 7581, de 29 de julio de 2015)

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ANNEX 1: OVERVIEW OF ANALYSED LEGISLATIVE AND ADMINISTRATIVE DOCUMENTS

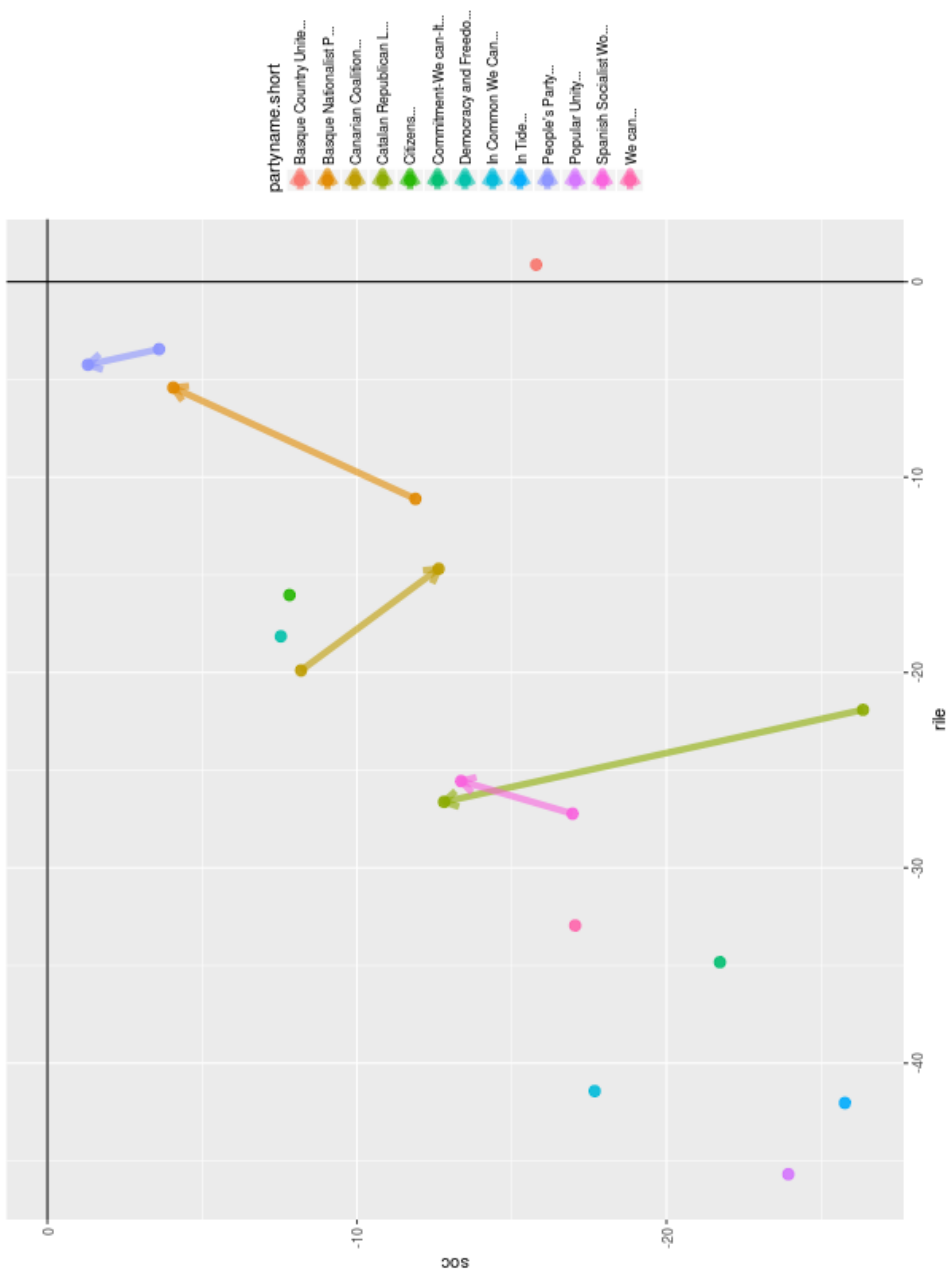| Autonomous community	Law/norm and date	Description
Andalucía	Instruction of 06/06/2013	The recognition of the right to healthcare in centres of the Public Service of Andalusia to foreigners in an irregular situation and without resources
Aragon	Instruction of 30/04/2013	The creation of the Aragonian programme of social protection of public health
	Instruction of 09/04/2014	Healthcare and treatment of special cases for public health reasons
	Instruction of 07/08/2015	Regulating the access to health care in Aragon for foreigners without sufficient financial resources or health care coverage in the national health system
Asturias	Instruction of 14/06/2012	The authorisation of healthcare, on a provisional basis, to foreigners in an irregular situation without resources
	Instruction of 30/08/2012	The authorisation of healthcare, on a provisional basis, to foreigners in an irregular situation without resources
Balearic Islands	Announcement of 30/08/2012	General criteria of application on the health assistance to all people who do not have the condition of insured or beneficiary
	Instruction of 17/07/2015	The procedures to be carried out in order to guarantee the right for foreigners without sufficient financial resources to access healthcare
Canary Islands	Order of 14/12/2012	Actions in the field of health promotion, prevention of disease and provision of health care addressed to unauthorised foreigners that are not registered as residents of the Spanish territory, and who lack sufficient economic resources
	Order of 16/08/2013	Modification of the norm of 14 December 2012
	Order of 14/12/2015	Modification of the actions in relation to health promotion, disease prevention and the provision of healthcare for foreigners without resources

