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Reinhard Schweitzer

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Health Care Versus Border Care: Justification and Hypocrisy in the Multilevel Negotiation of Irregular Migrants' Access to Fundamental Rights and Services

Reinhard Schweitzer

University of Sussex, Brighton, UK

ABSTRACT

Providing—and also not providing—public services to unlawful residents implies a certain cost for host societies, and both inclusion and exclusion involve localized renegotiations of fundamental rights, legitimate needs, and social membership. Based on original qualitative research data, this article compares how, why, and under which conditions irregular migrants are granted or denied access to healthcare services provided in London and Barcelona. From a multilevel perspective and by drawing on organization theory, I highlight key differences in how the responsible governments deal with the underlying contradictions and thereby either help or hinder effective policy implementation.

KEYWORDS

Irregular migration; public health care; immigration control; policy effectiveness; justification; hypocrisy

Democratic governance means that elected decision-makers translate peoples' ideas and opinions into formal legal frameworks that subsequently determine public policy and regulate everyday social interaction (Deutsch, 1970). The interests and rights of minorities and newcomers pose a significant challenge to this regulatory process (Hampshire, 2013; see Rosenberger's discussion in this issue) and immigration policies seem particularly prone to fail in achieving their publicly declared objectives and desired outcomes (Boswell, 2007; Castles, 2004; Joppke, 1998). According to the so-called gap-hypothesis, the official aims of these policies tend to reflect increasing public pressure to restrict further unwanted immigration or migrants' social and economic rights, whereas their actual outcomes are often more liberal than public demands (Cornelius, Martin, & Hollifield, 1994; Hollifield, 1986).

The situation of irregular migrants vis-à-vis mainstream public service provision very well exemplifies this gap: Even though their presence on the territory constitutes a breach of immigration law, their exclusion is rarely absolute but is intertwined with simultaneous pressures for their partial inclusion (Chauvin & Garcés-Mascareñas, 2012; Cvajner & Sciortino, 2010; De Genova, 2013). The underlying moral and political contradictions are becoming more pronounced as Western governments increasingly resort to measures

CONTACT Reinhard Schweitzer reinhard.schweitzer@aol.com University of Sussex, Geography, Brighton, BN1 9RH, United Kingdom.

of *internal immigration control*, whereby the responsibility to "take care" of the national border partly falls on institutions and individuals whose interests and priorities differ from those of immigration authorities (Boswell, 2007; Lahav & Guiraudon, 2006; Van Der Leun, 2006; Webber, 2014). This is particularly evident in the sphere of public health care, wherein powerful normative entitlements, intrinsic functional imperatives, and a particularly strong professional ethic often demand at least a certain level of access irrespective of immigration status (Hall & Perrin, 2015; Spencer, 2014).

This article contributes to these debates through a detailed comparative analysis of how, why, and under which conditions irregular migrants living in London and Barcelona are granted or denied access to publicly funded health care services. My aim is to show that these everyday negotiations reflect crucial differences in how the responsible governments deal with the incompatible demands for more-effective immigration control on one hand and a comprehensive health care provision on the other. Empirically, I thereby focus on the perspective of individual service providers and other local actors, as well as the legal-political contexts in which their actions, decisions and professional discretion are embedded. The underlying data was collected between July 2014 and October 2015 during the course of my PhD research in London and Barcelona (see Schweitzer, 2018). It includes official policy documents, media reports, and a subset of 13 semistructured interviews with health care professionals and administrators and representatives of nongovernmental organizations (NGOs) working in this field.[1]

Conceptually, I build on Brunsson's (1989, 1993) theoretical explanation of how organizations more generally respond to contradictory external demands and pressures; whereby they often accept and internalize significant inconsistencies between what is officially declared (*talk*), what is put into law (*decisions*), and what is effectively done (*actions*). The two cases I compare differ considerably in terms of their broader political context, the level of politicization, specific framing of irregular migration, and the corresponding policy approaches. Following Brunsson's (1993) conceptualization, I argue that as a result, the condition under which irregular residents of Barcelona can access public health care resembles what he called *justification*, whereas the situation in London represents the opposite: *hypocrisy*.

