EDITED BY NINA SAHRAOUI

Borders across Healthcare

MORAL ECONOMIES OF HEALTHCARE AND MIGRATION IN EUROPE

Borders across Healthcare

Borders across Healthcare

Moral Economies of Healthcare and Migration in Europe

Edited by
Nina Sahraoui

berghahn
NEW YORK • OXFORD
www.berghahnbooks.com

Contents

Illustrations

Figures

Tables

Acknowledgements

I would like to truly thank all contributors to this volume. This volume is the result of a widely shared call for chapters which has brought together most recent and relevant research across Europe around the moral economy of the healthcare-migration nexus. The adventure of this edited volume started while I was a post-doctoral researcher at the European University Institute in Florence within the EU Border Care project. I thank the PI, Vanessa Grotti, and my colleagues Cynthia Malakasis and Chiara Quagliariello, for the many conversations around our respective fieldworks. My gratitude equally goes to Laëtitia Atlani-Duault, director of the Collège d'études mondiales in Paris that hosted me as a visiting researcher while I was working on this publication project. A heartfelt thank you, finally, to Jordan Ajouaou who designed, created and photographed the artistic installation that features on the cover of this book and that elegantly captures what we collectively explore in this volume.

Funding

Introduction

Nina Sahraoui

A Europe-Wide Tension at the Crossroads of International Migration and Healthcare Provision

In May 2018, the British government suspended the memorandum of understanding between the NHS and the Home Office that allowed the latter to access patients' data in order to check their immigration status. The memorandum was part of a set of policies described by the Home Office as sustaining a 'hostile environment' that aimed at making life for undocumented migrants as difficult as possible in order to encourage their departure. Public health and ethical concerns, voiced by medical personnel and civil society organizations, but also by many MPs, finally defeated the data-sharing scheme several years after its discreet beginnings. In France, the preparation of the 2019 budgetary law revived the debate around State Medical Aid, a policy that provides access to healthcare for undocumented migrants after three months of residency. The Senate, a chamber historically dominated by right-wing parties, opposed the scheme and voted in its restriction to emergency care, with members of the Senate depicting access to healthcare as a pull factor for unauthorized migration. The parliament maintained the scheme for 2019, yet the debate exposed tensions that run through society as to who deserves to access healthcare. In Spain, within a few weeks of its arrival in power, the Socialist-led government reinstated in July 2018 undocumented migrants' right to healthcare services, access to which had been restricted to vital emergencies (except for pregnant

women and minors) by the previous right-wing government in 2012. While NGOs revealed some of the shortcomings of the new law and the many barriers that remained (see chapter 5 in this volume), this prompt overturning of the law illustrated how the question of universal rights to healthcare has become politicized and acquired symbolic significance in the political battlefield. In contrast, Italy recently witnessed the precarization of asylum seekers' access to healthcare. The 'Immigration and Security' decree, referred to by the media as the 'Salvini decree', became law in November 2018. The suppression of the administrative status of humanitarian protection rendered many 'illegal', illustrating how changing migration regimes can produce illegality (De Genova 2013). The illegalized cohorts will join the ranks of undocumented migrants, with their struggles to access healthcare. In spite of a formally inclusive system (see chapter 1 in this volume), health trajectories of undocumented migrants in Italy are fraught with selective rather than universal admission processes (see chapters 6 and 7 in this volume).

Clearly, the articulation of international mobility[1] and healthcare provision is construed as a tension within contemporary welfare regimes of European nation-states. While migration policies tend to become more restrictive across the board, access to healthcare of undocumented or partially documented migrants oscillates between inclusive and exclusive policies with telling intensity over the past few years. Most of the literature on migration and healthcare focuses on migrants' rights and formal entitlements to access healthcare services (for reviews in the European context see Rechel et al. 2011; Doctors of the World 2016; Woodward, Howard and Wolffers 2013; Winters et al. 2018). We are interested in the ideas, norms and values that underpin these entitlements and actors' practices in the field. Entitlement to healthcare for those who do not formally belong to the nation-state and whose presence is regarded by the state as undesired (from being undocumented to various precarious legal statuses) raises ethical, legal, moral and public health concerns, to name but a few. From the perspective of the state and its migration policies, unauthorized international mobility poses a challenge to sovereign border control. Chauvin and Garcés-Mascareñas consider that 'the state appears to validate breaches of its own sovereignty by recognizing people and processes seemingly located beyond its control' (2012: 253–54). Rather than clear-cut binaries, degrees of inclusion and exclusion describe the lived experience of irregularity more adequately. The notion of differential inclusion (Mezzadra and Neilson 2013) analyses such processes as serving migration regimes' work of 'filtering, selecting and channelling' (ibid. 2013: 165), and thus disciplining and controlling, in Foucauldian terms. The political economy that sustains Mezzadra

and Neilson's analysis, while enlightening as to fundamental aspects of migration regimes in their national and global manifestations, is not sufficient to account for the contentious domain of migration in healthcare settings. In this volume, we research healthcare professionals' and migrants' experiences with a view to examining the moral economies that take shape through their interactions and that arguably both reflect and impact on shifting criteria of deservingness. Quantitative (Jensen and Petersen 2017) and qualitative (Laenen, Rossetti and van Oorschot 2019) studies have argued that access to healthcare for undocumented persons tends to be viewed as more acceptable than any other type of welfare benefit among the general public. The bearing of humanitarian claims on national healthcare systems challenges the exclusionary policies that create migrants' irregularity. Ultimately, these competing frames are part and parcel of a moral economy of healthcare and migration.

Defining the Moral Economy of the Healthcare-Migration Nexus

To account for the multiple tensions that arise at the crossroads of international migration and health, this volume explores the moral economies produced by social actors. The notion of moral economy draws here on the work of Didier Fassin, who convincingly revisited the concept and demonstrated its relevance 'to unveil the ethic of contemporary states when it comes to the moral evaluation of difference' (2005: 366). Admittedly, this usage moves away from the initial conceptualizations of moral economy by Thomson (1971) and its further developments by Scott (1976). The moral economy of E.P. Thomson's classical historical study of eighteenth-century peasant riots in England derived from a political economy analysis of the motives of popular riots. The notion of a 'moral economy' served to capture the idea that the rising of a peasant community is only simplistically explained by a lack of food and can be better comprehended through a nuanced account of how the violation of certain moral norms triggered contestation. In later developments, Scott relied on the notion of moral economy to understand peasants' subsistence ethic (Fassin 2012: 28). The notion of moral economy served for both authors to feed into a political economy analysis of peasant economy and peasant communities' relations to the market and to elites. The 'economy' dimension in the notion of moral economy has taken up a different meaning in the uses proposed by Fassin. He defines a moral economy 'to be the production, distribution, circulation, and use of moral sentiments, emotions and values, and norms and obligations in

social space' (2009: 1237). The idea of 'an economy' is here transposed
to other social fields, without maintaining the original anchorage in the
political economy of material production. Building on Fassin's critical
contribution to foreground this field of enquiry, I sketch out in Figure 0.1
the interconnected dimensions of the moral economy of the healthcare-
migration nexus explored in this volume.

This figure foregrounds distinct yet related levels where the mani-
festations of a moral economy are to be observed. At the micro level,
the focus lies on people's emotions: how these are experienced, voiced
and acted upon. Within the healthcare/migration nexus, these chiefly
concern the daily interactions of medical and administrative person-
nel and migrant persons. Importantly, the significant proportion of
healthcare professionals who are also international migrants needs to be
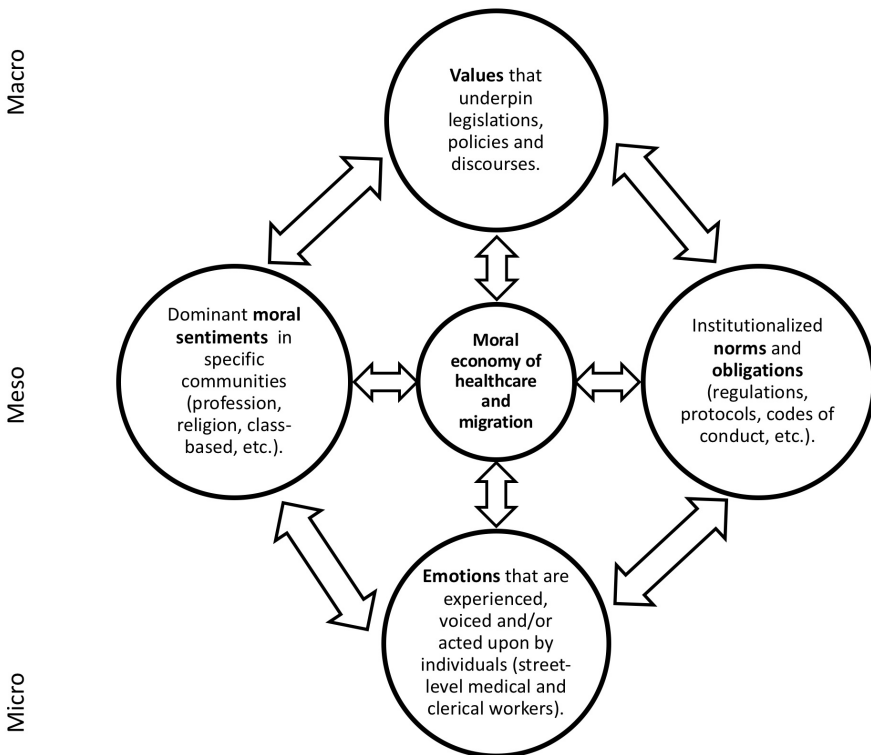
Figure 0.1. Defining a moral economy of the healthcare-migration nexus.
Source: Figure by the author, inspired by Fassin's definition of moral economy
(2009) in a scalar and relational perspective.

accounted for wherever relevant to deconstruct the healthcare worker/ migrant patient binary. At the meso level, prevalent moral sentiments within specific social groups or communities are of particular relevance. A professional deontology among doctors, for instance, reveals certain understandings of moral sentiments shared within the profession. In turn, when notions of morality come to be formally codified, they produce norms and obligations within organizations and institutions in the form of institutional regulations, protocols and codes of conduct. Finally, values underpin legislations, policies and discourses that equally shape the moral economy of healthcare and migration in that these values both reflect and shape individual emotions, collective moral sentiments and institutionalized norms.

By engaging with the various scales of the healthcare/migration moral economy identified in Figure 0.1, chapters in this volume collectively shed light on the relative importance of these scales on specific processes of inclusion/exclusion and illuminate the type of relations that link these levels of analysis. Most chapters engage with several of these levels simultaneously with a specific emphasis on one scale. For instance, the macro approach features prominently in chapters 1 and 4 that engage mostly with legislations and discourses; chapters 2 and 3, though building on ethnographic data, particularly emphasize in their analysis the meso level of institutional health programmes and cultures; and chapters 8 and 9, while referring to values that sustain moral framings, pay particular attention to feelings and emotions expressed by healthcare professionals and migrant women.

It is the contention of this edited volume that undocumented migrants' access to healthcare services has come to crystallize an issue of central relevance to contemporary European societies as they are torn apart over competing moral economies. We collectively propose to advance our understanding of the meanings and workings of these moral economies through fine-grained ethnographic accounts exploring how this problematic plays out within healthcare provision, for medical and clerical personnel, as well as for migrants with precarious legal statuses. Against the background of limited resources and healthcare systems exposed to neoliberal cuts to varying degrees across Europe, the relation to the undesired Other, as embodied by the racialized and gendered figure of the undocumented migrant, poses the question of who deserves to be included within society. The nine ethnographic chapters of the volume contribute to the task of unpacking (un)deservingness criteria at work in shifting moral economies produced by the intersection of international migration and healthcare.

Deservingness Criteria within the Moral Economy of Healthcare and Migration

The notion of deservingness has been most developed in welfare studies, used notably by quantitative research into people's perceptions of other groups' deservingness in relation to various welfare systems and benefits (Slothuus 2007). A trend of this literature specializes in the quantitative study of correlations between attitudes to welfare and attitudes towards immigrants (van Oorschot and Uunk 2007). A key interrogation concerns, for instance, whether the share of migrants in a given society impacts negatively on feelings of solidarity and thus on support for welfare spending (van Oorschot 2008). In contrast to the depiction of immigration conveyed by mainstream media, the quantitative approach to this question concluded that 'a higher rate of foreign-born citizens goes together with higher relative solidarity' (ibid.: 12). More recently, migrants' own views on welfare have come under scrutiny within this scholarly tradition. Again, unlike the widely reproduced stereotype of the quest for welfare benefits as a motive for migration, a Dutch study in social policy exposed significant divergences in migrants' views along class and nationality distinctions and overall, a tendency to support conditionality through contributions as well as aspirations for greater inclusion (Kremer 2016). Interestingly enough, major contributors to this field have lately advocated the use of qualitative methods to deepen our understanding of the formation of deservingness criteria, a challenge for which quantitative surveys are ill-equipped due to their deductive dimension (Laenen, Rossetti and van Oorschot 2019).

Departing from macro-level and quantitative designs, this volume is concerned with tracing the daily activities that are imbued with deservingness judgements in the context of healthcare provision to mobile persons whose presence has not been formally sanctioned by the state. The project of shedding light on the workings of deservingness aims at 'understanding vernacular frames, or local ways of knowing and responding to socio-juridical processes that circulate within and about communities of displaced persons' (Yarris and Castaneda 2015: 65–66). Different deservingness criteria are discussed in the literature. Sarah Spencer, in a study of undocumented children's deservingness to healthcare and education, emphasized a combination of elements including levels of need, levels of control, identity, attitude and reciprocity, on the basis of interviews with policy-makers across fourteen EU member states (2016). Drawing on focus groups conducted in the UK, Germany and Denmark, Laenen, Rossetti and van Oorschot (2019) found that in addition to these criteria, commitment to equality/universalism, cost effectiveness and social

investment have played a significant role in the formation of deserv-ingness judgements vis-à-vis migrants. More specifically, this volume contributes to the nascent literature on 'health-related deservingness'. Sarah Willen and Jennifer Cook conceptualized this notion as the 'the flip-side of rights' (2016: 96), placing the moral dimension at the heart of the enquiry. In this perspective, deservingness is 'reckoned in ways that are *relational, conditional, context-dependent, syncretic, affect-laden*, and *mutable*' (2016: 113–14, emphasis in original). This theme was turned into an interdisciplinary research field with the collective endeavour of a special issue edition of *Social Science and Medicine* in 2012 under the title 'Migration, "Illegality", and Health: Mapping Embodied Vulnerability and Debating Health-Related Deservingness'. A few years later, with the political and media debates having, if anything, intensified, their obser-vation concerning the 'dearth of anthropological research focusing on the implications of perceived moral worth, entitlement, and exclusion for immigrant health and healthcare' (Sargent 2012: 857) remains of pressing relevance. This volume contributes an answer to their call for 'additional research – including interdisciplinary research – that takes health related deservingness as a robust object of inquiry' (Willen 2012: 809). Besides this special edition, most qualitative studies referring to this specific theoretical framework have constituted single-case studies (Willen 2015; Vanthuyne et al. 2013; Huschke 2014) and no major collective publica-tion has emerged on this nexus. Yet, we believe that the special issue authors' call needs to be taken up, not least because of the intensification of the debates around migration to Europe post-2015 and the far-reaching ramifications of these questions for the social cohesion of European socie-ties. In continuation and development of this emerging field, we strive to make sense of the often contradictory manifestations of inclusion and exclusion within concrete interactions between undocumented migrants and various types of actors assuming the role of healthcare providers.

The ethnographic delving into health-related deservingness is particu-larly well suited to reveal the complex determinants of healthcare access, even in legislative contexts considered to be among the most inclusive among Western countries. Stéphanie Larchanché foregrounded, for instance, the 'intangible factors' that endanger undocumented migrants' access to healthcare in France: 'social stigmatization, precarious living conditions, and the climate of fear and suspicion generated by increas-ingly restrictive immigration policies' (2012: 859). In another setting where health policies are rather inclusive, the sanctuary city of San Francisco, Helen Marrow's qualitative study identified 'hidden bureau-cratic barriers' (2012) that become visible through ethnographic scrutiny. Studies presented in this volume concur with their findings and the

relevance of this methodological approach is further demonstrated in different national contexts and newly researched healthcare settings. Our concern with the manifest and latent expressions of deservingness within healthcare spaces further expands the field and contributes to theoretical developments of health-related deservingness.

This volume broadens the theoretical scope of the notion of health-related deservingness by linking it up with major sociological paradigms. Understanding actors' appropriation and use of deservingness criteria has so far been mostly related to the identification of specific discursive practices, such as human rights, humanitarianism, social justice and public health on the side of inclusive framings, and perceptions of illegitimate abuse, of migrants being given priority over natives, and of paying taxes for others' benefit, on the side of claims supporting increasing restrictions (Marrow 2012; Vanthuyne et al. 2013). Some of these insights remain under-theorized in the absence of a thorough discussion of racialization processes and of gendered ascriptions. We argue that it is crucial to mobilize theoretical devices developed by gender and critical race studies to grasp the complexity of the formation of (un)deservingness judgements and to apprehend their performativity. Belonging (or not) to a moral community is racialized and gendered: the undocumented male migrant employed in the informal sector and perceived as sub-Saharan, the white woman coming from outside the EU yet paying taxes under a different name, and the recently arrived male Muslim refugee fleeing a war-torn country, when 'labelled' as such, do not pull the same strings in terms of how deserving of accessing healthcare they are deemed to be, as demonstrated by this collection of chapters. Initial studies into health-related deservingness tended to construe the undocumented/unauthorized subject as an ideal figure, running the risk of glossing over the differentiations produced by gender and racialization. Deservingness criteria such as need, control, attitude, identity and reciprocity (Spencer 2016; Laenen, Rossetti and van Oorschot 2019) acquire different meanings according to intersectional lines of division that cut across the artificially homogenized group of undocumented migrants. The diversity of migrant cohorts across the chapters of this volume addresses this challenge in that it exposes the differentiated implications of the moral economy of the healthcare-migration nexus according to different social locations. Chapter 4 exposes, for instance, the orientalized processes of othering that recently arrived refugees in Germany are subject to, while chapter 9 illustrates the relative invisibility of the undocumented status of white women in a European country. Chapter 3 describes how migrants from Sub-Saharan Africa are targeted for a specific health programme and chapter 8 conceptualizes the notion

of a gendered health-related deservingness drawing on ethnographies in Southern Spanish and Greek borderlands.

Unpacking Moral Economies: The Case for Qualitative Methodologies

This volume brings together authors who have all relied on qualitative methodologies to unpack the workings of moral economies of healthcare and migration and to grapple with the question of the formation of (un) deservingness judgements in actors' daily activities. Most authors have resorted to participant observation as well as to interviews in a variety of formats, notably biographical, semi-structured and informal interviews. One chapter conducts a qualitative discourse analysis (Rohde-Abuba, chapter 4). With this collective enterprise we contribute to the literature on contemporary moral economies and, through the use of qualitative methodologies, respond to a gap identified in two strands of literature most concerned with deservingness. Within welfare studies, a qualitative turn is called for by key authors in the field (Laenen, Rossetti and van Oorschot 2019) and within the emerging current of health-related deservingness, Sarah Willen, who coined this term, advocated the development of interdisciplinary studies, including research beyond the field's anthropological beginnings (2012). Our methodological choices strongly resonate with the research challenges identified by these authors as we seek to collectively contribute some elements of response. Qualitative methodologies, and notably ethnographic methods, are particularly well-suited to apprehending emotions, moral sentiments, norms and values and understanding their bearings on individuals, communities and institutions. Only qualitative research can grasp the contradictions that the formation of (un)deservingness judgements often entails and grapple with their shifting meanings.

All chapters explore European contexts with case studies set in France (chapters 2, 3 and 7), Germany (chapter 4), Spain (chapters 5 and 9), Italy (chapter 6 and 7), Greece (chapter 9), and in one undisclosed country for ethical motives of data protection. Chapter 1 provides an overview of undocumented migrants' legal entitlements to healthcare in a comparative fashion for all these countries and is jointly authored for this purpose by a lawyer and an economist. The selection of country settings provides rich insights into the moral economies of healthcare and migration at a particularly heightened point in the history of European migration governance. Southern European countries – Spain, Italy and Greece – were at the forefront of the 2015 surge in arrivals that came to be depicted

as a migration, or alternatively, a refugee crisis, in the media. While
the construction, usage and performativity of the notion of crisis has
been critically questioned by anthropologists in its general acceptation
(Roitman 2013) and critiqued more specifically as a framing of recent
arrivals (Anderson 2017; Kirtsoglou and Tsimouris 2016), political and
media representations of migration as a crisis had concrete implications
for healthcare professionals and migrants in terms of configurations of
healthcare provision in Southern Europe (Grotti et al. 2019). France and
Germany equally represent key European cases, at the heart of shift-
ing moral economies of migration. The decision of Angela Merkel to
welcome Syrian refugees with about one million entries in 2015 con-
trasted with the French government's hostile stance on refugee arrivals
(the EU-Turkey deal struck in March 2016, strongly advocated by the
German government, terminated the country's 'open doors' policy). By
2018, the number of arrivals had fallen, and routes had changed with
most migrants arriving via sea to Spain and no longer to Greece and Italy
(see chapter 8 in this volume). Across Southern and Western European
countries, researching moral economies of the healthcare-migration
nexus is of timely relevance. The cross-national insights provided by this
collection of chapters illustrate the shared underpinnings of these moral
economies and offer rich material to help in understanding their local
manifestations.

Structure of the Volume and Overview of Individual Chapters

The volume is organized around two themes: 1) the disruptive presence
of borders within healthcare discourses, structures and provision; and
2) the performance of deservingness in healthcare spaces by managerial,
medical and clerical personnel as well as migrants themselves along their
health trajectories.

Borders Spring into Healthcare: Revised Legislations, Reconfigured Structures and Shifting Discourses

As illustrated by the recent manifestations of the healthcare/migration
tension described above, borders cut across healthcare in various ways.
Legislations define the conditions under which undocumented migrants
might, or not, access healthcare, and to what extent. Formal access often
depends on the sociodemographic characteristics of the migrant as well
as the type of healthcare needed. Inclusion thus represents a differenti-
ated process with overall greater coverage for primary healthcare than

for specialty care across Europe. This section is also concerned with the meso-level of health structures attending to non-authorized international migrants. Marjorie Gerbier-Aublanc (chapter 2) analyses how public servants need to operate in a humanitarian setting to provide healthcare at the Northern French border of Calais. Séverine Carillon and Anne Gosselin (chapter 3) explore the wanderings of a health programme that construes Sub-Saharan African immigrants as patients to be reached out to as a priority. In the context of increasingly restrictive migration policies that foster social precarity (the makeshift camp in Calais is destroyed by the police during Gerbier-Aublanc's fieldwork, while participants in Carillon and Gosselin's study suffer from precarious status and social isolation), how can healthcare structures carry on with their care duties, both in terms of the healthcare services they provide to individual patients and their responsibility in terms of public health? This section poses the question of the bearing of borders on the understandings of a healthcare system's role and how the latter translates into concrete structures and programmes. The chapter by Caterina Rohde-Abuba (chapter 4) makes a decisive intervention to complexify the interrogation at hand. The author carefully traces how male refugees are depicted in German media as embodying simultaneously a 'dangerous foreign masculinity' and 'traditional caring skills', while the older-age care industry aspires to tap into this potential pool of free (through unpaid internships) or cheap labour. In offering a critical perspective on shifting discourses around care and migration this chapter illustrates the contradictory tendencies of the disruptive work of borders, with a 'positive othering' coming to the rescue of the care industry's labour needs.

Chapter 1 by Danielle da Costa Leite Borges and Caterina Francesca Guidi assesses several layers of legal norms that form the legal context of undocumented migrants' access to healthcare, from international human rights law, to national and regional legislation for all the countries relevant to the ethnographic chapters of the volume. The authors compare how social health insurance (SHI) and national health systems (NHS) fare across European countries and offer a reading of which frameworks foster more comprehensive health systems and which elements induce more exclusionary healthcare regimes, so as to identify restrictions or inclusions on the levels of access to healthcare over the past decade.

In chapter 2, Marjorie Gerbier-Aublanc studies ethnographically the dislocation of a public hospital ward to the outskirts of the Calais camp at the French-British border and reflects on how different healthcare cultures shape care provision. She explores the improvised and ad hoc configurations of care that emerge at the border, naming these processes the 'tinkering of care'. The organization of healthcare in this unusual context

for hospital professionals leads them to adjust to the humanitarian setting by resorting to more flexible management tools and recruitment procedures. This new context of work was experienced by healthcare professionals as particularly engaging and thus as 'meaningful work'.

Anne Gosselin and Séverine Carillon tackle in chapter 3 the immigration and healthcare nexus from yet another meso-level angle: the implementation of a biomedical HIV prevention programme that seeks to reach out to Sub-Saharan African migrants. The chapter uncovers the paradox of these programmes' focus on individuals, silencing by the same token structural barriers to healthcare, while previous research has evinced the role of social precarity in exposure to the disease due to factors such as sexual violence fostered by inadequate housing. The migrants that the authors met in Parisian hospitals faced multiple social difficulties in their daily lives, exacerbated by restrictive migration policies and anti-immigrant sentiment in general, which prevented them from benefitting from the a priori inclusive design of the health programme under study. Reluctance to take public means of transportation for fear of being arrested represents a powerful deterrent to seeking healthcare services in this regard.

Chapter 4 by Caterina Rohde-Abuba, set in Germany, analyses discursive formations at the intersection of older-age care and male refugee care workers. Looking at migration and care from the perspective of migrants as healthcare workers, the author highlights that they fulfil a key role in keeping the healthcare system afloat. A widely shared scholarly focus on migrants' access to healthcare too often overlooks the fact that the professional corpus of doctors, nurses and healthcare assistants is itself composed of migrant workers, to varying degrees according to regions, specialities and facilities, who more often than not work in positions below their formal qualifications. This chapter looks into a section of the care sector, older-age care, that is particularly dependant on migrant care workers, and analyses how refugees are encouraged to work as volunteers or interns in the sector. Rohde-Abuba's critical analysis of media discourse reveals the moral shifts produced discursively around the figure of the 'Muslim refugee'. By identifying such ambiguous displacements, the chapter exposes how one discursively constructed group, that of recently arrived male Muslim refugees, can simultaneously be framed as undeserving and deserving in overlapping social fields.

In the Grey Zone between Legislation and Admission Practices: (Un)Deservingness in Action

As restrictive migration policies affect access to social services across the board, healthcare personnel are caught between injunctions to restrict

access and select patients, and individual moral convictions and professional ethics. Undocumented migrants face increasing bureaucratic and social barriers even when formal entitlements are granted. In the second part of the volume we strive to demonstrate the analytical pertinence of studying the admission procedures and healthcare interactions in their quotidian banality to reveal the workings of deservingness criteria. These chapters collectively demonstrate that medical and clerical workers in healthcare facilities find themselves in an 'uncomfortable' position. The admission processes and healthcare interactions are subjected to the contradictions that competing framings and institutional arrangements produce. In an alternative version of the 'frame discrepancy' described by Chauvin and Garcés-Mascareñas (2012) that summons undocumented migrants to perform both vulnerability (and thus victimhood) and civic engagement (and thus positive agency), workers in healthcare institutions, across professional positions, are torn between inclusive and exclusive practices. The range of case studies examined in this section – from hospital and health centres in the Spanish capital and the Piemonte region, to medical NGOs in Paris and Rome, to hospitals at Southern European borderlands – demonstrates that healthcare workers both in administrative and in medical positions play a significant role in determining access. It tends to be assumed that healthcare professionals facilitate access to healthcare services following their deontological codes of conduct. Yet, authors of these chapters depict a much more complex reality, where facilitators rub shoulders with gatekeepers from the level of individual interactions to that of the management of healthcare provision.

Another major collective contribution of these chapters is to refine our understanding of the relations between healthcare and clerical workers, who can come to follow the same logics and merge into one analytical category of 'health workers', as in the chapter by Perna (chapter 6), or be subject to different institutionalized norms, as in the case of administrative workers who fear being seen as too permissive by their non-medical hierarchy and their peers in a Madrid hospital (see chapter 5 in this volume). The section scrutinizes how healthcare rights are performed, or 'the moral life of rights', as authors of the latter chapter phrase it.

Finally, this section questions the shortcomings of the documented/ undocumented or regular/irregular binaries. These chapters provide novel insights into the lasting argument over whether migration statuses need to be construed as a continuum or as fixed categories. Chapter 5 describes how restrictive healthcare policies not only excluded undocumented migrants but also EU migrants in precarious situations and Spaniards who had spent time working abroad. Chapter 6 provides

ethnographic evidence that uninsured migrants, regardless of their status, are exposed to exclusionary practices. The peculiar situation of Fedyuk's respondents (in chapter 9), as irregular yet employed taxpayers, or the grey area navigated by women authorized to cross into the border city of Melilla yet not regular residents, further demonstrates the weakness of an abstract categorization of patients into documented/undocumented.

Chapter 5, by Marta Pérez, Irene Rodríguez-Newey and Nicolas Petel-Rochette, offers an elaborate analysis of what the authors name an 'ethnography of struggle'. All have been engaged in the collective Yo Sí Sanidad Universal for several years and have taken part in the organization's support and advocacy activities. A wealth of knowledge stems from their commitment as they provide nuanced accounts of the intricacies of healthcare bureaucracies. Their ethnography demonstrates the absolute necessity of a broader understanding of healthcare rights than a legalistic focus on entitlement would suggest. The notion of a 'relational right to health', developed in their concluding remarks, acknowledges the social complexities that access as a process entails, being embedded in a set of relations 'between citizens and professionals, among professionals themselves, and between people and professionals, and their institutions'.

In chapter 6, Roberta Perna delves into the everyday practices of healthcare workers in public sector facilities dedicated to undocumented migrants in the Italian region of Piemonte. She observes how medical and administrative workers need to determine who deserves access to healthcare in a context of limited resources. Her ethnography reveals how professional roles can conflict with healthcare workers' views, leading to the emergence of differential judgements about deservingness and the production of discretional practices. Yet again, through Perna's insights it is the social embeddedness of health entitlements that shine through as she reveals that undocumented migrants are not the only ones to be excluded from the public health system; migrants with pending asylum cases or uninsured intra-European migrants are also subject to discretionary judgements on the part of health workers.

In chapter 7, Cécilia Santilli explores how care providers from the voluntary sector in Paris and Rome are forced to select those migrants who are entitled to access their services in spite of the respectively universalist and egalitarian assumptions that underpin their activities. The author reveals ethnographically how humanitarian healthcare comes to operate on principles of selection dependent on local constructions of vulnerability. This chapter offers a fascinating account of how two different humanitarian organizations come to judge patients' suffering according to significantly different criteria. One adopts a 'present-oriented principle' that consists of assessing a person's vulnerability at the very moment

of the encounter with healthcare professionals, while the other fosters a 'past-oriented principle' that reckons a migrant person's deservingness should be evaluated on the basis of past actions. The performativity of these understandings leads the author to conclude that humanitarian organizations 'become producers of local forms of vulnerability'.

Chapter 8 by Cynthia Malakasis and Nina Sahraoui draws comparatively on fieldwork with midwives and nurses in two hospital settings where the presence of migrant patients is debated, in the Spanish enclave of Melilla and in the Greek capital, to conceptualize the gendered dynamics of a health-related deservingness. This joint chapter explores how gender plays out in the formation of deservingness judgements through the latent mobilization of the opposite figures of the victim, deprived of agency, of oppressive patriarchy on the one hand and that of the malevolent agent abusing perceived vulnerability to access resources on the other. The chapter uncovers the ambivalence of gendered representations expressed by healthcare professionals, at times feeding into expressions of empathy and at others exacerbating processes of racialized othering. By paying attention to the relational dimension of deservingness judgments in contexts of competing resources, the chapter unpacks the intersection of racialized and gendered processes of othering as they unfold in healthcare settings in the sociohistorical context of Southern European borderlands.

Chapter 9, by Olena Fedyuk, questions yet another dimension of 'access' by studying how migrant women in the EU (specific countries being undisclosed for ethical reasons), who pay taxes as workers under different names due to their undocumented status, are left with no other choice than to resort to their borrowed identities to access healthcare. This ethnography tackles a widely under-researched phenomenon: the experiences of migrants whose irregularity is the most hidden as they appear, to a range of actors from employers to healthcare providers, to be formally included. Most importantly, they contribute to a system from which they can hardly benefit, as illustrated by the trajectories of the pregnant women that the author recounts.

The conclusion to this volume goes back to the scalar presentation of the moral economy of healthcare and migration in an attempt to summarize what this collection of chapters collectively contributes to the linking of the micro, meso and macro levels of analysis within such a moral economy approach.

Nina Sahraoui is Postdoctoral Researcher at the Paris Centre for Sociological and Political Research (CRESPPA), CNRS. Nina is also affiliated with the Chair 'Exile and Migrations' at the Collège d'études

mondiales in Paris (FMSH). Previously, Nina was Postdoctoral Research Associate at the European University Institute within the EU Border Care project and conducted research on the politics of maternity care among undocumented migrants on the peripheries of the European Union. Nina completed her PhD in the framework of a Marie Sklodowska-Curie Fellowship at London Metropolitan University and published this research as a monograph: *Racialised Workers and European Older-Age Care: From Care Labour to Care Ethics* (with Palgrave Macmillan, 2019).

Note

1. A terminological clarification is necessary. While most chapters are concerned with situations of international migration, chapter 8 (by Malakasis and Sahraoui) illustrates that contexts of international mobility rather than migration, as in the case of the border city of Melilla, can raise similar issues to those of international migration, while producing a specific moral economy anchored in the sociohistory of this Southern European borderland.

References

Anderson, B. 2017. 'Towards a New Politics of Migration?' *Ethnic and Racial Studies* 40(9): 1527–37.

Bashford, A. (ed.). 2014. *Medicine at the Border: Disease, Globalization and Security, 1850 to the Present.* New York: Palgrave Macmillan.

Chauvin, Sébastien and Blanca Garcés-Mascareñas. 2012. 'Beyond Informal Citizenship: The New Moral Economy of Migrant Illegality', *International Political Sociology* 6: 241–59.

De Genova, N. 2013. 'Spectacles of Migrant "Illegality": The Scene of Exclusion, the Obscene of Inclusion', *Ethnic and Racial Studies* 36(7): 1180−98.

Doctors of the World. 2016. *Access to Healthcare for People Facing Multiple Vulnerabilities in Health in 31 Cities in 12 Countries.* Accessed on 12 March 2019. https://mdmeuroblog.files.wordpress.com/2016/11/observatory-report2016_en-mdm-international.pdf.

Fassin, Didier. 2005. 'Compassion and Repression: The Moral Economy of Immigration Policies in France', *Cultural Anthropology* 20(3): 362−87.

——. 2007. 'Humanitarianism as a Politics of Life', *Public Culture* 19(3): 499−520.

——. 2009. 'Les économies morales revisitées', *Annales. Histoire, Sciences Sociales* 64(6): 1237−66.

——. 2010. *La Raison humanitaire: Une histoire morale du temps présent.* Paris: Gallimard/Seuil.

_____. 2012.'Vers une théorie des économies morales', in Didier Fassin and Jean-Sébastien Eideliman (eds), *Economies morales contemporaines*. La Découverte, 'Recherches'.

Grotti, V., C. Malakasis, C. Quagliarello and N. Sahraoui. 2019. 'Temporalities of Emergency: Migrant Pregnancy and Healthcare Networks in Southern European Borderlands', *Social Science & Medicine* 222: 11–19.

Huschke, S. 2014. 'Performing Deservingness: Humanitarian Health Care Provision for Migrants in Germany', *Social Science & Medicine* 120: 352−59.

Jensen, Carsten, and Michael Bang Petersen. 2017. 'The Deservingness Heuristic and the Politics of Health Care', *American Journal of Political Science* 61(1): 68–83.

Kirtsoglou, Elisabeth, and Giorgos Tsimouris. 2016. '"Il Était un Petit Navire": The Refugee Crisis, Neo-Orientalism, and the Production of Radical Alterity', Occasional Paper 9, *Journal of Modern Greek Studies.* Accessed on 10 February 2019. https://www.press.jhu.edu/occasional-paper-9.

Kremer, M. 2016. 'Earned Citizenship: Labour Migrants' Views on the Welfare State', *Journal of Social Policy*, May: 1–21.

Larchanché, S. 2012. 'Intangible Obstacles: Health Implications of Stigmatization, Structural Violence, and Fear among Undocumented Immigrants in France', *Social Science & Medicine* 74: 858−63.

Laenen, T., F. Rossetti and W. van Oorschot. 2019. *Why Deservingness Theory Needs Qualitative Research: Comparing Focus Group Discussions on Social Welfare in Three Welfare Regimes*. SPSW Working Paper No. CeSo/SPSW/2019-01. Leuven: Centre for Sociological Research, KU Leuven.

Marrow, H.B. 2012. 'Deserving to a Point: Unauthorized Immigrants in San Francisco's Universal Access Healthcare Model', *Social Science & Medicine* 74: 846−54.

Mezzadra, Sandro and Brett Neilson. 2013. *Border as Method, or, the Multiplication of Labor*. Durham, NC: Duke University Press.

Rechel, Bernd, Philipa Mladovsky, Walter Devillé, Barbara Rijks, Roumyana Petrova-Benedict and Martin McKee (eds). 2011. *Migration and Health in the European Union*. Berkshire, England: Open University Press.

Redfield, P. 2005. 'Doctors, Borders, and Life in Crisis', *Cultural Anthropology* 20(3): 328–61.

Roitman, Janet. 2013. *Anti-crisis.* Durham, NC: Duke University Press.

Sargent C. 2012. Special Issue Part I: '"Deservingness" and the Politics of Healthcare', *Social Science & Medicine* 74(6): 855−57.

Scott, James C. 1976. *The Moral Economy of the Peasant: Rebellion and Subsistence in Southeast Asia.* New Haven: Yale University Press.

Slothuus, Rune. 2007. 'Framing Deservingness to Win Support for Welfare State Retrenchment', *Scandinavian Political Studies* 30(3): 323–44.

Spencer, Sarah. 2016. 'Postcode Lottery for Europe's Undocumented Children: Unravelling an Uneven Geography of Entitlements in the European Union', *American Behavioral Scientist* 60(13): 1613–1628.

Thomson, E.P. 1971. 'The Moral Economy of the English Crowd in the Eighteenth Century', *Past and Present* 50: 259−351.

Ticktin, M. 2011. *Casualties of Care: Immigration and the Politics of Humanitarianism in France*. Berkeley: University of California Press.

_____. 2014. 'Medical Humanitarianism in and Beyond France: Breaking Down or Patrolling Borders?', in A. Bashford (ed.), *Medicine at the Border: Disease, Globalization and Security, 1850 to the Present*. New York: Palgrave Macmillan.

Van Oorschot, W. 2008. 'Solidarity towards Immigrants in European Welfare States', *International Journal of Social Welfare* 17(1): 3–14.

Van Oorschot, W. and Uunk, W. 2007. 'Welfare Spending and the Public's Concern for Immigrants', *Comparative Politics* 40(1): 63–82.

Vanthuyne, K., F. Meloni, M. Ruiz-Casares, C. Rousseau and A. Ricard-Guay. 2013. 'Health Workers' Perceptions of Access to Care for Children and Pregnant Women with Precarious Immigration Status: Health as a Right or a Privilege?', *Social Science & Medicine* 93: 78–85.

Willen, S.S. 2012. 'Introduction: Migration, "Illegality," and Health: Mapping Embodied Vulnerability and Debating Health-Related Deservingness', *Social Science & Medicine* 74(6): 805–11.

_____. 2015. 'Lightning Rods in the Local Moral Economy: Debating Unauthorized Migrants' Deservingness in Israel', *International Migration* 53(3): 70–86.

Willen S.S., and J. Cook. 2016. 'Health-Related Deservingness', in F. Tomas (ed.), *Handbook of Migration and Health*. Cheltenham: Edward Elgar Publishing.

Winters, M., B. Rechel, L. de Jong and M. Pavlova. 2018. 'A Systematic Review on the Use of Healthcare Services by Undocumented Migrants in Europe', *BMC Health Services Research* 18(1): 30.

Woodward A., N. Howard and I. Wolffers. 2013. 'Health and Access to Care for Undocumented Migrants Living in the European Union: A Scoping Review', *Health Policy and Planning*: 1–13.

Yarris, Kristin, and Heide Castaneda. 2015. 'Discourses of Displacement and Deservingness: Interrogating Distinctions between "Economic" and "Forced" Migration', *International Migration* 53(3): 64–69.

Part I

Borders Spring into Healthcare Re-configuring Access, Structures and Care Provision Itself

Chapter 1

National and International Approaches to the Right to Healthcare for Undocumented Migrants

Danielle da Costa Leite Borges and Caterina Francesca Guidi

Access to healthcare services for migrants has become a crucial item on the social policy agenda at national and international levels. This prominence can be explained by different factors: first, because modern society devotes special concern to healthcare, due to its role in the maintenance of health (Ruger 2009), enabling individuals to lead socially and economically productive lives (Bhopal 2014); second, by the increase in global flows in the past quarter century, with more than 258 million international immigrants throughout the world (UNDESA 2017); and more recently, by the 2015–2016 so-called 'refugee crisis' (OECD 2016) which has heightened the importance of international migration as a subject of public debate and generated discussions of states' obligations as regards guaranteeing basic social rights to immigrants, including access to healthcare services.

The importance of this issue has been reinforced globally by the United Nations in its development of the Global Compacts on Migration and Refugees (2018) and in initiatives such as the Sustainable Development Goals (2015), or the Global Consultations from the International Organization for Migration (2010) and the World Health Organization (2017), as migrant health has been repeatedly recognized as a strategic area. The same concern has been underlined in the European Union (EU), since member states' health systems are expected to respond to immediate and longer-term health needs of migrants and refugees (WHO 2016; EPRS 2016).

While at the national level migration is often regarded as a 'threat', an approach which leads to restrictions on rights for migrants and to major

public health challenges (Zimmerman et al. 2011), international human rights law tends to propose a more integrative approach, especially when it comes to the situation of undocumented migrants, taking particular account of their vulnerability due to their lack of access to comprehensive social services, including healthcare (United Nations 2014). The subject of migration, for instance, has been recently addressed by the United Nations General Assembly, which in 2016 adopted the New York Declaration for Refugees and Migrants (United Nations 2016). Moreover, from an international human rights perspective, the lack or denial of access to healthcare may constitute an infringement of Article 12 of the International Covenant on Economic, Social and Cultural Rights, since states are under a specific legal obligation to ensure access to healthcare for all persons, including undocumented migrants and asylum seekers (United Nations 2000).