Autonomous community	Law/norm and date	Description
Cantabria	Order SAN/20/2013	The creation of the Cantabrian Program of Social Protection of Public Health and the procedure to access it
	Order SAN/38/2015	Regulating the inclusion in the Public Health System of Cantabria of people residing in the AC who do not have access to a public health protection system
Castilla La Mancha	Order of 09/02/2016	Universal access to health care in the AC of Castilla-La Mancha.
Castilla y Léon	N/A	N/A
Catalonia	Instruction of 10/2012	Access to public health to foreign citizens registered in Catalonia who do not have the status of insured or beneficiaries in the National Health System
	Instruction of 08/2015	Access to public health to foreign citizens registered in Catalonia who do not have the status of insured or beneficiaries in the National Health System
	Ley 27/06/2017 (Ley 9/2017)	The universalisation of healthcare from public funds through the Catalan Health Service
Euskadi	Law of 26/06/2012 (Decreto 114/2012)	The system of health benefits of the National Health System in the AC of Euskadi
	Instruction of 25/01/2018	Comprehensive health protection programme for the prevention of disease, health promotion and health care for people in an irregular administrative situation who are registered in a municipality of Euskadi
Extremadura	Instruction of 15/07/2013	The creation and application of the Follow-up Health Care Program in the AC of Extremadura (PASCAEX)
	Law of 21/07/2016 (Ley 7/2016)	Extraordinary measures against social exclusion
Galicia	Resolution of 31/08/2012	The provision of healthcare in Galicia to people who do not have the status of insured or beneficiary recognised by the National Institute of Social Security or by the Social Institute of the Navy
	Resolution of 21/09/2012	The creation of the Galician Program for Social Protection of Public Health