My analysis suggests that if the responsible government is unable or unwilling to openly justify a certain inclusiveness toward irregular residents, it has to resort to contradictory rhetoric and ambiguous legal frameworks. In everyday practice, much of the responsibility to resolve these contradictions thereby falls on the actors who implement the resulting policies. This increases the scope for individual discretion to be used and abused for the purpose of immigration enforcement, which not only undermines service users' fundamental rights but also conflicts with service providers' professional obligations. In the following sections I first outline the theoretical framework, then give some examples of how different political actors have framed the issue in both contexts, before examining how these distinctive framings and the corresponding policies shape organizational and individual action on the ground.

Public institutions as local mediators between conflicting functional imperatives of the state: The case of health care for irregular residents

Various explanations for the apparent discrepancy between officially declared objectives and actual outcomes of immigration policy focus on the mediating role of public

institutions (Guiraudon, 2003; Joppke, 1998). As argued by Boswell (2007, p. 83), such approaches share two crucial assumptions: that institutions "have sufficient independence from the political system and rival administrative agencies" and that "the actors within these institutions operate according to interests and norms that are at variance with those predominating politics or rival agencies." For Boswell, this ultimately reflects the fact that states are constantly driven by various functional imperatives, which often have contradictory policy implications that are therefore difficult to accomplish simultaneously. Hence, Boswell's (2007, p. 93) explanation for the gap between restrictive policy objectives and more-liberal outcomes is that "a state unable to meet all functional requirements may have an interest in the persistence of contradictions and inefficiencies in policy."

As I will show, inconsistent or ambiguous rules and rhetoric play a particularly crucial role in the context of intense politicization, and not only in relation to the making of policies but also in relation to their subsequent implementation. In comparing the actual provision of public health care to unlawful residents of London and Barcelona I thus focus more on institutional and individual agency than the role of the state, which in itself is a fragmented aggregation of institutions that are partly driven by their own interests and functional logics (Gill, 2010). My analysis builds on the growing body of critical migration scholarship that examines irregular migrants' inclusion and/or exclusion from public services through the analytical lens of citizenship. Some of this research shows that the frequent discrepancy between legal entitlements (juridical dimension) and effective access (empirical dimension) is partly mediated through different frames of deservingness (moral dimension) (Chauvin & Garcés-Mascareñas, 2014; Willen, 2012). Other studies specifically analyzed the crucial role that individual service providers can play in renegotiating the various pressures that result from these distinct dimensions, whereby they sometimes contest or even re-define the notions of citizenship and belonging (Aasen, Kjellevold, & Stephens, 2014; Van Der Leun, 2006). Yet others have shown that the general political climate and/or the way in which migrant irregularity is officially portrayed and addressed can significantly influence the disposition of individual practitioners toward this client group (Fassin, 2004; Larchanché, 2012).

To conceptualize and better understand how the micro-level of everyday practice is linked to the macro-level of policy-making, I employ Brunsson's (1993, p. 489) theoretical distinction of three possible relationships "between the ideas of constituencies and leaders on the one hand and organizational, and societal actions on the other." Whereas most understandings of rational decision-making (and democratic governance) assume that ideas always precede and control action, Brunsson argues that this is often impossible since it would lead to unresolvable conflicts at the point at which actions are to be carried out—that is, at the level of policy implementation. Instead, necessary action can either determine ideas or remain systematically inconsistent with them. Both, I will argue, can be the case when foreign residents are given (at least some) access to public health care even though their presence in the country is unlawful.

Whether such inclusion is demanded by international (or domestic) human rights law or driven by more-pragmatic concerns about public health or social cohesion, it can be seen as a functional imperative of contemporary welfare states. The concrete entitlement to access any particular health care system, however, is usually also linked to formal membership, which reflects another functional imperative of the nation-state:

to control immigration (da Lomba, 2011; Hall & Perrin, 2015). Based on the latter, politicians can easily declare that foreigners who reside in the country "illegally" should receive no state support. Even if popular among the public, however, the idea of their total exclusion would undermine the function of the health care system if it were to completely control the actions of doctors and other health care workers.

It is for such instances that Brunsson (1993) proposed two alternative ways in which ideas can be related to actions without fully controlling them: justification and hypocrisy. The former means that "planned or accomplished actions are defended in order to convince people that they are the right ones" (Brunsson, 1993, p. 500). If successful, the constituency's ideas are thus adjusted to actions and the consistency between them is restored at the expense of control (of ideas over action). For example, voters may be convinced that the public health implications of irregular residents' exclusion are serious enough to outweigh the expected gains in terms of immigration control. Where decision-makers find it impossible to openly justify the formal inclusion of irregular migrants, however, they have to resort to what Brunsson (1993, p. 501) calls hypocrisy:

Actions that are difficult to justify can be compensated for by talk in the opposite direction. Decisions, too, can be part of hypocrisy; they can be contrary to actions, compensating for action rather than controlling or justifying it. Through hypocrisy, the ideas of the constituency are isolated from action.