At the national level, however, laws tend to be more restrictive and to impose barriers to healthcare access for undocumented migrants. As an element of welfare policy, healthcare services are usually connected to citizenship rights and, therefore, to requirements such as nationality or residence. In the EU there is, in fact, great diversity in terms of the levels of care available to undocumented migrants: while some countries offer free access to primary and secondary care, others restrict access to emergency care alone, and there is a third group of countries in which even emergency care is not freely accessible for these immigrants, as in Sweden and Finland (Cuadra 2011). This is so even though Article 13.2 of Council of Europe Resolution 1509/2006 on Human Rights for Irregular Immigrants recognizes that emergency healthcare should be available to undocumented migrants. Moreover, the European Parliament Resolution of 2011 on reducing health inequalities in the EU calls on member states to ensure that the most vulnerable groups, including undocumented migrants, are entitled to and are provided with equitable access to healthcare. In the same vein is the European Parliament Resolution of 2014 on undocumented women migrants, which encourages member states to provide undocumented women with proper psychological, health and legal support.

Considering this scenario, this chapter aims first at providing an overview of the right of access to healthcare for undocumented immigrants according to human rights law. This approach will then be compared to the levels of access to healthcare available for undocumented migrants in some EU countries: specifically, in France, Germany, Greece, Italy, Spain and the United Kingdom, in an effort to explain the differences in access observed across these health systems and to identify restrictions or improvements on the levels of access to care over the last ten years. The

choice of countries is also connected to the fact that the other chapters of this book provide specific investigations of each of the countries or health systems analysed in the present chapter. Accordingly, this introductory chapter has the additional objective of familiarizing the reader with human rights law on access to healthcare for undocumented migrants, and national health systems' regulations and organization in relation to this migrant group.

The Right to Access Healthcare in Human Rights Law: Legal Framework and the Situation of Undocumented Migrants

The current legal framework on the right to health and access to healthcare consists of international and regional human rights documents as well as national legislation. These two different sets of legal documents tend to differ considerably in relation to the levels of access to healthcare granted to undocumented migrants. While international human rights documents protect the right to health and to access to healthcare as fundamental rights regardless of a person's legal status in a certain territory, national laws are usually stricter, providing for the right to health as a welfare right and thus subject to citizenship, territorial or other administrative requirements that take precedence over human rights and sometimes even over public health concerns (Piccoli 2016; Huma Network 2009).

At the international level, Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) sets out the 'right of everyone to the enjoyment of the highest attainable standard of physical and mental health' irrespective of nationality. In its interpretation of this provision, the UN Committee on Economic Social and Cultural Rights has further clarified in General Comment n. 14 that it comprises 'the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health'. Moreover, states are obliged to respect, protect and fulfil the right to health, which includes provision of a health system, which is affordable for all, including healthcare facilities, goods and services on a non-discriminatory and equitable basis. In this regard, the Committee has further clarified in its General Comment n. 20 that 'the Covenant rights apply to everyone including non-nationals, such as refugees, asylum-seekers, stateless persons, migrant workers and victims of international trafficking, regardless of legal status and documentation'.

Along the same lines, Article 12 of the International Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)

and Article 24 of the Convention on the Rights of the Child (CRC) address the right to health in relation to the respective groups they protect.

At the European level, the most important human rights document is the European Convention on Human Rights. Although this Convention does not specifically provide the right to health, the European Court of Human Rights (ECtHR), for instance, has decided that the lack or denial of access to healthcare may constitute a breach of Article 2 (right to life) (Tanko v Finland (1994); Osman v United Kingdom (1998); Nitecki v Poland (2002); Nevmerzhitsky v Ukraine (2005); R.R. v. Poland (2011)). and Article 3 (prohibition of torture, inhuman or degrading treatment). Moreover, the European Social Charter (ESC) in its Article 13 provides for the right to medical assistance, while the European Committee of Social Rights (ECSR), which monitors the application of the Charter, has held that the right to medical assistance applies to foreigners in an irregular situation (International Federation of Human Rights Leagues (FIDH) v. France, Complaint No. 14/2003, decision on the merits of 8 September 2004, §32*).

In addition, there are specific human rights documents at EU level enshrining health rights to undocumented migrants, such as the Council of Europe Resolution 1509/2006 on Human Rights for Irregular Immigrants, the European Parliament Resolution of 2011 on reducing health inequalities in the EU, and the European Parliament Resolution of 2014 on undocumented women migrants in the European Union.

Finally, the EU Charter of Fundamental Rights also recognizes in Article 35 the right of everyone to access preventive health care and to benefit from medical treatment, although it prescribes this right subject to the conditions established by national laws and practices.

Access to Healthcare and National Laws

At the national level the situation becomes more complex because, as explained, the provision of healthcare is related to the issue of membership of a community and is, thus, usually dependent on other territorial and/or personal requirements. Therefore, even health systems that are considered 'universal' restrict the access of certain groups of individuals who 'do not belong to the community' according to the rules established by national social laws. Hence, national laws will determine the levels of access to healthcare according to the person's legal status in a certain territory.

EU health systems, such as the ones analysed in this chapter, usually offer a comprehensive benefits package, comprising all levels of care

(primary, secondary and tertiary), as well as long-term care and specialist care, such as rehabilitation and mental health. However, the extensive list of benefits may not be equally available to undocumented migrants, as their 'irregular' presence in the territory is likely to affect their right to access healthcare. This is despite the fact that the right to health is present in several national constitutions in the EU, such as those of Belgium, Finland, Italy, Luxembourg, the Netherlands, Portugal and Spain.

Therefore, although all EU health systems are considered universal health systems (Council of the European Union 2006), there is great diversity in terms of eligibility to healthcare for undocumented migrants across EU member states (Schoukens and Buttiens 2017), as will be analysed in the following sections.

In these sections this chapter will carry out an analysis of the right of access to healthcare for undocumented migrants in France, Germany, Greece, Italy, Spain and the United Kingdom, to explain the differences in the levels of access offered by these systems. We will point out the legal rules applicable and then indicate the types of care available to this population and under which conditions.

Case Studies

As is well known, in Europe undocumented migrants are constituted as a heterogeneous group on several bases: their country of origin, their ethnic group, and the reasons why they became undocumented (Flegar et al. 2016). Therefore, undocumented migrants may include different categories of individuals, such as persons who are planning to seek asylum but have not formally submitted an application to competent authorities; asylum seekers whose application for asylum has failed; persons whose application for residence permit or family reunification is still pending (in some EU member states they are considered to be in a regular situation); persons whose application/renewal for residence permit or family reunification has failed; overstayers (those who need a visa and those who do not); and overstayers of expired residence or work permits (Huma Network 2009). With regard to the term 'undocumented migrants', this study adopts the definition of the Clandestino Project (2009): third-country nationals without the permit required to authorize their stay in the EU states, no distinction being drawn between those who enter the state unlawfully and those who enter lawfully but become overstayers during their prolonged residence. Irregularity is notoriously difficult to define as it involves a variety of dimensions, including the legal status at and after entry, the link between residence and employment status, and whether

persons are documented – with or without the authorities' knowledge (Kraler and Reichel 2011; Kovacheva and Vogel 2009).

The choice of this migrant category, in relation to national policies and access to healthcare services, is due to their peculiar situation; indeed, the provision of healthcare services changes across the different member states. Undocumented migrants are the product of restrictive migration policies despite the sensible increase of migration flows (Düvell 2011; Triandafyllidou 2010) and, as recently demonstrated, healthcare rights may be granted to them by a regional authority, while they are considered clandestine in relation to the state; at the same time they may be treated like regional citizens with full social rights by the relevant authorities at the sub-state level (Piccoli 2016).

With regard to the health systems researched, they fall within the two main models found in Europe, namely: social health insurance (SHI) and national health systems (NHS). The former model, also called Bismarckian, is found in France and Germany and is based on three main actors: sickness funds, insured patients and providers. Sickness funds collect the premiums and use the revenues from these premiums to fund collective contracts with providers for the provision of healthcare services for insured patients. As regards funding, mandatory contributions or premiums are the main source of financing for social health insurance systems, which are usually income-related and, thus, based on income from gainful employment, pensions or unemployment benefits (Busse et al. 2004). National health systems, also called Beveridgean systems, are found in Greece, Italy, Spain and the UK and are more centralized than SHI in terms of organization. Usually there is no independent structure that contracts with providers and very often the state operates its own health facilities directly, purchasing or contracting health services through its health authorities or departments of health. In terms of financing, national health systems are funded through general taxation on income, purchases, property, capital gains and a variety of other items and activities (Savedoff 2004).

Finally, it is important to clarify and distinguish the different levels of services offered by health systems in order to understand those that are or are not available to undocumented migrants. In this connection, primary care services focus on prevention and are the first point of contact for people in need of healthcare. General practitioners (GPs), family doctors, paediatricians, nurses, dentists or pharmacists may provide them. Secondary care refers to services provided by specialists, hospitals or clinics upon referral by primary care professionals. At hospitals and clinics, it means either urgent and emergency care, which may include maternity/delivery services, or elective/planned care. Tertiary care refers to highly

complex medical and surgical interventions, such as transplants, cardiac operations or neurosurgery.

France

France is an exception among Western European countries by virtue of omitting from its Constitution (1958) a provision recognizing the right to health (Matsuura 2013). References to the protection of health appear only in the preamble to the Constitution of 1946 (§11) – which is confirmed by the Constitution of 1958 – and in a provision in the Charter for the Environment declaring that 'Each person has the right to live in a balanced environment which shows due respect for health' (Article 1).

Nevertheless, the French healthcare system has been internationally recognized for its satisfactory level of access to care and service utilization, an abundant availability of choice without significant waiting lists, and a high level of life expectancy (Cases 2006). Indeed, it was ranked as the best health system in all the WHO member states for its performance, measured according to the overall level of health of the population, the system's responsiveness and fairness in the distribution of health, and in its financing (WHO 2000).

The French healthcare system is based on the Bismarckian model, with goals of universality and solidarity that have led to an increasingly Beveridge-type system with a more centralized character and stronger role for the state than other social insurance systems (Chevreul et al. 2015: 19).

Although the system had been traditionally based on employment status, it has slowly shifted to a residency-based system with the goal of achieving universal health coverage. Nowadays, Statutory Health Insurance (SHI) covers almost 100% of the population through different schemes. Working people and their dependants are affiliated with a certain scheme according to their employment status. Other schemes, however, are provided to guarantee access to care to those not covered by the statutory ones (ibid.).

With regard to undocumented migrants, in 1999 the French government passed the Universal Health Coverage Act, which has been in force since 2000. The law created a dual system: it introduced a new general scheme (Couverture Maladie Universelle – CMU) to cover those people not included in one of the obligatory employment statutory schemes but legitimately residing in France, and extended the right to access healthcare to those not regularly residing in France, through the so-called 'aide médicale de l'état' – AME. This dual system – CMU and AME – based on

the legal status of individuals was in fact considered a limitation of the universalist scope of the Act (Manson 2017).

Therefore, undocumented migrants in France have access to all levels of healthcare provision without paying at the point of delivery, yet this does not apply to the French overseas department of Mayotte. This benefit is valid for one year and is renewable (André and Azzedine 2016). However, even if considered a comprehensive health system for the undocumented population, administrative barriers as well as intangible factors, such as social stigmatization and precarious living conditions, may limit access to healthcare for this migrant population (Larchanché 2012). Other contributors to this volume, such as Marjorie Gerbier-Aublanc (chapter 2) and Cecilia Santilli (chapter 7), discuss some of these barriers in greater depth. In this regard, during the discussion of the 2011 Finance Law there was a debate in the Parliament over a proposal to impose a contribution of 30 Euros each year to grant undocumented migrants access to AME. This amendment was, nevertheless, rejected. The Commission of Social Affairs was of the opinion that this contribution would burden very poor people who would remain without basic medical care. This could lead to situations where simple diseases that could be treated at low cost could more easily become serious and present expensive complications (Duguet and Bévière 2011). Still, in practice, undocumented migrants face other barriers to AME entitlement since they must prove: their identity, residence in France for more than three months, and financial resources not exceeding a certain threshold. If they cannot prove all of these circumstances, access to healthcare is limited to treatment that is deemed urgent (Médecins du Monde 2015).

Germany

The healthcare system in Germany has been defined as a social insurance-based public-private system, developed within the Bismarck tradition (European Observatory on Health Systems and Policies 2014). The access to healthcare services for undocumented migrants is regulated through two separate laws: the Asylum Seekers Benefit Act (ASBA) and the Residence Act (RA). The ASBA also applies to undocumented migrants if they are liable to forced deportation, even if a deportation order is no longer or not yet enforceable (Flegar et al. 2016).

Within the scope of the ASBA, treatment of acute illness or pain and obstetric conditions must be ensured, including the provision of medicine and bandages, and all the other steps necessary for healing, recovery or relief. The government is also responsible for prevention, thus

guaranteeing access to vaccination programmes and necessary screenings. Dentures are only provided in urgent cases, while pregnant women are entitled to access to medical and nursery help and care, midwifery help, medicine, bandages and curative measures. Other measures may be provided if they are imperative for the health or livelihood of the person or essential to meet the needs of children (ibid.).

Therefore, in Germany irregular migrants are only entitled to gain access to some primary (basically preventive) and secondary care services, and only for acute health needs and not for chronic diseases (Spencer and Hughes 2015). Despite the policy that establishes a duty to provide maternal care and medical assistance with giving birth, the medical rights of undocumented migrants are limited by the requirement to pay the full costs of some of the care provided. The lack of access to preventive health care for undocumented migrants is aggravated by Article 6(a) of the ASBA and Article 87(2) of the RA, which introduced a reporting obligation for public authorities (Flegar et al. 2016).

In particular, in Germany no hospital treatment, other than in an emergency, is possible without payment before or after care, and if undocumented migrants want the state to cover their healthcare, they must apply to the *Sozialamt* (social security) office, which again has to respect the specific requirement to denounce and report them to the police, thus posing a further barrier to access (Spencer and Hughes 2015). Healthcare providers can claim their expenses for treatment of an undocumented migrant at the social security office, which must then notify the immigration office. However, the requirement of confidentiality effectively nullifies this provision and, if applied, allows undocumented migrants to remain anonymous (ibid.).

Due to the fear of being deported and the bureaucratic hurdles impeding reimbursement, undocumented migrants face many obstacles in accessing healthcare in Germany (ibid.), although at Bundesländer level there are many ongoing initiatives to facilitate access to healthcare for undocumented migrants. In addition, children can end up being excluded from access to care, including vaccinations: Médecins du Monde in Munich has purchased and paid the costs of all vaccines for the children of undocumented parents (Médecins du Monde 2013). In Berlin, for instance, undocumented migrants can get an anonymized health insurance voucher that allows them to access healthcare services without being reported and enables undocumented migrant children to receive preventive care, including immunization and screening programmes, free of charge (Flegar et al. 2016).

Greece

With the emergence of what has been called a humanitarian crisis during the same years in which the economic crisis arose, the country has seen a worsening in the physical and mental health needs of large numbers of migrants and refugees arriving in Europe and living in camps, hotspots, shelters and detention centres. This has produced a change in the organization of the Greek health system. Access to most health services in Greece is largely free of charge for most people, but de facto high levels of direct out-of-pocket payments – formal and informal – have undermined the principle of equity and imposed significant barriers to access. This situation has recently changed, mitigating the effect of the crisis on vulnerable citizens such as undocumented migrants, asylum seekers and refugees (European Observatory on Health Systems and Policies 2017).

Until 2016 irregular migrants could only access hospital emergency services for treatment of life-threatening conditions until their health stabilized. Thanks to Law 4368/2016, which came into force in August 2016, through the unemployment fund financed by the central government, budget coverage was expanded to provide access to care for those suffering from chronic, mental or rare diseases, people with disabilities hosted in social care units, and people with a disability rate of 67% or higher, irrespective of their legal status. In particular, emergency services as well as all inpatient services, laboratory and diagnostic tests, and pharmaceuticals from hospital pharmacies are provided free of charge for those patients living in refugee shelters and camps who have been referred by doctors providing care in these settings. Greece has experienced an extremely large influx of migrants and refugees, mainly from Afghanistan, Iraq and the Syrian Arab Republic – more than 1 million since 2015 (UNHCR 2016).

The new law ensured free access to health services for uninsured citizens and legal residents, the self-employed whose health insurance contributions were not up to date, refugees, children, pregnant women and those with chronic conditions or disabilities. The non-removable rejected asylum-seekers have the same rights (Schoukens and Buttiens 2017). The implementation of a healthcare migrant card that would allow migrants access to health services has been delayed. However, they can still access care provided that they present identification documents, such as identity papers or passports (European Observatory on Health Systems and Policies 2018).

Italy

Article 32 of the Italian Constitution recognizes the right to health as a fundamental right and free access to healthcare for the poor as a constitutional guarantee. Legislative Decree n. 286 of 25 July 1998 (LD 286/98) – the main piece of legislation providing for rights and obligations of migrants within the Italian territory – recognizes the fundamental rights established in Italian and international law (Article 2) in relation to all migrants, regardless of their legal status in the territory. According to Article 35 of LD 286/98 and agreement n. 225 of 12 December 2012, on the correct application of rules on access to healthcare for migrants (Accordo Stato Regioni n. 255 CSR, 12 December 2012, p. 20), undocumented migrants are entitled to access some types of care provided that they get a special card called STP (*Straniero Temporaneamente Presente*), which is usually valid for six months (renewable). Therefore, undocumented migrants in Italy, although entitled to access health services, are not allowed to register with the national health system as Italian citizens or people legally residing in the country, an exemption being provided for undocumented migrant children (0–17 years old) who can ordinarily register with the health system. Nevertheless, once in possession of the STP card, undocumented migrants can access the same healthcare services as are available to Italian citizens or regular residents. As a rule, emergency care, primary care (general practitioners' or family doctors' visits), preventive care (including vaccination, screening and HIV prevention), prenatal and maternity care (antenatal, birth and postnatal care) are offered free of charge. Although access to other types of care – such as secondary, rehabilitative or chronic diseases treatment – is provided upon payment, fees can be waived if undocumented migrants ask for an exemption from them.

It is important to note, however, that the Italian health system is decentralized and regions have competing powers to legislate on health matters. This has sometimes led to misinterpretation of the legislation on access to healthcare for undocumented migrants, which is variably applicable throughout the country, with some regions restricting rights and others extending them (Olivani and Panizzut 2016). For instance, while Lombardy has usually had more restrictive health policies towards undocumented migrants, Tuscany, by contrast, has had traditionally more inclusionary policies, encouraging assistance to all undocumented migrants in public hospitals and lobbying national institutions to adopt these practices statewide (Piccoli 2016; Cappellini and Guidi 2010). Moreover, migrants' experiences with Italian bureaucracy have been reported as characterized by misinformation and ambiguous laws, creating not only barriers but also anxiety and 'an enduring shadow over migrants' lives' (Tuckett 2018).

Spain

The right to health protection is provided in Article 43 of the Spanish Constitution of 1978 and is recognized as a fundamental right. Rights and entitlements arising from this constitutional provision are, however, to be defined by national laws, as stated in Article 43.2. Law 16/2003 on the Cohesion and Quality of the National Health Care System further describes those who are entitled to access health services through the public healthcare system (Article 3). Until summer 2012, any citizen living in Spain (irrespective of his/her legal status) was covered and had access to services at all levels of care, including primary, secondary, maternity and emergency care. However, Royal Decree-Law 16/2012 (RDL 16/2012) amended, amongst others, Article 3 of Law 16/2003, changing the basis of entitlement by linking the right to access health care services to the legal and working status of individuals. Hence, through the changes made by RDL 16/2012, undocumented immigrants ended up excluded from coverage, retaining only the entitlement to emergency care for serious illness or accidents until discharge, and to obstetric and child care for those aged under eighteen (Flegar et al. 2016).

The RDL 16/2012 reform has been heavily criticized. For instance, it was argued that the reform was targeted at the undocumented immigrant population. The lack of a rationale backing the decision (inasmuch as this population group is younger than the native population, with lower utilization rates despite their contribution via indirect taxes), the risk of widening health inequalities, and the potential negative consequences for the health of the population, led some autonomous communities to simply decline to implement the new regulation (Bernal-Delgado et al. 2018: 57). In effect, the Spanish National Health System (SNS – Sistema Nacional de Salud) is highly decentralized: it is made up of the central state and seventeen Autonomous Communities with their respective governments and parliaments. Health competences are transferred to the Autonomous Communities, with the national level being responsible for certain strategic areas as well as for overall coordination of the health system and national monitoring of health system performance (ibid.). Therefore, the devolution to regional governments in the field of health brings the management of healthcare services closer to citizens (Avanzas et al. 2017).

However, the recently elected Spanish government has approved a new Royal Decree-Law (RDL 7/2018) re-establishing the universality of the Spanish National Health System. The rule recognizes the right of all people in Spain to healthcare protection on the same conditions as those with Spanish nationality. This includes people who are not registered or

authorized as residents in the country, thus including undocumented migrants (La Moncloa 2018). Nonetheless, the immigrant population faces additional access barriers – administrative, legal or cultural – compared to Spanish citizens (Urbanos-Garrido 2016). An ethnography of these barriers is further conducted in this volume by Perez, Rodriguez-Newey and Petel-Rochette (chapter 5).

United Kingdom

In the UK, health policy is a devolved matter and there is separate guidance relating to NHS rules in Wales, Northern Ireland and Scotland. However, the devolved administrations currently retain a broadly similar framework of regulations regarding access to health services for undocumented migrants (Powell and Bate 2017). This chapter will address the case of NHS England of which the rules on access to healthcare are defined by the 2006 National Health Service Act. In relation to migrants, health rights are also provided for in the 2014 Immigration Act and in the 2015 NHS Regulation on Charges to Overseas Visitors.

Undocumented migrants are not eligible to receive NHS services on the same conditions as regular residents insofar as they cannot prove they are ordinarily residing in the country. Although most elements of NHS services offered to individuals regularly registered with the NHS are free at the point of delivery, undocumented migrants are considered overseas visitors and as such are subject to the rule that the competent NHS body must make and recover charges for any relevant services provided to them (Part 2 of the Regulation). Some services are exempted from this rule and are thus offered free of charge. They are: 1) accident and emergency care; 2) family planning services (this does not include termination of established pregnancy); 3) diagnosis and treatment of specified infectious diseases, including HIV (with diagnosis remaining exempt even if the outcome is negative); 4) diagnosis and treatment of sexually transmitted infections; and 5) treatment required for a physical or mental condition caused by torture, female genital mutilation, domestic or sexual violence.

Immediately necessary treatment is not exempted from charges but cannot be refused to patients whether or not they have been informed of, or agreed to pay, charges. This includes maternity care (antenatal, birth and postnatal care) and situations in which patients need treatment to save their lives, to prevent a condition from becoming immediately life-threatening, or to prevent, through prompt attention, permanent serious damage from occurring.

With regard to primary care, the situation is blurred. Although GP services are excluded from the charging regulations affecting overseas

visitors, GPs have the discretion to register anyone who applies at their practice. If undocumented migrants are accepted onto a practice's list of patients, they are entitled to free NHS primary care (Grit et al. 2012). Therefore, their access to care depends upon finding a provider willing and able to provide service without additional compensation (Gray and Ginneken 2012). Moreover, since July 2017, GPs are required to provide all new patients with the revised family doctor services registration form which includes a section for patients to self-identify as eligible for NHS charges or not (Powell and Bate 2017), which might prevent undocumented migrants from accessing primary care services.

Conclusions

The health systems analysed have different approaches to access to healthcare for undocumented migrants. Although, in practice, this migrant group can face several barriers to such access, in theory, the French, Italian, Greek and Spanish health systems can be said to be currently more comprehensive or universal than the British and German systems. The former countries provide access to healthcare for undocumented migrants on almost the same conditions as for regular residents at different levels of care – primary, emergency and maternity – which are offered free of charge. Moreover, even in the case of care provided upon payment, there are mechanisms to avoid burdening individuals who cannot afford to pay for it. This is the case in Italy, for instance, which exempts individuals who prove that they cannot afford to pay healthcare treatment costs.

By contrast, in the British and German health systems only emergency care, including maternity, and some preventive care services, are offered free of charge. In addition, in the UK and Germany, policies connected to the recovery of charges and to the identification of undocumented patients end up by creating great difficulties for this group in accessing health services. For instance, the rule in the UK is that charges for the provision of services must be recovered, with few exceptions, such as emergency care, treatment of some infectious and sexually transmitted diseases, and treatment required for a physical or mental condition caused by torture, female genital mutilation, domestic or sexual violence. In addition, more recently, after the entry into force of the rules on recovery of charges in the UK, NHS structures providing secondary and hospital care, including, for example, maternity/antenatal care, paediatrics and cancer treatment, are required by law to check whether patients are eligible for free care. The rule raises the prospect of patients having to present their passports and other identity documents before receiving most kinds of treatment,

with overseas patients being billed in advance for all non-urgent care. Since the rule's introduction, NGOs and the media have been arguing that thousands of migrants have been wrongly denied healthcare in cases of immediately necessary treatment, or have been wrongly charged for treatment, and NHS professionals have shown concern that they were becoming immigration officers (Bulman 2017; Ross 2017).

In a similar vein, the German health system covers free of charge only the basic levels of preventive and emergency care for undocumented migrants. Hospital care not connected to emergency situations and even some types of care provided during pregnancy may be subject to charges. Furthermore, the rules which impose reporting obligations on public authorities create threatening situations for undocumented migrants, given their inability to claim their rights and the possibility of being denounced to the authorities (Kuehne et al. 2015).

The differences in access to healthcare offered by EU member states to undocumented migrants allow for a categorization of the levels of care available. Indeed, in a famous paper, Cuadra (2011) proposed the use of three clusters to categorize the different levels of access. In this chapter we propose to use Cuadra's clusters to identify those countries which have limited or improved access to healthcare since 2011. The three clusters are based on the level of entitlement of (adult) undocumented migrants to healthcare; each cluster was further subdivided according to the method of financing the health system, as follows.

A. Cluster 1: less than minimum rights;
B. Cluster 2: minimum rights;
C. Cluster 3: more than minimum rights.

Table 1.1. Categorization of member states according the rights of access to healthcare of undocumented migrants.

Countries	Original cluster (Cuadra 2011)	Current situation (Borges and Guidi 2018)	Performance
France	3	3	↔
Germany	2	2	↔
Greece	2	3	↑
Italy	3	3	↔
Spain	3	3	↓↑
United Kingdom	2	2	↔

Table 1.1 shows that the only country to present a shift in clusters between 2011 and 2018 is Greece, which increased access for undocumented migrants by extending coverage to provide access for those suffering from chronic, mental or rare diseases, people with disabilities hosted in social care units, and people with a disability rate of 67% or higher, the access to include emergency services as well as all inpatient services, laboratory and diagnostic tests and pharmaceuticals from hospital pharmacies.

Spain, although currently in the same cluster as in 2011, deserves a closer look. This is because between summer 2012 and summer 2018 the Spanish healthcare regime excluded undocumented immigrants from free universal health coverage through the enactment of RDL 16/2012. Therefore, during a period of almost six years this population remained in theory only entitled to emergency care for serious illness or accidents until discharge, and to obstetric and child care for those aged under eighteen. This situation, however, has been recently changed by the new RDL 7/2018, which re-established the universality of the Spanish National Health System by recognizing the right of all people in Spain to healthcare protection. Hence, in a six-year interval, Spain has shifted twice between clusters: first to limit and recently to improve the rights of access to healthcare for undocumented migrants.

Therefore, the cases of Greece and Spain show that the recent moves made by EU member states regarding the rights of access to healthcare for undocumented migrants were in the direction of improving these rights. This can be explained by political arrangements, such as left-wing parties coming to power, but also by financial factors. In effect, denying undocumented immigrants access to healthcare can result in greater economic burdens on national health systems (European Union Agency for Fundamental Rights [FRA] 2015). Primary care is associated with lower health service costs, due to its preventive role (Starfield et al. 2005). Thus, leaving health to be managed at the level of emergency only runs counter to a policy intended to be economical and efficient (Huma Network 2009) and can actually increase the costs of healthcare (Bozorgmeh and Razum 2016), a situation which justifies a more holistic and preventive approach in relation to undocumented migrants. However, it might be worth pointing out that, as shown by several chapters in this volume, even though in some countries the right of access has improved, currently restrictive policies have been adopted. That is not a contradiction, since access to healthcare services can be granted in terms of rights, but denied in terms of utilization by means of barriers. Moreover, as shown in the case of Spain, the austerity programme stemming from the 2008 financial crisis led to the enactment of restrictive laws and policies between 2012 and

2018, which were, however, overturned quite recently with the rise of the new government, thus re-establishing universal access.

Danielle da Costa Leite Borges is currently a postdoctoral research fellow at Scuola Superiore Sant'anna in Pisa. She holds a PhD in Law and a master's degree in International, Comparative and European Law from the European University Institute (EUI). She also holds a master's degree in Public Health from the Brazilian School of Public Health (ENSP/FIOCRUZ). In the last ten years she has undertaken research in the fields of health law and migration from the perspectives of human rights, judicial enforcement of socioeconomic rights, and organization and delivery of healthcare services.

Caterina Francesca Guidi is currently Research Fellow at the Robert Schuman Centre for Advanced Studies (RSCAS), EUI, as part of the Global Governance Program (GGP). She holds a PhD in Economics from the University of Siena and she is an expert in analysis and modelling of quantitative data: her research interests are mainly concentrated on the impact of mobility and migration on European welfare and health systems. She also works on research and data analysis on reception systems and integration of migrants in Europe. Prior to joining the RSCAS, she worked with international organizations such as UNHCR, the European Commission, and other research centres and NGOs on policy research and analysis in Belgium, Bosnia and Herzegovina, Italy, Serbia and Spain.

References

André, Jean-Marie, and Fabienne Azzedine. 2016. 'Access to Healthcare for Undocumented Migrants in France: A Critical Examination of State Medical Assistance', *Public Health Reviews* 37(5): 1–16. doi 10.1186/s40985-016-0017-4.

Avanzas, Pablo, Isaac Pascual and César Moris. 2017. 'The Great Challenge of the Public Health System in Spain', *Journal of Thoracic Disease* 9(6): S430–S433. Accessed on 16 January 2020. http://dx.doi.org/10.21037/jtd.2017.04.59.

Bernal-Delgado, Enrique, Sandra García-Armesto, Juan Oliva, Fernando Ignacio Sánchez Martínez, José Ramòn Repullo, Luz María Peña-Longobardo, Manuel Ridao-López and Cristina Hernández-Quevedo. 2018. 'Spain: Health System Review', *Health Systems in Transition* 20(2): 1–179.

Bhopal, Raj. 2014. *Migration, Ethnicity, Race and Health in Multicultural Societies*, 2nd ed. Oxford: Oxford University Press, Oxford.

Borges, Danielle and Caterina Francesca Guidi. 2018. 'Rights of Access to Healthcare for Undocumented Migrants: Understanding the Italian and British National Health Systems', *International Journal of Human Rights in Healthcare* 11(4): 232–243. doi: 10.1108/IJHRH-01-2018-0006

Bozorgmeh, Kayvan, and Oliver Razum. 2016. 'Effect of Restricting Access to Health Care on Health Expenditure among Asylum-Seekers and Refugees: A Quasi-Experimental Study in Germany, 1994-2013', *PLoS ONE* 10(7): e0131483. doi: 10.1371/journal.pone.0131483.

Bulman, May. 2017. 'Thousands of Asylum Seekers and Migrants Wrongly Denied NHS Healthcare', *The Independent*, 16 April 2017. http://www.independent.co.uk/news/uk/home-news/asylum-seekers-migrants-wrongly-denied-nhs-healthcare-cancer-doctors-phil-murwill-a7672686.html.

Busse, Reinhard, Richard B. Saltman and Hans F.W. Dubois. 2004. 'Organization and Financing of Social Health Insurance Systems: Current Status and Recent Policy Developments', in Richard B. Saltman, Reinhard Busse and Josep Figueras (eds), *Social Health Insurance Systems in Western Europe*. New York: Open University Press.

Cappellini E., and C.F. Guidi. 2010. 'Immigrazione e salute in Toscana', Direzione Generale Diritto alla Salute e Politiche della Solidarietà. Florence: IRPET.

Cases, Chantal. 2006. 'French Health System Reform: Recent Implementation and Future Challenges', *Eurohealth* 12(3). Accessed on 16 January 2020. http://www.euro.who.int/__data/assets/pdf_file/0009/80478/Eurohealth12_3.pdf.

Chevreul, Karine, Karen B. Brigham, Isabelle Durand-Zaleski and Cristina Hernández-Quevedo. 2015. 'France: Health System Review', *Health Systems in Transition* 17(3): 1–128.

Clandestino Project. 2009. 'Undocumented Migration – Counting the Uncountable: Data and Trends across Europe'. *Final report*, Athens.

Council of the European Union. 2006. *Council Conclusions on Common Values and Principles in European Union Health Systems* (2006/C 146/01), Brussels.

Cuadra, Carin B. 2011. 'Right of Access to Health Care for Undocumented Migrants in EU: A Comparative Study of National Policies', *European Journal of Public Health* 22(2): 267–71.

Duguet, Anne Marie, and Bénédicte Bévière. 2011. 'Access to Health Care for Illegal Immigrants: A Specific Organisation in France', *European Journal of Health Law* 18: 27–35. doi: 10.1163/157180911X551899.

Düvell, Franck. 2011. 'Paths into Irregularity: The Legal and Political Construction of Irregular Migration', *European Journal of Migration and Law* 13(3): 275–95. doi:10.1163/157181611X587856.

European Observatory on Health Systems and Policies. 2014. 'Germany – Health System Review 2014', in Reinhard Busse and Miriam Blüme (eds), *Health Systems in Transition*, vol. 16, no. 2, 2014. Copenhagen: World Health Organization.

———. 2017. 'Greece – Health System Review 2017', in *Health Systems in Transition* 19(5). Copenhagen: World Health Organization.

European Parliament Research Service (EPRS). 2016. 'The Public Health Dimension of the European Migrant Crisis'. *Briefing*, January 2016.

European Union Agency for Fundamental Rights – FRA. 2015. *Cost of Exclusion from Healthcare: The Case of Migrants in an Irregular Situation*. Luxembourg: Publications Office of the European Union.

Flegar, Veronika, Maria Dalli and Brigit Toebes. 2016. 'Access to Preventive Health Care for Undocumented Migrants: A Comparative Study of Germany, the Netherlands and Spain from a Human Rights Perspective', *Laws* 5(9): 1–22.

Global Compact for Migration. July 2018. *Global Compact for Safe, Orderly and Regular Migration*', updated version. New York, Geneva.

Gray, Bradford and Ewout Van Ginneken. 2012. 'Health Care for Undocumented Migrants: European Approaches', Vol. 33, Issue Brief. New York: Commonwealth Fund.

Grit, Kor, Joost J. Den Otter and Anneke Spreij. 2012. 'Access to Health Care for Undocumented Migrants: A Comparative Policy Analysis of England and the Netherlands', *Journal of Health Politics, Policy and Law* 37(1): 37–67.

Huma Network. 2009. 'Access to Health Care for Undocumented Migrants and Asylum Seekers in 10 EU Countries: Law and Practice'. www.episouth.org/doc/r_documents/Rapport_huma-network.pdf.

International Organization for Migration (IOM). 2017. *Health of Migrants: Resetting the Agenda – Report of the 2nd Global Consultation.* Colombo, Sri Lanka.

Karanikolos, Marina, and Alexander Kentikelenis. 2016. 'Health Inequalities after Austerity in Greece', *International Journal for Equity in Health* 15: 83.

Kovacheva, Vesela, and Dita Vogel. 2009. 'The Size of the Irregular Foreign Resident Population in the European Union in 2002, 2005 and 2008: Aggregated Estimates'. Working Paper n. 4/2009. Hamburg Institute of International Economics – Database on irregular migration. Accessed on 16 January 2020. http://irregular-migration.hwwi.net/.

Kraler, Albert, and David Reichel. 2011. 'Measuring Irregular Migration and Population Flows – What Available Data Can Tell', *International Migration* 49(5): 97–128.

Kuehne, Anna, Susann Huschke and Monika Bullinger. 2015. 'Subjective Health of Undocumented Migrants in Germany – A Mixed Methods Approach', *BMC Public Health* 15: 926. doi 10.1186/s12889-015-2268-2.

La Moncloa. 2018. 'Ratification of Royal Decree-Law on Universal Access to National Health System', *La Moncloa* (Government of Spain), 6 September 2018. Accessed on16 January 2020. http://www.lamoncloa.gob.es/lang/en/gobierno/news/Paginas/2018/20180906universalhealthca.aspx.

Larchanché, Stéphanie. 2012. 'Health Implications of Stigmatization, Structural Violence and Fear among Undocumented Migrants in France', *Social Science & Medicine* 74: 858–63. doi: 10.1016/j.socscimed.2011.08.016.

Manson, Daniel. 2017. 'Securing a Right to Health: "Integration Villages" and Medical Citizenship of Roma People in France', *Health and Human Rights Journal* 19(2). Accessed on 16 January 2020. https://www.hhrjournal.org/2017/12/securing-a-right-to-health-integration-villages-and-medical-citizenship-of-roma-people-in-france/#_edn19.

Matsuura, Hiroaki. 2013. 'The Effect of a Constitutional Right to Health on Population Health in 157 Countries, 1970–2007: The Role of Democratic Governance'. Working Paper Series of the Program on the Global Demography

of Aging from Harvard School of Public Health, Working Paper n. 106. Accessed on 16 January 2020. https://cdn1.sph.harvard.edu/wp-content/uploads/sites/1288/2013/10/PGDA_WP_106.pdf.

Médecins du Monde. 2013. *Access to Health Care in Europe in Times of Crisis and Rising Xenophobia: An Overview of the Situation of People Excluded from Health Care Systems*. Paris: Médecins du Monde.

———. 2015. 'Legal Report on Access to Healthcare in 12 Countries'. Accessed on 16 January 2020. https://mdmeuroblog.files.wordpress.com/2014/05/mdm-legal-report-on-access-to-healthcare-in-12-countries-3rd-june-20151.pdf.

Olivani, Pierfranco, and Daniela Panizzut. 2016. 'Attuale legislazione sanitaria Nazionale per gli immigrati irregolari e attuale fruibilità di tale legislazione a livello regionale'. Naga – Associazione Volontaria di Assistenza Socio-Sanitaria e per i Diritti di Cittadini Stranieri, Rom e Sinti Onlus. Accessed on 16 January 2020. https://www.simmweb.it/attachments/article/973/Report_LEGIS_Naga_2019.pdf.

Piccoli, Lorenzo. 2016. 'Left out by the State, Taken in by the Region? Explaining the Regional Variation of Healthcare Rights for Undocumented Migrants in Italy, Spain, and Switzerland'. Nccr – on the Move', Working Paper Series No. 10, Neuchatel, Switzerland.

Powell, Thomas, and Alex Bate. 2017. 'NHS Charges for Overseas Visitors', Briefing Paper n. CBP 03051, House of Commons, London, 23 October.

Organization of Economic Cooperation and Development (OECD). 2016. 'Perspectives on Global Development 2017: International Migration in a Shifting World', Chapter 6. Paris: OECD Publishing.

Ross, Alice. 2017. 'NHS Hospitals to Charge Overseas Patients for Non-Urgent Care', *The Guardian*, 6 February 2017. https://www.theguardian.com/society/2017/feb/06/hospitals-check-patients-entitled-free-nhs-care-law-jeremy-hunt.

Ruger, Jennifer Prah. 2009. *Health and Social Justice*. New York: Oxford University Press.

Savedoff, William. 2004. 'Tax-Based Financing for Health Systems: Options and Experiences'. Discussion paper n. 4, World Health Organization (WHO), Geneva.

Schoukens, Paul, and Siemen Buttiens. 2017. 'Social Protection of Non-Removable Rejected Asylum-Seekers in the EU: A Legal Assessment', *European Journal of Social Security* 19(4): 313–34.

Spencer, Sarah, and Vanessa Hughes. 2015. 'Outside and In: Legal Entitlements to Health Care and Education for Migrants with Irregular Status in Europe'. Report from the Centre on Migration, Policy and Society (COMPAS) – University of Oxford. Accessed on 16 January 2020. https://www.compas.ox.ac.uk/research/welfare/service-provision-to-irregular-migrants-in-europe/.

Starfield, Barbara, Leiyu Shi and James Macinko. 2005. 'Contribution of Primary Care to Health Systems and Health', *The Milbank Quarterly* 83(3): 457–502. doi: 10.1111/j.1468-0009.2005.00409.x.

Triandafyllidou, Anna. 2010. 'Irregular Migration in 21st Century Europe', in Anna Triandafyllidou (ed.), *Irregular Migration in Europe, Myths and Realities*. Aldershot: Ashgate.

Tuckett, Anna. 2018. *Rules, Paper, Status: Migrants and Precarious Bureaucracy in Contemporary Italy*. Stanford, CA: Stanford University Press.

United Nations. 2000. 'General Comment N. 14 The Right to the Highest Attainable Standard of Health (Art. 12)'. Adopted at the Twenty-Second Session of the Committee on Economic, Social and Cultural Rights on 11 August 2000.

———. 2014. *The Economic, Social and Cultural Rights of Migrants in an Irregular Situation*. United Nations Human Rights Office of the High Commissioner. New York and Geneva: United Nations Publication.

———. 2016. 'New York Declaration for Refugees and Migrants'. Resolution adopted by the General Assembly on 19 September 2016. http://www.un.org/en/development/desa/population/migration/generalassembly/docs/globalcompact/A_RES_71_1.pdf.

United Nations, Department of Economic and Social Affairs, Population Division. 2017. *Trends in International Migrant Stock: The 2017 Revision*. New York.

United Nations High Commissioner for Refugees (UNHCR). 2016. *Mediterranean Situation.* United Nations Office of the High Commissioner for Refugees, Geneva. Accessed on 10 September 2018. http://data.unhcr.org/mediterranean/country.php?id=83.