Autonomous community	Law/norm and date	Description
La Rioja	Announcement of 02/09/2015	Health Ministry proposes to maintain the same procedure for assisting illegal immigrants in all communities
	Announcement of 08/10/2015	The management of health care for immigrants in an irregular situation
Madrid	Instructions of 27/08/2012	Instructions on health care to be provided by the Madrid health service to all those who do not have the status of insured or beneficiary
	Announcement of 21/08/2015	An email informing health professionals that healthcare must be provided to people in an irregular situation in the Community of Madrid
	Interior Notice of 28/08/2015	Health assistance to people in irregular situation. Note of clarification
Murcia	Instruction of 31/07/2014 (No 4/2014)	The provision of health care in the SMS centres to foreigners who are in the special situations included in article 3 of Law 16/2003, of 28 May, of Cohesion and Quality of the National Health System
	Instruction of 17/11/2015	Creation of a social protection programme for the prevention, promotion and provision of health of the foreign population in irregular administrative situation, resident in the Region of Murcia and with insufficient resources
	Instruction of 22/02/2016	Modification of social protection programme for the prevention, promotion and health care of the foreign population in irregular administrative situation, resident in the Region of Murcia and with insufficient resources
Navarra	Law of 25/02/2013 Ley Foral 8/2013	Recognition of the right of free access to healthcare for people living in Navarra
Valencia	Instruction of 31/07/2013	The implementation of the Valencian Health Protection Programme
	Law of 24/07/2015 (Decreto-ley 3/2015)	Regulations on universal access to health care in the Valencian Community

Source: own elaboration (based on Yo SÍ, Sanidad Universal and Cimas and others. (2016)).

ANNEX 2: OVERVIEW OF POLITICAL PARTY POSITIONS

Relative party positions in the 2015 elections compared to the 2011 elections

Note: On the y-axis one can derive the conservative – progressive position of the parties. On the x-axis one can derive the relative right-left positions of the party (based on rile index). According to this plot, none of the parties is a truly 'right wing' party, as it derives party positions from issues discussed in the party programmes and neglects to include more verbal aspects and performances, which is why I relate to the right-left positions in a relative way (relative to one another). Source: Manifesto Project.[232]

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[232] A Volkens and others, 'The Manifesto Data Collection' (Wissenschaftszentrum Berlin fur Sozialforschung/ WZB 2017) Manifesto project (MRG/CMP/MARPOR) Version 2017b <https://visuals.manifesto-project.wzb.eu/ mpdb-shiny/cmp_dashboard_selectable/>. Accessed 13 April 2019

ANNEX 3: INFORMATION SHEET ON HEALTHCARE FOR IRREGULAR MIGRANTS IN CANTABRIA

Los centros sanitarios de Cantabria prestan atención a todas las personas nacionales o extranjeras, "incluidas las no registradas ni autorizadas a residir en España" (Orden SAN/38/2015, de 7 de agosto).

Si necesita asistencia sanitaria, pregunte al personal de recepción del centro de salud o llame a estos teléfonos de información:

Health centers in Cantabria attend to all persons, both natives and foreigners, inclusive of those neither registered nor authorized to reside in Spain (Regulation No. SAN/38/2015, of 7th August)

If you need health care, ask at the reception desk in your health centre or dial the following telephone numbers and ask for information:

Les Centres Sanitaires de Cantabria offrent des soins médicaux à toute personne espagnole ou étrangère, même a ceux qui ne sont ni enregistrés ni autorisés à résider en Espagne (Ordonnance SAN / 38/2015, le 7 Août).

Si vous avez besoin de soins médicaux, demandez au personnel d'accueil de votre Centre de Santé ou téléphonez aux numéros ci-dessous:

تقدم المراكز الصحية في كانتابريا خدماتها للجميع، سواء المواطنين أوالأجانب، "بما في ذلك غير المسجلين وغير الحاصلين على إذن الإقامة في اسبانيا "(القانون رقم س ا ن / 38/2015، تاريخ7 أغسطس)

إذا كنت بحاجة إلى الرعاية الصحية، اسأل موظفي مكتب الاستقبال في المركز الصحي ،أو اتصل على الارقام التالية للاستفسار والحصول على المعلومات:

Bërëp bou fadjoukay you Cantabria yi gnëp lagnou fi nékal, boromi réw mi ak gan yi fi dëkoul yeup tamit, ba gni ngua khamné amougnou carte d'identité national bou Espagne (ordre San/38/2015, du 7 Aout).

Bo sokhla doctor yi séét la, lathie tél thi gni nék thi réception you bërëp bou fadjoukay yi wala ngua woté thi numéro téléphone yi....... nguir gnou khamale la.