What according to him theoretically links talk and action are decisions, which "are fundamental to organisations in which politics play an important part" (Brunsson, 1989, p. 38). When it comes to irregular migrants' access to public health care, politicians are supposed to decide in which cases to offer, deny, or require payment for a particular service and do so through more or less explicit laws and regulations. Given the complex nature of these decisions and the difficulty of "drawing administrable lines that define the limits of a shared humanitarian ethic" (Hall & Perrin, 2015, p. 132), the resulting frameworks leave significant room for case-by-case assessments through individual health professionals. If entitlement is contingent on legal residence status, however, health care providers and their decisions almost inevitably become engaged in controlling immigration. Whether or not this is supported by a majority of the population, it can challenge their own ethical and professional norms.

A certain ambiguity in what politicians say and decide can thereby not only increase individual discretion, but also make the underlying contradictions less visible to the public: "If decisions are ambiguous it is easier to interpret them as consistent with ideas, both when the decision is made and when the action is completed" (Brunsson, 1993, p. 499). The political conflict between the two functional imperatives of the state is thereby not solved but transferred to the health care system or other implementing agencies. Before looking at how local actors in London and Barcelona perceive and deal with these contradictory moral and legal demands, the following section provides the necessary context and a number of concrete examples of how irregular migrants' access to health care is being framed in these settings.

Between hostility and pragmatism: Ambivalent talk and decisions regarding the provision of public health care to irregular residents

Both in Britain and Spain public health care is delivered within predominantly tax-based national health systems. Originally founded on the principles of universal coverage and

free and equal access (Aasen et al., 2014), these systems have recently undergone significant reforms and restructuring (Department of Health, 2010; Legido-Quigley et al., 2013; MdM, 2014). Although mainly aimed at increasing overall cost efficiency, these reforms were also accompanied by debates concerning "health tourism"[2] and the presumed "pull effect" of explicitly inclusive provisions and, ultimately, linked access rules more closely to immigration status (DOTW, 2013; Wind-Cowie & Wood, 2014).

In Spain, the national health reform of 2012 categorically excluded irregular migrants—with the exception of emergencies, minor children, and pregnant women—from free public health care by invalidating the health cards to which they had been entitled on the basis of local residence and irrespective of their immigration status (MdM, 2014). In March 2015 however, the Spanish minister of health announced in an interview that the central government was planning to partly restore irregular migrants' access to at least primary health care. This became necessary, so the minister, for a number of "practical reasons" such as "avoiding the saturation of emergency services," which the excluded otherwise tend to fall back on (N.d., 2015). While thus recognizing the need to provide some form of access, however, the central government made sure not to present this move as a formal reinclusion of irregular migrants into the mainstream system. Instead the minister specifically emphasized his opposition to the idea of giving them access to normal health cards, since this would formalize "a right that in Europe does not exist in any other country" (ibid.).

Meanwhile, irregular migrants living in the United Kingdom are currently allowed to access free primary health care but should be charged the full cost of any secondary care they receive from the National Health Service (NHS) (Department of Health, 2013a, 2013b). First introduced in 2004, this charging regime has become more and more efficient, and although often presented as a measure against "health tourism" (Interview 3), it also reflects a central objective of the 2014 Immigration Act, whereupon "those persons who are here unlawfully should not remain and should have no entitlement to benefits or public services" (Department of Health, 2013b, p. 27). Public health care and many other spheres of social policy are crucial domains of the "hostile environment" that the government officially aims to create for irregular migrants, as then home secretary Theresa May first announced in 2012 (Kirkup & Winnett, 2012). Such exclusionary rhetoric disguises irregular residents' formal entitlement to access not only emergency but also primary health care, which sits uncomfortably with the government's overall approach. Only rarely are these rights explicitly defended in public and, thereby, typically framed in terms of public health concerns rather than genuine needs or even legitimate claims. For example, during a parliamentary debate in November 2013, then immigration minister Mark Harper reassured his critics that the government

> will not do anything that will worsen public health. Of course it is important for those who are in the United Kingdom, even if they are not here legally, to have access to public health treatment, because it has an impact not just on them, but on the rest of the community. (House of Commons, 2013)