United Nations Refugee Agency. 2016. *Mediterranean Situation*. United Nations Office of the High Commissioner for Refugees, Geneva. Accessed on 10 September 2018.http://data.unhcr.org/mediterranean/country.php?id=83.

Urbanos-Garrido, Rosa. 2016. 'Inequality in Access to Health Care Services: Policy Recommendations Aimed at Achieving Equity', *Gaceta Sanitaria* 30(S1): 25–30. http://dx.doi.org/10.1016/j.gaceta.2016.01.012.

World Health Organization (WHO). 2000. *The World Health Report 2000 – Health Systems: Improving Performance*. Geneva.

———. 2010. *Health of Migrants: The Way Forward – Report of a Global Consultation*. Madrid, Spain.

World Health Organization (WHO) Regional Office for Europe. 2016. 'Strategy and Action Plan for Refugee and Migrant Health in the WHO European Region'. Working document, Copenhagen.

Zimmerman, Cathy, Ligia Kiss and Mazeda Hossain. 2011. 'Migration and Health: A Framework for 21st Century Policy-Making', PLoS Medicine 8(5): 1–7. Accessed on 16 January 2020. http://journals.plos.org/plosmedicine/article/file?id=10.1371/journal.pmed.1001034&type=printable.

Chapter 2

Tinkering Care at the Border
When Calais's Public Hospital Is Challenged by
Migratory Policies

Marjorie Gerbier-Aublanc

At the end of the *chemin des Dunes*,[1] a hundred metres away from the last shelters of the self-built camp, stands the Jules Ferry consultation centre: an annex of the hospital's 'permanence d'accès aux soins de santé'[2] (PASS) (health service access point), relocated to the outskirts of the camp in March 2016. We enter the Jules Ferry PASS (JF PASS) through a gate leading to a gravel path. There people wait, seated in a courtyard, exposed to climatic hazards. Consultations are held in construction site containers positioned in two rows facing each other: on one side, the hospital doctors' boxes; on the other side, the boxes of the NGOs allowed to consult inside the Jules Ferry centre. Behind the hospital boxes, a sixteen-bed clinic provides care to patients who have been discharged from the hospital but who cannot yet re-enter their tent, shelter or container.[3] When they present themselves at the JF PASS, the patients follow an internal care channel. They are received in the first bungalow where their data (last name, first name, age and nationality) and the reason for their visit are registered by a nurse with an interpreter. Fifteen chairs are disposed in this bungalow to prevent people having to wait too long in the cold. Here, the nurse proceeds to an initial triage and orients the patients to the doctors' bungalow, to the pharmacy's bungalow, or to the first aid unit. If this nurse or the two doctors consulting daily cannot attend the patients on site, or if the latter require additional examinations, they are referred to the PASS of the Calais Hospital Centre (CHC PASS) or directly to the Emergency Ward, both located six kilometres away. In that case, the staff of the hospital can rely on employees of La Vie Active, the association managing the Jules Ferry Centre (JFC), to transport the

patients to the hospital. As every drive is limited to ten persons, priority is given to the patients in the most urgent need of care. Others have to wait, rely on NGO volunteers' generosity, or walk six kilometres. When patients arrive at the JF PASS at weekends, doctors are not consulting and the paramedical staff refer them to Calais Hospital in the case of serious issues, or to a British medical NGO providing first aid in the camp seven days a week. Indeed, beyond this hospital care channel, the JF PASS team was combined in this field with five medical NGOs[4] at the time of my research.

While giving a glimpse of the dedicated provision and organization of hospital healthcare for migrants in the city of Calais, this ethnographic description raises anthropological questions. Since the mid-1990s, the French city of Calais has been the theatre of successive migratory movements, gradually becoming a dead end for people trying to reach England.[5] At the end of 2014, the hardening of migratory policies produced the emergence of the unprecedented self-built camp called the 'New Jungle'[6] on the outskirts of the city (Babels 2017; Agier et al. 2018). While NGOs and the French Ombudsman denounced a worrisome health situation in this camp, Calais's public hospital engaged in restructuring to deal with the unprecedented situation. In this uncomfortable field, hospital professionals meet medical humanitarian culture, with different – and sometimes opposed – ways of doing and thinking. While hospital culture traditionally refers to medical specialities, advanced medicine and high-tech medical care, the creation of the PASS introduced a humanitarian dimension of the hospital, promoting a 'committed approach' to care for a socially excluded population (Geeraert 2017). However, the PASS organization and positioning differ from those of humanitarian NGOs. As a hospital ward, PASS pursues a mission of public service. In that sense, care activities developed in PASS are controlled by strict bureaucratic rules and medical protocols to guarantee quality and safety of care. These realities leave the hospital healthcare team little latitude for adjusting their practices to exceptional situations. By contrast, medical humanitarian protocols are more flexible. Even if some big NGOs are now managed by bureaucratic rules and try to implement generic 'humanitarian kit' (Redfield 2015), the humanitarian culture arose from emergencies and the need to adapt to social, environmental and political crises. Moreover, by rescuing populations in danger, humanitarian organizations exposed the inadequacies of public systems as well as linking their field interventions to advocacy work. Thus, in contrast to hospital culture, humanitarian culture is more flexible and undeniably political. Many studies have focused on political challenges and solidarities in refugee camps (Agier et al. 2018; Djigo 2016; Trépanier 2016; Gerbier-Aublanc 2018). But little research

has been done on the encounter of hospital and humanitarian medicine in such a context, even though Calais's camp has been defined as the 'laboratory of an exile medicine' (Rodriguez and Tisserand 2017). How has the public hospital intervened and adjusted its institutional norms to this unusual field? How did migration policies and political agendas lead hospital caregivers to 'tinker care' (Mol, Moser and Pols 2010) in this humanitarian context? What the phrase 'tinkering care' refers to is the need of hospital caregivers to invent and sometimes improvise alternative care protocols in this exceptional environment, drawing on their material and informational resources as well as on their representations of migrant patients. How did patient categories (undesirable/political patients; included in/excluded from the French healthcare system) shape the daily routine, the care provided to the patients and the experience of hospital staff in this dislocated ward? As part of the ongoing studies on tinkering care in clinics (Mol, Moser and Pols 2010; Mol 2008) and medical improvisation at the hospital (Livingston 2012), this chapter will explore how hospital professionals have been adjusting care in an environment where patients are 'undesirable' (Agier 2008) and the political agenda unpredictable. Indeed, the construction of the JF PASS took place at an uncertain time, when the French government did not know how to deal with this self-built camp and decided to destroy it, secretly and without preparation (Gerbier-Aublanc 2017), at the end of October 2016. How does the intertwining of political decisions, the humanitarian context and public health responsibilities shape the individual and collective emotions of hospital professionals (administrative and healthcare personnel)? How do hospital workers' moral sentiments play out within this experience of humanitarian health provision? This chapter illuminates the moral economy of healthcare and migration nexus produced by these political realities.

This chapter draws on socio-ethnographic research conducted in Calais in the autumn of 2016 through participant and integral observation (Olivier de Sardan 2008) of different health services located in the camp (NGOs, JF PASS) and at the hospital (CHC PASS and Emergency Ward). I could not obtain interviews with staff members of the JF PASS during this fieldwork as the granting of administrative authorization took several weeks. I finally got it during the destruction of the camp when the staff were no longer available. Therefore, data collection begun in the autumn of 2016 was completed in December 2017 by phone interviews with former JF PASS staff members, through which I gathered their retrospective viewpoints on this experience. These observations and interviews are combined in this chapter to focus on the dislocated hospital staff's experiences and daily routine in the camp from March to October 2016.

After a brief contextualization of this border situation, I propose to describe the organizational tinkering related to the structure of the JF PASS, the daily adjustments of care in this unpredictable environment and the feelings of the staff in this field. The chapter aims at identifying how geopolitical realities and institutional logics intertwined to shape the potential for adjustment of hospital professionals in such a border context.

A Public Hospital Challenged by Migratory Policies

The closing of the Centre of Sangatte in 2002, the French migratory policies and the successive Franco-British Agreements all gradually transformed the city of Calais into a dead end for migrants trying to reach the United Kingdom (Pette 2015; Sabéran 2012). In a significant event, the Agreements signed at the Le Touquet summit on illegal immigration in February 2003 facilitated border controls by British agents in French ports, in a sense displacing the British border to Calais.

In 2014, the number of persons blocked at the border increased. They found refuge in squats and self-built camps close to the city centre, resulting in complaints from residents, in a context of the rise of extreme right-wing political parties. In response, the municipality and the prefecture decided to create a day centre for migrants at the outskirts of the city, in a former summer camp located between an industrial area and the coast. Thus, the JFC opened in January 2015 and the thousands of people scattered in camps and squats were 'encouraged' to gather in the unhealthy wasteland around it. The 'New Jungle' was born, created but never officially acknowledged by the government, which was trying to push the migrants outside the city. That intention paradoxically gave them an unprecedented visibility (Babels 2017). In September 2016, the 'New Jungle' housed between 7,000 and 10,000 people – according to two censuses conducted by the police and NGOs – in precarious sanitary conditions, without access to water, toilets, or garbage disposal. The various political decisions and legislative measures produced extreme conditions of survival for migrants, exposing them to serious health threats directly linked to this situation (Alunni 2017): skin diseases (furuncles, irritations, abscesses), lung infections (persistent coughs, flu, chronic bronchitis, tuberculosis), epidemics (chickenpox, scabies), muscle soreness and injuries (wounds, sprains, fractures) linked to the attempt to reach the UK and to police brutality. This political treatment, combined with the traumas of emigration, also produced mental disorders and addictions. Finally, even though women were a minority in the camp,

their gynaecological and obstetric care were directly impacted by these unhealthy conditions and the lack of access to healthcare.

In that sense, migratory policies at this border gradually impelled the public hospital and the NGOs to create sanitary solutions inside the camp. At first, humanitarian NGOs provided primary care in parallel with advocacy campaigns, which resulted, in October 2015, in a visit by the 'Defender of Rights'[7] delegation and the publication of a national report (Toubon 2015) denouncing the non-recognition of migrants' fundamental rights to healthcare in Calais. This report was particularly critical of the Calais Hospital Centre (CHC), denouncing the situation of the CHC PASS, its distance from the camp and the lack of transportation between the camp and the hospital for sick people, in addition to healthcare discrimination. Nevertheless, the hospital administration had engaged since 2013 in dynamics of reconfiguration concerning healthcare access for migrants, for whom it was blocked in the city, and additional human resources (doctors, nurses and interpreters) were allocated to the CHC PASS by the Regional Health Agency (Rodriguez and Tisserand 2017). Furthermore, in March 2015, the hospital's director of care, at the request of the head of the association managing the JFC, detached a nursing team to receive the migrants directly in the camp, at first only in the afternoons and then all day long, from Monday to Friday. The publication of the Defender of Rights Report made the hospital team feel unrecognized in their efforts to deal with the situation. But at the same time, this event gave them more resources with which to 'medicalize' the Jules Ferry Centre and to open, in the autumn of 2015, a healthcare centre on the outskirts of the camp.

Supported by a governmental delegation of health experts, the hospital staff rehabilitated the Jules Ferry Centre's facilities in forty-eight hours, to create a consultation centre. During this gradual dislocation of the hospital ward, medical NGOs withdrew from providing care in the camp. In March 2016, the JF PASS officially opened and brought in the Doctors Without Borders clinic, located in construction site containers on the outskirts of the camp. There the hospital staff provided between 2,000 and 3,000 monthly consultations from March to October 2016, according to hospital statistics. Between 2015 and 2016, the staff of the PASS increased considerably. Apart from social workers, whose numbers were divided by three, the number of doctors was multiplied by three, the number of nurses by two and the number of health assistants by seven. Whereas in 2013 the CHC PASS included the equivalent of five full-time professionals, on 4 November 2016, when the JF PASS closed, the team comprised twenty-one full-time caregivers. Then, the JF PASS played a central role in migrants' access to healthcare by connecting the dedicated units in the camp with the Hospital Centre's general wards.

However, the dislocation of the JF PASS was experienced by the hospital administration and the healthcare team as an uncomfortable process. Strongly criticized by the NGOs and the Defender of Rights, Calais's hospital was also stigmatized by the local population, as this nurse explains: 'Calaisiens did not come anymore to the PASS. They saw the migrants' minibus and they accused us of not being a real PASS anymore'.

Indeed, the combination of the JF PASS with the association La Vie Active, by organizing patients' transportation from the camp to the hospital by minibus, helped to facilitate migrants' access to healthcare but at the same time made them more visible at the hospital. In that sense, the director of care as well as this nurse explained that not only did Calaisiens in precarious situations stop coming to the CHC PASS, but also that the hospital came to be identified in the social networks as a 'hospital dedicated to migrants', as rumours of the priority given to migrants at the Emergency Ward spread through the city. Because of that, the utilization of the Calais Hospital Centre by the general population had fallen by around 6% in the year 2016, although its infrastructures were renewed in 2012. This decline in activity was especially observed at the orthopaedic ward, as the nurse explains:

> Because there were double rooms and the Calaisiens did not want to be in the same rooms as migrants, because there is the vision of the dirty migrant, things like that … So, when we admitted a migrant, we put him in a single room. And afterwards, the Calaisiens said that we reserve single rooms for migrants. So, this was a bad advertisement for the hospital and that has been taken quite badly. The negative vision of the migrant who gets healthcare free of charge at the hospital, who takes the place of Calaisiens … And moreover, every time we admit a refugee, his friends came to visit him and we could identify them easily and it did not 'stain the landscape' for 'chic' people coming to the hospital. … Now, we have the feedback: for all programmed surgeries, people have fled to the private clinics and we lost part of our customers and we need to recover them now.

Simultaneously criticized by NGOs for not doing enough for migrants, and accused by the non-migrant population of prioritizing them at the local level, Calais Hospital caregivers faced an uncomfortable situation, as shown by the case of the orthopaedic ward. While nurses tried to answer the bilateral critics by putting migrants in single rooms, thus trying to forestall non-migrant patients' discontent by sheltering migrants from their sight, this initiative simply increased the tension between non-migrants and migrants. Indeed, it fed the hostility of the non-migrants towards migrants accused of 'taking the place of Calaisians', and generated a feeling of competition over access to healthcare in this public institution.

The caregivers' attempt to both provide quality care to migrants and ease tensions with the local population brought discredit on the hospital, tarnishing its image and repelling local people. In that sense, Calais's hospital caregivers have clearly been challenged by migratory policies and the uncomfortable border context.

From Economic and Regulatory Constraints to Organizational Tinkering

First, the dislocation of the PASS to the outskirts of the camp implied circumvention of regulatory and economic constraints through reliance on tinkering organization and recruitment.

Circumventing Regulatory Constraints: Changing the Ward's Name

The case of the sixteen-bed clinic which opened in Jules Ferry in April 2016 is a particularly significant instance of this organizational tinkering. After the publication of the Defender of Rights Report, the government sent an expert delegation to help restructure the healthcare provision in the camp. This delegation recommended, among other measures, that the hospital introduce 'nursing beds': a specific type of ward called in French 'Lits Halte Soins de Santé' (LHSS)[8] to provide care to patients discharged from the hospital who could not yet re-enter their tent, shelter or container. The director of care[9] explains that 'Systematically, between 20 and 30 migrants stayed on in beds in the hospital wards. … Humanly, psychologically and socially, we could not push them out the door even if nothing justified their hospitalization medically'.

The LHSS aims at providing medico-social care for homeless people whose state of health, although not needing hospitalization, is not compatible with life on the street. However, agreements and a building permit are required before opening this kind of facility. Yet, in the unstable political context of the camp, the hospital had neither the time nor the authorization to build such a ward. Therefore, the hospital administration found an alternative solution, as explained by its director:

> We could not call it 'Lits Halte Soins Santé' because it needed agreements. We did everything 'out of any legal framework'; that means that we built it in a field without a building permit because we needed to work quickly. To get the Regional Health Agency's agreement, we needed to wait from 6 months to one year. So, we decided to circumvent the rule and to call it 'Lits de sortie de soins'; that means hospital discharge beds. And we thought about an alternative construction's drawing and we chose to use construction site containers.

In this respect, the healthcare provision had to confront an uncertain temporality, as the hospital did not have a clear view of the political agenda. Here, changing the name of the hospital facility enabled the hospital administration to comply with the expert delegation's recommendation, to adjust to the survival conditions of the patients, to deal with the political context and to relieve the hospital of the unsustainable cost of patients' overstays. Drawing on existing structures in the camp, modular constructions appeared to be the most efficient solution to these varied constraints.

On 16 April 2016, the JF PASS opened a sixteen-bed nursing clinic, divided into four bedrooms, each with four beds, at the outskirts of the camp. The rooms were first organized following an 'ethnic logic' – allocating beds to the patients according to their nationality – to avoid potential brawls between communities, as the camp had experienced two violent fights between Afghans and Sudanese at the beginning of the year. Over time, however, this ethnic organization did not survive the patients' inflows and outflows. Despite their representations, the JF PASS's team quickly realized that no problems occurred when the patients shared the sanitary facilities and the refectory. In any case, this organizational tinkering allowed the hospital administration to circumvent regulatory constraints and to develop strategies to deal with economic limitations.

Dealing with Economic Limitations: 'Ethnicizing' Recruitment

The director of care explains how the recruitment of the JF PASS's team had been carefully considered so as to face budgetary realities: 'Our team, we thought about it. You know, we don't have a plethora of credits. Hospitals are loss-making and facing budget shortfalls. We could not get an indefinite envelope. So, we needed to play it intelligently'. To 'play it intelligently', the hospital administration recruited not only 'the good professionals' who were able to work in such precarious conditions, but also individuals with language skills. In practice, this strategy resulted in 'ethnicizing' healthcare team recruitment, as was brought to light by the director:

> We needed specific profiles and we chose Arab-speaking persons, English-speaking persons, persons who might have a similar culture or persons receptive to intercultural relations to improve communication. The psychologist was of Arab descent; she spoke three languages besides English. Our doctors: one was a Syrian, the other one of Moroccan descent. However, we had two 'Franco-French' nurses but they had a strong interest in inter-culturalism because they had humanitarian experiences.

The manager of the PASS explains that agents sent from the hospital to work in the camp were all 'volunteers' and 'motivated', but professionals coming from an immigrant background were strongly preferred. For that reason, hospital assistants of Arab or Afghan descent were also recruited under temporary, fixed-term contracts, to complete the team. This discriminatory strategy was used by the hospital administration to respond to budgetary restrictions and optimize therapeutic communication without having to recruit too many interpreters. Another dimension is also very evident in these discourses: a strong representation of migrants as different 'Others', needing culturally oriented healthcare. Here, nevertheless, cultural representations meet the need for caring healthcare in a particular political context, as expressed by the director of care:

> We even found the 'good professionals' for this kind of mission because I call that a 'mission': to find the right words, neither to do too much nor to provide an ordinary service. To work from one's heart. It's also to give a little bit of love. It is always weird to talk about love in a hospital setting but them, they worked from their guts. I think that we were providing this kind of humanization of healthcare that I don't find everywhere in my hospital.

Hospitals in France are facing quality of care challenges in a neo-liberal context (Belorgey 2010) and hospital working conditions have been widely and collectively denounced by healthcarers for years. Paradoxically, the Calais camp arose as an exceptional context where norms could be circumvented and reinvented by the administration and the professionals themselves to meet the 'invaluable dimension of care' (Chanial 2010). Indeed, the 'ways of doing' here constituted a 'committed approach' (Geeraert 2017) by contrast with the representations of undesirability conveyed in relation to migrants. For the hospital administration and the JF PASS's team, patients from the 'new Jungle' became 'political patients' needing humanized treatment, in opposition to the political mistreatment that had generated their plight.

Nevertheless, despite communication skills being presented as a guarantee of humanization of healthcare, in practice, the ability to speak Arabic did not prevent paternalism, as we were able to observe during CHC PASS consultations. Paternalism in the carer-patient relationship is a traditional issue in the anthropology of health (Jaunait 2003; Fainzang 2006), which is particularly reactivated when patients are migrants (Pourette 2010, 2013). In the PASS of Calais hospital, paternalistic consultations could partly be explained by the large number of patients, which caused the doctors to reduce the length of consultations and to adopt an authoritarian attitude. However, the following observation also helps us

to understand how healthcarers' representations of patients play in this relationship, even when the doctor is from an immigrant background:

> Mister Zein is a fifty-year-old patient, followed in the PASS for testicular pain. He does not speak English nor Arabic. The doctor, of Arabic descent, calls the interpreter. Mister Zein had an echography this morning and tries to explain it, but the doctor interrupts him without listening to what he was saying. He asks him to go to the Emergency Ward and to see a urology specialist, 'specialist of the balls' says the Doctor in a childish way. Mister Zein visibly disagrees with that proposition. The interpreter insists but Mister Zein answers something in his language in an unhappy tone. The interpreter translates 'Mister Zein is pouting, he has been waiting since the morning'. The doctor answers, irritated that his case is not an emergency, that he is prioritizing him to see a specialist because he is a migrant living on the street. If he was a Calaisien, he would have waited 2 or 3 months to get an appointment. So, either he goes to the Emergency Ward, or he waits for a classic appointment in 2 months 'like a Calaisien'. The consultation lasted 6 minutes without auscultation.

We can clearly observe here that the patient is not listened to, or allowed to manifest his discontent, or oppose the doctor's proposal. The latter considers himself to be doing the patient a favour because 'he lives on the street'. On the pretext of prioritizing migrants, this doctor treats them in a very paternalistic way.

Furthermore, the hospital is not a homogeneous entity and the observations collected at the Emergency Ward allowed us to realize how moral sentiments (undesirability and compassion) play a concrete role in carer-patient relationships. Whereas one doctor sent a sixteen-year-old patient in a state of shock back 'to the Jungle' on foot when he could barely stand up – his legs being covered with bruises caused by police brutality – another doctor offered a meal to a seventeen-year-old patient with an ankle sprain before applying a soft cast that was easily removable in case the young man should try to go on to the UK before the end of the recommended resting period. Here, the differential treatment of patients rests on the attitude of caregivers towards this category of migrants and the representations they build around them (Geeraert 2016). Some consider that healthcare access is not legitimated for migrants trying to reach another country, whereas others are committed to helping migrants outside the hospital. Possession of health insurance is another important criterion for some healthcarers, determining whether patients are included in or excluded from the French healthcare system. Yet, if most of the 'Jungle' patients were not insured, it was also because, in the PASS dedicated ward, doctors hardly ever sent them to the social worker to obtain such rights. As previously explained, social

workers saw their numbers divided by three in the PASS whereas health professionals' numbers strongly increased. This reality was justified by the doctors as well as by the hospital administration both in terms of the unpredictable mobility of the patients and their 'so-called' exclusion from registration in the French administrative system. According to a hospital professional, migrants were afraid to have their fingerprints taken in France because of the Dublin Agreements,[10] and this was why doctors and nurses did not send them to establish health insurance rights when they needed care, but instead tinkered with humanitarian treatment. This ethnography reveals how the creativity of hospital professionals in tinkering care is shaped by their representations of migrants (the need for cultural care; undesirable/political patients; included in/excluded from the French healthcare system) in this humanitarian field. Furthermore, consultations with patients of this kind need time and a specific commitment that the hospital setting does not always allow (Gerbier-Aublanc 2016).

In that sense, the camp emerged as an exceptional care setting where healthcare was mainly provided through the JF PASS dedicated ward. Here, the team could reinvent the care routine, by articulating different healthcare cultures according to the circumstances.

Adjusting the Care Routine in an Unpredictable Environment

For the hospital, the migrant camp of Calais seemed an unpredictable environment in several respects. First, as previously explained, there was the unforeseeable nature of the political agenda. Until the end of October, the hospital administration and field team did not know when the camp would be destroyed and what would happen to the JF PASS, its clinic and patients. Second, there were the mobility and uncertain trajectories of the patients. Indeed, some members of this camp's population were trying to reach the UK, and some would succeed in their plan, while others might be arrested by the police. In any event, many patients never came back to follow up on their nursing care and did not practise the recommended care for their health conditions, either because health was not a priority in such precarious living conditions (Desprès 2013), or because their living environment did not allow it (Alunni 2017). Third, there was the fact that in such a camp it was not always possible to follow hospital norms. To adjust to this unpredictable environment, hospital professionals working in the JF PASS combined different healthcare cultures that went beyond hospital standards.

At the Crossroads of Different Healthcare Cultures

'We had the same medications, the same material, the same disinfect-ant [as at the hospital]' explains a nurse. When interviewed, doctors, nurses and the director of care all defended the degree of observance of hospital norms in the dislocated PASS. According to the manager of this dedicated ward, quality of care protocols with respect to hygiene and security of the patients were, as in any other hospital ward, approved by the hospital hygiene unit. However, these protocols were adjusted to the realities of the field by mixing hospital standards with different healthcare cultures.

The ethnographic description that introduced this chapter showed how the Emergency Ward's organization was used in the JF PASS for the patients' triage, prioritizing them according to the seriousness of their health problems and directing them to the appropriate wards. At the nursing beds clinic, the organization was modelled on Home Nursing Care. As the nurses left the camp in the evening, they left on the bedside tables the medications to be taken at night and the next morning, as they would do when visiting patients at home. For bandages, they made an arrangement with La Vie Active, the association that managed the day Jules Ferry Centre and the 500 showers offered daily to the 7,000 to 10,000 refugees, to prioritize at the shower those patients whose band-ages should be changed, by giving them specific tickets[11] that allowed them to bypass the line.

Eventually, the JF PASS's team also resorted to humanitarian medi-cine to a certain extent. This was because, first, as I have shown, most of the patients were not oriented to the institutional healthcare channel as they had not been directed to social workers to establish their rights to public health insurance. Yet they were mainly assigned to be cared for in the dedicated ward at the outskirts of the camp. Second, it was because the ward itself was located in an exceptional and demanding field, where the team were confronted daily with violent and dehumanizing realities. Third, some patients did not want to be directed to other wards or to go to the hospital, so the nurses needed to improvise alternative solutions to relieve their suffering. Eventually, as this nurse explains, the patients' inflow and their precarious conditions of survival forced the team to alter their practices:

> We washed our hands and we put gloves on but we did not put on sterilized gloves. We did it at a lower cost and we did 'less fuss' because we needed to be efficient and quick. And it was not worth putting on sterilized gloves while the patient kept his shoes and his trousers on, just pulling up his pants

to clean the wound. Because at the hospital, patients take their clothes off, put on clean pyjamas and stay in a clean bed. … Here, we just had small single-use trays, with a small scalpel blade. We did not have big sterilized trays as we have for consultations at the hospital because here, we could not re-sterilize the instruments. We needed to be logical. So, at our level, we did logical things. We did it cleanly but without all this as we were not at the hospital; we could not do the same thing. So, we did as humanitarians did. We prepared a clean table, we disinfected it, we disinfected our hands and we opened cleanly our bundle of pads. But afterwards, we did it with our fingers. Even the patients sometimes, in explaining to us, put their fingers in the wound or in the bandage. So, it would have been useless. To help us and to prevent it from falling, they touched the sterilized pad with their fingers. We needed to do it as things came. However, I always ordered as many pads as I needed and we got all that we wanted from the hospital.

Indeed, the difference between this and this nurse's previous humanitarian experience lies in the means made available by the hospital. In Cambodia, where she had worked for some weeks, she was clearly lacking in therapeutic means. Here, the humanitarian status was based not on lack of means but on a demanding context and unusual facilities, in extreme conditions of healthcare. Tinkering care is more a way of meeting the survival conditions and the mobility situation of the patients, the categories imagined by healthcarers, the unpredictability of the political agenda and all the woes caused by these mixed circumstances, than of compensating for a lack of human or material means. Indeed, the nurse indicated that she never felt a lack of staff, by contrast with her previous experience in other hospital wards: 'We could have been twice or three times more of us but it was not the same problem as in hospitals because in hospital, nurses have more and more work, rooms are never empty and there are fewer and fewer of them. But it was absolutely not the same feeling that we had in this field'.

Some epidemics such as scabies particularly mobilized the collective imagination to adjust care, but tested the limits of tinkering. Indeed, the JF PASS's team sought to devise prevention tools with 'what's at hand', as this nurse explains: 'I made posters with pieces of sprays and drug boxes and I made drawings of little guys in the shower and I had the text translated into Arabic and other languages by different persons. And we gave that to the patients'. Nevertheless, the contagiousness of scabies, associated with promiscuity in the shelters – with ten migrants sometimes sleeping in the same tiny place – and with the mobility of the patients, who could not all come to the nursing area at the same time, made it impossible for the team to eradicate this epidemic. The head nurse explained that she had thought about a prevention system to alert

the migrants living in the camp. She wanted to shoot a small movie which could be shown in the waiting room and thus reach a substantial number of persons. However, she could not complete this project because of the government's sudden destruction of the camp. 'We had the ideas progressively but we did not have the time to implement them', she says. Yet, the epidemic of scabies is a significant illustration of the way in which the political context produces epidemics, by assigning the migrants to precarious living conditions as well as by impeding the implementation of innovative care and prevention protocols with which to face the situation. All the same, tinkering care at this border was experienced as 'meaningful work' by healthcare professionals.

The Invaluable Dimension of Care: Meaningful Work

I explained previously that the camp at Calais presented an exceptional context where norms could be reinvented by the professionals to meet the 'invaluable dimension of care' often perceived as lost in ordinary hospital wards (Chanial 2010). For this reason, working in the JF PASS was experienced by the detached team as meaningful, conferring a sense of purpose that brought them closer to home care nursing and humanitarian interventions, as this nurse noted: 'I was feeling that I was doing something useful, that I was helping them. A feeling that sometimes we don't have anymore at the hospital … For me, it has been a very, very, very beautiful and valuable experience. And I also improved my English [laughs]. I really benefitted from it [laughs]'. Despite time pressures, the JF PASS's staff were devising strategies for taking care of the patients through the consultations. Trauma care is a meaningful example of this 'work of care' (Molinier 2013). Trauma consultations for injuries and fractures were among the most common types of consultation. The first care channel, described in the introduction, could require patients to wait for more than two hours. Therefore, the nurses produced colour codes to facilitate access to the different carers' bungalows for the patients needing follow-up care. For daily dressing changes, the nurses marked with a pink marker the prescription sheets that were given to patients on their first visit, so the patient could bypass the line to go directly to the bandage dispensary. The head nurse justifies this strategy as follows:

> I tried to retrain them and to teach them a little bit of wounds hygiene for skin problems and bandages. Because when it was raining, windy and when there were puddles everywhere and they did not have shoes, we had an important educational role. So, I brought socks; we all brought some clothes from home for them to switch clothes. And as they came back on a regular basis for their

dressings, they realised the importance of care. And they were happy because even when it was a small dressing, we offered them a footbath, they could wash their hands and their face; we had a small washbasin. It was a little moment of hygiene and solace. It did not last a long time but it was something they missed.

Here, therapeutic education aimed at adjusting healthcare to the patients' unhealthy context of survival. However, the nurses' mission significantly exceeded this dimension through the additional time, attention and care given to the patients. Besides care itself, important caring attention was provided daily in such a field. This 'art of adjustment' (Molinier 2013) underlines how collective creativity was feeding a 'logic of care' (Mol 2008), establishing care as 'a matter of tinkering, here and now' (Mol, Moser and Pols 2010: 136). This logic of care was clearly imbued with compassion and the representation of migrants as deserving patients, both due to the image associated to 'refugees' (Geeraert 2016) and to their inhumane survival conditions within the camp.

The commitment of the hospital administration as well as the support of the Regional Health Agency contributed significantly to the potentialities of this caring attitude. Indeed, in order to take care of the patients, the caregivers themselves need to be cared for by their hierarchy (Nakano Glenn 2000). As the nurse noticed, the carers team never lacked human or material resources in the camp. The manager of the PASS as well as the director of care were doing their best to protect the staff from the perceived risks of such fieldwork (by making available a hospital car to get to the camp or by closing access to the clinic in case of brawls) and to meet their needs. To protect the hospital team from criticism, access to the JF PASS was also limited for NGO workers, even if that fed the tensions existing between these two categories of health workers. To augment the staff, the hospital administration could eventually rely on the financial support of the Regional Health Agency. Resting on collective moral sentiments, this 'channel of care' allowed the team to work 'from their heart', to care 'from their guts', daily giving the patients 'a little bit of love' as previously described by the director of care.

At the same time, the JF PASS's team felt acknowledged by the patients, as described by this nurse:

They almost made you forget about your everyday worries. When you arrived there, they were smiling and saying 'hello'. When we left the camp in the evening, they could have said 'She is going home, she will get warm …'. I had a feeling of guilt when it was raining hard and they were on that path. We felt that our stomachs were going into knots. But the next day, when we came back, they were smiling at us.

The care receivers' acknowledgement represents the last step in the 'total process of care' (Fisher and Tronto 1990), proving the adequacy of the care provided. At the same time, patient acknowledgement strongly nurtured what is described by the JF PASS's staff as 'meaningful work'.

Conclusion

Because of its size, its sanitary conditions and the development between March 2015 and October 2016 of original healthcare provision, the migrants' camp at Calais represents an unprecedented field for observation of the reinvention of hospital work in a humanitarian context. I have pointed out throughout this chapter how the Calais public hospital tried day by day to integrate the response to financial, political, social and geographical constraints, not only to answer public health concerns and honour migrants' fundamental rights to healthcare, but also and above all to cater to the care needs of these 'undesirable' patients, relegated to a place 'at the edge of the world' (Agier 2002). Even if this 'art of adjustment' (Molinier 2013) was anchored in day-by-day experiences, tinkering care at this border required the commitment of people at all different levels of hospital work: from administrative managers to healthcare workers in the field. Indeed, 'the creativity that belongs to the regime of care, the creativity of tinkering, involves the collective sphere. It shifts and fosters the distributed links that make it possible to "get on with it"' (Mol, Moser and Pols 2010: 135). By improvising (Livingston 2012) new practices of care and reinventing hospital norms, the Calais hospital emerged as a resilient institution (Gilson et al. 2017; Ridde, Lechat and Meda 2016) in such a political context, even if its resilience mainly appeared in a dedicated ward. This ethnography has shown how geopolitical realities and institutional logics intertwined to shape hospital workers' moral sentiments and these professionals' potential for adjustment, when access to healthcare is directly linked to migratory policies, rights-based categories and the representation of the Other. Nevertheless, these reflections on the moral economy of healthcare and migration need to be followed up to shed light on the tensions and discomforts which particularly characterized the encounters of hospital professionals and NGO staff in this humanitarian field.

Acknowledgements

Marjorie Gerbier-Aublanc is a socio-anthropologist. Her research focuses on migrants' access to legal, social and sanitary rights in France in an intersectional perspective. She has worked on various personal and collective projects (Parcours, Babels, Accedab) within which she studied the logics of categorization and agency of migrants in liminal situations as well as emergent solidarities toward them. She recently published 'Être accueilli chez l'habitant' in the *Cahiers de Rhizome* and 'Numériser les vulnérabilités des migrants' in *Socio-anthropologie*. She co-coordinated the book *Hospitalité en France* (2019) for the Babels' collective.

Notes

1. Name of the street.
2. The Permanences d'Accès aux Soins de Santé (PASS) – Health Service Access Points – are public hospital wards for socially uninsured persons: those without health insurance or outside the health care system. For details, refer to the Doctoral thesis in Sociology by J. Geeraert (2017), 'La question sociale en santé: L'hôpital public et l'accès aux soins des personnes en marge du système de santé en France à l'aube du XXIe siècle', Université de Paris XIII, under the supervision of Marie Jaisson.
3. At the outskirts of the camp, an enclosed and controlled area – named Centre d'Accueil Provisoire (CAP) (temporary accommodation centre) – comprises 125 heated, 14-square-metre containers, each holding twelve beds and individual lockers. With a total of 1,500 units of accommodation, the CAP is the French governmental answer to the destruction of the southern part of the self-built camp in February 2016. For details, refer to Ticktin (2016).
4. Besides the British First Aid Support Team, the transnational NGOs Doctors without Borders and Doctors of the World both assume psychological care. As its name suggests, Gynecologists without Borders takes care of women's health. Elise Care, a

French NGO, provides physical therapy, osteopathy and acupuncture to deal with patients' pain.

5. By virtue of a bilateral agreement signed in 2003 at Le Touquet, travellers are processed in Calais before being allowed to enter the UK.

6. The word 'jangal' means 'forest' in Dari and Pashto, two Afghan languages, and was used by migrants to name the self-built camps in the forests around Calais. This word, first pronounced in English, gradually entered the common language of volunteers, NGOs, the media and even academic researchers working in Calais, despite its negative connotation, which symbolizes how borders collapse in this exceptional context.

7. 'Défenseur des Droits': French Ombudsman.

8. The 'Lits Halte Soins de Santé' were created in 1993 by Doctor Xavier Emmanuelli, founder of the NGO Samu Social for persons in situations of major exclusion. This facility has been legislatively recognized since 2005 through successive laws and decrees.

9. In French hospitals, the 'director of care' is a member of the executive team in charge of the general coordination of the care project, its activities and its regulation.

10. The Dublin III regulation assigns responsibility for the asylum application process to the first European state where a person's fingerprints have been taken. This agreement is strongly denounced by NGOs as it is considered a trap for migrants.

11. Shower tickets were distributed daily by La Vie Active to allow 500 persons to have a shower the next morning.

References

Agier, Michel. 2002. *Aux bords du monde, les réfugiés*. Paris: Flammarion.

——. 2008. *Gérer les indésirables: des camps de réfugiés au gouvernement humanitaire*. Bibliothèque des savoirs. Paris: Flammarion.

Agier, Michel, Yasmine Bouagga, Maël Galisson, Cyrille Hanappe, Mathilde Pette and Philippe Wannesson. 2018. *La jungle de Calais: les migrants, la frontière et le camp*. Paris: Presses Universitaires de France.

Alunni, Lorenzo. 2017. 'De la méfiance morale à la suspicion politique: Enjeux de santé publique dans les camps roms de Rome', *Anthropologie & Santé: Revue internationale francophone d'anthropologie de la santé* [Online] 14. Accessed on 28 January 2020. http://journals.openedition.org/anthropologiesante/2618.

Babels. 2017. *De Lesbos à Calais: comment l'Europe fabrique des camps*. Paris: Le Passager Clandestin.

Belorgey, Nicolas. 2010. *L'hôpital sous pression enquête sur le 'nouveau management public'*. Paris: La Découverte.

Chanial, Philippe. 2010. 'Le New Public Management est-il bon pour la santé? Bref plaidoyer pour l'inestimable dans la relation de soin', *Revue du MAUSS* 35(1): 135–50.

Desprès, Caroline. 2013. 'Négocier ses besoins dans un univers contraint: Le renoncement aux soins en situation de précarité', *Anthropologie & Santé: Revue internationale francophone d'anthropologie de la santé* [Online] 6. Accessed on 28 January 2020. http://journals.openedition.org/anthropologiesante/1078.

Djigo, Sophie. 2016. *Les migrants de Calais: enquête sur la vie en transit*. Contre-feux. Marseilles: Agone.

Fainzang, Sylvie. 2006. *La relation médecins-malades: information et mensonge.* Paris: Presses Universitaires de France.

Fisher, Berenice, and Joan C. Tronto. 1990. 'Toward a Feminist Theory of Caring', in Emily K. Abel and Margaret K. Nelson (eds), *Circles of Care: Work and Identity in Women's Lives.* Albany: SUNY Press.

Geeraert, Jérémy. 2016. 'Le touriste et le réfugié', *Cliniques méditerranéennes* 2: 69–82.

——. 2017. 'La question sociale en santé: L'hôpital public et l'accès aux soins des personnes en marge du système de santé en France à l'aube du XXIe siècle'. Sociology thesis. Paris: Université de Paris XIII.

Gerbier-Aublanc, Marjorie. 2016. 'Du care à l'agency: l'engagement associatif des femmes d'Afrique Subsaharienne dans la lutte contre le VIH/sida en France'. Doctoral thesis in Sociology. Paris: Paris Descartes.

——. 2017. 'L'humanitaire instrumentalisé à Calais', *Plein droit* 112(1): 32–35.

——. 2018. 'L'improvisation humanitaire: potentialités et limites des solidarités citoyennes dans les camps de migrants à Calais et à Paris', *Fondation Croix-Rouge française: Les Papiers de la Fondation* 15: 31.

Gilson, Lucy, Edwine Barasa, Nonhlanhla Nxumalo, Susan Cleary, Jane Goudge, Sassy Molyneux, Benjamin Tsofa and Uta Lehmann. 2017. 'Everyday Resilience in District Health Systems: Emerging Insights from the Front Lines in Kenya and South Africa', *BMJ Global Health* [Online], 2. Accessed on 28 January 2020. https://gh.bmj.com/content/bmjgh/2/2/e000224.

Jaunait, Alexandre. 2003. 'Comment peut-on être paternaliste? Confiance et consentement dans la relation médecin-patient', *Raisons politiques* 11(3): 59–79.

Livingston, Julie. 2012. *Improvising Medicine: An African Oncology Ward in an Emerging Cancer Epidemic*. Durham, NC: Duke University Press.

Mol, Annemarie. 2008. *The Logic of Care: Health and the Problem of Patient Choice*. London/New York: Routledge.

Mol, Annemarie, Ingunn Moser and Jeannette Pols. 2010. *Care in Practice: On Tinkering in Clinics, Homes and Farms*. Bielefeld: Transcript-Verl.

Molinier, Pascale. 2013. *Le travail du care*. Paris: La Dispute.

Nakano Glenn, Evelyn. 2000. 'Creating a Caring Society', *Contemporary Sociology* 29(1): 84–94.

Olivier de Sardan, Jean-Pierre. 2008. *La rigueur du qualitatif: les contraintes empiriques de l'interprétation socio-anthropologique*. Louvain-La-Neuve: Academia-Bruylant.

Pette, Mathilde. 2015. 'Les associations dans l'impasse humanitaire?' *Plein droit* 1: 22–26.

Pourette, Dolorès. 2010. 'Maternité et sexualité des femmes "africaines" vivant avec le VIH/sida en France: préjugés et expériences', *L'Autre: cliniques, cultures et sociétés* 11: 301–11.

——. 2013. 'Prise en charge du VIH et de l'hépatite B chronique chez les migrants subsahariens en France: le rôle-clé de la relation médecin-patient', *Santé Publique* 25(5): 561–70.