Teléfonos del SCS para información:
942 202770
942 207772

SCS

GOBIERNO
de
CANTABRIA
CONSEJERÍA DE SANIDAD

ANNEX 4: INTERVIEW GUIDE

The Regional Ministry of Health of Cantabria/Navarra (questions were asked in Spanish)

1. Could you describe to me who you are and what you do for the health ministry?

>> How long have you been working for the health ministry?

2. In general, how would you describe the health ministry and its role in relation to the development and execution of health policies and services in the AC?

3. How would you describe RDL 16/2012?

4. In what way did RDL 16/2012 change the healthcare system in the AC and how did the regional health ministry respond to RDL 16/2012?

5. Can you explain to me why *Orden SAN/20/2013* (Cantabria) / *Ley Foral 8/2013* (Navarra) was enacted?

6. Back in 2012, your AC was ruled by the same/a similar political party that enacted RDL 16/2012 at a national level. Could you describe to me why the PP in Cantabria/the UPN in Navarra has been more sympathetic toward providing access to health services for irregular migrants compared to the national party?

7. In what way has the decentralisation of the health system facilitated the creation of more inclusive policies in the AC?

8. In deliberating on how to respond to RDL 16/2012, to what extent has the health ministry in your AC cooperated with other health ministries or regional governments?

9. Could you describe to me the response by the central authorities following the more inclusive legislation in your AC? Have the central authorities in any way repressed your efforts in designing inclusive policies following RDL 16/2012? If so, in what way?

10. What do you think has been the role of street level bureaucracy in providing healthcare to irregular migrants, eg doctors refusing not to treat someone because of their Hippocratic Oath?

11. Could you describe to me how irregular migrants are informed about their rights in terms of healthcare?

12. Can you describe to me how CSOs responded to RDL 16/2012 in your AC?

13. Civil society actors have criticised the drafting process of RDL 16/2012 as they argue that the process did not involve any consultations with relevant stakeholders. To what extent do you share this critique?

14. Are there any estimates on how many irregular migrants have been excluded due to RDL 16/2012 and/or included due to your AC's response to RDL 16/2012?

15. In designing more inclusive regional policies in response to RDL 16/2012, which kind of arguments (eg social, economic etc) and or type of language do you use to legitimise your policies?

Medicos del Mundo

1. Could you describe to me who you are and what you do for Medicos del Mundo?

2. How would you describe RDL 16/2012?

3. What has been the role of Medicos del Mundo in challenging RDL 16/2012? To what extent would you say it has been a priority for the NGO?

4. Could you tell me a bit more about REDER?
>> Why and how was REDER set up?
>> What does REDER do?
>> What is your role in the network?

5. What has been the importance of the network in creating more inclusive policies at the regional (or national) level? Has there been any success as a result of the platform/network?

6. What are the strategies you deploy to advocate against RDL 16/2012?

7. Have the central authorities in any way repressed your efforts to fight against RDL 16/2012? If so, how?

8. To what extent do you think the decentralisation of the health system facilitated the fight against RDL 16/2012?

9. Why do you think that some ACs with a ruling centre-right party designed inclusive health policies, while others did not?

10. What do you think has been the role of street level bureaucracy in providing healthcare to irregular migrants, eg doctors who refuse to treat someone because of their Hippocratic oath?

11. Could you describe to me how you lobby at national and/or regional level?
>> To what extent is the decentralised health system taken into account when advocating against RDL 16/2012?

12. To what extent do the most inclusive AC adhere to the universality of the human right to health?
>> What is the strategy of Medicos del Mundo or REDER in relation to the ACs that have designed inclusive health policies versus those that have not?

13. How did the movement against RDL 16/2012 spread over Spain?
        >> Are there certain regions where the social movement is stronger than others?

14. When advocating against RDL 16/2012, what arguments and / or type of language do you deploy in the struggle for moral authority?
        >> What has been the relevance of human rights?

Kayin Venner

The Making of Human Rights Polities

Contentious Governance and the Uneven Implementation of Human Rights

The Case of Irregular Migrants' Unequal Access to Healthcare in Spain after Royal Decree Law 16/2012