Such statements reflect the inherent contradictions between the pressure to reserve these scarce public resources for "legitimate" members of the community and the need to find pragmatic solutions for people who unlawfully reside among them. In both

countries, the restrictive national reforms attracted criticism from health professionals and NGOs, often highlighting the importance of universal coverage for preventing the spread of communicable diseases but also detecting domestic violence and abuse (MdM, 2014). Making early and preventive treatment more accessible also significantly reduces the number of patients requiring long intensive care and is thus, overall, cheaper for the health care system (Steele, Stuckler, McKee, & Pollock, 2014; Wind-Cowie & Wood, 2014). Among practitioners working in both cities this was a crucial argument for the inclusion of irregular migrants (Interviews 4 and 10).

An important structural difference between both country cases is that in Spain the responsibility for the provision of health care is devolved to the level of its 17 autonomous regions, which allowed several regional governments to effectively circumvent the restrictions imposed by national legislation (DOTW, 2013). The government of Catalonia was among the first to establish its own legal and administrative norms, according to which all irregular residents explicitly continue to have access to free health care provided by the Catalan public health service CatSalut. At least initially, the underlying disagreement between the different levels of government and the resulting contradictions and disparities in terms of access rules created a climate of misinformation and confusion among service users and providers (MdM, 2014), as several of my interviewees remembered (Interviews 8, 9, and 12).

Also in the British context has the value of universal health care coverage been predominantly stressed by lower levels of government. In 2012, for example, the Greater London Authority, which has no regulatory competences in the area of health, published a leaflet in 20 languages to raise awareness among migrants and asylum seekers and to reinforce their right to register with the NHS. It particularly emphasized that migrants are not legally required "to prove their identity or immigration status to register" and that practices cannot refuse registration on this or other discriminatory grounds (Mayor of London, 2012). The city authority thereby also responded to the frequent misinterpretation of existing norms regarding (particularly irregular) migrants' access to NHS services, and was heavily criticized by right-wing pressure groups for encouraging "health-tourism" (Johnson, 2012).

All this suggests that local institutions and individual health care workers in both cities have been exposed to varying degrees of contradiction regarding the actual relevance of a patient's immigration status. What follows is a closer examination of the respective legal frameworks and local implementation practices, through which official talk and formal decisions are translated into everyday action. This will reveal the significance of justification and hypocrisy in relation to local policy implementation.

The local renegotiation of irregular migrants' access to health care: Justification and hypocrisy from the perspective of policy implementation

Primary health care for irregular residents of London and Barcelona

Although formally entitled to access free primary health care, unlawful residents of London and Barcelona can remain effectively excluded due to administrative barriers, a general lack of awareness, or the specific fear of triggering immigration enforcement

(OHCHR, 2014). In both contexts, their entitlement is based on actual local residence, which they have to prove through more or less specific documentation.

In all of Spain, proof of residence is provided through the inscription in a municipal register, which is obligatory for all residents and irrespective of immigration status. Recognizing how difficult it can be to provide a permanent address, some local authorities, including in Barcelona, also offer the possibility to register without a fixed abode. Additional requirements to access health care services for irregular migrants living in Catalonia consist in a declaration of insufficient financial resources and a minimum of three months of local registration (Ajuntament de Barcelona, 2013). As a senior CatSalut official explained to me, this temporal limitation is a necessary measure against mostly European "health-tourism" rather than preventing irregular residents' access to these services (Interview 13).

Most applications are made directly at a local health center at which applicants have to produce official confirmation of their residential registration, a copy of their passport or other ID, and a document obtained from the National Institute of Social Security certifying their lack of national insurance coverage (Ajuntament de Barcelona, 2013). Only those (relatively few) applicants who are literally "undocumented"—in the sense of being unable to provide a valid ID—are processed via organizations like the Red Cross; whereas irregular immigration status per se does not prevent inclusion into the mainstream system, as several health administrators and professionals assured me (Interviews 9, 10, and 11). This is supported by a qualitative study carried out by the Public Health Agency of Barcelona, which found no significant difference between the self-reported experiences of regular and irregular migrants in terms of health care access (Agència de Salut Pública de Barcelona, 2011). Likewise, more than half of the 72 cases of arbitrary exclusion against migrants in Catalonia that were recorded (during a period of two years) by an independent platform of health professionals and NGOs concerned lawful residents (PASUCAT, 2014).