Redfield, Peter, 'Medical Vulnerability, Or Where There Is No Kit', *Limn* [Online] *5: Ebola's Ecologies*. Accessed on 28 January 2020. https://limn.it/articles/medical-vulnerability-or-where-there-is-no-kit/.

Ridde, Valéry, Lucie Lechat and Ivlabehire Bertrand Meda. 2016. 'Terrorist Attack of 15 January 2016 in Ouagadougou: How Resilient Was Burkina Faso's Health System?', *BMJ Global Health* 1.

Rodriguez, Jacques, and Marie Tisserand. 2017. 'Calais, "laboratoire d'une médecine de l'exil', *Hommes et Migrations* 1316: 132–36.

Sabéran, Haydée. 2012. *Ceux qui passent*. Paris: Carnets nord.

Ticktin, Miriam. 2016. 'Calais: Containment Politics in the "Jungle"', *The Funambulist Magazine*, June 2016.

Toubon, Jacques. 2015. *Exilés et droits fondamentaux: la situation sur le territoire de Calais*. Rapport du Défenseur des Droits.

Trépanier, Madeleine. 2016. 'Les Britanniques à Calais: La solidarité européenne à l'échelle locale dans une ville-frontière', *Multitudes* 64(3): 82–91.

Chapter 3

Tensions between Restrictive Migratory Policies and an Inclusive Prevention Programme

An Ethnography of a Biomedical HIV Prevention Programme among Sub-Saharan Africa Immigrants in the Paris Area

Séverine Carillon and Anne Gosselin

Introduction

February 2017, Paris, Porte de la Chapelle: huge blocks of stone have been brought by the municipality to a place under the bridge where hundreds of immigrants had found shelter before being received by the nearby 'humanitarian centre' of the Paris City Council. Immigrants are from now on prevented from sleeping there. June 2018: the French government, following the Maltese and Italian ones, does not allow the NGO-led humanitarian boat *Aquarius*, with 629 immigrants on board, to dock in French harbours. August 2018: the 'Asylum-Immigration' Law, which lengthens the maximum duration of foreign persons' retention and shortens the time lapse within which immigrants can appeal a refusal of asylum, is definitively adopted. All these events illustrate the 'restrictive and security-centred management of mobility at the European level'[1] (Bontemps, Makaremi and Mazouz 2018) and a crisis of hospitality and welcome policy in France (Akoka, Carlier and Coussemaker 2017).

In this particular context, we argue that a biomedical prevention programme which consists of giving medicine to individuals to prevent them from acquiring HIV raises several issues: how can immigrants access such a programme despite all the barriers they encounter, and how does this focus on prevention relate to their other needs? In other words, we

argue that this clash between restrictive migratory policies and an inclusive prevention programme creates difficulties for healthcare providers and care receivers, generates tensions among healthcare professionals, and represents a real disconnection between the prevention programme and the immigrants' needs.

The French healthcare system is widely considered protective of the overall population, including undocumented migrants (Nay et al. 2016); in particular, it gives access to healthcare for undocumented migrants after only three months in the territory. However, the current hostile climate does not spare the social protection network. Two important systems enabling immigrants' access to healthcare – the residence permit for healthcare reasons and Medical State Aid, which are particular features of the system in France – are also affected. The residence permit for healthcare reasons[2] is increasingly restricted (Observatoire du Droit à la Santé des Etrangers 2018). The healthcare insurance scheme for undocumented immigrants who can access Medical State Aid after three months is frequently threatened (Musso 2017; AIDES and ARDHIS 2018). One of the latest episodes of this debate goes back to June 2018: in the Senate, the suppression of Medical State Aid was first voted in, to be replaced by a scheme addressing emergencies and limited to serious illnesses or acute pain; an annual fee was also included. Finally, the National Assembly rejected this modification. The restriction of these rights and the multiplication of obstacles to accessing the healthcare system combined to delay people's contact with healthcare professionals. Their effective entry into and retention in the health system is thus compromised. As recent studies point out, practical barriers to healthcare have increased due to recent administrative changes and restrictive immigration policies (AIDES and ARDHIS 2018; Martinez et al. 2015).

In France, people born in Sub-Saharan Africa are the second group most affected by HIV; some of the HIV infections in these populations occur after arrival in France (Desgrées du Loû et al. 2015). Furthermore, exposure to HIV (transactional relationships, sexual violence, unprotected sex) is linked to social hardships and structural difficulties which immigrants face when they settle in France (Desgrées du Loû et al. 2016). In a context of increasing medicalization of HIV prevention (Nguyen et al. 2011), the French government has decided to make preventive treatment against HIV (pre-exposure prophylaxis, or PrEP) free and available for all, including undocumented migrants, the aim being to give HIV-negative people every opportunity to remain so by accessing prevention and screening. New prevention programmes seeking to address the epidemiological situation and scale up the utilization of this new prevention tool have been implemented (Morlat 2015).

During the summer of 2017, the Regional Agency for Health in Ile-de-France, with the support of the French Ministry for Health (DGS), launched a consultation between different medical and civil society actors in order to propose, at the beginning of 2018, a geographic and population scaled-up PrEP policy in the Paris region, via access to PrEP in Sexual Health Clinics (CEGIDD) in particular. At the same time, the fact that PrEP is mostly unknown among immigrants from Sub-Saharan Africa and the Caribbean, according to the scarce data on this topic (Hadj et al. 2017), and that these populations are absent from PrEP consultations, contribute to collective mobilization and a profusion of initiatives in the Paris region. Different actors working in hospitals or in civil society organizations set up 'combined prevention consultations' in hospitals; working groups, alliances between community-based organizations and hospital departments were set up to create PrEP communication tools for use with immigrants.

At the end of 2017, the French Ministry of Health announced its project of placing 15,000 persons on PrEP by 2020, and 50% in Ile-de-France (greater Paris area).[3] In the Paris region, the Regional Agency for Health was to fund free and full access to PrEP (extending to persons without medical insurance, and covering the whole package including medicines, blood tests, consultations, etc.) in all Sexual Health Clinics from January 2018 (Goyet 2017). However, no clear instruction on implementation was issued to the actors in the field.

In June 2018, more than 10,000 persons initiated a PrEP treatment in France in many centres spread across the country, mostly in Ile-de-France. Nearly 50% of people on PrEP live in the Ile-de-France region, in Paris for the most part. Among these persons on PrEP, there are almost no immigrants, 98% are men, mostly MSM, thirty-eight years old on average, with a high socioeconomic level (Billioti de Gage et al. 2018; ANSM 2018). The majority of PrEP users have medical insurance. The use of PrEP, then, is limited to a quite specific public which is homogeneous in terms of social and economic conditions, and access is still not effective for immigrants.

The PrEP scheme actually contains implicit elements that can explain its provisional failure mong immigrants. The epidemiological reality, the results of clinical trials conducted with MSM populations at risk for HIV (Grant et al. 2014; McCormack et al. 2016; Molina et al. 2015), and activist pressure on the French government to make PrEP more widely available, guided the implementation of the project and defined the target populations; MSM were identified as a priority population from the outset. This epidemiological reality takes into account neither the heterogeneity of

populations nor people's social reality, primary needs and living conditions. This makes the implementation of PrEP difficult for the immigrant public. We propose in this chapter to highlight, through an ethnography of the implementation of PrEP in hospitals in the Paris region, the difficulties for healthcare providers seeking to implement this prevention programme and for immigrants seeking to access this drug in a sustainable way.

The ethnography consists of observations of PrEP consultations with different publics (MSM, heterosexual immigrants), community-based organizations, awareness campaigns addressed at immigrants, and outreach HIV and STI testing activities, in addition to participant observation in working groups of health professionals and civil society organizations. Semi-directive interviews were carried out with professionals involved in broadening the access to PrEP: institutional actors, healthcare professionals (doctors, nurses), social workers and civil society actors as well as immigrants oriented towards PrEP. The interviews were recorded with the respondents' consent, transcribed and anonymized. This information is summarized in Table 3.1.

In the first part we will show how the lack of clear implementation guidelines and the difficult context of Sub-Saharan immigrants impact on the everyday practice of healthcare professionals in their working time and during their consultations. Then we will show why the PrEP programme as it is currently implemented can be disconnected from immigrants' needs.

Table 3.1. Observations and interviews: synthesis.

	PrEP consultations (56)
	Activities of awareness on prevention (2)
Observations	Activities of outreach testing of HIV and Sexually Transmitted Infections (2)
	Working groups (3 groups followed, 6 meetings)
	Institutional actors (1)
	Healthcare professionals (6 doctors, 1 nurse)
Semi- directive interviews	Social workers (2)
	Civil society organizations members (7)
	Immigrants oriented towards PrEP (3 women and 1 man)

A Day-to-Day Do-It-Yourself System for Healthcare Professionals

The Process of Initiating PrEP – A Long and Winding Road for Healthcare Providers and for Patients: The Case of Ms Lassina, Dr D.'S Patient

October 2017: in a hospital in the Paris region, Dr D., a young medical doctor involved in the prevention of HIV and healthcare of HIV patients, has recently opened a 'combined prevention consultation', frequently called a 'PrEP consultation'. This consultation is dedicated to the prescription of PrEP and the users' follow-up. However, the consultation is also thought to be open to sexual health questions, in order to guarantee a global prevention approach that includes contraception, abortion, etc. Dr D. sees mostly MSM but she tries to welcome heterosexual immigrants as much as possible, as they represent an important part of the public who attend the hospital.

Dr D. sees Ms Lassina[4] for the third time. Their first encounter took place a few weeks earlier, during a medical consultation at a Sexual Health Clinic located in the same hospital. Free consultations are given there without appointments. Ms Lassina is a young woman from Nigeria, aged twenty-one, who speaks English. She arrived in France eighteen months ago. Her asylum application was accepted and she benefits from medical insurance (CMU). She is hosted by a fellow countryman in the Paris region and works as a sex worker in a wood near Paris. She went to the Sexual Health Clinic on a friend's advice because she was afraid she might be pregnant. Dr D. offered her, in addition to a pregnancy test, a test for Sexually Transmitted Infections (STIs) including HIV. She talked to her about contraception and referred her to a gynaecologist colleague at the hospital, with whom the doctor directly booked an appointment for her patient. She also took the opportunity to talk about PrEP to Ms Lassina, emphasizing protection against HIV and the fact that the treatment is free. She then gave her an appointment for the 'PrEP Consultation' later, expressing the intention 'to talk about it again' once the contraception question was settled.

Dr D. saw Ms Lassina a second time but this time it was in the 'combined prevention consultation' for a pre-PrEP check-up. This check-up included medical procedures (blood tests, Hepatitis B vaccination, etc.) which can be organized in the same hospital, as well as explanations about PrEP: why it is interesting, how to take it, and the medical follow-up. Ms Lassina had never heard of PrEP before meeting Dr D. The doctor provided a great deal of information in English and told me, after the

consultation, that she had 'reassured the patient',[5] who was a little scepti-
cal about taking a pill every day at a given time, and was worried and
even suspicious about the medicine, which she feared could make her
unfertile. Dr D. then referred the patient to the hospital laboratory to
have the blood tests and a first injection of Hepatitis B vaccine. She also
referred her to a social worker within the hospital service, to obtain an
assessment of the steps Ms Lassina had previously taken to obtain a
medical insurance certificate; this was necessary to start PrEP. Finally,
Dr D. offered an appointment for a PrEP initiation a month later. She
also made an appointment for her patient with the nurse of the service to
have a second injection of Hepatitis B vaccine, on the same morning as
the upcoming PrEP consultation.

Third consultation of Dr D. with Ms Lassina who comes at 4pm to
potentially start PrEP: Dr D. receives her and asks why she came. Ms
Lassina mentions 'the medicine against HIV'. Dr D. also asks about her
patient's healthcare itinerary since the last consultation. The patient was
able to see the gynaecologist and access contraception (consisting of an
intrauterine device). She also had blood tests and received a first injection
of Hepatitis B vaccine. Her blood tests are good, so there is no obstacle
to PrEP. However, Ms Lassina could not go to the appointment for the
second injection of Hepatitis B vaccine on the same morning because she
had spent the whole morning at the prefecture.[6] Dr D. then arranges to
have Ms Lassina vaccinated the same afternoon, even though the vac-
cination consultations usually only take place in the morning. After the
doctor makes a few phone calls to find a nursing colleague who is avail-
able and who can find a dose of vaccine, Ms Lassina will be able to have
her vaccine following the PrEP consultation, so that she can start PrEP the
same day. Dr D. also asks about Ms Lassina's administrative situation.
Ms Lassina has not yet received the medical insurance certificate. Dr D.
goes to the social worker's office to obtain the certificate. It is 4:25pm. The
social worker refuses to take care of Ms Lassina: this patient has missed
two appointments with her already. Dr D. returns from this discussion
twenty minutes late, saying that she had 'negotiated at length to win the
case' but was blocked by the administration: 'More time spent with the
administration than with the patient', Dr D. laments. She comes back
nevertheless with the certainty that the patient has medical insurance,
because, lacking the compulsory paper certificate, she has obtained a
screen capture of this certificate. Dr D. then calls the hospital pharmacy
to explain Ms Lassina's case. She arranges with the pharmacist that the
patient will come to the pharmacy with the screen capture of the certifi-
cate. The pharmacist makes his team aware of the situation so that the
patient can be welcomed that day before 6pm. Ms Lassina will then be

able to get the medicines. Before that, she is directed towards the 'support for PrEP Consultation', which is set up in the hospital with civil society actors. She then goes to the pharmacy. She is out of the hospital after 6pm with her medicines and an appointment with Dr D. for a month later. She will have spent more than two hours in the hospital to get PrEP after no fewer than three consultations with Dr D., two appointments at the laboratory, two consultations with the gynaecologists, and missed appointments with the social worker, which will entail a refusal to follow her up in regard to her administrative situation. The plan is that she will try PrEP and come back after one month with it, but she does not come back to the follow-up consultation.

Ms Lassina's singular healthcare itinerary and Dr D.'s experience of prescribing PrEP sheds light on the reality of the PrEP initiation for an immigrant woman in a hospital in the Paris region at the end of 2017, even though access to PrEP for immigrant populations is still in its early stages. The episode that we describe here is similar to that of other women we met during this research. It shows on the one hand the 'management work' (Baszanger 1986) that the doctor takes on in order to have her patient participate in PrEP; and on the other hand, a patient's long and winding road, involving both medical and administrative constraints, even before receiving the PrEP prescription.

Dr D.'s experience as described above illustrates how the doctor had to coordinate Ms Lassina's path, spending more time in other professionals' offices than in her consultation room. This shows how proposing PrEP to immigrant women demands time, energy, networks, adaptations and also a certain amount of creativity. It also entails overcoming the concrete problem of access to medical insurance for immigrants, which is more and more difficult because of recent administrative changes (AIDES and ARDHIS 2018). At the end of 2017, at the time this ethnography was conducted, PrEP itself and the prescription and follow-up scheme were still not well known outside the gay community and medical teams specializing in Infectious Diseases. The scheme was originally designed with and for MSM, i.e. for a population who wish to access PrEP and for whom PrEP is often a point of entry to healthcare. After that, it is the professionals who have to adapt the PrEP scheme – consultations, prescriptions, follow-up, support, but also explanations and key messages – to the social, cultural and medical diversity of the populations in their care. In this context, medical practices and discourses (on PrEP, sexuality, medicines) are adjusted, and it is a time of fumbling and arrangements in the face of different constraints.

Healthcare providers who prescribe PrEP are responsible for identifying those among their patients who could benefit from it. In recent

French guidelines, PrEP can be considered by healthcare providers on a case-by-case basis for female sex workers exposed to unprotected sexual intercourse and for persons in a vulnerable situation of exposure to HIV transmission from high-risk unprotected sex, i.e. those who have sex with people in a group with high HIV prevalence (Morlat 2015). Whereas the guideline for MSM is quite clear-cut, in the case of immigrants from Sub-Saharan Africa (a group with high HIV prevalence), there is a wider margin of interpretation for healthcare providers. 'Being born in an SSA country' (ANSM 2016) or being a 'person in a vulnerable situation exposed to high-risk unprotected sex of HIV transmission' (Morlat 2015) cannot be sufficient criteria, and thus the healthcare professionals have to define during the consultation who is 'vulnerable' and at 'high risk'. This margin of interpretation is not easy to handle, besides which, in a context where consultation time is limited, it is sometimes difficult to conduct a thorough assessment of the person's situation. Ms Lassina is thus identified as a potential beneficiary of PrEP because she is considered to be at high risk of infection in the course of her work: she is a sex worker with multiple partners, condom breaks and difficulty in negotiating condoms.

For Dr D., to propose PrEP means engaging herself in prolonged and costly educational work. The offer of PrEP does not stem from a need for HIV protection as expressed by the patient, by contrast with MSMs who often come to the consultation with this precise request because they feel exposed to HIV. The PrEP proposal here does not correspond to a need of her own identified by Ms Lassina: she does not feel at risk of HIV, but at risk of pregnancy. Furthermore, the PrEP proposal is difficult to handle with a patient who is afraid of the medicine itself. This context does not appear very favourable for PrEP from the patient's point of view; it thus requires Dr D. to find the right words, explain and illustrate, and in English, in this case. Such a task of education, communication and translation requires a consultation period which is longer than that of a standard PrEP consultation. In addition, Dr D. does not hide 'the lack of appropriate key messages … How to talk about PrEP to these women? What arguments should be highlighted?' The pre-existing communication tools turn out to be not really adapted to this population. Communication on PrEP is mostly directed towards MSM and spread in these networks; it thus seems a little exclusive, conveying the idea that 'PrEP is only for MSM', as a civil society leader explains. He adds: 'Certain migrants say that PrEP is for homosexuals. But I am not homosexual, they say'. The appropriation of the tool by non-MSM populations thus becomes more difficult. Although leaflets have been designed by civil society actors with the support of healthcare

professionals and then distributed among immigrants, there are only a few of these tools and they are not distributed widely enough.

A few community-based organizations have been asked to spread information about PrEP, conduct awareness campaigns, or even refer their public to PrEP consultations. A few of them tend to become 'migrant pools', or even 'suppliers of potential PrEP users'. The risk is then to create a reverse process in terms of public health, whereby individuals are sought for a pre-existing healthcare scheme, rather than the scheme being adapted to individuals' needs (Carillon, Hadj and Desgrées du Loû 2018). In consequence, in the case described above, Dr D. improvises healthcare pathways in her hospital so that her patient can complete all the medical and administrative steps needed to receive PrEP. Phone calls and trips from one office to the other make the task heavier. This personalization of healthcare comes from the lack of an adapted healthcare scheme and turns out to be time-consuming and exhausting, while being associated with an increasing bureaucratization of healthcare practices which keeps the patient at a distance from the healthcare professional.

Dr D.'s experience shows how PrEP prescription means more work for her and her colleagues. A social worker explains: 'We need to dedicate time to these new patients …, we need time for social matters'. She adds that PrEP demands at once 'availability' and then 'rearrangements of the social matters'. 'Persons who need PrEP are the ones who have experienced complex pathways. We need to ask questions about violence, potential addictions'; professionals also need time to deal with access to rights. Thus, PrEP disrupts the healthcare organization and the patients' pathways in the hospital. Yet the social workers were not initially part of the PrEP scheme. The use of a social worker was not included in the person's pathway. Social workers are 'in the margins of the process', one of them explains. 'PrEP, it's medical. It goes to the medical, independently of the administrative status or the medical insurance. It goes very fast. … We don't have much time. The social, it's the exhaust valve: when you're stuck, you call the social worker'. In this quote, this social worker highlights both the over-medicalization of access to PrEP and the risk of a lack of healthcare professionals' availability for precisely those patients who need more time.

Finally, the healthcare professionals are under a certain amount of pressure to put individuals on PrEP. This emerges in doctors' or institutional actors' declarations at scientific conferences or in working groups, declarations such as 'We need to increase the number of PrEPers if we want an effect at a national level', 'There are not enough PrEPers in

France', 'We need to do more [*faire du chiffre*]'. It seems that there is a certain urgency to include people, and immigrants in particular, because PrEP, in terms of preventive efficacy, promises big gains. It is an element in optimistic projections of the end of the HIV/Aids epidemic within a few decades. This perspective seems to contribute to a type of biomedical innovation race that may ignore the diversity of targeted groups, their specific needs and their living conditions. 'The Aids industry' seems to be once more at work (Musso and Nguyen 2013).

In the context of a scheme that cannot offer differentiated forms to take the patients' constraints into account, this pressure on PrEP could in the long term create difficulties for healthcare professionals because of the many obstacles that need to be overcome to enable their patients to access PrEP, and because of the original conception of the scheme as not applicable to heterosexual immigrants. A few professionals, as they try to extend access to PrEP to immigrant populations, find it difficult to meet both the prescription conditions of PrEP and the growing needs of their patients, who are more and more affected by restrictive migratory policies that tend to drive them away from the healthcare system.

A Health Care Scheme Disconnected from Immigrant Populations' Needs: In the Hierarchization of Risks in Immigrants' Daily Lives, Prevention Loses

Not only is the clash between migratory and health policies a difficulty for healthcare professionals, it also means that for immigrants themselves, social and sanitary needs are multidimensional and PrEP can be the least of their concerns.

Ms Lassina's healthcare itinerary described above shows that, for her, PrEP is accessible after several consultations, once other medical problems have been solved. The identified need that the patient expresses when seeking care is a need for contraception rather than for protection against HIV. For other women that we met, the expressed need is for an abortion, or for treatment for pain following sexual violence or STIs. The question of HIV prevention and the even more specific question of PrEP seems to be tackled only afterwards and at the doctor's initiative. PrEP is still not well known among Sub-Saharan African and Caribbean populations (Hadj et al. 2017); the possibility of it does not arise from the patients' demand. As Dr D. explains, in order to avoid leaving priority needs unanswered, 'We cannot propose only PrEP … these women hold several vulnerabilities at the same time which are not addressed by

PrEP'; at the same time, PrEP depends on these vulnerabilities but 'we cannot not take it into account'. For these women, PrEP is then part of an often long and sometimes complex preliminary healthcare itinerary.

In addition to the identified sexual health needs of these immigrant women, there is the need to access medical insurance and to obtain rights in general, and these are often the person's priority. Ms Lassina's itinerary shows that the PrEP consultation is part of a process that involves different professionals: in this case, gynaecologists, social workers, and also sometimes health mediators, interpreters and, ideally, sexologists. The path within the hospital is progressively organized so that the medical tests for PrEP are more accessible and patients can have them in the same place, but a family planning appointment or an interview with a social worker, for instance, which is not included in the planned PrEP scheme, can make the path more complex, taking a few hours or several days longer – and heavier, with the multiplication of administrative steps and the repetition of painful stories. However, the intervention of social workers or health mediators can be necessary. Migratory paths expose immigrants to violence with long-term consequences for their physical and mental health, in different ways according to gender and sex, which need to be taken into account (Pannetier et al. 2018). This shows that PrEP cannot be considered in isolation. A PrEP prescription for populations whose difficulties are multidimensional (social, administrative, sexual health-related) demands both a more global healthcare approach involving different professionals, and the structuration and diversification of the PrEP scheme, in terms of organization and healthcare paths. It is not so much a question of setting up prevention programmes specifically aimed at migrants – with the risk of further stigmatizing an already stigmatized population – as of widening access to PrEP for all who need it by proposing adaptations to their needs.

From this perspective, the support for PrEP users which is ritually proposed after the first PrEP consultations and which is often handled by MSM and focused on the pill-taking scheme, sexual risks, sexual practices, drug and other products use, etc., could be inappropriate for immigrant populations who have neither the same needs nor the same preoccupations and difficulties. Ms Lassina's experience indicates a need for support with administrative formalities and medicine-related questions, and for the integration of this medicine in everyday life.

PrEP schemes thus show a lack of answers to immigrant populations' needs, shedding an unflattering light on a French healthcare system which appears unable to adapt its services to diverse population groups.

Furthermore, we argue that individuals facing social, administrative and economic hardship can struggle to access preventive healthcare and

regular medical follow-up because of the constraints of their daily lives (Larchanché 2012). This is the case for Ms Sidibé, a woman from Mali whom we met in a hospital in the Paris region when she attended a consultation for a follow-up on PrEP.

Individuals Facing Conflicting Constraints: The Case of Ms Sidibé

Ms Sidibé[7] has been in France for six months. She arrived alone, fleeing from family violence in her country of origin. She is hosted by a woman from her country in the Paris region and takes care of her host's children to pay for housing; she also has sex in exchange for money to enable her to pay her own children's school fees in her country. The father is dead. She sums up: 'I do the whore so my daughter doesn't have to do the whore herself'. In her daily life, she feels constrained in the place where she lives, far away from her close ties, and she is permanently looking for ways to earn more money. She now also has health issues. Ms Sidibé goes to the hospital for the first time when she is repeatedly in pain following sexual violence experienced on her arrival in France. This is the starting point of a hospital marathon: among other medical consultations, she goes to a combined prevention consultation, which she arrived at after being referred by the Sexual Health clinic, where she had originally gone to be tested for HIV and STIs after a rape. She is identified at once as a potential PrEP beneficiary and she accepts it after several consultations. The hospital becomes for her a place of comfort: 'They take care of me … I was told about the excision reconstructive surgery. I met with the surgeon'. She now wishes to give up prostitution and 'find a real job'. Later, however, her host asked for money and took the keys of the apartment from her; she then missed medical appointments because she could not avoid domestic work, but also and mostly because she could not pay for transport. She mentions the suppression of the Transport Solidarity Scheme – which gave State Medical Aid beneficiaries a 75% reduction in the price of transport tickets – as rendering the cost prohibitive. She gave up using public transport for fear of travelling without a ticket and being caught. The fear of having to pay a fine or being caught, arrested and excluded from the territory means giving up certain healthcare measures: she will go to a few gynaecologist appointments that she considers necessary but will give up PrEP. The prevention it offers does not seem to have a place in this hierarchization of risks. Ms Sidibé's experience illustrates the clear tension between the requirements of regular medical follow-up at the hospital, for persons who are not ill and who do not feel at risk of infection, and the priorities of everyday life in a hostile climate for immigrants.

This example illustrates the tension between increasingly restrictive migration policies and an inclusive health programme which makes HIV-preventive treatment free and available for all, including undocumented migrants, in order to give HIV-negative people every opportunity to remain so by accessing prevention and screening. But, without transport tickets, how can she get to the hospital regularly?

In addition, conditions in France for access to fundamental rights are becoming increasingly difficult. The ANRS PARCOURS study shows that six or seven years after arriving in France, half of Sub-Saharan African migrants still do not have all three basic elements of a settled life: a residence permit valid for at least one year, a personal dwelling and an activity that provides enough income to live on (Gosselin et al. 2016). People without a residence permit, or in a situation of administrative pre-cariousness, suffer from increasing restrictions on access to health coverage. Such access varies for foreign persons according to the regularity of their stay and the seniority of their presence in France. The conditions for regularity of residence are becoming more and more stringent (AIDES and ARDHIS 2018). The procedures for obtaining a residence permit are taking longer and longer; the supporting documents required are more and more numerous, in particular with regard to civil status. In a study from the Observatory on Access to Rights and Care in France, Médecins du Monde, a French NGO, notes that among the hosted patients who did not have health coverage (88%), more than three-quarters were entitled to it. The obstacles to access to rights encountered by Médecins du Monde seem to be mainly linked to the complexity of the procedures, to which are added abusive practices (refusal of a declaratory address, requests for non-compulsory supporting documents, etc.) and/or administrative delays and other dysfunctions (Chappuis, Tomasino and Didier 2016). Many foreigners experience successive passages between regularity and irregularity, for example by obtaining precarious residence permits. Their sustainable access to health coverage is thus compromised. For immigrants, health pathways are sometimes as random as administrative pathways. Finally, the general climate of hostility to migrants tends to increase the fear of travel lest they be stopped in transit, for instance. In this context of policies producing precariousness and insecurity for immigrant populations, HIV biomedicalization programmes become difficult to access.

Furthermore, PrEP is not only a medicine: it is also a follow-up system, including consultations, vaccination recalls, blood tests, etc. – for healthy people. HIV-negative people who are considered 'healthy' should see a doctor every three months to remain on PrEP, while people living with HIV generally go to the doctor twice a year. To initiate PrEP demands

autonomy, the capacity to identify one's own risks, and the knowledge and ability to take care of one's own health. All this is not obvious, in particular for immigrant people experiencing social hardship. The PrEP scheme presupposes that the person knows where to go and how to negotiate with doctors and other healthcare professionals to seek healthcare regularly. Many implicit elements of PrEP clash with the migration situation characterized by social, economic and administrative precariousness. PrEP requires management work that people going through experiences of social hardship can undertake only with difficulty. These factors show that, while there was a will to extend access to PrEP to immigrant populations, there was no thought given to what a daily pill and regular medical follow-up would involve for these persons, or of how PrEP would be inscribed in the individuals' social lives and specific systems of representation and values.

Thus, beyond sheer problems of access, this ethnography also shows that PrEP users were implicitly expected to be organized and compliant persons. Reviewing scientific publications on PrEP, Martin Holt showed how, while the technology was under trial, the primary focus was on the 'at-risk' subject in need of PrEP, with little or no consideration of the other qualities needed for successful use. However, several qualities were gradually identified as conditions of PrEP success, namely incorporating the habit of pill use, managing disclosure of the drug regime, and compliance with medical supervision (Holt 2015). It is clear that at this level also, social inequalities can play a role: for example, how do you take a daily pill, or even stock the pills, when you are always sleeping in different places?

Finally, among the persons we met, the representations associated with the medicine are often negative. The medicine is an object of fear and distrust. Some confusion of PrEP with contraception and sterility were expressed by the women: 'I am afraid of the medicine … I don't trust it. Will I be able to be pregnant while I take it?' one of them asked the doctor during a consultation. Healthcare providers confirm that these fears exist among the people they follow. Some users fear side effects too. The question of trust in the drug as a determining factor in its use reappears here in a prevention context (Desclaux 2001; Sarradon-Eck, Blanc and Faure 2007). Then, taking a pill to be protected from HIV is not obvious or trivial, even less so for the immigrant population in the current context. Research in anthropology has shown the variety of representations, uses and meanings given to medicines according to social and cultural contexts and the individual and social logics governing the drug use (Desclaux and Egrot 2015; Fainzang 2001, 2003). Research on existing representations of PrEP was conducted on HIV-negative or HIV-positive

MSM. It shows mixed representations of PrEP, including the view that PrEP confers social stigma, which overwhelmingly underpinned individuals' perceptions of it (Brisson and Nguyen 2017; Jaspal and Daramilas 2016). One of the few research studies that takes migrants' viewpoints into account reports critical perspectives on it: for instance, participants were largely critical of the perceived commodification of HIV prevention as seen through PrEP (Young, Flowers and McDaid 2016). Further research would be needed to explore these observed sources of reluctance towards the daily taking of medicines among immigrant people: what are the values and meanings associated with this free drug, prescribed for healthy people? It seems that this is another element playing against PrEP in people's evaluation of their priorities.

Conclusion

In this chapter, we described the day-to-day implementation of a biomedical prevention tool among immigrants from Sub-Saharan Africa in the greater Paris area, showing how restrictive migratory policies make it harder for healthcare professionals to broaden the access to PrEP and how in this context it poses many challenges related to the political and economic conditions of its implementation.

These restrictive policies and obstacles to immigrants' settlement in France have several consequences: first, less contact with the medical system due to administrative obstacles, health insurance issues, and fear of being arrested in transit; second, once the contact is made, the difficulty of taking a pill regularly because of unfavourable living conditions, lack of time for follow-up visits due to experiences stemming from social hardship, etc. These inequalities are only exacerbated by the current political and social climate of hostility to migrants, in which the police presence can deter people from using means of transport, or the opportunity of a job becomes priority number one, ahead of preserving one's health. Migrants are still always 'caught in contradictions of welcome and rejection, of affirmed solidarity and of the inequality suffered' (Fassin 2007). Our ethnography illustrates once again and reminds us – if reminder is needed – that the constraints around migration and mobility can have long-term effects on health. It illustrates what Didier Fassin calls 'political schizophrenia' (Fassin 2007).

These contradictions renew the challenges and limitations of targeting prevention in the context of HIV: how can we most effectively reach vulnerable populations or communities that are already stigmatized? Targeting migrants risks stigmatizing a population already historically

affected by the HIV epidemic, but the epidemiological reality requires action with these populations. There is therefore a need to strike a complex balance between the need for targeted information and prevention and the risk of double discrimination by identifying the disease as that of a minority and potentially stigmatizing targeted populations. This renews an old debate on the fight against AIDS (Girard 2017), going beyond the question of the 'racialization' of patients in the healthcare system (Sauvegrain 2012). Targeting the population is not without difficulty, but conversely, not targeting seems to reproduce inequalities of access.

Finally, to a greater extent, this ethnography makes it possible to highlight the fact that people who potentially become infected with HIV partly because of structural difficulties in settling in can be put on preventive medication. On the one hand, HIV infection can be considered to be socially produced and on the other hand the French government answer is to offer drugs. While the drug prevents HIV infection, it cannot overcome the structural and social conditions of infection.

Political and legal constraints shape and often restrict immigrants' access to healthcare (Musso 2017). 'All HIV prevention interventions must engage with the everyday lives of people and be integrated into their social relations and social practices' (Kippax and Stephenson 2012); engaging in the everyday life of immigrants in France means taking account of their needs, which are often both social and health-related. It seems that it is only on this condition that the fundamental human right to health can be ensured.

Acknowledgements

Séverine Carillon is currently a contractual research fellow at CEPED-IRD (http://www.ceped.org), in Paris Descartes University. Her research interests are in inequalities in access to healthcare. She conducts a study about migrants' access to biomedical prevention and is working on an interventional research aiming at improving Afro-Caribbeans' sexual health in the Paris greater area.

Anne Gosselin holds a PhD in Public Health from Paris Descartes University. Her PhD comprised a life-event survey, the PARCOURS Study (www.parcours-sante-migration.com), exploring Sub-Saharan immigrants' settlement trajectories in France and the social consequences of HIV and chronic Hepatitis B on their lives. At the crossroads between Public Health and Demography, her research interests are in health inequalities, social determinants of health, but also participatory research with community-based organizations and interventional research design and analysis. She currently works as a postdoctoral researcher at the French Collaborative Institute on Migration (www.icmigrations.fr) in Paris on an interventional research aiming at improving Afro-Caribbeans' sexual health in the Paris greater area.

Appendix: PrEP – Definition, Terms of Use and Access

PrEP – Pre-Exposure Prophylaxis: Definition

PrEP is an antiretroviral treatment that prevents HIV infection among non-infected persons who are highly exposed to HIV (World Health Organization 2015). When used appropriately, it reduces the risk of HIV infection to next to zero (Grant et al. 2014; McCormack et al. 2016; Molina et al. 2015). In France, the preventive use of this medicine was authorized and made free from January 2016. This authorization is regulated by a Temporary Utilization Recommendation (RTU in French), delivered by the French National Agency for Medicines and Health Products Safety (ANSM). In addition to Men who have Sex with Men (MSM), the Recommendation clearly states that other populations who are exposed to HIV can access the treatment. Thus, 'given the demonstrated preventive effect, it is admitted that prescribers could be confronted in their practice with individual situations where the treatment is needed. In this respect, it is admitted, in particular, that situations where the HIV infection risk is high have been identified among heterosexual persons born in Sub-Saharan Africa or living in Guyana' (ANSM 2016). PrEP, then, is intended in particular for MSM and immigrants from Sub-Saharan Africa who are exposed to HIV.

Intended Uses of PrEP and Public Health Expectations

PrEP appears as a pragmatic response to a public health challenge: 6,000 new diagnoses of HIV per year in France, an increase in condomless sex practices and the quite high incidence of HIV among certain groups

of the population (Santé Publique France 2017). The epidemic remains concentrated among MSM and people born in high prevalence countries, mostly from Sub-Saharan Africa and the Caribbean, but who may have acquired HIV after their arrival in France (Desgrées-du-Loû et al. 2015). This data calls for a new approach to prevention in which PrEP constitutes an additional tool for combined prevention that includes testing, condoms and treatments, to be used according to the person's situation and needs. Its preventive efficacy makes it a promising tool which helps to foreshadow the end of HIV/Aids epidemics in the next decades.

Access to PrEP

PrEP is prescribed in hospitals and, since 2018, in a few Sexual Health Clinics (Free Centres of information, testing and diagnosis, CEGIDD), during a consultation with a specialized doctor who is used to treating patients living with HIV, following evaluation of their exposure to STIs and blood tests. The medicine is available in pharmacies by prescription. The follow-up consists of a medical consultation and blood tests after the first month and then every three months. PrEP users can take either one pill per day or, for men only, two pills before sexual intercourse, then another pill one day and another two days after the first pill. In addition to the prescription and the medical follow-up, the PrEP users are asked whether they wish to have support organized by community-based organizations after the PrEP consultation. The aim of this step is to improve adherence to this new prevention tool and adoption of lesser-risk sexual practices in combatting all Sexually Transmitted Infections (Morlat 2015).

Notes

 1. Our translation.
 2. The permit of residence for medical reasons allows foreigners who are suffering from a serious condition, without access to care in their country of origin, to obtain a residence permit in France, often a renewable one-year permit.
 3. The administrative Paris region is also called Ile-de-France or Paris greater area; we use both terms throughout the text.
 4. To ensure participant anonymity, their names have been changed for this chapter.
 5. For all the discourses in French, the English translation given is our own.
 6. In France, the prefecture is the administrative authority that delivers the residence permits.
 7. To ensure participant anonymity, their names have been changed for this chapter.

References

AIDES and ARDHIS. 2018. 'VIH, hépatites, la face cachée des discriminations'. Accessed on 3 December 2018. https://www.aides.org/sites/default/files/Aides/bloc_telechargement/AIDES_RAPPORT%20DISCRIMINATIONS_2018.pdf.

Akoka, Karen, Marine Carlier and Solange de Coussemaker. 2017. 'Ce n'est pas une crise des migrants mais une crise des politiques d'hospitalité', *Revue Projet* 360 (October): 77–83. Accessed on 18 September 2018. https://doi.org/10.3917/pro.360.0077.

ANSM. 2016. 'La RTU Truvada dans la prophylaxie Pré-Exposition (PrEP) au VIH établie par l'ANSM est effective – Point d'Information'. https://ansm.sante.fr/S-informer/Points-d-information-Points-d-information/La-RTU-Truvada-dans-la-prophylaxie-Pre-Exposition-PrEP-au-VIH-etablie-par-l-ANSM-est-effective-Point-d-Information.

ANSMM. 2018. 'Suivi de l'utilisation de Truvada® ou génériques pour une prophylaxie pré-exposition (PrEP) au VIH'. http://www.ansm.sante.fr/S-informer/Points-d-information-Points-d-information/Utilisation-de-la-prophylaxie-pre-exposition-PrEP-au-VIH-par-Truvada-ou-generiques-entre-janvier-2016-et-juillet-2017-Point-d-information.

Baszanger, Isabelle. 1986. 'Les maladies et leur ordre négocié', *Revue française de sociologie* 27(1): 3–27.

Billioti de Gage, S., F. Raguideau, A. Rudnichi and R. Dray-Spira. 2018. 'Utilisation de la prophylaxie pré-exposition au VIH par l'association fixe emtricitabine/ténofovir (Truvada® ou génériques): étude longitudinale à partir des bases médico-administratives françaises', *Revue d'Épidémiologie et de Santé Publique*, 10e Colloque Données de santé en vie réelle Cité Internationale Universitaire de Paris, 7 June 2018, 66 (June): S226. https://doi.org/10.1016/j.respe.2018.04.032.

Bontemps, V., C Makaremi and S. Mazouz. 2018. *Entre accueil et rejet: ce que les villes font aux migrants*. Lyons: Le passager clandestin, 'Bibliothèque des frontières'.

Brisson, Julien, and Vinh-Kim Nguyen. 2017. 'Science, Technology, Power and Sex: PrEP and HIV-Positive Gay Men in Paris', *Culture, Health & Sexuality* 19(10): 1066–77. https://doi.org/10.1080/13691058.2017.1291994.

Carillon, S., L. Hadj and A. Desgrées du Loû. 2018. 'Médicamenter ou accueillir: L'approche de la PrEP pour les migrants en France est-elle pertinente?' Oral communication, presented at the AFRAVIH conference, Bordeaux.

Chappuis, M., A. Tomasino and E. Didier. 2016. 'Observatoire de l'accès aux droits et aux soins de la mission France de Médecin du Monde. Rapport 2015.' Médecin du Monde et Observatoire régional de la santé de Midi-Pyrénées. Accessed on 28 January 2020. https://www.medecinsdumonde.org/fr/actualites/publications/2016/10/14/rapport-de-lobservatoire-de-lacces-aux-droits-et-aux-soins-en-france-2015.

Desclaux, Alice. 2001. 'L'observance en Afrique: question de culture ou "vieux problème" de santé publique?', in L'observance aux traitements contre le VIH/sida, ANRS. Collections Sciences sociales et sida. Paris: Éditions EDK.

Desclaux, Alice, and Marc Egrot. 2015. *Anthropologie du médicament au Sud: la pharmaceuticalisation à ses marges*. Paris: L'Harmattan. http://search.ebscohost.com/login.aspx?direct=true&scope=site&db=nlebk&db=nlabk&AN=1276070.

Desgrées du Loû, Annabel, J. Pannetier, A. Ravalihasy, A. Gosselin, V. Supervie, H. Panjo, N. Bajos, F. Lert, N. Lydie and R. Dray-Spira. 2015. 'Sub-Saharan African Migrants Living with HIV Acquired after Migration, France, ANRS PARCOURS Study, 2012 to 2013', *Eurosurveillance* 20(46): 31–38. https://doi.org/10.2807/1560-7917.es.2015.20.46.30065.

Desgrées du Loû, Annabel, Julie Pannetier, Andrainolo Ravalihasy, Mireille Le Guen, Anne Gosselin, Henri Panjo, Nathalie Bajos, et al. 2016. 'Is Hardship during Migration a Determinant of HIV Infection? Results from the ANRS PARCOURS Study of Sub-Saharan African Migrants in France', *AIDS* 30: 645–56.

Fainzang, Sylvie. 2001. *Médicaments et société: Le patient, le médecin et l'ordonnance*. Paris: Presses Universitaires de France.

———. 2003. 'Les médicaments dans l'espace privé: Gestion individuelle ou collective', *Anthropologie et Sociétés* 27(2): 139. https://doi.org/10.7202/007450ar.

Fassin, Didier. 2007. 'La santé des étrangers: une question politique', *La santé de l'homme* 392: 50.

Girard, Gabriel. 2017. 'Pour une prévention attentive aux normes sociales qu'elle véhicule', in Michel Dorais (ed.), *Prévenir*. Quebec: Presses de l'Université Laval. https://hal.archives-ouvertes.fr/hal-01582179.

Gosselin, Anne, Annabel Desgrées du Loû, Eva Lelièvre, France Lert, Rosemary Dray-Spira and Nathalie Lydié. 2016. 'How Long Do Sub-Saharan Migrants Take to Settle in France?', *Population and Societies* 533: 4.

Goyet, F. 2017. 'Déploiement de la PrEP en Ile de France: principes et répartition des moyens nouveaux'. Colloque annuel du COREVIH Ile-de-France, Paris, 30 November.

Grant, Robert M., Peter L. Anderson, Vanessa McMahan, Albert Liu, K. Rivet Amico, Megha Mehrotra, Sybil Hosek, et al. 2014. 'Uptake of Pre-Exposure Prophylaxis, Sexual Practices, and HIV Incidence in Men and Transgender Women Who Have Sex with Men: A Cohort Study'. *The Lancet Infectious Diseases* 14(9): 820–29. https://doi.org/10.1016/S1473-3099(14)70847-3.

Hadj, Laure, Annabel Desgrées du Loû, Jean Dupont and Vinh Kim Nguyen. 2017. 'Acceptabilité et freins chez les populations africaines et caribéennes vivant en Île-de-France d'une nouvelle offre de prévention du VIH: le Truvada® en prophylaxie pré-exposition (PrEP). Une enquête exploratoire'. *Bull Epidémiol Hebd.* 6 (March): 110–14.

Holt, Martin. 2015. 'Configuring the Users of New HIV-Prevention Technologies: The Case of HIV Pre-Exposure Prophylaxis', *Culture, Health & Sexuality* 17(4): 428–39. https://doi.org/10.1080/13691058.2014.960003.

Jaspal, Rusi, and Christos Daramilas. 2016. 'Perceptions of Pre-Exposure Prophylaxis (PrEP) among HIV-Negative and HIV-Positive Men Who Have Sex with Men (MSM)', ed. Albert Lee, *Cogent Medicine* 3(1): 1256850. https://doi.org/10.1080/2331205X.2016.1256850.

Kippax, Susan, and Niamh Stephenson. 2012. 'Beyond the Distinction Between Biomedical and Social Dimensions of HIV Prevention through the Lens of a Social Public Health', *American Journal of Public Health* 102(5): 789–99. https://doi.org/10.2105/AJPH.2011.300594.

Larchanché, Stéphanie. 2012. 'Intangible Obstacles: Health Implications of Stigmatization, Structural Violence, and Fear among Undocumented Immigrants in France', *Social Science & Medicine*, Part Special Issue: *Migration, 'Illegality', and Health: Mapping Embodied Vulnerability and Debating Health-Related Deservingness* 74(6): 858–63. https://doi.org/10.1016/j.socscimed.2011.08.016.

Martinez, Omar, Elwin Wu, Theo Sandfort, Brian Dodge, Alex Carballo-Dieguez, Rogeiro Pinto, Scott Rhodes, Eva Moya and Silvia Chavez-Baray. 2015. 'Evaluating the Impact of Immigration Policies on Health Status Among Undocumented Immigrants: A Systematic Review', *Journal of Immigrant and Minority Health* 17(3): 947–70. https://doi.org/10.1007/s10903-013-9968-4.

McCormack, Sheena, David T. Dunn, Monica Desai, David I. Dolling, Mitzy Gafos, Richard Gilson, Ann K. Sullivan et al. 2016. 'Pre-Exposure Prophylaxis to Prevent the Acquisition of HIV-1 Infection (PROUD): Effectiveness Results from the Pilot Phase of a Pragmatic Open-Label Randomised Trial', *The Lancet* 387(10013): 53–60. https://doi.org/10.1016/S0140-6736(15)00056-2.

Molina, Jean-Michel, Catherine Capitant, Bruno Spire, Gilles Pialoux, Laurent Cotte, Isabelle Charreau, Cecile Tremblay et al. 2015. 'On-Demand Preexposure Prophylaxis in Men at High Risk for HIV-1 Infection', *New England Journal of Medicine* 373(23): 2237–46. https://doi.org/10.1056/NEJMoa1506273.

Morlat. 2015. 'Prise en charge médicale des personnes vivant avec le VIH - Recommandations du groupe d'experts – Actualisation 2015 – Prophylaxie pré-exposition'. https://cns.sante.fr/wp-content/uploads/2015/10/experts-vih_prep2015.pdf.

Musso, Sandrine. 2017. 'Comment l'anthropologie de la santé éclaire', *Idées économiques et sociales* 189 (October): 20–27. https://doi.org/10.3917/idee.189.0020.

Musso S., and Vinh-Kim Nguyen. 2013. 'D'une industrie l'autre', *Genre, Sexualité et Société* 9. Accessed 19 January 2020. http://journals.openedition.org/gss/2882. doi: 10.4000/gss.2882.

Nay, Olivier, Sophie Béjean, Daniel Benamouzig, Henri Bergeron, Patrick Castel and Bruno Ventelou. 2016. 'Achieving Universal Health Coverage in France: Policy Reforms and the Challenge of Inequalities', *The Lancet* 387(10034): 2236–49. https://doi.org/10.1016/S0140-6736(16)00580-8.

Nguyen, Vinh-Kim, Nathalie Bajos, Françoise Dubois-Arber, Jeffrey O'Malley and Catherine M. Pirkle. 2011. 'Remedicalizing an Epidemic: From HIV Treatment as Prevention to HIV Treatment Is Prevention', *AIDS* 25(3): 291–93. https://doi.org/10.1097/QAD.0b013e3283402c3e.

Observatoire du Droit à la Santé des Etrangers. 2018. 'Projet de loi Collomb sur l'asile et l'immigration: l'ODSE dénonce des atteintes supplémentaires à la santé des personnes étrangères'. Accessed on 29 January 2020. https://www.odse.eu.org/L-ODSE-DENONCE-DES-ATTEINTES?lang=fr.

Pannetier, Julie, Andrainolo Ravalihasy, Nathalie Lydié, France Lert and Annabel Desgrées du Loû. 2018. 'Prevalence and Circumstances of Forced Sex and Post-Migration HIV Acquisition in Sub-Saharan African Migrant Women in France: An Analysis of the ANRS-PARCOURS Retrospective Population-Based Study', *The Lancet Public Health* 3(1): e16–23. https://doi.org/10.1016/S2468-2667(17)30211-6.

Santé Publique France. 2017. 'Point épidémiologique – Découvertes de séropositivité VIH et de sida en 2015'. http://invs.santepubliquefrance.fr/content/download/135287/485871/version/4/file/SurveillanceVIHSida2003_2015.pdf.

Sarradon-Eck, A., M.-A. Blanc and M. Faure. 2007. 'Des usagers sceptiques face aux médicaments génériques: une approche anthropologique', *Revue d'Épidémiologie et de Santé Publique* 55(3): 179–85. https://doi.org/10.1016/j.respe.2007.01.026.

Sauvegrain, Priscille. 2012. 'La santé maternelle des "Africaines" en Île-de-France: racisation des patientes et trajectoires de soins', *Revue européenne des migrations internationales* 28(2): 81–100. https://doi.org/10.4000/remi.5902.

World Health Organization. 2015. *Guideline on When to Start Antiretroviral Therapy and on Pre-Exposure Prophylaxis for HIV*. Geneva: WHO Press. http://www.ncbi.nlm.nih.gov/books/NBK327115/.

Young, Ingrid, Paul Flowers and Lisa McDaid. 2016. 'Can a Pill Prevent HIV? Negotiating the Biomedicalisation of HIV Prevention', *Sociology of Health & Illness* 38(3): 411–25. https://doi.org/10.1111/1467-9566.12372.

Chapter 4

The Positive Othering of Young Muslim Male 'Refugees' as Ideal Elderly Care Workers in the German Media Discourse

Caterina Rohde-Abuba

Introduction

In reaction to increased 'refugee'[1] immigration to Germany, in 2015 the public media discourse quickly changed from the initial acceptance of 'refugees' who 'deserve' help to the 're-demonizing process of refugees', which led to their being labelled undeserving migrants or illegitimate 'economic migrant[s]' (Vollmer and Karakayali 2017). The dominant discourse line after 2015 specifically focuses on young Muslim men, who represent the largest number of 'refugees', and depicts them as a threat to German society due to their presumed traditionalist, misogynist and undemocratic values as well as their violent behaviour (DISS 2017: 182).

Starting in 2015, a large number of initiatives and projects by public and private social actors were established to support the integration of 'refugees' into the labour market.[2] Germany is currently facing a severe lack of elderly care workers due to low wages, poor working conditions and the low status of this labour market sector. The care economy, which developed as a consequence of the implementation of governmental policies allowing care consumers to receive cash to spend on their choice of care (Ungerson 2003), be it at-home care services or care homes, struggles to find sufficient workers within the German and European population. In the context of commodifying care work (Ungerson 1997),

e.g. direct cash transfers in exchange for care, which had previously been covered predominantly by female family members, migrant workers have become an important workforce for this employment sector. Workers, mostly from Eastern European countries in a legal 'twilight zone', have already been covering a large share of elderly care in private households for more than a decade (Lutz and Palenga-Möllenbeck 2010). In contrast, elderly care homes have only recently begun to search for options to employ migrant workers.[3] Apart from recruiting skilled workers from abroad, some public and private care providers also seek options to use 'refugees' as workers in elderly care homes. The employment of migrants in public and private elderly care homes has brought this phenomenon to the attention of the public, so that a media discourse about the integration of 'refugees' in elderly care homes has developed. The research question explored in this chapter is whether and how participants in these integration projects are constructed as 'suitable' elderly care workers, resulting in a counter-discourse to their depiction as 'dangerous' and 'unproductive migrants' (Mühe 2017: 23).

Previous research has shown that the recruitment of migrant workers to cover shortages of workers in low-paid, often subordinated jobs is associated with a positive stereotyping of these workers as being especially suitable for this work (MacKenzie and Forde 2009; Scrinzi 2011; Näre 2013b). Beyond that, previous research had shown that the 'suitability' of Asian migrant men for reproductive work in private households in Italy was connected with their Catholic identity, while Muslim workers do not benefit from sharing a religion with the receiving society (Gallo and Scrinzi 2016). The case of 'refugees' integrated in elderly care work in Germany is different from the above-named cases: in the German context, due to the underdeveloped system of labour immigration, 'refugees' are perceived as an important group of available care workers. According to the demographic structure of 'refugee' immigration,[4] this group of potential care workers is dominated by young Muslim men. Hence, work relations have to bridge religious differences. Besides that, the social and residential category of being a 'refugee' – rather than a labour migrant – requires that these persons are constructed as tolerated in Germany for humanitarian reasons, which may contradict the notion of a demand for care workers.

The theoretical approach of the chapter is focused on the narrative mechanism of othering employed in discourses to differentiate social groups and locate them in a hierarchy in relation to each other. In this process, othering is informed by various social categories of differentiation such as culture, religion or gender. Using Critical Discourse Analysis,

the public media discourse is analysed in German regional and federal online and print newspapers and journals reporting on integration projects which placed 'refugees' in elderly care homes.

'Othering' as a Narrative Mechanism of Constructing a Subordinated Social Position of 'Refugees'

The subjectification in the discourse of 'refugees' in elderly care homes is multidimensional, as it deploys meaning structures that construct the social positions of being from a 'Muslim country', being a 'refugee' and being a 'care worker'. Meaning structures that construct these categories rely on narratives of othering that differentiate these social positions from those of other population groups. The narrative mechanism of othering is an inherent element of orientalism, a term which describes the reiteration of 'European superiority over Oriental backwardness' (Said 1978: 15). Hence, orientalism uses the narrative mechanism of othering to establish discursive power relations by constructing cultures or persons as different and thus unequal 'others' (cf. Ashcroft, Griffiths and Tiffin 2007: 156; Spivak 1985). Narratives that use othering may include forms of cultural essentialism, which is according to Grillo the 'conception of human beings as "cultural" (and under certain conditions territorial and national) subjects, i.e. bearers of a culture, located within a boundaried world, which defines them and differentiates them from others' (Grillo 2003: 158). In these discourses power is maintained through representation of a 'fixed', e.g. rigid and unchanging, order of cultural, historical or racial differences (Bhaba 1983: 18). By providing knowledge and identification, these discourses allow the subjectification not only of migrant workers but also of the receiving society, because it co-constructs superiority and inferiority at once (Bhaba 1983: 27).

Using cultural essentialism in othering means that certain attributes or behaviours that are ascribed to a cultural group are viewed as inherent and static, whereby they appear independent of the context (Watkins, Ho and Butler 2017: 2284). This is especially visible in the discourse on Muslim migrants in Germany, which intermingles categories of religion and culture in the imagination of a cultural homogeneous group of 'the Muslims' (Shooman 2014; Amirpur 2015; Attia 2018), which is often stereotyped as representing violence and terrorism, intolerance and the suppression of women (Naumann 2006). Dietze argues that the image of the 'sexually dangerous muslim refugee' (Dietze 2016: 1) reveals the ethnosexism in this discourse. Ethnosexism is discrimination against ethnic groups based on their assumed 'specific, problematic or "backwardly"

sexuality' (ibid: 4), as shown in the media discourse on the attacks by assumedly young Muslim men on women on New Year's Eve 2016 in the German city of Cologne, which resulted in a moral panic among the population. Scheibelhofer (2016) points out that the subsequent public discourse constructs an image of the 'Muslim man' or 'Arab man', who due to his origin is per se more inclined to violent behaviour, so that all of his actions are assumed to be predetermined by his culture or religion, leading to a form of violent masculinity.

The incidents in Cologne have been perceived as validation of long-standing worries about the risks to the German population from 'refugee immigration'. This narrative of othering allows commentators to present the 'Western' order of sexuality as the 'perfect model of every possible civilisation' (Dietze 2016: 13). The discourse is grounded in the perception of a homogeneous 'Muslim culture', which is traditional and irrational and thus incompatible with modern, rational European societies (Nökel 2002; Attia 2009).

Following Niedrig and Seukwa, the use of the term 'refugees' itself displays a postcolonial perspective on this form of migration, mirroring the self-definition of the social majority by 'rescuing' the 'true refugees' (Niedrig and Seukwa 2010: 181). Central to the discourse on 'refugee' immigration in Germany is the term 'integration', which suggests the inclusion and participation of migrants, but denies diversity and heterogeneity among migrants and demands that they adopt an imagined homogeneous German culture (Georgi 2015). Friedrich shows that the current discourse on 'refugee' integration has replaced former racist discourses, implying that 'refugees' are biologically different, with a 'merits paradigm', which presents migrants as integrated into society based on their merits (Friedrich 2011: 26–27). An example of this is the widespread assumption that women from less privileged countries still possess 'natural competencies' for care work (Rerrich 2006: 48–49).

Even though care work is most often assigned to female migrants, which is why Sarvasy and Longo (2004) identify the globalization of this employment sector as feminized neo-colonial relations of care, some research also shows the re-masculinization of paid domestic and care work in Europe (Kilkey et al. 2013). Research reveals that male care workers are often subjectificated with 'subaltern masculinities': in her study on male domestic workers from Sri Lanka in Italy, Näre shows that employers construct them as 'effeminate, asexual, and unthreatening' (Näre 2010: 65). Similarly, Gallo shows that the Catholicism of Asian workers in Italy is used as a reference structure for constructing 'gendered models of the legitimate and trustable worker' (Gallo 2018: 180). Scrinzi shows that the intersection of gender, migration and religion in Italy is the

basis for constructing migrants as 'Christian racialized Others' (Scrinzi 2016: 1) who are trustworthy domestic and care workers. While Muslim migrant men are othered as a danger to society through stigmatization and sexualization, Christianity is used as a central category of differentiation between 'the "good" migrants that are easy to integrate and those whose integration is deemed impossible because – it is assumed – their culture and religion are radically different and do not fit Western liberal democratic standards' (Scrinzi 2016: 5).

The Methodological Approach of the Critical Discourse Analysis

For the general public, the employment of 'refugee' care workers is a phenomenon still only known through mass media and not as a primary experience. Following Foucault's perspective on discourses, media (such as written or spoken language) do not only represent reality, but rather produce reality through the implementation of categories and differentiations (Felder 2012). In specific discourses of power, individuals are transformed into subjects of specific forms of knowledge within their sociohistorical circumstances (Foucault 1990). In this chapter, the media are regarded collectively as one place where this subjectification of individuals occurs. Employing the perspective of Critical Discourse Analysis, this chapter focuses on how power and inequality are established in this discourse through the implementation of categories and differentiations between 'refugees' and locals, as well as by legitimizing the employment of 'refugees' through integration projects. The analysis of this chapter is aimed at studying 'the way social power abuse, dominance, and inequality are enacted, reproduced, and resisted by text and talk and political context' (Van Dijk 2001: 352).

The term discourse in Foucault's approach refers to the conglomeration of texts that are related by their content. Discourses are social interactions, as they are constructed intertextually and intermedially (Frass and Klemm 2005). A discourse comprises a number of statements that belong to a common system of formation (Frass and Klemm 2005: 3). As a methodological procedure, sequential analysis oriented on the hermeneutic technique of Oevermann (1973) was used, which aims to reconstruct manifest and latent meaning structures of the data. The articles were searched by browsing results for the terms 'refugees + care' and 'refugees + elderly care'.[5] All relevant sources that appeared in the browsing results were listed and randomly chosen in succession for the analysis. As no new discourse structures appeared, the sample was closed. The sample comprises twenty-nine articles in German online and print magazines

(daily and weekly) published between 2014 and 2018. The sample is not representative, but covers the most important national journals with a wider circulation, like *Zeit*, *Süddeutsche Zeitung*, *Spiegel* and *Focus* as well as local newspapers of different German regions.

The 'Win-Win Scenario' of Integrating 'Refugees' in Elderly Care Work

The analysis of the media coverage on 'refugees' in elderly care homes shows that these integration projects are legitimized by the lack of care workers. It is argued that from a macro perspective two different societal challenges – the 'care crisis' and 'refugee immigration' – are solved by using 'refugees' as elderly care workers. A typical example of this interpretation is seen in the weekly magazine *Der Spiegel* (1 December 2017), which introduced the topic by citing the 'Care Report 2030' by the Bertelsmann Foundation. This report claims that in fifteen years there will be a shortage of about 500,000 full-time care workers in Germany. The immigration of 'refugees' is interpreted as a 'giant challenge for Europe: millions of refugees have to be integrated'. After portraying the male 'refugee' 'Zia Hayafi' – who is undertaking an apprenticeship in care assistance, and extensively describes his devotion to elderly care work – it is reasoned:

> And suddenly it is there – the idea that someday in the future you will wait for death in the circle of foreign people [meaning: being cared for by migrants]. Will you have somebody around you who is as affectionate as Zia Hayafi? Whose humanity navigates him through the everyday care like a passenger in an overcrowded train compartment? (*Der Spiegel*, 1 December 2017)

Hence, the 'refugee' is presented as the saviour of the elderly, because he offers them good, empathetic care despite understaffed care homes. This narrative already reveals the main image of the media discourse: 'refugees' are not only additional workers, but they are also ideal workers with superior moral values.

In the online newspaper *tz* (1 September 2016), integration projects in the field of elderly care are interpreted as a 'win-win situation' because 'trainees in care work are badly wanted'. Furthermore, the aim of this project is that 'young refugees are integrated into the labour market and particularly into the social life'. Similarly, in the online magazine *NDR Info* (10 March 2016), the managing director of the care congress 'German care day' is cited as stating that 'refugees may contribute to solve the situation of the skilled worker market. I believe that elderly care contributes to

the integration, which is socially really needed'. These examples show that, in the discourse line of a 'win-win scenario', the elderly care sector is constructed as a specific labour market niche suitable for the integration of 'refugees', while 'refugees' are constructed as suitable workers for the elderly care sector. Moreover, the reference to elderly care as 'skilled work' is characteristic of the German context, as vocational training is required for elderly care workers and assistants. Accordingly it is suggested that 'refugees' be integrated into the skilled care market, which is about to collapse due to the care workers' shortage. This echos the finding of Mavelli (2017) that 'the humanitarian government of refugees may not just be about saving some of them while securitizing the rest, but also about "saving" host populations' (ibid.: 832). 'Refugees' can only function as a (partial) solution to the care workers' shortage if they are not deported. Against this background a new policy has been implemented in some German federal states which grants temporary residential permits to 'refugees' who are undertaking vocational training, a policy received very positively in the media. For example in the online magazine *Deutschlandfunk* (4 September 2018), it is argued that this policy 'offers care colleges and employment agencies certainty, that they have not vainly invested money in the training of migrants, because they suddenly are deported'. This statement highlights the function of 'refugees' as a commodity in the care market that has to generate revenue in the long term. Hence, the humanitarian discourse on 'refugees' is inseparably bound up with their labour market potential.

From the micro perspective, the employment of 'refugees' in low-paid or unpaid elderly care jobs is presented as a form of 'refugee aid' by care homes which support the integration of these persons, thus projecting the social position of 'refugees' as persons dependent on the receiving society. This interpretive pattern becomes visible, for example, in the online newspaper *Westerwald Kurier* (13 February 2017), reporting on a local conference on the topic of 'refugees in elderly care'. A director of an elderly care home who is characterized as 'engaged' in 'refugee aid' is quoted as follows: 'When so many refugees entered the country, we asked ourselves what we could do as an elderly care home and quickly found an answer'. The strategy of this employer is to offer long-term internships to 'refugees' to prepare them for their future career, through the opportunity to learn the language and acquire professional skills. In the *Torgauer Zeitung* (8 November 2017), the internship of three participants is interpreted as 'a chance to test themselves'. Due to the care shortage, elderly care homes not only desperately search for skilled care workers; it is even more difficult to find locals who are willing to volunteer in elderly care homes to support the over-burdened skilled workers. However, when the volunteering of

'refugees' is discussed, often only the positive effects for them rather than for the care system itself are mentioned, even though volunteers cover indispensable tasks like feeding the elderly. In this line of interpretation, the care work of 'refugees' is often framed as a phase of practical language learning. These quotes illustrate the 'welfare narrative' that is widespread in the care sector, portrayed as employers of migrants from economically less-privileged countries (see also Anderson 2007), and thus positioned as charitable actors who 'rescue' 'refugees' (Niedrig and Seukwa 2010: 181) by offering them a chance to enter the German employment market. It is de-thematized that volunteers or interns actually work in elderly care homes and cover tasks that benefit employers and the elderly; rather, the interpretation of the situation is that elderly care homes[6] contribute to the 'integration' of 'refugees' by offering them a context in which they can learn the language and gain labour market experience.

Marchetti argues that there is a 'racialization' of the care sector (Marchetti 2015: 137). This can be applied to the case of 'refugees' in elderly care work, because the least favourable positions in elderly care (as measured by the professional hierarchy and income) – which can no longer be placed with local staff – are included in integration projects aimed solely at newly-arrived migrants with few language skills and thus few prospects of finding paid work. The assumed benefits of volunteering, such as gaining insight into the German occupational system and improving language skills, are not relevant to large sections of the local population. Therefore, unpaid positions in care work – which were formerly filled by volunteers who did this work for charitable reasons, or by young men who refused military service (which was obligatory until 2011) – are now offered to 'refugees'. In the case of 'refugees', volunteer positions are interpreted as training positions and their work is not interpreted as a service to the community, but rather as the employers' charitable contribution to the integration of 'refugees' into society. Hence, the interpretation of a 'win-win scenario' resulting from the use of 'refugees' as elderly care workers is based on the reclassification of unpaid positions that have always been a part of the elderly care system – like volunteering and interning – within integration measurements. The actual output of 'refugees' and their economic value in understaffed elderly care homes are not discussed, as 'refugees' are not paid for their work. Thus, as long as they are participants of integration projects, 'refugees' are presented as unproductive members of society who passively receive support for their integration but do not actively contribute to the care system. The recurrent references to the demand for skilled workers suggests that once 'refugees' have passed through this extensive training period they will contribute economically to the care market as skilled workers.

The Assumed Intrinsic Motives of 'Refugees' to 'Help the Elderly'

Against the background of the negative image of elderly care work in Germany, many articles state that elderly care is a career aspiration or even a dream job for those 'refugees' who are introduced in these articles. To support this argument, positive emotions of 'refugees' talking about this job are commonly described. For example, in the *Rhein-Neckar-Zeitung* (20 June 2016), the caption to a photo of a group of apprentices reads: 'They are delighted that they are permitted to learn the profession of elderly care assistants'. In the magazine *Der Schlepper* of the Schleswig-Holstein 'refugee' council (1 December 2016), a group of 'refugees' is introduced whose aim, presented as their 'common new career wish', is to become elderly care assistants. This presentation of 'refugees' as workers who enjoy elderly care can be interpreted as an additional aspect of the welfare narrative and the conceptual pattern of the 'win-win scenario', in that employers offer 'refugees' a chance to work in their desired profession. Accordingly, 'refugees' are constructed as a social group who, unlike the native population of Germany, possess an intrinsic motivation to care for the elderly.

As elaborated above, many articles point out that care providers employ 'refugees' for charitable reasons, which may also cause difficulties for providers. In the *Aachener Zeitung* (7 July 2015), employing a particular 'refugee' as an apprentice is interpreted as a 'risky' strategy because it is uncertain whether this person will obtain a permanent or temporary permit to remain in Germany. Despite having only a temporary residence permit, he was offered by the director of an elderly care home an apprenticeship as a skilled elderly care worker. The director stated: 'I consciously run this risk, because Mister Islam[7] interacts with our residents in an absolutely dignified way'. Hence, the employment of the 'refugee' is legitimized by his exceptional suitability for care work. It is typical of the media discourse that 'refugees' are not only presented as 'normal' workers, who are not that different from local workers, but are idealized, and thus commodified as an especially suitable workforce for the care sector.

Very often the motive of 'refugees' for working in elderly care is referred to as the wish 'to help the elderly'. In *Der Schlepper* (1 December 2016), one young man is quoted as stating 'Today for the first time I have bathed a person. That was a happy feeling for me – to be able to help a bit'. Apart from intrinsic motives, experiences on the flight to Germany are also constructed as motives for working in elderly care. For example, in the *Westerwald Kurier* (13 February 2017) a twenty-five-year-old 'refugee'

is featured who speaks 'with sparkling eyes' about 'his career wish'. He enjoys elderly care work because on his flight he took care of an old lady in Greece and, based on this experience, he knew that he 'wanted to help old people' in Germany. The online magazine *Deutschlandfunk* (1 March 2018) introduces Khadim – a young man from Afghanistan, who has taken a four-month long course in basic care and now works in elderly care for dementia patients. It is stated that he works 'with care and naturalness, as if he had never done anything else before'. He says that during his flight to Germany he lived in different countries but never received any help from the people or their governments. In Germany, he has decided to undertake an apprenticeship in elderly care so that he can give something in return for the help that he has received in that country.

A male 'refugee' is presented similarly in the *Berliner Zeitung* (26 February 2014). Here a young man, currently working as additional care staff, argues that his preference would be to undertake an apprenticeship in elderly care work. He also says that it is more important to him to leave work every day with a good feeling than to earn much money. He explains: 'The people are grateful, that you care for them. That makes me very happy'. As in this example, in many articles it is emphasized how much the elderly enjoy the devoted care they receive from 'refugees', which suggests that the integration of people like him in elderly care is of mutual benefit because the elderly are grateful for the care he gives.

This interpretive pattern can be analysed as a form of positive othering, because solidarity with the elderly does not sufficiently mobilize the local population to work in elderly care. Such positive othering of 'refugees' as devoted elderly care workers negates the discourse on poor working conditions in elderly care, which is usually presented in the media to explain the reluctance of the local population to work in this employment sector. In this sense, 'refugees' are othered from the local population firstly with regard to their intrinsic motivation to care for the elderly, which is in the dominant German discourse perceived as disgusting and dirty work, and secondly with regard to their irrationality in choosing this occupation despite its bad working conditions.

The Essentializing Notion of Culture-Specific Respect for the Elderly

Aside from the intrinsic motivation to 'help the elderly', the discourse on 'refugees' in elderly care work also refers to meaning structures that connect suitability for elderly care work with intersecting categories of

culture, religion or gender. In the *Rhein-Neckar-Zeitung* (20 June 2016), it is explained that more men than women participate in apprenticeships for care assistance because, according to a male participant, 'in the Muslim culture the care of an older person is granted with a lot of social prestige. That is not a typical female occupation there'. In a homogenizing way, it is explained that in the cultures of origin the elderly are respected, which makes elderly care a respectable task. It is argued that in these contexts elderly care is handled within families, which enables 'refugees' to transpose their experience of caring for elderly relatives to the professional care setting in Germany. In this line of discourse, media articles often contain narratives of 'refugees' who report actual previous experiences of caring for a family member, or who envision professional elderly care as a familial task. It is specific to the discourse that journalists rely on direct quotations of either 'refugees' themselves or their local superiors in constructing specific cultural attitudes of 'refugees' towards professional elderly care. In general, media sources (which are rather brief) do not engage with the complex question of whether culture-specific care skills even exist or whether they are exhibited in the care work of migrants in the German care system. The citing of 'refugees' themselves or of local healthcare professionals legitimizes the assumption of culture-specific care skills through the reference to these 'first hand experiences'.

In the magazine *Der Schlepper* of the Schleswig-Holstein 'refugee' council (1 December 2016), a male 'refugee' states that he thinks it is sad that many old people in German elderly care homes are not visited by their relatives. By contrast, many old people in Afghanistan are cared for by their relatives. He states that we should remind ourselves of what our parents have done for us, suggesting that the younger generation is obliged to reciprocate. Similarly, the regional newspaper *Passauer Neue Presse* (11 August 2018) introduces a young man from Afghanistan who claims: 'I really enjoy to help old people … I always imagine that I take care of somebody from my family … I will be old too someday and then I will be happy if someone will help me'. In this article the 'refugee' is presented as irrational because he imagines that he is caring for his relatives when providing commercial care work, and naive because he expects to receive the same kind of care[8] in return when he is old.

In *Der Spiegel* (1 December 2017), it is also explained that a male 'refugee' took care of his grandfather until the latter's death, because 'in his homeland you do not know elderly care homes'. The manager of his unit in the elderly care home is cited as stating that '"refugees" often have exceptionally much empathy, more than Germans'. She explains: 'I believe, many still have different respect for the elderly than us Germans. There it is much more common to take care of each other'. These statements show

a form of positive othering of 'refugees' who are constructed as morally superior because they care for the elderly. By emphasizing that in the contexts of origin there is still a different respect for the elderly, this narrative shows the neocolonial interpretation that people in less privileged countries hold 'natural competencies' (Rerrich 2006: 48–49) for care work, which have vanished in the post-industrialized world.

In the same vein, essentializing care skills is the basis for idealizing 'refugees' as an especially valuable commodity in the care market. In the online newspaper *tz* (1 September 2016), it is argued that 'refugees innately hold an attitude, which is strongly desired in the elderly care centre', namely the assumed culture-specific respect for the elderly. In the online magazine *NDR Info* (10 March 2016), the managing director of the 'German care day' conference, argues, as an expert on the elderly care sector, that 'refugees' 'innately hold the right preconditions for the elderly care occupation. In Afghanistan and Syria care within families is very important'. The assumption that care skills are innate depicts how cultural skills are naturalized in the discourse on 'refugees', which is – according to Friedrich (2011) – the current version of racism against migrants. This narrative of innate cultural care skills allows the suggestion that these skills are so essential to the personality of 'refugee' workers that they will be displayed irrespective of the context, e.g. poor working conditions in elderly care homes (see also the quotation about 'Zia Hayafi', above).

In the online magazine *NDR Info*, the managing director reasons that 'this could be turned into an opportunity for professional elderly care in Germany'. This statement on the chances of commodifying the assumed cultural care skills of 'refugees' may be understood as the employer-led construction of an 'ethnic niche' in the employment market based on the ascription of a specific suitability of ethnic groups for certain professions (Friberg and Midtbøen 2017). Hence, in the discourse on integration projects in elderly care work, 'refugees' are constructed as passive participants who only become productive members of society because managers detect and commodify their specific care skills. 'Refugees' are commodified as ideal elderly care workers with reference to their personal ability to feel compassion for the elders' loneliness and helplessness, as well as their culture-specific respect for older people and reciprocal obligations. This shows that the narrative of cultural suitability draws on the assumption of a value system that subordinates young Muslim men to their elders in the role of sons and grandsons. It is suggested that values of care within families are transmitted to the professional care relation and that care workers provide a family-like care relation. This discourse line echoes the '"familial" idea of care' (Farris and Marchetti 2017: 112) which originates in the unpaid care work of female family

members, commonly referred to as 'the labour of love' (Bock and Duden 1977), and underlies the similar logic in the imaginary of low-paid, but family-like care work of 'refugees', based on respect.

Conclusion

The chapter has discussed the media discourse on the inclusion of 'refugees' in Germany's elderly care system in the context of a severe shortage of care workers. In contrast to the use of migrant workers in private at-home care – which started after the dissolution of the Soviet Union and is a widespread phenomenon within a legal 'grey zone' – elderly care homes occupy a much more public space. Therefore, the inclusion of migrants in this care sector is discussed in the media more openly by different stakeholders, who act in relation to an 'elderly care market'. In the course of commodifying care work in Germany, care providers compete for care consumers. Against the background of the shortage of current care workers, care providers have started to recruit 'refugees' and to promote their care skills to consumers. This discourse on 'refugees' in elderly care work produces and reproduces 'social identities of and relationships between people and groups of people' (Fairclough and Wodak 1997: 258), identities which, despite the value of the people in question as a needed workforce, maintain the social status quo by subordinating 'refugees' to the local population through the mechanism of narrative othering.

In detail, this chapter shows that the use of 'refugees' for elderly care work is legitimized in the discourse on this phenomenon as a charitable welfare strategy on the part of care providers who offer 'refugees', through integration projects, a chance to prepare for entry into the German labour market. This form of othering maintains the status of 'refugees' as receivers of humanitarian aid and as economically unproductive migrants, because their work in elderly care is interpreted as an extensive training phase during which they learn language skills, gain insights into the labour market, and test their suitability for elderly care work before being considered fit to provide skilled care work. However, frequent references to the urgent need for skilled care workers suggest that 'refugees' may 'contribute to the emotional and biological life of the host population' (Mavelli 2017: 832) once they have learnt to independently cover basic care work. Consequently, the humanitarian stance on 'refugees' is connected to their labour market potential, which becomes most apparent in the media and political discourse on granting visas for vocational training. This narrative allows us to respond to two current

problems of the public discourse on German policies: firstly, the legitimacy of accepting 'refugees' from 'Muslim countries', and secondly, the need for additional care workers. 'Refugees' are thus turned into a commodity to fill gaps in the workforce while maintaining the humanitarian rhetoric of 'rescuing' them. In light of Mavelli's findings (2017: 832) it can be concluded that the value of the life of 'refugees' and their ascribed culture is measured in the German discourse by their potential contribution to the receiving population.

At the heart of this discourse are narratives of positive othering that construct the suitability of 'refugees' for care work. An image of a homogeneous 'Muslim culture' is used to argue that 'refugees' are ideal elderly care workers (especially in the area of basic care), due to their 'respect for the elderly' and desire to 'help the elderly'. Even though this notion of young Muslim men seems to diametrically contradict the dominant negative stereotype of this population group as 'dangerous foreign men', both notions rely on the same narrative of a traditionalist patriarchal 'Muslim culture'. In the context of elderly care work, 'refugees' are not constructed as hypersexual adult men. By suggesting that they will care for the elderly as if they were their own family members and hereby calling up an ideal of 'familial' care, a subaltern masculinity is constructed that subordinates them to the elderly in the role of quasi-sons and quasi-grandsons. In the German discourse, patriarchy is understood as the central element of 'Muslim culture', simultaneously causing the subordination of women to men of the same generation as well as the authority of the elderly over these men.

This assumption about the value patterns of young Muslim men allows the perception of them as, at the same time, a threat to women of their own age group and saviours of the elderly, thus stimulating both moral panic and moral praise in relation to these young men. Hence, the care relation is interpreted as a non-sexual, non-gendered relation determined by the respect for and authority of the elder, which provide the core elements of commodifying specific 'Muslim' care skills in the German care market.

In comparison with research on Christian migrant care workers, this study shows that the construction of care skills is not bound to a specific religion, as it never refers to religious beliefs or practices, but rather to the postcolonial assumption of traditional cultures in the sending countries, which enable migrants to enjoy care work that is avoided by the local population due to poor working conditions. Therefore, the current discourse on young Muslim male 'refugees' in elderly care work draws on the same patterns of othering that portray a homogeneous Muslim culture as ancient, irrational and thus inferior to Western or European

culture. This imaginary of ideal Muslim male care workers accepting poor working conditions out of respect for the elderly underlies a logic resembling the imaginary of the female 'labour of love' within families, that was, up to today, perceived as an economically unproductive and therefore irrational but, for these women, emotionally fullfilling task. Hence, labour market integration projects in elderly care work show two different scales of a moral economy (compare the introduction of this volume by Sahraoui): it demands the morality of 'refugees' to care for the elderly in spite of poor working conditions, while it allows their employers to publicly promote their morality in supporting 'refugees'.

Acknowledgements

Caterina Rohde-Abuba holds a PhD in sociology awarded in 2013 by the University of Bielefeld (Germany). Her dissertation focused on the au pair migration of Russian women to Germany and included fieldwork in Germany and Russia. Caterina has worked as a researcher and lecturer at the University of Bielefeld, Bielefeld University of Applied Sciences (Germany) and Rhine-Waal University of Applied Sciences (Germany). Caterina has studied sociology with a focus on European Studies and migration at Otto-Friedrich-University Bamberg (Germany), the University of Riga, the University of Vienna and the University of Bremen (Germany). She is currently an associated researcher at the Centre for German and European Studies, at the University of Bielefeld and St Petersburg State University, and head of research at the NGO World Vision Deutschland e.V. in Berlin. Her research focuses on migration, gender, care work and childhood.

Notes

1. Inverted commas indicate that in the German context 'refugee' is a rather vague and derogatory term within the public discourse (Flüchtlinge/Geflüchtete), which does not conform to the legal definition of asylum seeker or asylum holder, but partly also refers to persons with different immigration statuses.

2. In Germany, health and elderly care workers are trained vocationally for three years. Skilled healthcare workers (nurses) work in hospitals, while skilled elderly care workers work in elderly care homes or outpatient care. Healthcare work offers higher status and better wages, so that the workers' shortage is greater in elderly care work. Skilled health and elderly care workers are assisted by so-called health and elderly care assistants, who are mainly concerned with basic care. Below this position, paid additional care staff and unpaid volunteers and interns are also employed to cover basic care. Integration projects in the elderly care sector normally do not focus on migrants who already hold medical or care qualifications, because these persons usually enter through the regular recognition process of their qualifications into skilled care work; rather, integration projects focus on migrants who have not worked in professional elderly care before. The main aspect of these projects is to place participants in unpaid positions in elderly care homes in the form of volunteering, interning or work shadowing, so that they gain their first experiences in this employment sector.

3. Approximaltely one-third of elderly care receivers are placed in elderly care homes, while the others receive at-home care (Destatis 2015).

4. In 2016 the most important countries of origin were Syria (266,250 applicants, 63.6% male), Afghanistan (127,012 applicants, 68.2% male) and Iraq (96,116 applicants, 61.5% male). The most important age groups of these applicants were 18 to 25 years of age (23.5% of all applicants) and 25 to 30 years of age (14.1% of all applicants). 75.9 % of all applicants are Muslims, 12.2% are Christians and 5.9% are Yazidis (BAMF 2017: 21–25). Concerning labour market participation, 49.8% of male 'refugees' but only 11.5% of female 'refugees' work (Worbs and Bund 2016: 6). This is mainly attributed to the 'traditional role patterns' of the culture of origin (Lange and Ziegler 2017), but it cannot be ignored that in the local population of Germany there is also a gender imbalance in labour market participation resulting from local traditional gender patterns, labour market discrimination against women and inadequate childcare options.

5. 'Flüchtlinge (Geflüchtete) + Pflege' and 'Flüchtlinge (Geflüchtete) + Altenpflege'.

6. It is specific to the German care system that public and private care providers compete equally in the 'care market' and contribute in the same ways to the discourse of using 'refugees' to cover the current care shortage.

7. It is unknown whether this is the real name or a pseudonym.

8. Due to the low wages paid, care workers in Germany will typically be unable to purchase for themselves the same kind of care that they are providing.

References

Amirpur, Donja. 2015. 'Othering-Prozesse an der Schnittstelle von Migration und Behinderung – "Die muslimische Familie" im Fokus', *Zeitschrift Für Inklusion* 3. Accessed on 23 July 2018. https://www.inklusion-online.net/index.php/inklusion-online/article/view/299.

Anderson, Briget. 2007. 'A Very Private Business. Exploring the Demand of Migrant Domestic Workers', *European Journal of Women's Studies* 14(3): 247–64.

Ashcroft, Bill, Gareth Griffiths and Helen Tiffin. 2007. *Post-Colonial Studies: The Key Concepts*, 2nd edn. London: Routledge.

Attia, Iman. 2009. *Die 'westliche Kultur' und ihr Anderes: Zur Dekonstruktion des Orientalismus und antimuslimischen Rassismus*. Bielefeld: Transcript.

――――. 2018. 'Was ist neu und was rechts am antimuslimischen Rassismus extrem rechter Argumentationen?', in Mechtild Gomolla, Ellen Kollender and Marlene Menk (eds), *Rassismus und Rechtsextremismus in Deutschland*. Basel: Weinheim.

BAMF. 2017. Das Bundesamt in Zahlen 2016. Accessed on 15 October 2018. https://www.bamf.de/SharedDocs/Anlagen/DE/Publikationen/Broschueren/bundesamt-in-zahlen-2016.pdf?__blob=publicationFile.

Bhabha, Homi. 1983. 'The Other Question …', *Screen* 24(6): 18–36.