To register with a general practitioner (GP) in London, applicants also have to prove their actual, rather than legal, residence within a certain locality. In the absence of a general system of residential registration, other documents like tenancy agreements, utility bills, or bank statements constitute official "proof of address." While medical practices are obliged to provide immediately necessary treatment to any person within the practice area, they have some discretion in terms of whether or not to register someone as a regular patient (da Lomba, 2011). Other than in Catalonia, there is no specific legislation regulating the provision of primary care to what the law calls "Overseas Visitors"[3] nor an established minimum period of prior residence. Even persons staying for less than three months can either be registered as temporary residents or be included in the regular patient list (Department of Health, 2012).

According to official guidelines, GPs can refuse a patient based on reasonable, non-discriminatory grounds, but are not expected to ask for proof of identity or immigration status (BMA, 2013; Wind-Cowie & Wood, 2014). Even so, it is a widespread practice to require personal identification and/or proof of legal residence at registration (Interviews 1 and 5), and according to Doctors of the World (DOTW, 2013), over two thirds of London's Primary Care Trusts even issued official guidance that is incompatible with GPs' legal obligations. The resulting confusion and insecurity among many practitioners

is revealed in the way one of the doctors I interviewed in London reflected on this issue. In this case the doctor wrongly extended the so-called ordinary residence criterion from secondary into primary care:

> It's true that we have a very good system that is free at the point of delivery, but you still have to have an NHS number. That means that you would need to be a resident in the UK for at least 6 months in a year. […] But it depends, of course. It's different from one doctor to another, from one surgery to another, even in primary care. I personally would […] probably try and help patients to get [treatment], even though sometimes they are not eligible, so it's probably not right … but … it's difficult. I think it's sometimes the right thing to do if it's for the best interest of the patient. (Interview 6)

Also the Department of Health (2012, p. 9) acknowledged that in contradiction to official rules "some practices have deregistered or failed to register people they believe to be 'ineligible' in some way due to their immigration status."

Such misconceptions and administrative mistakes partly reflect the increasing intersection of individual health care workers' legitimate discretion, with the interests, logics, and rules of the immigration regime. On one hand, it lies in the nature of health care provision that professionals have considerable discretionary power to decide what constitutes an "emergency" or "immediately necessary care" (DOTW, 2013; OHCHR, 2014). The medical director of a health center in Barcelona quite proudly maintained that this allows him to basically treat everyone without regard to any law:

> We [doctors] can decide that, and that opens a door for us to make different exceptions when we think it is appropriate from a medical point of view. […] According to the law you can treat any urgent [case], someone that you consider is an urgent case. And I can consider that everything that comes through the door is an urgent case. (Interview 12)

On the other hand, and this is particularly true for the British context, there is a tendency of health care staff increasingly being expected to participate in the policing of immigration. Especially GPs, whose crucial role as gatekeepers of the NHS is recognized by the Department of Health (2010), are thereby put in a difficult position, as one of them specifically emphasized:

> If, for example, someone comes in and they are an illegal immigrant and I see them as an emergency and they say, "oh please don't say [anything]," then this is … I don't know what to do in that situation; I wouldn't know. (Interview 6)

This uncertainty is partly the product of a heated and one-sided public and political discourse that deliberately mixes the issues of "health tourism" and general welfare abuse with the need to discourage "illegal" immigration and residence. As an NGO representative put it, "The more technical and confusing the system gets and the more there is this rhetoric around 'are you entitled or not,' the more likely it is that people are wrongly turned away" (Interview 1). The negative framing thereby not only undermines fundamental rights and individual doctors' duty of care (DOTW, 2013) but also jeopardizes confidentiality and trust between service providers and patients, which are essential for a correct diagnosis and successful treatment (Kilner, 2014; Wind-Cowie & Wood, 2014).

With respect to primary health care, there is a fundamental difference between the two cases: Although irregular residents of both cities are formally entitled to access such services, only those living in Barcelona can thereby rely on explicit legal frameworks, while local service providers can follow a well-established administrative procedure.

Both are the product of a political decision—taken by the Catalan government—through which the necessary inclusion of this particular group of foreign residents has been officially justified. Irregular migrants trying to access even basic NHS services in London, on the contrary, are treated as "an exception to the rule that makes eligibility contingent on lawful residence" (da Lomba, 2011, p. 363). The lack of explicit norms and procedures also blurs the boundary between necessary (and thus legitimate) professional discretion and discriminatory practice, both of which can be part of individual gatekeepers' trying to reconcile the politically unresolved conflict between health care and border care. This becomes even more evident in the sphere of secondary health care.