Bock, Gisela and Barbara Duden. 1977. *Arbeit aus Liebe – Liebe als Arbeit: zur Entstehung der Hausarbeit im Kapitalismus*, Frauen und Wissenschaft: Beiträge zur Berliner Sommeruniversität für Frauen, Juli 1976. Berlin: Courage-Verlag.

Destatis. 2015. Pflegestatistik 2015. Accessed on 21 July 2018. https://www.destatis.de/DE/Publikationen/Thematisch/Gesundheit/Pflege/PflegeDeutschlandergebnisse5224001159004.pdf?__blob=publicationFile.

Dietze, Gabriele. 2016. 'Ethnosexismus: Sex-Mob-Narrative um die Kölner Sylvesternacht' *Movements: Journal for Critical Migration and Border Regime Studies* 2(1). Accessed on 26 October 2018. http://movements-journal.org/issues/03.rassismus/10.dietze--ethnosexismus.html.

DISS (Duisburger Institut für Sprach- und Sozialforschung). 2017. 'Von der Willkommenskultur zur Notstandsstimmung: Der Fluchtdiskurs in deutschen Medien 2015 und 2016'. Accessed on 30 March 2018. http://www.diss-duisburg.de/wp-content/uploads/2017/02/DISS-2017-Von-der-Willkommenskultur-zur-Notstandsstimmung.pdf.

Fairclough, Norman, and Ruth Wodak. 1997. 'Critical Discourse Analysis', in T. van Dijk (ed.), *Discourse as Social Interaction*. London: Safe.

Farris, Sara R. and Sabrina Marchetti. 2017. 'From the Commodification to the Corporatization of Care: European Perspectives and Debates', *Social Politics: International Studies in Gender, State & Society* 24(2): 109–131.

Felder, Ekkehard. 2012. 'Linguistische Mediendiskursanalyse: Zur Bestimmung agonaler Zentren in der pragma-semiotischen Textarbeit', in Franciszek Grusca (ed.), *Tagungsakten zur Sektion 53 'Diskurslinguistik im Spannungsfeld von Deskription und Kritik' des Warschauer IVG-Kongresses*. Frankfurt: Peter Lang Verlag.

Foucault, Michel. 1990. *The Use of Pleasure: History of Sexuality*. Vol. 2. New York: Vintage Books.

Frass, Claudia, and Michael Klemm. 2005. 'Diskurse – Medien – Mediendiskurse: Begriffsklärungen und Ausgangsfragen', in Claudia Fraas and Michael Klemm (eds), *Mediendiskurse: Bestandsaufnahme und Perspektiven*. Frankfurt am Main u.a.: Lang (= Bonner Beiträge zur Medienwissenschaft 4).

Friberg, Jon, and Arnfinn Midtbøen. 2017. 'Ethnicity as Skill: Immigrant Employment Hierarchies in Norwegian Low-Wage Labour Markets', *Journal of Ethnic and Migration Studies* 44(9). Retrieved 28 January 2020 from doi: 10.1080/1369183X.2017.1388160.

Friedrich, Sebastian. 2011. 'Rassismus in der Leistungsgesellschaft: Einleitung', in *Rassismus in der Leistungsgesellschaft: Analysen und kritische Perspektiven zu den rassistischen Normalisierungsprozess der 'Sarrazindebatte'*. Münster: Edition assemblage.

Gallo, Ester. 2018. 'Religion, Masculinity, and Transnational Mobility', in Bernardo Brown and Brenda Yeoh (eds), *Asian Migrants and Religious Experience: From Missionary Journeys to Labor Mobility.* Amsterdam: Amsterdam University Press.

Gallo, Ester and Francesca Scrinzi. 2016. *Migration, Masculinities and Reproductive Labour: Men of the Home.* London: Palgrave Macmillan.

Georgi, Viola. 2015. 'Integration, Diversity, Inklusion'. Retrieved 26 October 2018 from www.diezeitschrift.de/22015/einwanderung-01.pdf.

Grillo, Ralph. 2003. 'Cultural Essentialism and Cultural Anxiety', *Anthropological Theory* 3(2): 157–73.

Kilkey, Mayella, Diane Perrons, Ania Plomien, Pierrette Hondagneu-Sotelo and Hernan Ramirez. 2013. *Gender, Migration and Domestic Work: Masculinities, Male Labour and Fathering in the UK and USA.* Basingstoke: Palgrave Macmillan.

Lange, Miguel Montero, and Janine Ziegler. 2017. 'Die Arbeitsmarktintegration geflüchteter Frauen: Zahlen, Fakten und internationale Erfahrungen'. Accessed on 15 October 2018. https://www.netzwerk-iq.de/fileadmin/Redaktion/Bilder/Fachstelle_Einwanderung/FE_WP_FF4_GeflFrauen_2017-04-21_Datei_f%C3%BCr_Druck.pdf.

Lutz, Helma, and Ewa Palenga-Möllenbeck. 2010. 'Care Work Migration in Germany: Semi-Compliance and Complicity', *Social Policy and Society* 9(3): 419–30.

MacKenzie, Robert, and Chris Forde. 2009. 'The Rhetoric of the "Good Worker" versus the Realities of Employers' Use and the Experiences of Migrant Workers', *Work Employment and Society* 23(1): 142–59.

Marchetti, Sabrina. 2015. 'Resentment at the Heart of Europe: Narratives by Afro-Surinamese Postcolonial Migrant Women in the Netherlands', in Sandra Ponzanesi and Gianmaria Colpani (eds), *Postcolonial Transitions in Europe: Context, Practices and Politics*. London: Rowman & Littlefield.

Mavelli, Luca. 2017. 'Governing Populations through the Humanitarian Government of Refugees: Biopolitical Care and Racism in the European Refugee Crisis', *Review of International Studies* 43(5): 809–32. doi:10.1017/S0260210517000110.

Mühe, Marieluise. 2017. 'Rassistische Diskurse im Einwanderungsland Deutschland, Das Aus-handeln von Flucht und Asyl über soziale Medien im lokalen Raum', Working Paper Nr. 15, February 2017, Center for North African and Middle Eastern Politics, Freie Universität Berlin, Berlin, January 2017.

Näre, Lena. 2010. 'Sri Lankan Men Working as Cleaners and Carers: Negotiating Masculinity in Naples', *Men and Masculinities* 13(1): 65–86.

———. 2013a. 'Migrancy, Gender and Social Class in Domestic Labour and Social Care in Italy: An Intersectional Analysis of Demand', *Journal of Ethnic and Migration Studies* 39(4): 601–23.

_____. 2013b. 'Ideal Workers and Suspects: Employers' Politics of Recognition and the Migrant Division of Care Labour in Finland', *Nordic Journal of Migration Research* 3(2): 72–81.

Naumann, Thomas. 2006. 'Feindbild Islam: Historische und theologische Gründe einer europäischen Angst – gegenwärtige Herausforderungen'. Accessed on 23 July 2018. http://www.uni-siegen.de/phil/evantheo/mitarbeiter/naumann/dokumente/feindbild_06_druckfsg.pdf.

Niedrig, Heike, and Louis Henri Seukwa. 2010. 'Die Ordnung des Diskurses in der Flüchtlingskonstruktion: Eine postkoloniale Re-Lektüre', *Diskurs Kindheits- und Jugendforschung* 2: 181–93.

Nökel, Sigrid. 2002. *Die Töchter der Gastarbeiter und der Islam: zur Soziologie alltagsweltlicher Anerkennungspolitiken*; eine Fallstudie. Bielefeld: Transcript.

Oevermann, Ulrich. 1973. 'Zur Analyse der Struktur von sozialen Deutungsmustern'. Accessed on 7 March 2012. http://www.agoh.de/cms/en/downloads/overview/func-startdown/57/.

Rerrich, Maria. 2006. *Die ganze Welt zu Hause: Cosmobile Putzfrauen in privaten Haushalten*. Hamburg: Hamburger Edition.

Said, Edward. 1978. *Orientalism*. London and Henley: Routledge, Kegan Paul.

Sarvasy, Wendy, and Patrizia Longo. 2004. 'The Globalization of Care', *International Feminist Journal of Politics* 6(3): 392–415.

Scheibelhofer, Paul. 2016. 'Konstruktionen von Männlichkeit und Gewalt in Debatten um "Köln": AEP – Informationen', *Feministische Zeitschrift für Politik und Gesellschaft* 2.

Scrinzi, Francesca. 2011. 'Gender, Migration and the Ambiguous Enterprise of Professionalizing Domestic Service: the Case of Vocational Training for the Unemployed in France', *Feminist Review* 98: 153–72.

_____. 2016. 'Latin American Migration, Evangelical Christianity and Gender in Italy', EUI Working Paper RSCAS 2016/41. Accessed on 20 July 2018. http://cadmus.eui.eu/bitstream/handle/1814/42842/RSCAS_2016_41.pdf?sequence=1&isAllowed=y.

Shooman, Yasemin. 2014. '*… weil ihre Kultur so ist': Narrative des antimuslimischen Rassismus*. Bielefeld: Transcript-Verlag.

Spivak, Gayatri Chakravorty. 1985. 'The Rani of Sirmur', *History and Theory* 24(3): 247–72.

Ungerson, Clare. 1997. 'Social Politics and the Commodification of Care', *Social Politics, International Studies in Gender, State & Society* 4(3): 362–81.

_____. 2003. 'Commodified Care Work in European Labour Markets', *European Societies* 5(4): 377–96. doi: 10.1080/1461669032000127651.

Van Dijk, Teun. 2001. 'Critical Discourse Analysis', in Deborah Schiffrin, Deborah Tannen and Heidi E. Hamilton (eds), *The Handbook of Discourse Analysis*. Oxford: Blackwell Publishers.

Vollmer, Bastian, and Serhat Karakayali. 2017. 'The Volatility of the Discourse on Refugees in Germany', *Journal of Immigrant & Refugee Studies* 16(1–2): 118–39.

Watkins, Megan, Christina Ho and Rose Butler. 2017. 'Asian Migration and Education Cultures in the Anglo-Sphere', *Journal of Ethnic and Migration Studies* 43(14): 2283–99.

Worbs, Susanne, and Eva Bund. 2016. 'Qualifikationsstruktur, Arbeitsmarktbeteiligung und Zukunftsorientierung. Kurzanalyse 01.2016', Nuremberg. Accessed on 26 October 2018. https://www.bamf.de/SharedDocs/ Anla-gen/DE/Publikationen/Kurzanalysen/kurzanalyse1_qualifikations-struktur_asylberech-tigte.pdf?__blob=publicationFile.

Part II

Understanding the Grey Zone between Legislation and Admission Practices (Un)Deservingness in Action

Chapter 5

Belonging to Everyone, for the Use of Everyone?

Ethnography of (a) Struggle for Healthcare in Spain

Marta Pérez, Irene Rodríguez-Newey and Nicolas Petel-Rochette

One afternoon in Madrid in May 2018, we met Lucía, a four-months-pregnant young woman who had been unable to see a doctor during her pregnancy. Lucía did not have a residence permit and, because of this, was not entitled to a healthcare card issued by the national public healthcare system (Servicio Nacional de Salud, SNS).

At that time, the Royal Decree-Law 16/2012 (RDL) passed by the government of the Partido Popular (Popular Party) in April 2012 was still in force.[1] From September 2012 to July 2018, this law excluded different groups of people from the SNS: people without a residence permit, EU citizens with precarious status, elderly people with residence permits but with no connection to the Social Security system, and Spaniards living in other countries but spending periods of time in Spain (Pérez 2015). People in these groups either had their healthcare cards deactivated or were simply denied a card altogether.

The 2012 law also specified exceptional circumstances in which people without healthcare cards would be able to receive healthcare – in an emergency, during pregnancy, or as minors, recognized victims of trafficking, or persons under international protection. Nevertheless, Lucía was being denied care because the professionals she encountered maintained that she did not meet the bureaucratic requirements to gain access via these exceptional clauses.

Because the SNS is decentralized in each of the seventeen regions that form the Spanish state, the application of the law produced a myriad of competing norms differing both in rank – ranging from regional laws

to administrative procedures – and in content – some regions explicitly opposing the national law, while the majority focused on regulating the exceptions so as to re-admit people based on concerns about public health, humanitarianism and the management of social exclusion. From 2015 onwards, most regions issued instructions to temporarily re-admit undocumented migrants to Primary Care through bureaucratic procedures that, nevertheless, did not recognize their right to healthcare.[2]

Over time, bureaucracy has become central to mediating and segregating access to care. It has become the greatest barrier and the main instrument in a process of differential inclusion in healthcare (Ávila and Malo 2009; Mezzadra and Neilson 2013; Sahraoui, Introduction in this volume).[3] As a pregnant woman, Lucía had the right to a specific registry code in Madrid's health system. The regional instruction stated that both ID in some form and proof of address in the local census had to be included in the registry at some point, but not necessarily at the moment of being registered; they could be presented later on. When Lucía went to her primary care centre on her own, she was denied access because she could not present proof of address. A few days later, she went back to the centre with a member of a local accompaniment group, and her registration was accomplished so smoothly that one would never have suspected that it could have happened otherwise.

Such discretionary outcomes represent one of the main consequences of the profound change the law has created in the system, by granting differential access to healthcare based on people's working, administrative, family and economic status, and by greatly undermining the previous universalistic logic whereby people had access based on their residence in the country. It legally introduced the notion of the insured and the uninsured into public discourse and health practice, reformulating the old Francoist notion of 'healthcare for workers and their families', under a Europeanist and market-based logic that pushes for an individual-insurance and risk-based model of social (in)security (Maurer 1999; Castel 2007; Figueras and Mackee 2012), as well as bringing charity back as the option for those who are uninsured (Minué and García 2012a).

The RDL was part of a wider range of austerity measures affecting public services in Spain and throughout the European Union (Stuckler and Basu 2013; Legido-Quigley et al. 2013a and 2013b). Its justification connected two intuitively conflicting logics in a unique way: universal healthcare, a centrepiece of the welfare logic in Spain, and the 'rationalization' of public services, a key concept in modern neoliberal European Spain. Universal healthcare had to be 'restricted' in order to uphold it.

Even though the law changed the very meaning of the right to healthcare and its subjects across the board, what became most visible was the exclusion of migrants, who were presented as a danger to the rational use and sustainability of the system.

This idea is related to the fact that Spain has formed, for three decades, the external southern border of Europe (Suárez 2004). After entering the Schengen Area in 1986, the state developed not only restrictive and selective border policies but also social policies that have, over time, built up an agglomeration of internal borders from which healthcare had been spared until 2012.[4] This array of border mechanisms ranges from the increased bureaucracy surrounding access to any public service – the documents needed to regularize and obtain work permits, rent-transfers for housing or family support, unemployment benefits, etc. (Oliver 2013) – to racial profiling by the police in urban centres, and other forms of institutional racism (Brigadas Vecinales de Observación de Derechos Humanos 2011, 2012, 2014). It also involves the construction of foreigners as Others, the proliferation of racial and class segregation in cities (Ávila and García 2015), and the overall difficulty of constructing migrants' legitimacy (Pazos and Devillard 2017).

As we shall see throughout the chapter, the 2012 law situates the right to healthcare at the centre of these policies that generate internal borders. Far removed from a strongly shared consensus around the value and relevance of a national and public healthcare system belonging to everyone, for the use of everyone, the 2012 RDL feeds on the historical fissures and discontinuities that have characterized the three decades of the system's existence, from its welfare-based exclusions and differential inclusions to those resulting from the introduction of market practices within public services.

Studies and analyses focusing on the effects of the 2012 law regarding public health, healthcare efficiency and human rights are numerous and well-documented (Semfyc 2012; FRA 2015). There are also some approaches that present a narrative of the barriers that migrants encounter when seeking to access healthcare, resulting from the tense relationship between welfare and market logics (McKee and Stuckler 2011; Minué et al. 2012b). The key to our analysis, however, is that it is rooted in our observation, participation and discussion with actors and their daily discourses and practices at healthcare centres. In addition, it focuses on exploring how this legal change has contributed to the shift in meaning and practice of the right to healthcare. We have done this work as a result of our activism as members of Yo Sí Sanidad Universal.

Ethnography of (a) Struggle

Yo Sí Sanidad Universal began in Madrid in May 2012 as a political response to the enactment of the RDL, motivated by the belief in the right to health and its inseparable link to universal access to public healthcare, the efficiency of primary healthcare for everybody, the redistribution that occurs in public health systems, and the collective dimension of health. Activists from migrant support networks, healthcare professionals and citizens in general got together to research, invent and share strategies that would guarantee access to the healthcare system for everyone who had been excluded.

One of our strategies was to create local accompaniment groups to go together to health centres in order to gain access to healthcare; another was to mount claims against illegal bills issued for receiving emergency care; a third was to organize workshops for health and admission workers. The political implications of these strategies were discussed rigorously within the collective. We were aware of the need to develop a practice which partly consisted of using the exceptions recognized by the RDL as points of entry into the system. Therefore, the collaborative approach to people and healthcare centres was focused on building mutual support to guarantee access to healthcare on the one hand, and to expand the exceptions so as to universalize them and make the norm(s) inoperable on the ground, on the other (Fernández-Savater 2013).

As part of a wide network of members working inside various branches of the healthcare system, as well as people getting to know its internal functioning from the outside, being participants in Yo Sí Sanidad Universal put us in a privileged position to collect, systematize and analyse data on the functioning of the law. But it also involved us in asking questions about our own practices, as actors who were destabilizing healthcare centres' routines in various ways and to various degrees. Contrary to classic academic ethnography, we, as activists, caused that destabilization on purpose.

When Lucía went back to the primary care centre with an activist companion, this accompaniment explicitly introduced factors that rebalanced the power dynamics of the situation. These included the use of expert knowledge of the relevant norms, and also the fact that, in her companion, there was a witness – and a whiteness – challenging the refusal. However, these 'intangible factors' (Larchanché 2012, quoted in Sahraoui's Introduction) do not play out in the same way in every situation and outcomes are not always positive: it depends on the value agents assign to the various factors. These variations provide clues to

the identification of those factors which mediate access to healthcare in general, and those which mediate access in each specific situation.

The two main practical questions we asked ourselves each time we approached a healthcare centre were: what is being fought for on this occasion? What instruments, arguments and objects are we using in this encounter? These became ethnographic questions because, for our interventions to be effective, we needed to understand all the complexities, contradictions and ambiguities constituting the situations in which we were engaging. Research emerged as a necessity from and for practice, and this has had an impact on the way we collected data and planned our interviews and places of intervention. By situating ourselves in an explicitly involved position, we had to collectively revise and discuss our work continuously, so as to maintain the analytical distance necessary for both our research and our practice.

As a collective, we were able to gather data on the discourses and daily interactions in all sorts of healthcare facilities where health exclusion was taking place (e.g. emergency services, hospitals' ethics committees, primary care admission desks, work meetings, official and informal interviews with workers, etc.). However, as we were guided by the need to understand difficulties of access, as researchers we sacrificed strategies with which to objectify our practice, such as seeking consistency. For example, we did not always continue to collect data in places where difficulties were resolved, nor were we present in all the situations we have taken into account. Also, the fact that we were participants in the collective might have contributed to some of the difficulties – and refusals – we encountered as researchers when dealing with some of the administrative and political branches of the SNS in Madrid.

Lastly, ethical dilemmas have continuously arisen, not only regarding data production and analysis, but also in relation to the privatization of knowledge that has been collectively produced. When faced with these issues, discussions of the tense relations between ethics and anthropology have taken place (Scheper-Hughes 1995 and subsequent discussion), and collectively we have decided on a course of action.

Thus, we have developed an 'ethnography of (a) struggle', a title with a double meaning: firstly, our ethnography focuses on the main day-to-day aspects of a struggle against healthcare exclusion; secondly, it is an ethnography of struggle (*etnografía de batalla*) which partly sacrifices or modifies some of its features – such as systematic exercises of objectivation driven by theoretical problems – in order to prioritize the needs of the struggle. This does not mean that our exercise is one of speculation or ideological analysis. On the contrary, we attempt to elaborate a critique

that, taking the norm as the starting point, reflects not only on our role in the situations we analyse, but also on the analysis itself as an exercise in collective thinking to produce avenues of transformation (Foucault 1997; Butler 2001), connecting us with a tradition of situated (Haraway 1995) and militant research (Malo 2004).

The specific epistemological angle we have adopted is to ask ethnographic questions of the law and the way in which it is put into practice by different actors –namely, professionals working in the healthcare sector, who are not primarily the most precarious people. This is not to say that precarized people are not active in the implementation of the law; rather, we decided to focus on those who most directly influence the way public policies are put into practice on a day-to-day basis.

We have focused on situations 'at the margins': those in which people in precarious situations have to deal with how workers operate public healthcare services, the former being those who experience their closure most acutely. Epistemologically and politically, we agree with the argument that it is at the margins that we can best explore how health and welfare are constructed and how people are governed (Das and Poole 2004; Rancière 2004). It is at the margins that access to healthcare is being fought for daily, and arguments for and against it are put forward. To critically analyse those arguments, we draw on Didier Fassin's concepts of moral economies and moral subjectivities, and their relationship to institutions (Fassin et al. 2015).

An Exploration of the Moral Life of Rights

According to Fassin, moral economies tell us 'how values and affects are produced, circulate, and are appropriated around a given situation that society construes as a problem', understanding this given situation as 'a social fact' (i.e. immigration or asylum) and not as 'a specific group or activity' (i.e. there are no moral economies of 'judges' or of 'justice') (Fassin et al. 2015). These moral economies are grounded in a specific historical and social context, and they define 'a sort of common sense and collective understanding of the problem' for that context (ibid.). In our case, the exploration is twofold as it calls for a critical reflection on the relationship between the moral economies of health and welfare, and the moral economies of migration. In this chapter, we present an exploration of the former in the Spanish context, and we rely on other authors' accounts of how the moral economy of migration in the European Union, and in Spain – which has a complex but traceable line of continuity with

the country's colonial past (Colectivo Ioé 1999) – has historically evolved towards a construction of migration as a problem, which is related not only to security and risk at external borders but to welfare itself (Balibar 2004; Agier 2016).

While moral economies constitute and are constituted by media and political discourses, legislation and public debate, they do not entirely determine what people actually do with respect to the issue at hand. There are also moral subjectivities, which 'reveal the values and affects involved in the ethical issues and dilemmas faced by agents with respect to these problems' (Fassin et al. 2015). Fassin connects the two 'morals' – economies and subjectivities – through institutions such as regional healthcare systems. Institutions have their own constraints on action – related to law, resources and means (e.g. their computer systems) – and are composed of agents who are also influenced by moral economies, as well as by their professional ethos (the idea of what it means to do a good job) and their own ethical actions (how they act to confront a singular ethical dilemma in their daily work).

In sum, moral economies are not ideologies, just as moral subjectivities are not psychological aspects of agents; they are theoretical devices that help us explore how values and affects are embedded in our understanding of particular issues, in how institutions relate to and work with those issues, in how agents act towards those issues, and in how all these relationships are dialectical.[5]

This conceptualization connects our analysis with the field of legal anthropology and sociology (Gilboy 1991; Coutin 2006), and the anthropology of bureaucracy (Stoler 2004; Hull 2012; Gupta 2012). It also brings us to the anthropology of health, which takes into account how the biological and the social frame what is understood as a health problem and, accordingly, how, when and to whom healthcare is going to be provided in each specific context (Fassin 2000; Biehl 2010). These studies have focused on precarious populations constructed as 'others', such as migrants, the poor or the mentally ill, and have introduced the notion of biolegitimacy, that is, political and social recognition based on the person's condition as a suffering body. While the notion is very useful for understanding structural inequalities, it has also been diversely problematized (Fassin et al. 2015; Feldman and Ticktin 2010; Ong 2006; Collier and Lakoff 2007). Following these authors' critical endeavours, we understand biolegitimacy as a notion related to a complex calculus that measures deservingness not only in relation to factors which define a suffering body – illness, race, ethnicity, class, gender, age, or the capacity to construct a 'proper' representation of victimhood – but also

in relation to public discourses and expectations, institutional arrange-ments, work routines, one's alignments and tensions, and each actor's ethical dilemmas within his/her specific context (Ong 2006).

In sum, this conceptual framework helps us to understand how, in a particular healthcare centre, the admission staff work by following a specific and self-made procedure for denying access, adding require-ments which are not written into the norms, such as a specific length of time of residence in the country or registration in the local census, thus producing para-norms. In fact, the production of para-norms through-out work routines and relations between workers and different branches of the Madrid healthcare system has been one of the most puzzling yet consistent phenomena we have encountered in our six years of practice.

Thus, differential inclusion is expanded and generalized without adherence to classic biolegitimacy exceptions, which include pregnant women like Lucía, minors and HIV patients. This is because, as a health-care centre coordinator once told us, we 'have to understand that here, what works is what they [the administrative staff] believe is the norm'. Consequently, to understand what happens in this centre, we cannot accept an interpretation which is only focused on the arbitrariness of agents. Instead, our critical framework helps us to put forward an ethnographic analysis of moral economies, the institution and moral subjectivities, for the purpose of finding consistency and explaining the systematic way in which healthcare exclusion has taken place on the ground, as well as the implications for our understanding of health and welfare.

Over the last six years in Spain, at the heart of this understanding is the debate about who should be included in the system and who should be left at the margins. This debate strongly connects healthcare with migration, while overlooking how the relationship between the margins and the centre has been part of the provision of healthcare from its very beginnings. Historical exclusions and differential inclusions constituted the foundation for the introduction of the 2012 insurance-based way of understanding healthcare within a universal system.

Moral Economies of Health and Welfare in Spain

The Spanish welfare state was developed later than that of most other European countries because of the Franco dictatorship. Often described as weak and not well developed, it was founded in the midst of the crisis of the capitalist Fordist model, when social protections were at risk because of job insecurity, contributing to a concurrent and expanding

movement for individual-based rights in Europe (Castel 2007; Rose 1997). There are, however, two public services that did achieve successful development in Spain, and that have become the two main pillars of the Spanish welfare state: the education and healthcare systems. They were formed out of the tensions and struggles between the surviving institutional elements, moral economies and subjectivities of Franco's regime (Pons 2010), together with the European social-democratic tradition of welfare (Guillén 2006). They were also deeply influenced by the creativity of social movements, and new institutional imaginaries and practices aimed at emancipation: that is, the new pedagogy in education (Lara 2004), community health and primary care (Aguiló 2018).

Over the years, these two institutions have aggregated strong values and affects, becoming crucial components of what it means to be a citizen in Spain and the centre of fundamental struggles for social rights over the last decade.

The institutional framework for healthcare was drafted in the late 1970s, in connection with global movements for universal public, primary and community healthcare which had a very active group of advocates in Spain (Martínez Cía et al. 2018). During the first decade of the SNS, these movements shared a strong common focus on universality, the development of primary healthcare, the territorialization of services and, to a lesser extent, citizens' participation in the system (Aguiló 2018). Some of them also embraced the 1970s critique of welfare that considered it to be a disciplining, normalizing, bureaucratized and exclusionary institution.

However, by the end of the 1980s, there were also trends pairing and advancing the biomedical and the marketization models of healthcare (Irigoyen 2010a and 2010b): the idea and the practice of healthcare as an individual entitlement and responsibility on behalf of patients, on the one hand, and as a highly technical biomedical expertise-based job on behalf of health professionals, on the other. In fact, the emphasis on management and on cost-benefit analysis from an economic point of view has been gaining ground in European public healthcare ever since, and it is at the heart of a 'new public management' policy (Laval and Dardot 2013) that has introduced de-territorialization, co-payments, private-public arrangements and the pro-choice policy into Spanish healthcare (Martínez et al. 2014). Daily practice in healthcare centres gradually left the 'psycho' and the 'social' behind, becoming institutionally unable to systematically cope with inequalities and singularities which needed to be taken into account in order to achieve universality (Aguiló 2018).

Before 2012, the Spanish system had followed a trend towards universality that, nevertheless, preserved a link to the Francoist social security system which prevented it from becoming truly universal (that is, by associating the right to healthcare with residence in the territory). This link worked on three interacting levels: 1) at the discursive level – although it is commonplace to call the public healthcare system 'the Social Security', and the idea that only those who work in the formal sector are contributing to pay for healthcare through their social security payments is very widespread, in fact, the system has been completely tax-funded since 1999; 2) at the normative level, successive laws on migration and social security have regulated the inclusion of precarized groups such as the long-term unemployed and undocumented migrants, and this has effectively made these groups depend on the bureaucracy of social security institutions (INSS), as well as that of the healthcare system, to obtain their healthcare cards; and 3) this bureaucratic level has increasingly gained strength from the shift of healthcare priorities towards management and economic efficiency.

Thus, when the Royal Decree of 2012 came into force, centralizing the approval of all healthcare applications within the INSS, there was already a routine in healthcare centres that distinguished between poor and undocumented people and everyone else, combined with a historical legal fragmentation that regulated universal access, a social belief linked to access to the Social Security, and a growing presence of market practices and subjectivities within the public system.

In fact, since the 2012 law, the Social Security has prioritized its own interpretation of foreigners' national and European laws (as well as its own social security norms) to the detriment of health laws, resulting in its systematic rejection of applications from EU citizens with a precarious status, as well as those of elderly people with residence permits but no work history under the Social Security – even though the health laws give them the right to healthcare and the Spanish courts regularly rule in their favour.[6] This practice has not changed with the new 2018 law. At the same time, at the level of daily work, asking people for residence permits and work status documents at health centres' admission counters are practices that have become widespread to an extent previously unknown.

However, up until 2012, no political party dared to challenge universal access openly, as universality enjoyed a strong sociocultural consensus even though, historically, it had suffered fissures. But from 2012, advocates of the law built upon these fissures, maintaining that the system was still universal while challenging the very core of the notion of universality (Feldman and Ticktin 2010) more explicitly than ever before.

The Question of Belonging in Daily Practice

The spring and autumn of 2013 provided us with the perfect opportunity to address the question of belonging in relation to the daily routines in healthcare centres, and to confront growing hegemonic public discourses about health and welfare with discourses and practices at the grassroots level. During those months, routines in health centres were disrupted by a powerful movement of healthcare professionals uniting against a privatization plan that the Madrid government wanted to introduce: seven hospitals and more than twenty primary healthcare centres were to be managed privately, while their ownership and costs would remain public.[7] The plan met with frontal opposition which was able to connect with citizens and maintain a public presence over many months, leading to massive demonstrations, strikes lasting over a month, occupation of hospital hallways, and campaigns to inform and bring people together under one motto: 'public healthcare belonging to everyone, for [the use of] everyone'. The movement was able to construct a hegemonic discourse around the defence of public healthcare that, nevertheless, overlooked the question of who was included in that 'everyone', at a time when it was specifically being restricted by the 2012 law. In fact, the daily routines continued and, among them, those that refused healthcare to people without healthcare cards and billed those people for emergency care.

> Spring, 2013. We are in the assembly hall of a large hospital in Madrid. The room is full: there are doctors, nurses, porters, administrative workers, cooks, cleaning staff, and people from outside the hospital. They are all there to discuss ways to fight the privatization plan. One of us poses the question of whether the fight against healthcare exclusion could create a possible alliance for the anti-privatization struggle. At that very moment, Amin – a young Bangladeshi man without a residence permit who earns his living by selling roses in the street – is in the hospital's emergency room recovering from emergency heart surgery and his friends are worried about a possible bill. A doctor from the audience responds: the hospital takes care of everybody and no bills are sent. There is huge applause, and we join in.

> However, days later, Amin is discharged without a public prescription for his medication, which amounts to 100€ per month if paid upfront. He has documents to ask for appointments with the cardiologist, but the administrative officer at the desk tells him that she cannot give him the appointments or, if she does, she has to register him as a 'private patient', which will generate bills. After a short discussion, she realizes that there is a way to register Amin without having to record him as a private patient. But she confesses to being afraid of doing so, as the appointments given by administrative staff are now evaluated on an individual basis, and not as part of the work of the whole administrative team, as they used to be. She refers Amin to his primary

healthcare centre in order to obtain the registration. With the support of a local accompaniment group, Amin manages to get the registration, the appointments, and the public prescriptions for the medication. He also manages to cancel the bill for his emergency heart surgery, which arrived some weeks after that day in the hospital's assembly room, and which amounted to more than 8,000€. It turned out that Amin had been registered as a private patient from the very beginning.

Let's examine this vignette in the light of our ethnographic questions mentioned above. As we will see, what is being fought for here is an understanding of and compliance with the norms in general and against the way in which that understanding and compliance have been institutionalized in this specific hospital.

The way in which this institutionalization produces exclusionary effects has to do with several factors: 1) the change from team evaluation to individual evaluation, which shapes the way in which workers think a job is well done and adds to the understanding of the law that they build on in daily practice; 2) what is being evaluated and valued, for example, the chance to issue invoices in the emergency room; 3) what agents believe is their responsibility, whom/what they answer to and to what extent: their own ethical thinking, public expectations, patients, administrative peers, doctors, hospital managers, or billing departments of the hospital; and 4) the instruments and tools they have (or feel they have) available to do what is considered 'a good job': mainly documents and options within the computer system, but also the possibility of referring the patient to another professional or centre.

Thus, the story of Amin is not an isolated one. Although illegal, billing people without residence permits for emergency care has been a systematic practice in all hospitals in Madrid.[8]

These hospitals have not used the special registry for people without residence permits, even though it was technically and legally possible: in the summer of 2015 we learnt that it had been used only seven times in seven months across all the hospitals in Madrid.

The dissemination of information about this registry has been minimal and, added to this, when someone goes to emergency, he/she has to fill out a form with different options for identification and none of those options include this registry. So, a person without a healthcare card does not have a viable option to mark on the document, and the systematic practice is for workers at the desk to register them as 'private patients'. This registration option was designed in 1986 for tourists and/ or residents who did not have public healthcare cards but did have private insurance that would pay the bill generated automatically by the hospital's system. No changes have been made to this form since 2012

even though the situation is entirely different: there are thousands of people without public healthcare cards and without private insurance, but with the right to receive free emergency care.

The evolution of the 'private patient' registry helps us to further explore how the use of this bureaucratic figure is aligned with a key feature of the public discourse about restrictions on access: namely, the discourse on 'healthcare tourism'. Even though there are neither reports nor data to demonstrate the existence of healthcare tourism on the part of poor and precarious people, the idea that this phenomenon really exists has spread among the population. Justifications for refusals and billing practices over and above the law – which include not only actual billing but also the practice of making people sign payment commitments before seeing a doctor – have drawn on arguments relating to the 'crisis' of the healthcare system due to its 'abuse' by 'foreigners', the so-called healthcare tourists. This category has expanded sufficiently to include both well-off, northern European retirees who use the Spanish healthcare system without its being able to charge them for this use through their public or private insurance, and young, precarious Latin American domestic workers surviving in the informal economy (Pérez 2015). And references to this expansion are not only present in the law, but are also widespread in the media, in private meetings and at health centre desks.

Identification of someone as a healthcare tourist obscures other categorizations that could be labelled xenophobic, racist or classist. The term allows for purportedly colour-blind refusals of medical attention that reach a risible level: accompanying sub-Saharan African street vendors, we have heard questions such as: 'How do I know you are not a German healthcare tourist?' When refusals are not direct, use of this category – and its translation into the bureaucratic figure of 'the private patient' – allow for a ready-made response to complicated ethical dilemmas.

Lastly, it also allows responsibility for the inefficacies in managing healthcare payments to be diverted from the public system to the sick poor people who, afraid of being billed, do not dare to ask for emergency care.[9] Such was the case of young Jeanneth Beltrán, a domestic worker in Toledo who, afraid of being billed, did not go to the emergency department until she was seriously sick from an illness that, with proper care, is not life-threatening. She died in the waiting room of the hospital on 23 May 2014 (Yo Sí Sanidad Universal July 2014b). After her death, the hospital sent her family a bill for her visit as a 'private patient'. In fact, 2018 research by economists of health at the Pompeu Fabra University shows that, in the first three years of the 2012 law, there was a 15% increase in the mortality rate of people without a residence permit in Spain: this

amounts to 210 deaths directly caused by the implementation of the law during this period (Juanmarti, López and Vall 2018).

Unpacking Bureaucracy

If bureaucratic practices comprise such a complex array of larger processes, as well as values, affects and sentiments on behalf of actors, a key task for understanding the situations we describe here is to unpack bureaucracy. The category of healthcare tourism influences institutional arrangements, as well as actors' understandings of the norm and their duties; but this is possible because there are other processes that help to materialize this influence into purportedly objective bureaucratic practices, while reinforcing their centrality to daily work.

The bureaucratic compartmentalization of individual tasks and the division of duties among professional statuses and hierarchies both help to assist in the management of daily work, and to objectifying decisions and judgements. As anthropologists, Alameda and Pazos have shown that, for primary healthcare doctors (2009), a key aspect of their perceptions of their work is the gap between their vocational mission and their real daily tasks, which are perceived as overwhelming. Our practice has documented a similar gap in the perceptions of administrative and social workers. Added to these bureaucratic limitations, which are useful to them in dealing with their daily work (which is experienced as outside their control), there is the growing use of individual evaluations, the decline of the team approach that once informed the practice of healthcare, and the increasingly computerized and monitored nature of administrative work at health centres.

These delimitations may go far beyond what the law and historic ethical principles of medicine prescribe, locating bureaucratic practice at the centre of the arguments on access to healthcare. This helps us to understand how a doctor can deny a sick patient care on the grounds that the person's lack of a healthcare card is 'a bureaucratic problem' that the doctor 'can't do anything about'; and how administrative staff can state that it is 'the computer that dictates who has the right'; or how any of them come to refer people to NGOs while – in theory – working within a universal system. These technical delimitations of tasks can, of course, be removed and reformulated through actors' agency: an agency that takes shape depending on factors such as the actors' trajectories, motivations and alignments.

Even if such alignments are sometimes individual, they are also particular to every healthcare centre as a whole: there are tensions and/or

alliances amongst workers around a particular interpretation of the law, as well as historical alignments or dissension around different branches of the system. For example, in June 2018, two people without residence permits went to the same healthcare centre, accompanied by activists from the local group. One of them was registered, but the other was not – and an admissions worker explicitly in favour of exclusion refused to register one, while a worker who was new to the centre registered the other.

On another level, until July 2018, in situations where people were being denied registration, we asked professionals to write an email to a healthcare manager, who authorized registration for all the cases we know about. When the same query was sent to a different managerial branch of the health system, registry was systematically denied. The sending of such emails becomes an exercise in detachment from a specific understanding of the law that prioritizes management principles over clinical ones. It also presents us with the ethical dilemma of reproducing the case-by-case approach, but from a medical perspective.

However, the question of to whom actors must guarantee universal access is never posed entirely on a case-by-case basis. It is considered together with other questions stemming from a complex and contextual constellation of moral economies and subjectivities, as well as institutional arrangements. For professionals to give emergency care without complying with their centre's routines, they need a particular will to construct a different and critical understanding of the law, which differs from bureaucratic inertia, their peers' and managers' expectations, and the public discourses present in daily refusals of care.

This detachment involves using the back door created systematically by the norm, instead of pretending to evaluate each individual case or rejecting all of them. Thus, it disputes the truth enunciated by the law: that people without health cards do not have the right to healthcare. Interestingly, this position would nonetheless be technically compliant with the norm, as the law is enunciated through clauses of exception.

In Amin's story, the administrative worker could be afraid of losing status within the institution, especially if there is an individual evaluation of her work. But there is also a self-assessment going on: if the ordinary procedure is to register undocumented people as private patients, would not use of the specific registry be a way to give rights to people, rights they do not currently have? In the vignette, when confronted, the admissions worker decides to pass on the responsibility to medical actors.

This story helps us to identify a key element of the shift in practice of the right to healthcare: far from being an entitlement, it is within each particular situation that the right is enunciated. The exceptional circumstance of bureaucratic figures mediating this right creates a space

for judgement and deservingness that greatly and systematically moves away from the traditional understanding of what a right is, because even though these judgements are situated, they are far from being completely arbitrary: rather, they are the result of hegemonic moral economies, institutional cultures and the moral subjectivities of the actors involved.

Negotiations surrounding bureaucratic practices, while absent from the media-political rhetoric and high-level laws, constitute, nevertheless, the field of forces where the right to healthcare takes actual form, in a context where the modern condition of precarity is increasingly managed by bureaucracy (Fassin et al. 2015). Despite the central role gained by bureaucracy, when the aggregation of arguments present in each situation is unpacked, the technical-bureaucratic mediation is destabilized as a given, objective and universal construction, and a practical and political discussion on the right to healthcare and its relational character can be initiated.

Towards a Discussion on the Relational Nature of the Right to Health(care)

In outlining some of the factors and processes that form situations in which the right to healthcare is enunciated, our aim has not been to elicit judgements or moral differentiations among actors' approaches towards the ethical dilemmas these situations entail. But neither was it to conclude that the discretion and arbitrariness we have encountered in these situations calls for a (sole) reinforcement of the right to healthcare in a legalistic way. If there is something we have learnt through this research, it is that what is being fought for in each situation of health exclusion is a certain set of relations – between citizens and professionals, among professionals themselves, and between people and professionals, and their institutions.

To base the discussion on the relational nature of the right to healthcare is not, however, to diminish the importance of legal clarification of that entitlement. On the contrary, it is imperative to push for a legal instrument of protection that takes account of the multiple political, cultural, economic, social, moral and institutional conditions that make the exercise of the right possible. It is to acknowledge the collective dimension of the right, which connects the way we understand and practise healthcare with a wider field, that of the right to health as a social construct and practice, in which healthcare plays a part but not the only part. In this approach, we encounter the need to re-think the traditions of communitarian and social health combined, and that of the welfare critique, which

formed the basis of the construction of universal healthcare systems as pieces of larger institutional attempts to implement health for all (Pérez and Salvini 2019).

Through our practice in Madrid we have concluded that the involvement of actors – doctors, administrative staff, social workers, managers and citizens in general – in bureaucratic practice has been the main way of guaranteeing access to healthcare. It is that way today, as the 2018 law has fortified bureaucracy in healthcare centres. From this seemingly simple idea, we derive key components for our ongoing discussion about health as inherently relational: involvement in such practices requires a critical relationship with bureaucratic practice and the divisions it creates. In turn, this critique produces relations among different professional sectors and between professionals and citizens, bringing about a practical reformulation of roles, because the presence of citizens in healthcare centres to negotiate access is one way in which the citizenry penetrates the institutional and moral milieus of healthcare.

Acknowledgements

Marta Pérez is a participant in Yo Sí Sanidad Universal, Adjunct Faculty at Universidad Complutense de Madrid, Anthropology Department, and at Duke University in Madrid, where she teaches a course on mobility, health and healthcare systems. She holds a PhD in social anthropology from the Universidad Autónoma de Madrid, with doctoral research focused on access to healthcare in Spain, and she is engaged in research on practices of health in Southern Europe (research collective Entrar Afuera) and in academic research on the right to health, mobility and borders.

Irene Rodríguez-Newey, participant in Yo Sí Sanidad Universal and nurse, holds a Masters in Public Health from the Escuela Nacional de

Sanidad, and has combined working in Primary Care and Public health services focused on community health and health promotion. She currently works on community health with the Municipality of Madrid and is part of the research collective Entrar Afuera.

Nicolas Petel-Rochette is a participant in Yo Sí Sanidad Universal and a lecturer of didactics and methodology in Madrid. He holds a PhD in History of philosophy from Complutense University (Madrid). His doctoral research was a theoretical and practical exploration of alternatives to the modern link between political charisma, the mechanics of believing, reason and aesthetics.

Notes

1. Real Decreto –ley 16/2012, de 20 de abril, de medidas urgentes para garantizar la sostenibilidad del Sistema Nacional de Salud y mejorar la calidad y seguridad de sus prestaciones, BOE Núm. 98, 24 de abril de 2012. In July 2018, the new PSOE government presented a new law that theoretically restored universal access to healthcare, but which made exclusion worse in various regions. For a critical evaluation of the law see https://yosisanidaduniversal.net/noticias/valoracion-del-real-decreto-ley-7-2018. A report on the application of the law is available at: https://yosisanidaduniversal.net/noticias/informe-de-la-exclusion-sanitaria-tras-el-rdl-7-2018.
2. A list of norms is available at: https://yosisanidaduniversal.net/materiales/exclusion-inss/estado-de-las-normativas-regionales.
3. See reports by Yo Sí Sanidad Universal (Madrid and Spain, www.yosisanidaduniversal.net), JO SÍ Sanitat Universal and PASUCAT (Catalunya, www.http://lapasucat.blogspot.com), ODUSALUD (Comunitat Valenciana, www.http://odusalud.blogspot.com) and Médicos del Mundo España (www.medicosdelmundo.org).
4. As Nina Sahraoui, drawing on qualitative and quantitative publications, notes in the Introduction of this volume, access to healthcare for undocumented persons is deemed more acceptable than any other type of welfare benefit.
5. For a figure summing up Fassin's proposal, see page 4 of the Introduction in this volume.
6. See: https://yosisanidaduniversal.net/materiales/exclusion-inss/carta-de-bienvenida-afectadas-por-el-inss and https://mareagranate.org/en/author/marea-granate-sanidad/. However, on 24 April 2019, the Supreme Court ruled in favour of Social Security's interpretation. Since then, at least one court has rule that it is the Ministry of Health, not the Social Security, the branch of the administration that has to decide on these people's right to healthcare.
7. Plan de medidas de garantía de sostenibilidad del sistema sanitario público de la Comunidad de Madrid, available at: http://www.ajs.es/files/noticias/2013/01/Plan_medidas_garantia_sostenibilidad_sistema_sanitario_publico_comunidad_madrid_2013.pdf. The movement stopped the plan in court, and the PP politician responsible for it, Javier Fernández Lasquetty, resigned in January 2014.

8. See note 4.
9. Soledad Torrico died in Valencia on 20 February 2013. She tried to get medical attention several times, but was sent away and threatened with bills (Red Latinas 2015). Alpha Pam died of TB in Mallorca on 21 April 2013, after several refusals and threats in healthcare centres (Echave and González 2014).

References

Agier, Michel. 2016. *Borderlands: Towards an Anthropology of the Cosmopolitan Condition*. Cambridge: Polity.

Aguiló, Elena. 2018. 'La Atención Primaria desde dentro', in Javier Segura del Pozo, *Blog Salud Pública y otras dudas*. Accessed 10 January 2020. https://saludpubli-cayotrasdudas.wordpress.com/2018/06/23/la-atencion-primaria-desde-dentro/.

Alameda, Almudena, and Álvaro Pazos. 2009. 'Investigación cualitativa sobre la conceptualización de la hiperfrecuentación por parte del personal médico de atención primaria', *Revista Española de Salud Pública* 83: 863–75.

Ávila, Débora, and Sergio García. 2015. *Enclaves de riesgo: Gobierno neoliberal, desigualdad y control social*. Madrid: Traficantes de Sueños.

Ávila, Débora and Marta Malo. 2009. 'Manos Invisibles: La lógica neoliberal en lo social', Universidad Nómada, *Trabajo Social Hoy* 59: 137–71. Accessed 10 January 2020. http://www.universidadnomada.net/spip.php?article348.

Balibar, Ettiène. 2004. *We, the People of Europe? Reflections on Transnacional Citizenship*. Princeton and Oxford: Princeton University Press.

Biehl, João. 2010. 'Medication is Me Now: Human Values and Political Life in the Wake of Global AIDS Treatment', in Ilana Feldman and Miriam Ticktin (eds), *In the Name of Humanity. The Government of Threat and Care*. London: Duke University Press.

Brigadas Vecinales de Observación de Derechos Humanos, Reports I, II y III (2010–2011, 2011–2012, 2012–2014). Accessed 10 January 2020. http://brigadasvecinales.org/.

Butler, Judith. 2001. 'What Is Critique? An Essay on Foucault's Virtue', in Instituto Europeo para Políticas Culturales Progresivas. Accessed 10 January 2020. https://eipcp.net/transversal/0806/butler/en.html.

Castel, Robert. 2007. *La inseguridad social: ¿Qué es estar protegido?* Buenos Aires: Manantial.

Colectivo Ioé. 1999. *Inmigrantes, trabajadores, ciudadanos: una visión de las migraciones desde España*. Valencia: Universidad de Valencia, Patronat Sud-Nord.

Collier, Stephen J. and Andrew Lakoff. 2007. 'On Regimes of Living', in Ainha Ong and Stephen J. Collier (eds), *Global Assemblages: Technology, Politics, and Ethics as Anthropological Problem*s. Oxford: Wiley-Blackwell.

Coutin, Susan B. 2006. 'Cultural Logics of Belonging and Movement: Transnationalism, Naturalization, and U.S. Immigration Policy', *American Ethnologists* 30(4): 508–26.

Das, Veena and Deborah Poole (eds). 2004. *Anthropology in the Margins of the State*. Santa Fe: School of American Research Press.

Echave, Pedro and Javier González. 2014. *Muerte accidental de un inmigrante. El caso de Alpha Pam*. Mallorca: QuinDrop.

Fassin, Didier. 2000. 'Entre politiques du vivant et politiques de la vie: Pour une anthropologie de la santé', *Anthropologie et Sociétés*, Special issue 'Terrains d'avenir' 24(1): 95–116.

———. 2001. 'The Biopolitics of Otherness: Undocumented Immigrants and Racial Discrimination in the French Public Debate', *Anthropology Today: Journal of the Royal Anthropological Institute* 17(1): 3–7.

Fassin, Didier et al. 2015. *At the Heart of the State: The Moral World of Institutions*. London: Pluto Press.

Feldman, Ilana and Miriam Ticktin. 2010. *In the Name of Humanity: The Government of Threat and Care*. London: Duke University Press.

Fernández-Savater, Amador. 2013. 'Entrevista a Yo Sí Sanidad Universal', *eldiario.es*, 24 May 2013. Accessed 10 January 2020. https://www.eldiario.es/interferencias/sanidad_publica-Yo_Si_6_135846437.html.

Figueras, Josep and Martin Mackee (eds). 2012. *Health Systems, Health, Wealth and Societal Well-being: Assessing the Case for Investing in Health Systems*. Berkshire: Open University Press.

Foucault, Michel. 1997. 'What Is Critique?', in Sa. Lothringer and L. Hochroth (eds), *The Politics of Truth.* New York: Semiotexte.

FRA (European Union Agency for Fundamental Rights). 2015. 'Cost of Exclusion from Healthcare – The Case of Migrants in an Irregular Situation'. Accessed 10 January 2020. http://fra.europa.eu/en/publication/2015/cost-exclusion-healthcare-case-migrants-irregular-situation.

Gilboy, J.A. 1991. 'Deciding Who Gets In: Decisionmaking by Immigration Inspectors', *Law and Society Review* 25(3): 571–600.

Guillén, Ana Marta. 2006. 'Los sistemas sanitarios públicos europeos y el sistema sanitario público español', *La sanidad pública en España: reflexiones, jornadas, ponencias e intervenciones*: 31–48.

Gupta, Akhil. 2012. *Red Tape: Bureaucracy, Structural Violence, and Poverty in India*. London: Duke University Press.

Haraway, Donna J. 1995. *Ciencia, cyborgs, y mujeres: La invención de la naturaleza*. Madrid: Cátedra.

Hull, Matthew S. 2012. 'Documents and Bureaucracy', *Annual Review of Anthropology* 41: 251–67.

Hunt, Alan. 1994. *Foucault and Law: Towards a Sociology of Law as Governance*. London: Pluto Press.

Irigoyen, Juan. 2010a. 'La reestructuración de la profesión médica', *Política y Sociedad* 48(2): 277– 93.

———. 2010b. 'La metamorfosis de la evaluación', *Salud 2000* 129: 16–19.

Juanmarti, Arnau, Guillem López and Judit Vall. 2018. 'The Deadly Effects of Losing Health Insurance' (CRES-UPF working paper #201804-104), Centre de Recerca en Economia i Salut, Barcelona, Universitat Pompeu Fabra. Accessed 10 January 2020. https://ep00.epimg.net/descargables/2018/04/13/617bc3f9263d9a0dbcf3704f8d75a095.pdf.

Lara, Francisco. 2004. *La escuela como compromiso*. Madrid: Editorial Popular.

Laval, Christian, and Pierre Dardot. 2013. *La nueva razón del mundo: Ensayo sobre la sociedad neoliberal*. Barcelona: Editorial Gedisa.

Legido-Quigley, Helena, Elena Urdaneta, Daniel La Parra, Carles Muntaner, Carlos Álvarez-Dardet, José M. Martín-Moreno and Martin McKee. 2013a. 'Erosion of Universal Health Coverage in Spain', *The Lancet* 382(9909): 1977.

———. 2013b. 'Will Austerity Cuts Dismantle the Spanish Healthcare System?', *British Medical Journal* 2013(346): f2363.

McKee, Martin, and David Stuckler. 2011. 'The Assault on Universalism: How to Destroy the Welfare State', *British Medical Journal* 2011(343): d7973.

Malo, Marta. 2004. *Nociones Comunes: Experiencias y ensayos entre investigación y militancia*. Madrid: Traficantes de Sueños.

Martínez, Ana, Gemma Tarafa, Joan Benach and Montse Vergara. 2014. *Cómo comercian con tu salud: Privatización y mercantilización de la sanidad en Catalunya*. Barcelona: Icaria Editorial.

Martínez, Nieves, Marta Pérez, Julio Heras-Mosteiro, Gonzalo Guitiérrez, José Manuel Díaz and Juan Luis Ruiz-Jiménez. 2018. 'Encuentros y Desencuentros entre Salud Comunitaria y Sistema Sanitario Español', in Blanca Botello, Jara Cubillo, Vicente Gea and Sebastià March (eds), *Informe SESPAS 2018 (Salud comunitaria y administración local). Gaceta Sanitaria* 32(S1): 17–21.

Maurer, Bill. 1999. 'Forget Locke? From Proprietor to Risk-Bearer in New Logics of Finance', *Public Culture* 11(2): 365–85.

Médicos del Mundo. 2014. 'Dos años de reforma sanitaria: más vidas humanas en riesgo'. Accessed 10 January 2020. https://www.medicosdelmundo.org/index.php/mod.biblio/mem.detalle/id.390/relcategoria.4998/relmenu.134.

———. 2015. 'Derribando el muro de la exclusión sanitaria: Dos años de la puesta en marcha del Real Decreto Ley 16/2012 en la Comunidad de Madrid'. Accessed 10 January 2020. https://www.medicosdelmundo.org/index.php/mod.biblio/mem.detalle/id.396/relcategoria.4998/relmenu.134.

Médicos del Mundo et al. 2015. 'Informe REDER. Radiografía de la reforma sanitaria. La universalidad de la exclusión'. Accessed on 10 January 2020. https://www.medicosdelmundo.org/index.php/mod.biblio/mem.detalle/id.405/relcategoria.4998/relmenu.134.

Mezzadra, Sandro, and Brett Neilson. 2013. *Borders as Method, or the Multiplication of Labor*. Durham, NC and London: Duke University Press.

Minué, Sergio and José Francisco García. 2012a. '¿Ciudadanos o asegurados? ¿es importante?', *AMF* 8(8): 422–23.

Minué, Sergio, José Francisco García and Juan José Mercader. 2012b. 'Beginning of the End for Spain's National Health System', *British Medical Journal* 2012(344): e3213.

Oliver , Pedro (ed.) 2013. *Burorrepresión, sanción administrativa y control social*. Albacete: Editorial Bomarzo.

Ong, Ainha. 2006. *Neoliberalism as Exception: Mutations in Citizenship and Sovereignty*. New York: Duke University Press.

Pazos, Álvaro, and Mari José Devillard. 2017. 'La construcción cotidiana de la legitimidad del sujeto inmigrante en el contexto español actual', *Alteridades* 27(53): 73–82.

Pérez, Marta. 2015. 'Exclusión y segregación sanitarias y sus agenciamientos: el aseguramiento como modelo y la salud como vínculo', *Revista de Documentación Social* 179: 63–88.

Pérez, Marta, and Francesco Salvini. 2019 (in print). 'Entering Outside in the Crisis of Welfare: on the Possibilities for a Dialogue among Practices of Health and Care in Southern Europe', *Ephemera Journal.*

Pons, Jerònia. 2010. 'El seguro obligatorio de enfermedad y la gestión de las entidades colaboradoras (1942-1963)', *Revista de la historia de la economía y de la empresa* 4: 227–48.

Rancière, Jacques. 2004. '"Who Is the Subject of Human Rights?', *The South Atlantic Quarterly* 103.2(2): 297–310.

Red Latinas. 2015. 'Por Soledad y por Solidaridad', 25 February 2015. Accessed on 10 January 2020. http://redlatinas.blogspot.com.es/2013/02/por-soledad-y-la-solidaridad.html.

Roitman, Janet. 2014. *Anti-Crisis.* Durham, NC: Duke University Press.

Rose, Nikolas. 1997. 'El gobierno en las democracias liberales "avanzadas": del liberalismo al neoliberalismo', *Archipiélago* 29: 25–40.

Scheper-Hughes, Nancy. 1995. 'The Primacy of the Ethical: Proposition for a Militant Anthropology', *Current Anthropology* 36(3): 409–40.

Semfyc (Sociedad Española de Medicina de Familia y Comunitaria). 2012. 'Análisis ético ante la retirada de asistencia sanitaria a inmigrantes sin permiso de residencia: Grupo de trabajo de ética SEMFyC'. Accessed on 10 January 2020. http://aebioetica.org/docrecien/semfyc%20atencion%20inmigrantes.pdf.

Sevilla, Francisco. 2006. 'La universalización de la atención sanitaria: Sistema Nacional de Salud y Seguridad Social', *Fundación Alternativas* Doc. 86/2006. Accessed 10 January 2020. http://www.seg-social.es/prdi00/groups/public/documents/binario/51587.pdf.

Stoler, Ann. 2004. 'Affective States' in David Nugent y Joan Vincent (eds), *A Companion to Anthropology of Politics*, 2006. Malden, MA: Wiley-Blackwell. http://press.princeton.edu/chapters/i7675.pdf.

Stuckler, David, and Sanjay Basu. 2013. *The Body Economic: Why Austerity Kills*. London: Basic Books.

Suárez, Liliana. 2004. *Rebordering the Mediterranean: Boundaries and Citizenship in Southern Spain.* Oxford and New York: Berghahn Books.

Yo Sí Sanidad Universal and Somamfyc. 30 September 2014. 'Informe REDES'. Accessed 10 January 2020. https://yosisanidaduniversal.net/media/pages/materiales/informes/3778483872-1576313745/informe-redes.pdf.

――――. July 2014a. 'Informe de irregularidades detectadas en la aplicación de las instrucciones sobre la asistencia sanitaria a prestar por el Servicio Madrileño de Salud'. https://yosisanidaduniversal.net/media/pages/materiales/informes/2311920133-1576313745/informe-sermas2014.pdf.

――――. July 2014b. '¿Por qué está muerta Jeanneth?', *Periódico Diagonal*, 7 July 2014 and blog *Interferencias* de *eldiario.es*, 9 July 2014.

――――. 1 September 2013. 'Un año de exclusión, un año de desobediencia'. Accessed 10 January 2020. https://yosisanidaduniversal.net/media/pages/materiales/informes/3042604298-1576313745/dossieraniversariordl.pdf.

Chapter 6

Humanitarian Exceptions in Hostile Environments

Institutional Tensions and Everyday Healthcare
Practices for Migrants with Irregular Status in Italy

Roberta Perna

Introduction

'Illegality' has become an increasingly salient juridical status in Europe (De Genova 2002). The CLANDESTINO Project estimated that in 2009 approximately 1.9 to 3.8 million migrants with irregular status (MIS) were to be found in the EU (Vogel 2009). Following a short period at the beginning of 2010 in which this number slightly decreased, Eurostat data then reported an increase of non-EU citizens apprehended due to irregular stays, amounting to a total of 2,154,675 people in 2015 (Eurostat 2018).[1]

The presence of MIS living within state borders represents a puzzling challenge to concepts of national sovereignty and social membership (Bommes and Sciortino 2011: 12), in response to which nation-states have found the most disparate ways to delimit 'the community of legitimate receivers of welfare state benefits' (Geddes 2003: 150). In the field of healthcare, the Migration Policy Index reports that only four EU countries guarantee MIS the same extent of coverage that nationals have (Belgium, France, Luxemburg and the Netherlands), while fifteen other countries limit coverage to 'emergency care' or even less (IOM 2016). Consequently, MIS are often displaced to the margins of healthcare systems, precariously lying at the borders of the realm of social citizenship.

Nevertheless, while governments have the power to define specific migrant categories and their related degrees of eligibility to healthcare, the responsibility of defining who is considered a member of one's moral community is in the hands of street-level workers that are on the

front-line of healthcare systems (Lipsky 1980). Health workers are not passive recipients of policies when it comes to assessing migrants' eligibility to public healthcare. Instead, these actors may advocate for MIS' rights, grounding their claims on different rationales, including human rights (MIS as human beings who are therefore entitled to the human right to health), social justice (MIS as members of a disadvantaged and under-served population) and humanitarianism (MIS as suffering bodies in need of care) (Ambrosini and van der Leun 2015; Hall and Perrin 2015). Even more, they can exploit loopholes deriving from ambivalent policies, adopting and adapting policies to provide healthcare access to those they consider to be deserving of care (Fassin 2012). Therefore, the question of who should receive what kind of care is continuously negotiated and redefined in concrete encounters, making the assessment of deservingness consistently discretionary.

As was extensively discussed by Sahraoui in the Introduction of this volume, the process of constructing deservingness contrasts with the legal stipulation of the right to receive medical care (Huschke 2014). As Willen suggests (2012: 813–14), 'Whereas rights claims are expressed in a formal juridical discourse that presumes universality and equality before the law, deservingness claims are articulated in a vernacular moral register that is situationally specific and often context-dependent. And unlike the juridical discourse of rights, which presumes blindness to individual particularities, moral assessments of deservingness are typically relational'. Therefore, conceptions of deservingness do not come out of the blue. Instead, they are shaped by personal values and commitments, as well as by the political, economic and social contexts in which workers carry out their job and interact with migrants on a daily basis. Surprisingly, little is still known about the ways in which health-related deservingness is enacted and different deserving subjects are constructed through practices. Although previous studies have documented the construction of MIS as undeserving of public health services across different national contexts (Vanthuyne et al. 2013; Larchanché 2012; Willen 2012), the majority of them focus on the discursive construction of deservingness outside of the actual encounters between health workers and migrants.

By presenting an ethnographic case study on practices of healthcare for MIS in Piemonte, a Northern Italian region, this chapter aims to explain the process through which migrants' deservingness is constructed and enacted by focusing on health workers' narratives and practices. It suggests that the interpretations of health workers about migrants' 'illegality' and their professional responsibilities have a central role when it comes to constructing MIS' differential deservingness of healthcare. This meaning-making process structures different patterns of daily practices that are

simultaneously relational and embedded in the wider institutional and discursive landscape health workers operate in.

The Italian Context: Health-Based Exceptions in a Worsening Environment

After almost a century of emigration to continental Europe and America, migration inflows to Italy have been growing since the late 1970s, progressively turning the country into one of the largest immigration destinations in the EU. The demand for a flexible, low-skilled labour force to be employed in low-paid and demanding jobs has been key in creating and maintaining the need for a migrant 'reserve army' (Sassen 1991) to fill spots in irregular occupations, particularly in the agricultural, construction, domestic and care sectors (Fullin and Reyneri 2011).

Responding to this need, Italy's immigration policies have contributed greatly to the production of illegality in the country, rendering migrants' legal access and stay in the country precarious (Triandafyllidou and Ambrosini 2011). Quoting Zincone, Fasani (2009: 16–17) explains that 'the lack of adequate possibilities for legally accessing the Italian labour market – "the policy of closing the front door of legal entry, while keeping the back door of illegal entry half open" (Zincone 1998) – has played a major role in increasing undocumented stocks and flows'. Governments have responded to this by adopting generalized regularizations in order to legalize migrants' status (seven amnesties in twenty-seven years). The systematic resort to this policy tool reveals a 'needed but undeserving'
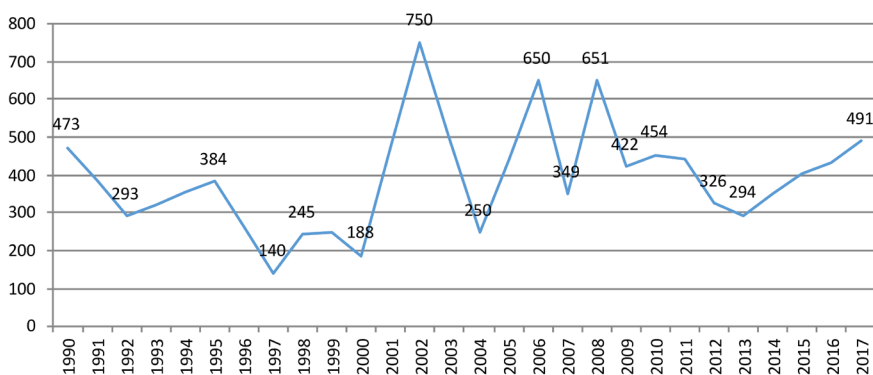

Figure 6.1. Estimates of MIS in Italy – absolute values (x 1,000) – years 1990–2017. *Source*: Years 1990–2013: ISMU database (http://www.ismu.org/ricerca/dati-sulle-migrazioni/); years 2014–2017: Buonomo and Paaparusso 2018.

frame in Italy's migration policy-making: MIS are pragmatically welcomed by Italian employers and implicitly tolerated by policymakers, but are explicitly conceived as undeserving of legal recognition and social protection.

Accordingly, the issue of healthcare access for MIS was neglected in the Italian migration debate throughout the 1970s and 1980s and, except for emergency care, MIS were excluded from the Italian Sistema Sanitario Nazionale (SSN). Addressing this exclusion, during the early 1990s various humanitarian organizations and voluntary associations concerned with migrants' health joined their efforts to promote the adoption of an inclusive framework regulating healthcare access for MIS. This coalition grounded its claims in medical-humanitarian discourses, invoking the ethical and moral imperative to provide care to vulnerable and suffering people in a period characterized by increasing inflows through the Balkan route due to the outbreak of the Yugoslavian wars.

As a result of this mobilization, a provision granting access to healthcare for MIS was included in the text of the 1998 Immigration Law, which still constitutes the legal framework on this issue. Its Health Section stipulates that MIS shall be guaranteed 'urgent and essential care' on a continuous basis, which must be provided free-of-charge to those who lack sufficient economic resources.[2] Public health measures (prophylaxis, diagnosis and treatment of infectious diseases, vaccinations), pregnancy and maternity care, and childcare are explicitly guaranteed to MIS and unconditionally covered by the SSN.

In procedural terms, access to public healthcare is opened through the issue of a 'STP code' (Straniero Temporaneamente Presente – temporary-present foreigner), which consists of an anonymous code that is given to MIS accessing healthcare for the first time. It consists of a renewable code that is valid for six months. Registration can be carried out also if the person has no identity documents, and health workers cannot report MIS to the police when the latter require health treatments.

Health-related issues also play an important role in the country's immigration policies. Accordingly, repatriation may be stopped when MIS are diagnosed with severe pathologies requiring medical treatments that are not available in their counties of origin, and which would have serious consequences on the persons' life if left untreated. Similarly, repatriation is prohibited in the case of pregnant women, who may be granted legal residence permits for maternity reasons during the period of pregnancy and for the first six months after childbirth.

Therefore, health protection for MIS in Italy is indisputable 'on the book', and this healthcare extension appears as an exception in a context

of increasingly restrictive immigration policies, cuts on public health spending, and exponentially negative attitudes towards foreigners.

Since the early 2000s, in fact, Italy's immigration interventions have strengthened their focus on issues of security and control, turning illegal migration into a key issue in political debates and public opinion (for a synthesis, see Zincone 2011). Although these measures –mainly adopted by right-wing governments including the anti-immigration party Lega– did not formally modify articles concerning healthcare for MIS, they introduced several pathogenic elements affecting migrants' health.

Specifically, by tying migrants' stay permit to the duration of their job contract, the new legal framework gives rise to blackmailing and labour exploitation, therefore imposing a precarious lifestyle on migrants that harmfully affects their health status. Similarly, by making the procedures concerning regularization more complex, it favours precariousness, which is a significant risk factor for migrants' health. In addition, in 2009 a provision of the so-called 'Security package' proposed by the Lega aimed to force public health workers to report to the police any migrants with irregular status requiring healthcare. This norm triggered a bottom-up mobilization of humanitarian organizations, professional associations and health workers, named 'Io non denuncio' (I do not report), leading to its withdrawal from the text of law. However, it established an atmosphere of fear and suspicion among MIS and health workers, affecting the accessibility of the healthcare system.

Next to restrictions in migration inflows, exclusionary policies and discourses have linked immigration with increasing shortages in welfare and health services, invoking the need to stop a (alleged) 'medical tourism'. 'In these times of crisis' – stated a MP of the Lega – 'we need to radically modify the Italian policy, which has allowed the entry of millions of not-chosen immigrants, whose protection affects the sustainability of our welfare and healthcare system' (Parliamentary question to the Ministry of Labour and Social Policies, 13 October 2011). This link between migration inflows and health services shortages has become a legitimating key that is used to strengthen controls on the front-line of the system. Accordingly, health workers have been required to toughen their assessment of which MIS are eligible for healthcare under the threat (although never concretely pursued) that they themselves will be responsible for the costs of health services provided to those MIS who should not be enrolled in the system (this information was provided to me on a confidential basis during fieldwork).

In this increasingly hostile environment, anti-immigration discourses and attitudes were fuelled. Migrants have been increasingly depicted

as unwanted, undesirable and undeserving of protection (Valtolina 2016). Racist incidents have been reported in Italy since the early 2010s (Lunaria 2014), and humanitarian organizations participating in search-and-rescue operations in the Mediterranean have been blamed (and even prosecuted) for facilitating sea crossings and smuggling (Fekete 2018). More generally, interventions previously legitimated on solidarity claims have been widely questioned in public and political discourses, creating a tension between a humanitarian logic on the one hand, which argues for caring for vulnerable migrants, and a control-oriented logic on the other, which advocates against illegal migration and (alleged) migrant privileges.

Research Design and Methods

This chapter is based on an ethnographic study that was carried out between April 2015 and February 2016 in the context of a doctoral project investigating the policy-practice gap in the field of healthcare for MIS. The research set out to explain the implementation gap by looking at the inter-relations occurring between the everyday level of practice and the broader institutional and organizational context in which practices take shape.

The focus on Piemonte as a representative region derives from the decentralized governance structure of the Italian SSN, which leaves the responsibility of identifying the most appropriate ways to guarantee access to urgent and essential care for MIS to each region. Although different initiatives have been undertaken in this field (Olivani and Panizzut 2016), the majority of regions, including Piemonte, have created specific public health structures. Specifically, this last region provides healthcare to MIS through public Immigrant Health Clinics (IHC) (a pseudonym), which employ trained administrative workers, intercultural mediators, doctors and nurses who are first in charge of assessing MIS's eligibility to healthcare and, secondly, providing primary care to them.

Among Italian regions, Piemonte is a representative case also in terms of migration dynamics: it is characterized by a growing and 'super-diverse' foreign population. In 1992 it represented 0.8% of the total regional population (1.0% on a national level), 9.6% in 2016 (8.3% at the national level), accounting for 174 foreign nationalities in 2016 (ISTAT 2016). Concerning MIS, no systematic estimates have been conducted on a regional level, but some information can be gathered from data collected by IHC regarding the number of MIS that have required access to primary care since 2000 (Figure 6.2). Accordingly, following a period of continuous increase until 2006, the years 2007–2013 were characterized

by a progressive contraction that was likely due to two factors. The first of these was the accession of Romania and Bulgaria in the EU in 2007, which implied that people from these two countries became EU citizens. The second one was the 2006 and 2009 regularizations, which consistently reduced the numbers of MIS. Since 2014, however, a slight increase in the presence of MIS has been reported in line with the national trend, to a large extent driven by rejected asylum seekers.

During the study, data was collected through document analysis, semi-structured interviews and observation. Documents analysed included national and regional texts on immigration and healthcare policies adopted in the period 1980–2016, and documents adopted by humanitarian organizations, professional and voluntary associations concerned with MIS' health.

Semi-structured interviews were conducted with twenty-three health professionals (doctors, nurses, intercultural mediators) and thirteen administrative workers operating in three IHC. Interviews concerned participants' motivations for and experiences of providing care to MIS, the procedures they adopted in assessing MIS' eligibility to healthcare, and the practices carried out when dealing with complex cases due to migrants' health and/or legal status. Interviews were audiotaped whenever it was considered appropriate to do so and only with prior authorization.
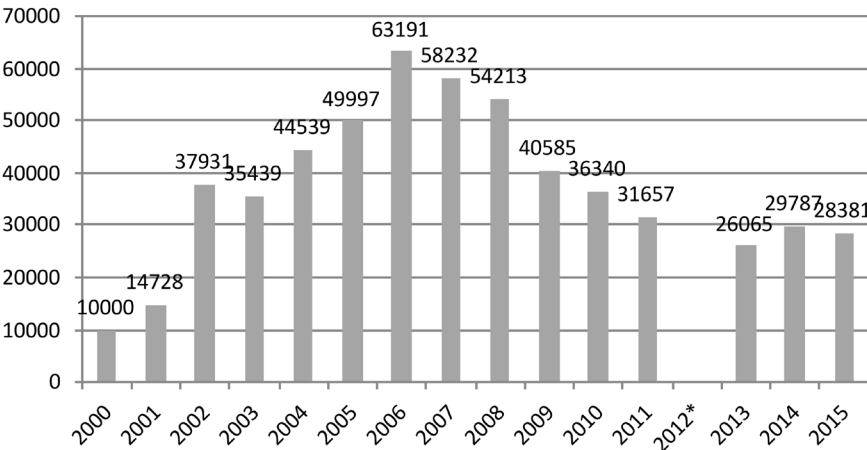

Figure 6.2. Number of MIS requiring access to IHC in Piemonte – absolute values – years 2000–2015.
Source: data collected during the research. *missing data. It should be noted that data gathered by IHC underestimates the presence of MIS, as it considers only those who requested primary care during the year.

Observation was mainly conducted at the clinics' registration desk due to the sensitive nature of the issue under analysis, and therefore it largely involved administrative workers and intercultural mediators. Nevertheless, it became possible to also 'observe' health professionals' narratives and practices, as they took part in the registration procedure (being the ones responsible for assessing the urgent and/or essential nature of the treatment needed by the person) and they often discussed specific cases with administrative workers or their professional peers.

Verbatim interview transcripts and field notes were coded with the support of Atlas.ti, largely relying on a priori concepts for the definition of interpretative and theoretical codes. However, in vivo codes have been integrated in the process, particularly when specific keywords captured the essence of a piece. A unique codebook has been applied across the whole data set to compare and contrast participants' views and practices in relation to common themes and events. To ensure data validity and to uphold the ethical standards of research, findings and conclusions were discussed with academic scholars and research participants.

Social science research is not subject to ethical review in Italian academic institutions. To conduct the study, a letter requesting authorization was sent to clinic managers to explain the aim of the research, timing, techniques that would be used during the study and the ways in which personal data would be treated anonymously. Likewise, health workers involved were informed about the research, its aim and methods. All names and data that could lead to the identification of participants were changed or removed.

This chapter contains some racially-charged interview and field-note excerpts that could hurt the readers' sensitivity. These excerpts have been reproduced to illustrate the processes that lead to the construction of migrants' illegality and deservingness that take shape on a daily basis.

Constructing Migrants' Identity: Victims vs. Agents of Illegality

Over time, the 'STP' category by which access to healthcare for MIS is enabled has included a broad range of individuals and circumstances sharing only a state-imposed status of 'illegality' in the eyes of the SSN. Nowadays, this label is applied to third-country nationals present in Italy on an irregular basis (either because they have entered the country without permission or because they have overstayed their residence permit). Likewise, it is used to provide healthcare to European citizens who have been living in Italy for more than three months but who

cannot apply for residentship because they do not have a formal work contract, and thus cannot apply for mandatory registration with the SSN. Finally, it applies to recently arrived asylum seekers whose application for asylum submission is pending, as well as to rejected asylum seekers who are appealing the initially negative decision of the Asylum Commission.

Against this one-size-fits-all label, health workers developed alternative categories based on their daily interactions in order to manage applications and make sense of their interactions with migrants. In order to create these categories, they mobilized various discursive repertoires that differed not only in the labels used to address migrants, but also in the logics and views underlying these constructions.

Some workers (fifteen out of thirty-six participants) mobilized a medical-humanitarian framework involving professional and humanitarian principles to argue in favour of providing healthcare to MIS. These workers typically referred to MIS as 'vulnerable patients', that is, sick people with precarious status that should be treated unconditionally when in need. As a nurse argued, 'those who come to the IHC are in real pain, they really need to have that treatment or medication. Otherwise, they would not come, I can assure you that. They truly need it'.

Looking at migrants as 'sick or suffering bodies' (Ticktin 2006: 39), the health status of the person was the central concern of these health workers, who insisted on pain and suffering as the legitimating keys to provide healthcare to MIS. As one of the doctors mentioned, 'when I encounter a sick person who needs care, I'll take care of her'. Therefore, medical and humanitarian imperatives were central in these workers' narratives. On the contrary, appeals to the legal provision defined by the 1998 Law granting healthcare access to MIS were rarely mobilized.

This humanitarian framing was grounded in the construction of MIS as 'victims' of Italy's migration policies. Specifically, restrictions in policies regulating the admission and stay of migrants in the country, the absence of regularizations over the last years and the difficulties related to the legal employment of migrants who are already present in the country were identified as the main causes that led to migrants' illegality. Likewise, these factors were interpreted as contributing to the increasing number of 'long-term "integrated" undocumented migrants' (Chauvin and Garcés-Mascareñas 2014: 425). From these workers' perspective, in fact, the category labelling MIS as 'temporary-present foreigners' contrasted with the reality, that is, people who are staying in the country on a continuous and long-term basis in spite of their legal and administrative status.

While these workers presented MIS as victims, in other workers' narratives the stigma of criminality was placed upon them instead. Accordingly, legalistic arguments were mobilized by health workers who were against providing public healthcare to MIS (twenty-one out of thirty-six participants), connecting negative ascriptions to 'foreigners'. In their words, migrants' illegality was a rational choice, voluntarily sought and perpetuated to take advantage of a 'benevolent state' (doctor).

Among this group, some of them (seven out of twenty-one workers) focused on migrants' disregard of the appropriate ways of conduct. By defining them as 'illegal', 'clandestine', 'unwilling to integrate' or even 'violent', these workers traced a cause-effect nexus between migrants' condition of irregularity and their personal behaviours. As MIS entered and/or overstayed in the country without complying with immigration law and procedures, this group of workers believed that MIS are not interested in respecting any of the laws or shared values of Italian society. Consequently, from this group's perspective, once minimum services are provided, no additional care is needed, because 'in the end, we are talking about clandestine people' (doctor). As the person is 'illegal', no further energy, other than what is already used to guarantee public health security, must be wasted on her or him. In the words of a doctor, 'there are people going in and out of prisons so, what are you doing here in Italy? I mean, this is not fair!'

The majority of them (fourteen out of twenty-one workers), however, described MIS as 'fraudsters', who abuse the healthcare system and enjoy public health services 'at the expense of those who actually deserve it' (doctor), implicitly referring to Italian citizens and taxpayers. MIS were frequently represented as people that 'instrumentally move to Italy to receive free-of-charge treatments that either lack or are highly expensive in their country of origin' (administrative worker). What's more, they were often depicted as people who, although having an – illegal/irregular – job in the country, provide false arguments to support their condition of economic indigence, because 'they know that if they claim to be in such condition, they will not pay. And if you can avoid paying, then why should you [pay]?' (doctor). From this perspective, MIS were not seen as part of the community of tax payers to which honest contributors (and these health workers among them) belong. Consequently, according to these workers' point of view, migrants arriving in Italy already affected by (expensive) severe pathologies or pregnant migrant women should not be covered by public resources. From this angle, the eligibility of MIS to healthcare should be limited to basic (and cheap) care only, while access should be denied in case of expensive health treatments.

Demarcating Workers' Responsibility: Healthcare givers vs. Gatekeepers

The role and responsibilities taken on by health workers were directly related to the construction of migrants' illegality. Against what Stivers (1994) describes as a tension between bureaucratic responsibility (towards patients when they engage in professional, ethical and moral actions) and bureaucratic responsiveness (in relation to the state, the policy and the public health organization), it was possible to identify different reactions on the ground. Regardless of their specific professional role, health worker practices were channelled more by 'meanings' – which were related to the narratives used when constructing the identity of migrants – than by 'functions'.

Accordingly, health workers dealing with 'vulnerable patients' interpreted their work in terms of 'healthcare givers', that is, public workers who are individually and professionally committed to caring for someone in need. Their role as doctors, nurses, intercultural mediators or administrative workers in health services was described in terms of their ability to respond adequately to the specific demands of patients. Along these lines, they referred to their profession as 'a service to others' (doctor), as 'providing care in any situation, as our profession is centred on the patient' (nurse). In spite of being in charge of evaluating migrants' eligibility to urgent and essential care, these workers clearly stood up for their responsibility towards migrants' health. In the words of an administrative worker, 'we're not police officers. Of course we must be careful, but it is not our task to scan documents. We are responsible for people's health; we have to meet their health demands'.

Consequently, the worst the health status of the person was, the more actively engaged these workers were in taking care of patients. However, although these workers coherently supported providing MIS with access to healthcare, they often highlighted the complicated nature of their job on a daily basis, describing it as 'a complex controversy' (administrative worker). In ideal terms, they agreed on providing care for truly vulnerable patients, that is, 'helpless irregular migrants' (doctor), 'poor EU devils' (administrative worker) and 'real refugees' (nurse). At the same time, however, they contested abuses of scarce resources by 'freeloaders' (doctor) and 'rich refugees' (nurse). Hence, they evoked a tension between an ideal conception of humanitarian care and its practical implementation on an everyday level, establishing a hierarchy of migrants' deservingness of care based on economic grounds.

Accordingly, these workers' decisions to bend the law were mediated by economic considerations. As it emerged during the fieldwork,

when dealing with a person in need who could not be registered in the STP system, these health workers engaged in discretional practices of 'affordable care', assuming the responsibility of bending the law on an individual basis. These individual practices included providing free samples of basic medicines or antibiotics, or allowing a non-enrollable person to be examined by a doctor. As one of them explained to me:

> We always try to act with prudence. In the immediate moment, we evaluate the person's health status and needs. If that need is urgent, then we usually provide the treatment and issue a code with a very short duration, to have time to come to a [administrative] decision while guaranteeing the person's health. In case the need is not urgent, we do not issue the code but we take our time to study the situation and find the most appropriate solution for the person and the organization too.

However, the more expensive the treatment needed, the less individual discretional decisions could be carried out, and the more likely these health workers would narrow the scope for individual discretion (and responsibility). As a doctor clearly explained:

> At the beginning it was easy. The 1998 Law was really extensive in terms of eligibility and coverage. When someone accessed our centre with no documents, we enrolled that person in the healthcare system almost like we do with Italians. Then, the 2002 reform of the law, the fiscal deficit of the SSN, and now the economic crisis and the contextual arrival of thousands of refugees … Well, because of all these events, we must pay more attention … we have become more restrictive in our daily work.

Likewise, after refusing to register a person and directing the latter to a voluntary health association, a nurse explained that 'There are some aspects of the law that we cannot by-pass, particularly when these involve expensive treatments. In these cases, the only thing we can do is send the person to voluntary associations we know. There are some things that we cannot really do'. Therefore, when dealing with complex and expensive cases, these workers shifted up the responsibility, blaming the law for the decisions they made on a daily basis, often describing themselves as 'mere executants of the law' (doctor). Similarly, they shifted out the responsibility by directing migrants to health providers in charge of secondary and tertiary care or other private health structures operating out of the public SSN, and by trivializing their encounters with MIS, describing these interactions as 'mere moments of administrative registration or of prescriptions of medications' (doctor).

On the contrary, health workers dealing with 'foreigners' acted (and at times described themselves) as 'gatekeepers', protecting the SSN 'from

thieves' (nurse). They stressed their responsibility towards the SSN and public health organizations, which were usually portrayed as being 'in the red' (doctor), as well as to honest citizens and needy taxpayers, who were interpreted as the ones suffering the effects of critical health service shortages.