Secondary health care for irregular residents of London and Barcelona

While primary and secondary care are closely linked through internal referral systems, access to the latter implies much higher costs to the health care system and is therefore subjected to stricter rules and controls. The policy framework initially established in Catalonia in 2012 normalized irregular migrants' access to secondary care only after a continuous residence of one year, during which any specialized treatment had to be authorized on a case-by-case basis by a special commission within CatSalut. According to a senior official, almost all of the "60 or 70 cases a year" had been approved:

> The decision is based on a clinical report issued by a hospital, saying this person with this diagnosis would have to be provided access to specialised care. And so, the commission is formed of [… various professionals, who] analyse the case and then say yes or no. Basically in all the cases presented, I think 99%, they said yes. (Interview 13)

Only one health center receptionist I spoke to remembered "one or two non-urgent cases" of patients who had to wait until they fulfilled the one-year residence requirement (Interview 9). From the perspective of CatSalut, this temporary distinction between "irregular" and "regular" patients thus primarily created extra work and unnecessary delays, while Medicos del Mundo (MdM, 2014) had criticized the absence of transparent assessment criteria. Together with significant pressure from professional associations, this eventually led the government to abolish the one-year waiting period in July 2015, thus allowing irregular migrants to access the full range of services after only three months of certified residence (Blay, 2015).

In the United Kingdom, on the contrary, all foreigners who are not "ordinarily resident" have to pay for NHS hospital care (da Lomba, 2011; Department of Health, 2013a). Exceptions cover the diagnosis and treatment of certain communicable diseases while any treatment that is considered "urgent" or "immediately necessary" cannot "be delayed or withheld pending payment" (Department of Health, 2013b, p. 55). Also here, the underlying decisions are thus primarily based on the responsible doctor's assessment of the patient's medical condition. With regard to "Overseas Visitors," however, the UK Department of Health (2013a, p. 43) specifically defines treatment as "urgent" if it "cannot wait until the person can be reasonably expected to return home." Clinicians are thus required to also consider the likelihood and possible timing of their foreign patients' returning (or being deported) to their country of citizenship (da Lomba, 2011). While completely unrelated to doctors' professional expertise, these issues directly

depend on the patient's immigration status and are particularly difficult to assess in the case of irregular migrants, who are estimated to represent more than 60% of the "chargeable population" (Department of Health, 2012, 2013a). The apparent conflict between such provisions and their professional obligations—including confidentiality and duty of care—triggered significant mobilization among health care workers across the United Kingdom.

The Department of Health (2013b, p. 13) also emphasizes that all "residency based, tax-funded systems rely on the identification of those who are not entitled […], with the onus on staff to identify those who should be charged." While in the Catalan system the level of entitlement is therefore clearly indicated on every patient's personal health card, irregular migrants who manage to register with the NHS receive the same card as any other patient and a standard NHS number. The lack of any indication of their limited entitlement beyond primary and emergency care is a notable remainder of the system's universal origins, and has even created the need for specific administrative personnel: The main responsibility of these so-called Overseas Visitors Managers (OVM) is to fulfill NHS hospitals' formal obligation "to determine whether the Charging Regulations apply to any overseas visitor they treat" (Department of Health, 2013a, p. 16). During my interview with the OVM of a mid-sized London hospital, my interviewee received a phone call from the hospital's maternity ward notifying her about the arrival of a new patient. Afterwards she explained her role in more detail:

> In that case I would be very surprised if that person is entitled to NHS care. So we will go up to see her, we will ask her to see her documentation. […] It could be that she has got Leave to Remain. It may have been that she was just here to see her family and just came down … you know, we cannot guarantee that. But that case we would class as suspicious. (Interview 3)

Asked what will happen in case the patient is unable to prove her entitlement or even to produce valid identification, my interviewee insisted that

> they have to produce their passport, which […] will have a stamp in it, so that will show whether that person is entitled or not. From there, once we have identified her, we will raise an invoice. If she doesn't pay … again: we have to treat this patient, but if she doesn't pay, then in three months' time that invoice will be going over to … we will inform the Department of Health. (Interview 3)

Her account clearly reflects a set of rules that, not only establish an immediate link between immigration status and health care entitlement, but also make each hospital responsible for covering the costs of treating "Overseas Visitors" who subsequently fail to pay their bill. This creates a strong incentive for requesting payment in advance and otherwise denying any treatment that is not considered "urgent" enough. The interest of NHS hospitals to recover these costs thereby overlaps with the efforts of immigration authorities to detect irregular migrants or at least deter their use of public services. OVMs thus work at the intersection of healthcare and immigration policy, and thereby, rely on a formal mechanism that allows

> NHS bodies [… to] share non-medical information with the Home Office, via the Department of Health, on those [patients] with a debt of £1,000 or more once that debt has been outstanding for three months, with a view to better collect debts owed. The Home Office can then use that information to deny any future immigration application to enter or remain in the UK. (Department of Health, 2013a, p. 63)

Although such information exchange does not require patients' consent, they should be made "aware of the potential immigration consequences of not paying" (ibid.). This provides individual gatekeepers with an effective means to discourage irregular migrants from accessing (Interviews 1 and 4) but also "poses an enormous ethical challenge for health care professionals and the NHS as a whole" (Wind-Cowie & Wood, 2014, p. 13). A maternity health advocate I interviewed in North-London described this dilemma from the perspective of a midwife:

> Should she say, "I will treat you because you are entitled to maternity care, but I have to tell you that you will be billed, and if you can't pay the bill, that information will be sent to the Home Office"? I mean, I don't know what I would do if I was a midwife, but that would be the correct information. (Interview 2)

This mechanism and recent media reports about the Home Office routinely "accessing NHS records to help track down illegal immigrants" (Ball, 2014) strikingly highlight the lack of what human rights organizations call a *firewall* between the state's health services and its immigration agencies (FRA, 2013; OHCHR, 2014). A representative of DOTW told me that "at the moment […] we feel fairly confident that accessing healthcare won't result in immigration enforcement action against undocumented migrants, but increasingly that is a concern" (Interview 1).

All this stands in stark contrast to the situation in Barcelona, where the full and unconditional entitlement of minor children and pregnant women was explicitly upheld by national legislation and none of my interviewees felt that public health care was becoming a tool of immigration enforcement. Even if health care workers are not formally obliged or incentivized to discriminate patients on the basis of their immigration status, however, there is always potential for individual racism, as a representative of Caritas Barcelona pointed out:

> It is true that going to social services or to the doctor you can find racist people or people who are against immigrants, and so a migrant can [be treated] wrongly, but this is an individual issue […] It is not that the educational or sanitary institutions, or social services, would carry out controls for the police or the ministry of the interior, no. That doesn't exist, and nobody would defend it or say it should exist. (Interview 7)

Where they do occur, both kinds of local practice will effectively lead to exclusion that is not officially intended or legally prescribed. Only through explicit entitlements, clear legal frameworks, and well-established procedures can racist behavior be effectively challenged and breaches of confidentiality and other administrative mistakes systematically avoided. As I will discuss in the following, this not only requires talk and decisions that establish and unambiguously defend the necessary level of inclusion, but also institutional structures that guarantee the functional separation of health care provision from immigration control.

Discussion

The comparison of irregular migrants' access to public health care services delivered in London and Barcelona reveals elements of both justification and hypocrisy. The British government's official approach of creating a "hostile environment for illegal migration" not only directly interferes with local service provision (since it relies on the

internalization of immigration control) but also makes it difficult for decision-makers to openly justify any necessary inclusion of unlawful residents. The way health care access is thus being handled—both politically and in practice—reflects Brunsson's conceptualization of hypocrisy, through which people's ideas can be isolated from organizational action. The absence of specific legislation regarding irregular migrants' access to primary health care enables them to benefit from universal entitlements and helps the government to avoid political contestation by making its rule less visible. Unlawful residents' formal exclusion from secondary care is more explicit but its implementation largely left to individual hospitals and their employees. The latter have to weigh their own moral and statutory obligation, to provide any treatment they consider medically necessary, against the financial cost that their decision might imply. In addition to being highly conditional, irregular residents' entitlement is also administratively blurred by placing them in the same legal category ("Overseas Visitors") as suspected "health tourists" even though they face very different realities (Wind-Cowie & Wood, 2014).

Arguably, also the ambiguous outcome of the Spanish health care reform of 2012 and the subsequent announcement of the responsible minister—to restore irregular migrants' access to primary care without reincluding them into the mainstream system—reflects a certain hypocrisy. At least rhetorically, both national governments seem to prioritize effective immigration control over comprehensive health care provision even though in practice they need to provide, or at least enable, both.

The response of the Catalan government, on the contrary, resembles what Brunsson called justification, whereby the electorate's ideas are adjusted to necessary action. Being responsible for the local provision of health care but not immigration control made it politically easier for the regional authority to establish (and defend) a legal framework and administrative procedure that explicitly include irregular migrants into the mainstream system. In open contradiction to national legislation, this decision officially justified irregular residents' being treated as legitimate recipients of the services provided by CatSalut, whereas nonresident "health tourists" are to be charged.

Health care workers are thereby largely absolved from having to reconcile the logic and demands of immigration control with their professional duties and moral principles. For irregular migrants themselves, however, the established procedure entails additional dealings with public institutions, including the National Institute for Social Security (which certifies their lack of national insurance coverage) and the City Council (which registers their residence). Such a system can only work in practice if none of these institutions is linked to the immigration regime and within an overall environment that is *not* perceived as hostile toward irregular migrants. In fact, successful justification not only requires effective firewalls but also a certain acceptance of irregular migration and residence as part of a country's social reality, which has to be accommodated—rather than controlled—across the various fields of public policy.

Conclusion

The question of whether or not, or to what exact extent, irregular migrants should be given access to free public health care poses a challenge to contemporary welfare states. Providing these services to unlawful residents undermines the idea that their presence

and claims are fully illegitimate and instead reflects their recognition, by the government, as de facto members of society. Restricting their access, on the other hand, whether by denying registration, requiring payment or involving immigration enforcement, not only tends to breach fundamental human rights obligations but also gives rise to serious public health concerns.

The health needs of irregular migrants thus bring two functional imperatives of the state in direct opposition and thereby compel a political decision that gives preference to one over the other. For the resulting laws and regulations to be effective, however, they must not be in conflict with the guiding principles and intrinsic functions of the institutions made responsible for their implementation nor expect individual actors to comply with rules that are contrary to their professional ethics.

This article contributes to the ongoing academic debate on (irregular) migrants' access to health care and other services by providing a conceptual link between the micro-level of individual and institutional agency and the macro-level of political decision-making regarding formal structures of inclusion and exclusion. The cases I have compared fit Brunsson's conceptualization of the possible relationships between the ideas of constituencies (or their elected representatives) and certain actions that the former cannot fully control without regard to inherent functional logics. What the responsible politicians can do is either try to adjust their decisions (or even the underlying ideas) to become more compatible with these logics (justification) or to establish and defend a set of rules that is ambiguous enough to serve contradictory aims (hypocrisy). Whereas the former helps the implementing actors in doing their job, the latter requires them to use and sometimes abuse their professional or administrative discretion to manage on their own the underlying moral and political conflicts.

List of interviews

Interview 1: Senior policy officer at Doctors of the World in London, October 9, 2014
Interview 2: Maternity health and migrant rights advocate in London, October 29, 2014
Interview 3: Head of the "Overseas Department" of a mid-sized London hospital, October 31, 2014
Interview 4: General practitioner (GP) working in North-London, November 10, 2014
Interview 5: Head of reception of a health center in North-London, 19 November 19, 2014
Interview 6: General practitioner (GP) working in South-East-London, February 5, 2015
Interview 7: Senior policy officer at Caritas Barcelona, 17 April 2015
Interview 8: Case worker/lawyer at the Catalan Refugee Aid Commission in Barcelona, April 30, 2015
Interview 9: Reception manager at a health center in Sant Martí, Barcelona, May 7, 2015
Interview 10: Family doctor working in health center A in Ciutat Vella, Barcelona, May 18, 2015
Interview 11: Receptionist of health center A in Ciutat Vella, Barcelona, May 18, 2015
Interview 12: Medical director of health center B in Ciutat Vella, Barcelona, May 19, 2015
Interview 13: Senior official of CatSalut, Barcelona, June 4, 2015

Notes

1. See list of interviews for more information regarding my interviewees.
2. *Health tourism* refers to entering another country with the primary intention of receiving a particular treatment that is unavailable or more expensive in one's country of habitual residence. The notion is usually employed in relation to intra-European mobility, which is beyond the scope of this article.
3. Foreigners who are not "ordinarily resident" in the United Kingdom include those holding a tourist or visitors' visa and those residing in the country without authorization.

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ORCID

Reinhard Schweitzer http://orcid.org/0000-0002-6029-2071

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