From these workers' perspective, controls appeared as necessary and even rational against the moral hazard represented by migrants. Consequently, they used their margins for manoeuvre to intentionally hinder migrants' access to healthcare. By asking for additional papers and documents than the ones required by law at the registration desk, or multiplying specific questions about migrants' legal and economic conditions to detect alleged lies, these workers shifted down the responsibility for exclusion to migrants, as the following extract suggests:

> A young man arrived at the registration desk. The intercultural mediator looked at him and, in her usual cold tone, said, 'tell me'. The man, who clearly did not speak Italian well, just said 'STP', pointing his finger at her and showing her a sheet of paper. She went onto the second sentence: 'Documents'. The man handed a card to the worker through the slot in the counter. Without taking it, she immediately replied: 'This is not a document. This is the card of a dormitory. This is not a document. Come back with a document', and then she looked back at the computer. Nevertheless, the man remained at the counter, silent and motionless.

> The intercultural mediator annoyingly looked at him: 'I said that you must come back with a document: a passport, a visa, a real document. That is not a document!'. The man stood still, handing in the same card.

> Worker: 'Again? Really? I told you that that's not a document. I need a document, a document!'

> He did not react and, clearly irritated, she took the card, holding it in a hand while picking up a pen and tapping it on the desk.

> Worker: 'Ok, let's see! So, when were you born?'

> Man: '[19]99'.

> Worker: 'Yes, 99 when?' (the man did not reply). 'So, when were you born?' (rising the tone of her voice).

> Man: '99'.

> Worker: 'Yes, but what day? What month?' (she looked impatiently at the card, then the man, then the card again).

> The man did not reply, shaking his head, as if he did not understand the meaning of that question.

> Worker: 'I want to hear it from you! I must control that you are really you!'

The man looked startled and he did not reply.

Worker: 'Ok then, write down your name!' (she said while handing to him a small sheet of paper and a pen. She then crossed her arms and looked at him smiling smugly). 'I want you to write it!'

The man, exhausted, took the paper and wrote the name. When the worker read it, she burst into a hysterical laugh. The man wrote the name making a mistake, inverting two letters.

Man: 'Ok, I understand. You don't want to help me' (he struggled to say in Italian).

Worker: 'Oh no! I tried to help you, asking you several times when you were born!' (standing up). 'Tell me how old are you?'

Worn out, he started laughing, shaking his head.

Worker: 'How old are you?'

Man: '17' [years old].

Worker: 'Really??? 17?' (she said with an ironic tone). 'If you are 17, you are a minor! So you don't have to come here. Are you a minor?'

Man: 'Yes'.

Worker: 'So you don't have to come here!'

She called the next number, throwing the card back to the man through the slot.

In the same way, by insisting on potential contradictions found in the migrants' stories, these workers legitimated their exclusionary decisions to themselves and their peers. After refusing access to a pregnant Turkish woman who had arrived in Italy recently and held no documents, an administrative worker explained his decision to me:

Obviously, he was not her husband [the woman was accompanied by a man]. He had probably taken some money from her to become the fake foster parent of her children, or something similar. And, of course, she has her documents! But because she knew about the three-month issue, that everything before must be paid for, she said that she had lost her documents. Moreover, they said she is four months pregnant. But, if he lives here, how exactly did she become pregnant? Was it the Holy Spirit? They are sly, aren't they? But if they try to hide the truth, I'll call their bluff! (smiling, satisfied with himself). I know that directives actually state that, even without documents, the STP code should be issued. However, we have decided to ask for documents. You know, it is by hiding documents that they trick the system!

Conflictive encounters between 'gatekeepers' and migrants were also visible in the medical room. Doctors and nurses opposing healthcare for

MIS often asked migrants about their health needs in the hallway of the centre or on the doorway of the medical room, without respecting the migrants' privacy or the principle of professional confidentiality. They often asked to verify identity documents from migrants or refused to grant co-payment exemptions to them. Sometimes, they openly and formally contested the enrolment of a person into the STP system, requiring explanations for that decision from administrative workers. As one of them stated during an interview:

> There are people with diabetes, there are those with hepatitis, and well, treating that does not cost two cents. There are those with HIV, and that is not cheap to treat either! This is really absurd. I mean, if I know that you are not employed and I come to your home and ask you: 'How do you eat? By paying nothing? I mean, you either regularize yourself or you go away!' And maybe we, as doctors, should report them to the police.

Hence, regardless of their formal professional role, these workers took on a different role in their daily jobs. Far from providing care, they acted as immigration gatekeepers and national saviours, assessing MIS' deservingness of healthcare on the basis of the 'moral righteousness' of a person's migratory history.

Un/intended Consequences of Exceptions: Delimiting Deservingness in Policies and Practices

Drawing on her research on the role of humanitarianism and the 'illness clause' in the French politics of immigration, Ticktin convincingly demonstrated the unintended consequences of granting rights on the basis of humanitarian discourses and practices. As she concluded, '[h]umanitarianism is about the exception rather than the rule, about generosity rather than entitlement' (2006: 45).

To a similar extent, health-related exceptions to the systematic exclusion of MIS from citizenship rights in Italy have been the result of a shift in the framing of the issue, from a rights-based perspective to a medical-humanitarian one. Accordingly, the 1998 Immigration Law states that MIS shall be guaranteed access to healthcare, but no reference is made to concepts of rights or entitlements. Therefore, the possibility of accessing health treatments for MIS in Italy is not the result of migrants' 'right to' (healthcare, public resources). Instead, it depends on the recognition of a 'need of' (healthcare, specific protection for particular groups, i.e. women and children) from state actors.

Moreover, the Law guarantees access to healthcare for 'temporary-present foreigners'. Although prima facie this label might appear as less criminalizing than 'illegal migrants' or 'clandestine', it conveys two implicit meanings. First, it depoliticizes migrants' status, to the extent that 'illegality' – as a status produced by law (De Genova 2002) – is hidden, left without perpetrators or causes. Second, it gives rise to the interpretation that a person is not a potential, would-be citizen of the society. Rather, it places the person in a state of transitoriness, as someone who – in that temporary situation –would not require the state's long-term concern. Hence, it renders questions about migrants' participation in the wider society irrelevant or invisible.

Finally, the Law states that MIS can access 'urgent and essential care'. Yet, no lists of urgent and essential treatments exist, meaning that health workers are required to interpret the law, whereas those asking for healthcare depend entirely on the decisions made on the system's front-line. Ultimately, from the perspective of the 1998 Law, MIS are not active agents in the process of defining and enacting social membership and its related rights in the country. Rather, they are subject to the health workers' will to acknowledge them as deserving bodies.

From policies to practices, this study suggests that the ways in which health workers construct migrants' identity and interpret their own roles in their daily encounters with MIS shape migrants' health trajectories. In their encounters with MIS, front-line workers developed different conceptions of their duty and the responsibilities that came with it, assuming the role of 'healthcare givers' or 'gatekeepers', according to the person they had to deal to, i.e. a 'vulnerable patient' or a 'foreigner'. In a healthcare giver-patient relation, health workers acknowledged that they were responsible for the health status of the person, enjoying spaces for inclusive discretion on a health-related basis. On the grounds of a medical-humanitarian conception of healthcare, 'committed providers' (Marrow 2012) conceived migrants as vulnerable subjects to be cared for, failing to acknowledge them as agents entitled to rights. In a patrol-foreigner relation, health workers contended the need to protect the SSN and honest taxpayers from abuses of malevolent health tourists. They adopted discretional practices of exclusion on the basis of moral judge-ments, while neglecting the juridical stipulation guaranteeing access to healthcare for MIS as defined in the text of the law.

Although deriving from state actors' views and commitments, these patterns also reproduce the social divisiveness characterizing the politics of health and migration in the country, which have been increasingly polarized between a medical-humanitarian logic on the one hand, which legitimates the provision of healthcare to vulnerable migrants, and a

control-oriented logic on the other, concerning immigration and health expenditure. These symmetric tensions between the macro-level of policies and the micro-level of everyday practices highlight the undeniable interrelation that exists between individual decisions and the institutional and discursive environment in which they unfold. Connecting the macro and micro levels identified by Sahraoui to define a moral economy of the healthcare-migration nexus (Figure 0.1), this chapter reveals the embedded nature of the process of constructing migrants' deservingness of healthcare.

Moreover, this parallelism points out an additional unintended consequence of health-related exceptions based on humanitarian grounds, that is, their precariousness. Quoting Brauman, Ticktin (2011: 254) argues that 'a confusion between humanitarianism and politics – two fundamentally different orders of activity – can only lead to a mutual weakening of both'. As this case study reveals, as long as humanitarianism has been acknowledged in – and is even part of – the politics of health and immigration, it has legitimated policies and practices aimed at caring for 'human beings crushed by fate' (Fassin 2007: 517). However, when humanitarian claims were increasingly contested, this became the legitimating basis for also contesting providing care not only in political debates but also on a daily, on-the-ground level. In times of perceived economic fragility, increasingly restrictive legislation on immigration and a declining social acceptance of foreigners, the institutionalization of illegality as a threat to the larger society – and to health workers' perceived loss of privileges as citizens – has given rise to the interpretation of migrants as fraudsters, undeserving of public healthcare. Simultaneously, practices based on medical-humanitarian claims have been increasingly contested or even prosecuted both at external and internal borders, including those delimiting the legitimate receivers of healthcare protection.

Conclusions

Studying workers' daily practices in their encounters with MIS on the front-line of the public health system served as a window into the process of constructing migrants' differential deservingness in contrast with formal entitlements and regardless of their juridical status. As this research reveals, it is not only the 'irregular migrant' who experienced discretional barriers. Pending asylum seekers were also excluded from or included into the public healthcare system based on the same discretional judgements. Nor did EU citizenship guarantee access to healthcare. Uninsured EU citizens were subject to the same practices of care

or control, regardless of their juridical status. Ultimately, health workers systematically confronted the legal prescriptions granting access to public healthcare for MIS, de facto re-delimiting the borders of social membership and its related rights through daily practices on the frontline of healthcare systems.

Beyond their materiality, borders are not only sets of rules and procedures. As social constructs, they carry discourses and narratives concerning the meaning of the border itself and the legitimacy of crossing it. Like physical borders, healthcare systems are powerful institutional forces embodying ideas and practices associated with inclusion, exclusion, membership, belonging, entitlement and identity. From this perspective, humanitarianism can make borders permeable (Cuttitta 2015): it may open channels of legal entry and stay in the EU, or it may introduce exceptions within restrictive migration frameworks to take care of vulnerable groups. Yet, humanitarian concerns can make it harder to cross borders: they may legitimate external controls to fight against smugglers and save lives, or they can lead to increasingly restrictive healthcare policies and practices for those who are deemed unworthy of humanitarian care.

Roberta Perna holds a PhD in Political Sociology from the University of Turin. Currently, she is a postdoctoral fellow at the Institute of Public Policies of the Spanish National Research Council (CSIC-IPP, Madrid), where she conducts her research on the welfare-migration nexus, with particular attention on healthcare and the politics of deservingness in contemporary Europe. She was a member of ISCH COST Action IS1103 – 'Adapting European health systems to diversity (ADAPT)', and a research fellow at CSIC-IPP and the Fondazione Luigi Einaudi (Turin). As well as academic research, she collaborates with the Forum of International and European Research on Immigration (FIERI, Turin).

Notes

1. Eurostat only provides data concerning the presence of MIS after juridical and/or police interventions.
2. Urgent care refers to services that cannot be deferred without putting the person's life and health at risk. Essential care includes diagnostic and therapeutic services related to non-dangerous pathologies in the short term, but that could cause greater damage to the person's health over time (e.g. complications, chronic conditions). Continuity of care implies providing patients with a complete therapeutic and rehabilitation cycle.

References

Ambrosini, Maurizio, and Joan van der Leun. 2015. 'Introduction to the Special Issue: Implementing Human Rights: Civil Society and Migration Policies', *Journal of Immigrant & Refugee Studies* 13(2): 103–15. doi: 10.1080/15562948.2015.1017632.

Bommes, Michael, and Giuseppe Sciortino. 2011. *Foggy Social Structures: Irregular Migration, European Labour Markets and the Welfare State*. Amsterdam: Amsterdam University Press.

Buonomo, Alessio, and Angela Paparusso. 2018. 'Irregolari, Sanatorie e Rimpatri: Qualche Numero di Sfondo', *Neodemos* (27 July). Accessed on 2 September 2019. http://www.neodemos.info/articoli/irregolari-sanatorie-e-rimpatri/.

Chauvin, Sébastien, and Blanca Garcés-Mascareñas. 2014. 'Becoming Less Illegal: Deservingness Frames and Undocumented Migrant Incorporation', *Sociology Compass* 8(4): 422–432. DOI: 10.1111/soc4.12145.

Cuttitta, Paolo. 2015. 'Humanitarianism and Migration in the Mediterranean Borderscape: The Italian-North African Border Between Sea Patrols and Integration Measures', in Chiara Brambilla, Jussi Laine, James W. Scott and Gianluca Bocchi (eds), *Borderscaping: Imaginations and Practices of Border Making*. Farnham-Burlington: Ashgate.

De Genova, Nicholas P. 2002. 'Migrant "Illegality" and Deportability in Everyday Life', *Annual Review of Anthropology* 31(1): 419–47. doi: 10.1146/annurev.anthro.31.040402.085432.

Eurostat. 2018. Statistics on Enforcement of Immigration Legislation. Eurostat Statistics Explained. June 2018. Accessed on 26 July 2018. https://ec.europa.eu/eurostat/data/database.

Fasani, Francesco. 2009. *Country Report Italy –Undocumented Migration: Counting the Uncountable. Data and Trends across Europe*, August 2009. Accessed on 2 September 2019. http://irregular-migration.net/typo3_upload/groups/31/4.Background_Information/4.4.Country_Reports/Italy_CountryReport_Clandestino_Nov09_2.pdf.

Fassin, Didier. 2007. 'Humanitarianism as a Politics of Life', *Public Culture* 19(3): 499–520. doi: 10.1215/08992363-2007-007.

⸻. 2012. *Humanitarian Reason: A Moral History of the Present*. Berkeley and Los Angeles, CA: University of California Press.

Fekete, Liz. 2018. 'Migrants, Borders and the Criminalisation of Solidarity in the EU', *Race & Class* 59(4): 65–83. doi: 10.1177/0306396818756793.

Fullin, Giovanna, and Emilio Reyneri. 2011. 'Low Unemployment and Bad Jobs for New Immigrants in Italy', *International Migration* 49(1): 118–47. doi: 10.1111/j.1468-2435.2009.00594.x.

Geddes, Andrew. 2003. 'Migration and the Welfare State in Europe', *The Political Quarterly* 73: 150–62. doi: 10.1111/j.1467-923X.2003.00587.x.

Hall, Mark A., and Jacob Perrin. 2015. 'Irregular Migrant Access to Care: Mapping Public Policy Rationales', *Public Health Ethics* 8(2): 130–38. doi: 10.1093/phe/phv016.

Huschke, Susann. 2014. 'Performing Deservingness: Humanitarian Health Care Provision for Migrants in Germany', *Social Science & Medicine* 120: 352–59. doi: 10.1016/j.socscimed.2014.04.046.

IOM – International Organization for Migration. 2016. *Summary Report on the MIPEX Health Strand & Country Reports*, IOM Migration Research Series no. 52, August 2016. Geneva: International Organization for Migration. Accessed on 2 September 2019. https://publications.iom.int/system/files/mrs_52.pdf.

ISTAT. 2016. Demo.Istat database. Accessed on 7 August 2018. http://demo.istat.it/str2016/index.html.

Larchanché, Stéphanie. 2012.'Intangible Obstacles: Health Implications of Stigmatization, Structural Violence, and Fear among Undocumented Immigrants in France',*Social Science & Medicine* 74(6): 858–63. doi: 10.1016/j.socscimed.2011.08.016.

Lipsky, Michael. 1980. *Street-level Bureaucracy: Dilemmas of the Individual in Public Services*. New York: Russell Sage Foundation.

Lunaria. 2014. *Chronicles of Ordinary Racism: Third White Paper on Racism in Italy*. Rome: Lunaria.

Marrow, Helen B. 2012. 'The Power of Local Autonomy: Expanding Health Care to Unauthorized Immigrants in San Francisco', *Ethnic and Racial Studies* 35(1): 72–87. doi: 10.1080/01419870.2011.594168.

Olivani, Pierfranco and Daniela Panizzut. 2016. *Attuale legislazione sanitaria italiana per gli immigrati irregolari e attuale fruibilità di tale legislazione a livello regionale*. Milan: NAGA.

Sassen, Saskia.1991. *The Global City*. Princeton: Princeton University Press.

Stivers, Camilla. 1994. 'The Listening Bureaucrat: Responsiveness in Public Administration', *Public Administration Review*, 54(4): 364–369. doi: 10.2307/977384.

Ticktin, Miriam. 2006.'Where Ethics and Politics Meet: The Violence of Humanitarianism in France', *American Ethnologist* 33(1): 33–49. doi: 10.1525/ae.2006.33.1.33.

―――. 2011. 'The Gendered Human of Humanitarianism: Medicalising and Politicising Sexual Violence', *Gender & History* 23(2): 250–65. doi: 10.1111/j.1468-0424.2011.01637.x.

Triandafyllidou, Anna, and MaurizioAmbrosini. 2011. 'Irregular Immigration Control in Italy and Greece: Strong Fencing and Weak Gate-Keeping Serving the Labour Market',*European Journal of Migration and Law* 13(3): 251–73. doi: 10.1163/157181611X587847.

Valtolina, Giovanni G. 2016. 'Italian Society and Migration', in Vincenzo Cesareo (ed.), *The Twenty-first Italian Report on Migrations 2015*. Milan: McGraw-Hill Education.

Vanthuyne, Karine, Francesca Meloni, Monica Ruiz-Casares, Cécile Rousseau and Alexandra Ricard-Guayc. 2013. 'Health Workers' Perceptions of Access to Care for Children and Pregnant Women with Precarious Immigration Status: Health as a Right or a Privilege?', *Social Science & Medicine* 93: 78–85. doi: 10.1016/j.socscimed.2013.06.008.

Vogel, Dita. 2009. *Size and Development of Irregular Migration to the EU*. Comparative Policy Brief – CLANDESTINO Research Project, October 2009. Accessed on 2 September 2019. http://clandestino.eliamep.gr/wp-content/uploads/2009/12/clandestino_policy_brief_comparative_size-of-irregular-migration.pdf.

Willen, Sarah S. 2012. 'How is Health-Related "Deservingness" Reckoned? Perspectives from Unauthorized Im/Migrants in Tel Aviv', *Social Science & Medicine* 74(6): 812–21. doi: 10.1016/j.socscimed.2011.06.033.

Zincone, Giovanna. 1998. 'Illegality, Enlightenment and Ambiguity: A Hot Italian Recipe', *South European Society and Politics* 3 (3): 45–82. doi: 10.1080/13608740308539547.

———. 2011. 'The Case of Italy', in Giovanna Zincone, RinuxPenninx and Maren Borkert (eds), *Migration Policymaking in Europe: The Dynamics of Actors and Contexts in Past and Present*. Amsterdam: Amsterdam University Press.

Chapter 7

The Local Construction of Vulnerability

A Comparison between Two Associations in Paris and in Rome

Cecilia Santilli

The notion of 'vulnerability' has become increasingly central when it comes to migrants (Beneduce and Taliani 1999; Gerbier-Aublanc 2017; Musso 2005, 2011; Van Aken 2008). In fact, this notion now represents a fundamental criterion in the selection practices – the triage – of migrants who can hope to have access to rights. It is therefore essential in hierarchizing people's suffering (Nguyen 2009; Willen 2012). Mainly used in the field of emergency medicine and organ transplants (Elster and Herpin 1992), the practice of triage has experienced a strong expansion in recent years following the economic rationalization of social systems (Lachenal, Lefeve and Nguyen 2014). In medicine, triage is 'the operation by which a doctor classifies patients in order of priority' (ibidem: 2). This operation is only apparently simple. Actually, triage in medicine follows two contradictory logics: utilitarianism – taking care of as many patients as possible, and egalitarianism – treating all people equally. Currently, the logic of selection has extended not only to all areas of medicine but also to all contexts of redistribution of limited resources. For example, the order of entry into administrative or associative schemes is a specific form of triage (Elster 1992; Dubois 2012; d'Halluin-Mabillon 2012).

In France and Italy free access to health has been provided to all migrants since the 1990s. This shared political openness relies on health systems based on different principles – equality in France and universalism in Italy – and nowadays clashes with the tightening of migration policies and the economic rationalization of health systems. In fact, the responsibility for newly arrived migrants is increasingly entrusted to

the sphere of associations. Those concerned with the health of migrants receive less and less public funding and have to cope with an increasing number of requests from migrants. With limited economic and human resources, they are forced to select the migrants who are entitled to receive help.

Which moral values and criteria are used by associations in France and Italy in their everyday practice to select those people to whom priority should be given? Who is the most vulnerable migrant?

The present chapter is based on qualitative research conducted within two associations dealing with medical, psychological and social issues of newly arrived migrants applying for a residence permit, in Paris (COMEDE, Comité pour la Santé des Exilés – Healthcare Committee for the Exiled) and Rome (SAMIFO, Centro di Salute per Migranti Forzati – Health Centre for Forced Migrants). The analysis draws on my long-term ethnographic fieldwork (between 2014 and 2016) as an activist/volunteer. In both associations I took on the role of volunteer, helping the staff members in their daily work (Santilli 2017a). My role was not the same in the two associations. In Rome I was a linguistic mediator, translating from French to Italian and vice versa; in Paris my activity dealt more with research, besides which I sometimes helped the reception staff to see patients undergoing the admission procedures. This methodological choice resulted from the difficulty of accessing data in a context of struc-tural violence (d'Halluin-Mabillon 2005; Vidal 1996). Migrants accepted by these associations are involved in difficult situations due to political, economic and psychological problems, so it is necessary to build up a relationship of trust before proceeding with research and interviews. Furthermore, this choice makes it possible to create trust with the mem-bers of the associations and to reduce the conflicts caused by the research itself (Vidal 1996).

In addition to participant observation and in-depth interviews in each of these two associations, I conducted semi-structured interviews with fifteen healthcare providers (nurses, healthcare assistants, sociocultural mediators) and doctors and with twenty migrants – ten in Rome and ten in Paris, from Sub-Saharan Africa, from twenty-eight to thirty-five years of age. Of these, twelve were men and eight were women. The sample of surveyed migrants reflects the proportion of these characteristics in the migrant population visiting the two centres.

Starting with a presentation of the French and Italian health care systems and how migrants access them, in this chapter I will investigate the principles underlying the 'triage' (Nguyen 2009) process used by COMEDE and SAMIFO to identify migrants with urgent needs and enable them to access healthcare. I will demonstrate that local forms

of justice are implemented in every context examined (Elster 1992) and that such forms of justice are determined by the history of national healthcare systems. The paradox I will bring out is that the principles of equality and universalism become in practice criteria of selection and hierarchization of vulnerability based on deservingness (Huschke 2014; Willen 2012; Castaneda 2009).

Political Context: Universalism or Egalitarianism

France and Italy are the only two countries of the European Union that have implemented legal instruments, in 1998 (Dlgs 286/1998; Law No 99-641 of 27 July 1999; Testo Unico Art 34, 35, 36 1998), that guarantee free access to the national health system for all migrants, including irregular ones. Access to the health system is not limited to urgent care but includes the global care of the migrant's health (general medicine, vaccines, screening, prevention, pregnancy etc.) (Santilli 2017b). Despite this similarity, the political openness supported in both countries by the associations' demonstrations in the 1990s is based on different and historically opposite health system models (Esping-Andersen 1990; Palier 2007).[1]

The French health system is based on the Bismarck model: a mixed system (partly financed by public funds and partly by the private sector) in which healthcare costs are charged to health insurance policies funded by social contributions (Esping-Andersen and Palier 2008).[2] In this system the availability of rights is conditional on payment of occupational contributions which depend on salary and income (Palier 2007, 2008). Although this feature places more importance on workers than on the poorer sections of the population, the French system also takes some elements from the Beveridge model, in that it allows a redistribution of national wealth to ensure social protection even for people with low incomes (Cattacin and Chimienti 2009; Chabanet 2012; Palier 2009).

The Italian health system, established in 1978, is based on the Beveridge model: it is a universal system of social protection that guarantees access to treatment to all Italian citizens regardless of income.[3] It is funded by the public sector and taxes. The French system is thus based on the coexistence of an egalitarian approach and a selective logic, whereas the Italian system is based on a universal logic (Cattacin and Chimienti 2009; Santilli 2017a).

These basic differences have led to the implementation of different devices to allow access by migrants in the two countries, but they have also created specific problems relating to the actual access to healthcare

within each national system. In Italy, free access to the national health-care system (emergency care and prevention) is guaranteed by the Consolidation Act on Immigration of 1998 (Testo Unico 1998). This Act states that all migrants living in a precarious economic situation are enti-tled to urgent treatment, complete medical care and even tests, all free of charge. Care and monitoring of pregnancy, care of children, vaccines, prevention, management and detection of infectious diseases are also free. This universalism creates implementation problems due to the fed-eralism of the healthcare system that was put into operation in 2001. The Italian health system is managed at the regional level, and every migrant must be registered in his declared region of residence when applying to any regional medical centre or hospital (Bowling and Ferguson 2001). The Consolidation Act on Immigration is legally applied in all regions, but the way in which healthcare for migrants is organized varies from one region to another (Geraci 2006, 2014). In some regions, the law is not applied efficiently and the care of migrants is entrusted to asso-ciations by local institutions, whereas in others the national healthcare system is involved. In the Rome area healthcare institutions and asso-ciations collaborate. The main limitation of this system is therefore that migrants access health differently depending on regional administra-tions. In France, free access to healthcare services for irregular migrants is determined by the Law No. 99-641 of 27 July 1999, which has been at the heart of political debate and subject to reconsideration by govern-ments. Irregular migrants are entitled to AME (Aide médicale d'Etat – State Medical Aid), whereas those holding a residence permit, even a temporary one, are entitled to CMU (Couverture Médicale Universelle – Universal Health Insurance Coverage) and CMU-C (Couverture Médicale Universelle Complémentaire – Complementary Universal Health Insurance Coverage). These instruments are fully funded by the state. The migrant must prove that he has stayed in France for over three months, has a place of residence, and is within the reception system: filling in the application for AME and CMU requires the help of an expert. Waiting times to obtain the insurance coverage may vary from five to nine months (COMEDE 2015) and during that period migrants do not have the right of access to free medical treatment. Generally, humanitarian associations take care of the health of these individuals in the specified period (Carde 2009; Hoyez 2011). The problem in France is that the growing insecurity of the types of residence permits, which are increasingly short-term throughout the EU, and the complexity of the system of access to treatment, make it more difficult for migrants to access their rights (Carde 2009; Cognet et al. 2009; Fassin 1999; Maille and Veïsse 2000).

The increase in migratory flows in recent years,[4] the ever more restrictive migration policies and the economic rationalization of health systems are undermining these systems (Santilli 2018). In France as well as in Italy, public spending on the health of migrants is called into question primarily by the right and far-right political forces. The care of irregular migrants is increasingly entrusted to the associations. This sector is also undergoing the economic rationalization begun in the 2000s and intensified with the austerity policies stemming from the economic crisis of 2008. The associations dealing with migrants' social and health issues are therefore in a paradoxical situation: on the one hand they must guarantee universalism and egalitarianism of health systems in economic difficulty; on the other they lack the economic and human resources to do it thoroughly.

Local Context

The ethnographic data analysed in this chapter was collected within the COMEDE (Healthcare Committee for the Exiled) in Paris and the SAMIFO (Health Centre for Forced Migrants) in Rome, two associations dealing with the medical, psychological and social issues of irregular migrants applying for a residence permit. These two associations operate in two regions, Ile de France and Lazio, both having a high rate of migrant populations and a significant number of associations that offer support to migrants (Baglio and Fortino 2015; Hoyez 2011). In Ile de France the associations dealing with migrants are historically linked to the humanitarian sphere, whereas in Lazio they are mainly charitable and Catholic associations (Hoyez 2011; Muehlebach 2012; Santilli 2017a).

The COMEDE was founded in 1979 by some members of Amnesty, Cimade and Gas (French associations providing legal support to foreigners and assisting them in accessing their rights) and some Latin American doctors belonging to a humanitarian association with a strong activist background. After a professionalization process, the COMEDE is now one of the historical centres of the region and a reference point at the regional and national level (d'Halluin-Mabillon and Hoyez 2012; Fassin 1998). The association no longer claims to be humanitarian and militant but rather a highly professionalized solidarity organization. The services it offers are: general medicine, infirmary care, psychological treatment, and social and legal assistance.

The SAMIFO was established in 2006 as a result of collaboration between the Jesuit Refugee Service association and the ASL (local unit of public health facilities) of Rome. It is now a health centre for migrants,

independent and recognized by the state as providing public utility services, and composed of employees of the public hospital, members of the Jesuit Refugee Service association and volunteers. The services it offers are: general medicine, psychiatry, psychology, gynaecology, infectiology, social assistance and interpreting.

In addition to these activities, both associations are dedicated to research and lobbying activities. In recent years the number of migrants asking to be accepted has increased for both associations due to the increase in migratory flows and the ever more restrictive migration policies. At the same time, following the economic crisis of 2008, there has been a reduction in public funding. Unable to hire staff, the COMEDE and the SAMIFO are forced to work under increasing pressure and to select their users (Santilli 2017a). Below I will show how members of associations hierarchize priorities and actually build the local principles of justice – that is, the process of constructing deservingness.

The Double Selection Process at the COMEDE

Unfortunately, if requests for assistance due to increasingly stressful situations are constantly growing, the means of response at the Health Centre are the same, or are even declining (COMEDE 2014: 5).

The reception of migrants at the COMEDE is done by appointment. The migrant who arrives there for the first time has two possible courses of action: he can call and ask for an appointment with a professional or go directly to the reception desk. If he calls, the receptionist will ask him general questions about his health and social problems. This allows the association to evaluate the situation and decide whether to have the migrant come to the COMEDE or to direct him to external centres. If the situation of the migrant is assessed as a priority, the operator will make an appointment with a COMEDE nurse who will examine him to ascertain his health problems.

When a migrant goes directly to the COMEDE and asks to speak with a doctor, the reception staff asks whether he is already a COMEDE patient or whether he has an appointment. If he is a new patient without an appointment, one of the receptionists gives him a numbered ticket indicating his turn.

Every day, the COMEDE accepts about fifteen new migrants. The reception staff, coping with the daily influx of people seeking healthcare or support from the COMEDE, must assess whether or not the new migrants can be assisted in the centre. This assessment is based on a series of questions and some criteria that determine the degree of

vulnerability. These criteria, which have been discussed and shared by the entire association team since 2000, include: food (in the last few days have you had enough to eat?); insufficient oral competence in French or English; accommodation conditions (difficulty or problems with housing); relational isolation (no-one to rely on or to share emotions with); social isolation (does the person need to be accompanied in his or her activities?); health protection (neither CMU-C nor AME); residency permit; and financial resources. These criteria are required to objectify the migrant's situation and 'to make the assessment less tough', as one of the reception professionals told me. He added: 'without these criteria it is as if our subjectivity were not filtered. These criteria are a guideline to help us understand'.

Another aspect considered fundamental in assessing the migrant's vulnerability is the presence of a chronic disease or health problem. Particular attention is given to women, especially if they are pregnant. However, as one of the receptionists told me, the issue of disease is problematic: 'The disease is a criterion of vulnerability, but I am not a doctor and I do not ask this sort of questions. I have no information about the state of health and if the person talks about his health condition, I tell him that he can discuss this matter later with the nurse' (Lucille).

As Lucille says, nurses above all are the people who evaluate the 'health vulnerability' of the migrants who arrive at the COMEDE. Serious friction is experienced and felt by the reception staff when choices must be made. Questions such as 'How many factors of vulnerability must accumulate to consider one person more important than others?' (COMEDE 2014: 6) are recurrent and the selection of migrants often leaves the staff in a state of frustration. The hardship experienced can also be linked to the lack of resources: 'The number of patients that we can report is limited; sometimes we send away people who need aid' (Maxime, receptionist).

There is also friction surrounding the power relationships that exist in the association. Reception professionals sometimes have the feeling that the specific difficulties of their role are not recognized by other professionals:

> Working at the reception requires skills and experience; you have to listen and often make choices. People who are not accepted are directed towards other solutions, so you need to know all the services, the associations, the problems of the patients. Many people are convinced that it's an easy kind of work, but the reception is the first place where patients go and where it is decided who can be accepted and who has to go elsewhere. (Aline, volunteer)

The first phase of reception is therefore based on the skills of professionals, skills that Aline defines as determined by experience. As she says,

these skills – on which is based the initial selection of those who will be accepted by the association and those who won't – are not recognized as real skills by other professionals. According to Aline, nurses, doctors and social workers do not see the violence that this first phase hides, both for the reception staff and for the migrants.

After the Reception Phase

People who have passed the initial reception phase are then received by a nurse. Depending on his/her state of health, the migrant will or will not be included in the list of patients to be seen on site that day. In fact, it is recalled that doctors reserve some vacancies every day for new visiting migrants. The nurse receives an average of nine people in the morning and six or seven in the afternoon. When dealing with newcomers, the nurse's role is to evaluate those who must be referred to the doctors of the COMEDE. In addition to the eight criteria applied at reception, the nurse has to assess the person's state of health by performing the first medical examination. Previously, it was the job of the nursing service, and not the reception service, to carry out the complete assessment of the person's social and health status, and to make the 'selection' – the term used by one of the nurses. Today the selection process is divided into two parts. The first part is carried out by the reception staff through an evaluation of the global and general situation of the migrant. The second part is carried out by the nursing service through a detailed evaluation of the person's health status (access to public health system and presence of disease):

> This service plays a central role because here we make the most important selection: we assess the health state of people as well as asking questions about CMU, AME and precarious situations. People without access to care, who live in precarious conditions and suffer from chronic diseases have priority. Here, we witness a variety of situations that doctors do not see because many people are being addressed elsewhere. That's why there are so many diseased migrants here. (Bernard, nurse)

Bernard emphasizes the importance of the nursing service in the selection of patients who will be accepted by the COMEDE and argues that patients with chronic illnesses are considered to have priority in this process. He also emphasizes that with this selection process, doctors have a limited view of the patients who arrive because they eventually see only the 'most vulnerable'. This leads to the situation in which the COMEDE is a place where people living in situations of economic, social and health insecurity are the majority.

Unlike the COMEDE, where this double selection has been carried out to guarantee equality of access to the association as well as high quality assistance, professionals of the SAMIFO make greater use of the principle of universalism, based on arrival times: a criterion by which everyone can be accepted. Given the lack of time – a phenomenon that I analyse in the next section – this principle is mitigated by issues of legal status and efficiency.

How the Principles of Order of Arrival and Administrative Status Are Used to Determine Entrance to the SAMIFO

At nine o'clock in the morning when I arrived at the SAMIFO, I always found more than thirty patients waiting to see the doctor. The migrants, those arriving for the first time as well as those already known to the SAMIFO, draw a ticket from a ticket distribution machine. Once they have a ticket they go to the reception where the operator finds their file (medical record) or compiles a new one if they are newcomers. To prepare new dossiers some documents are required: registration with the NHS (National Health System), plus a document stating that the application for asylum or humanitarian permit has been submitted. This implies that only refugees and asylum seekers, such as migrants who use the asylum system or already have a permit, are accepted. Migrants who have never requested one of these residence permits are referred to other treatment centres or are seen by professionals who ask them questions about their condition and their history and explain how to apply for asylum.

The first selection is based on administrative status (Elster 1992), the second on an evaluation of the migrant's history and situation:

> The SAMIFO is a centre for migrants asking for asylum. Sometimes migrants have not applied for asylum, but they could fall into this category without knowing it because they are not familiar with the system. So, we talk to them to see if that's the case. Most of them decide to start this process. Our role is to tell them what to do and have them come back here. (Carlo, social worker)

As Carlo says, the SAMIFO is a centre for migrants asking for asylum or applying for a residence permit linked to the policies and politics of asylum (that is, a humanitarian permit). This aspect may appear to be inconsistent with the universalist principle of the association and of the Italian National Health System. In reality, the SAMIFO operates within a health system that guarantees free access to healthcare to all migrants, including irregular ones. In Italy the universalist principle is guaranteed

by law. The fact that other organizations or public health centres will take care of migrants who are not admitted by the association is the first argument that members of the SAMIFO use to justify this administrative restriction. The second argument is that, in their opinion, asylum seekers are more vulnerable than other migrant populations.

The order of transit for general medical examinations is the same as the order of arrival, except for medical emergencies. The receptionist calls the patients waiting to enter the doctor's office and asks if they speak Italian. If they don't, a member of the team of interpreters or an operator who speaks the patient's language will accompany him to the doctor. Usually the patient is accompanied by the first available interpreter or operator.

Specialist doctors, by contrast, schedule appointments directly with the patient, without going through reception. A member of the reception staff, composed of sociocultural mediators and volunteers who also carry out administrative work, then simply takes the file from the archives and, as for general medical consultations, accompanies the patient. For consultations in psychology or psychiatry, the patient is generally followed by the same interpreter, chosen among those with more experience. Sometimes general practitioners or social workers ask these doctors to see a patient or to give advice on his treatment.

> **SAMIFO, 22 February 2015.** This morning I accompanied a patient for a check-up with the family doctor. The patient told the doctor that he was there because he had been feeling sick for a week. He was '*hurting everywhere*'. Mario, the doctor, asked him if he had done any exams. Mr Adbu extracted from the documents in his bag the results of the examinations he had done a year before. '*It's all here*' he told me. Among his results, there was the HIV test. It was positive. '*Do you know what's written here?*'
>
> Mr Abdu looked at me and told me he had done the screening in a hospital. He knew he was HIV-positive. '*Are you on treatment?*' '*No. I started, but then I stopped because I had to go to work*'. Mario asked me to go in his office at the hospital and get the phone number of the specialist in infectious diseases, then asked him to make an appointment immediately. Mario left his office and went to the psychiatrist of the SAMIFO to ask him to meet the patient. Once the consultation was over, I told Mr Abdu to wait a while in the waiting room. Then I went to the psychiatrist to explain to him the situation. The psychiatrist answered me: '*Yes, I'll see him right after the next appointment, but what do you think? Is he stressed?*' I told him that Mr Abdu seemed calm. '*Okay, come with him then. We can also see with Giulio* (sociocultural mediator) *if he needs social-administrative assistance*'.

This extract from field notes illustrates how professional collaboration works. Giulio is a sociocultural mediator who deals with social and administrative monitoring, besides accompanying patients during

medical visits. He has worked at the SAMIFO since its creation. Patients often drop in and see him after the medical examination. The passage of migrants from one professional to another often occurs without an appointment and without involving a particular organization; rather, it is based on the specific situation of the patient. Professionals with less experience in this work ask to be helped by others who find time to listen to all patients. The professionals of the SAMIFO have never started a collective debate to consider other ways of receiving and taking care of migrants and, unlike the COMEDE, they have never changed their method:

> With all the arrivals we have every morning, it is difficult to use alternative methods to the arrival order established by the ticket. The SAMIFO is open only in the morning. We have two general practitioners. We need to help as many patients as possible and this is the only way to do it, although every consultation lasts only five minutes. There are other professionals who listen to them and explain what the doctor says. (Sara, volunteer)

These words illustrate the daily functioning of the reception. Unlike what is claimed by the COMEDE, here the skills, including the ability to listen to the migrant patient, must be put into practice quickly. Apparently, there is no real selection of patients to be admitted, but rather a reduction in the time to be devoted to each one, because 'after each patient, there is another one waiting' (Giulio, sociocultural mediator).

How Is Vulnerability Established?

The description of the daily work of receiving migrants at the COMEDE and the SAMIFO illustrates the role that associations play today in resolving the contradictions that arise when health policies meet migration policies.

France and Italy have for some time entrusted the reception of migrants to the realm of associations. Organizations such as the COMEDE and the SAMIFO perform the function of guaranteeing access to health for all migrants, thus defending the constitutive principles of national health systems. Their economic and human resources are, however, limited, so that they must select the people to be accepted through what we can define as a more-or-less structured and explicit local triage process.

The COMEDE has created vulnerability criteria to guarantee a selection which is as rational and egalitarian as possible. The SAMIFO uses the principles of administrative status and order of arrival. The operation of these instruments can only be interrupted by medical emergencies.

Furthermore, these two types of organization are based on different ethical justifications rooted in the history of national health systems.

In the COMEDE, the principle is to guarantee equality in giving assistance. Essentially, ensuring equality means that patients who do not go through the selection process (appointment with the reception staff and interview with a nurse) cannot hope to become patients of the association. The double selection process of the COMEDE is carried out to 'guarantee equality in access to the association as much as possible', thanks to criteria that are, in the words of one of the professionals, 'as objective as possible'. According to Jon Elster, equality is one of the regulatory principles underlying procedures for the distribution of rare resources or practices of 'local justice': 'Equality is the cardinal principle that naturally applies … when we have to solve problems of distribution. When the egalitarian attribution is not feasible, we must explain why this principle is not maintained' (Elster 1992: 15).

When agents of institutions do not guarantee equality, they can invoke several reasons, generally: limited time available, efficiency, need, or even resources. These reasons also become principles that, like equality, guarantee the correctness of the procedures. In the COMEDE, decision-makers adopt, besides equality, the principle of need, which can be translated as 'the greatest vulnerability'. This principle is 'present-oriented' and gives priority 'to the one who is currently at the lowest level of well-being' (ibidem: 19). To do this, professionals of the COMEDE rely on a set of criteria defined as 'objective'. The migrant who does not speak the French or English language, has housing and financial problems, lives in relational and social isolation, has neither a health protection nor residency permit, and is affected by chronic disease or health problems, is the one who most needs aid. These criteria are certainly useful in helping the members of the COMEDE to objectify the migrant's situation. However, in practice it is difficult for subjectivity not to have an influence on assessments of the situation of migrants.

Most migrants arriving at the COMEDE experience difficult situations, need treatment or psychological and legal support. How do the staff determine which criterion is more important than the other? Which health problem is more serious than the other? Is it more important to have a place to sleep or to have enough food? It is only in daily practice and interaction between the staff member and the migrant that the decision can be made on who is entitled to be accepted. The answer to these questions is based on the individual subjectivity of the operators. The COMEDE is aware of the limits of the objectivity of its vulnerability criteria, but at the same time considers them the only sound method for reducing subjectivity and guaranteeing a selection which is as fair as

possible. The use of these criteria is also designed to limit the number of medical examinations or legal interviews, to focus on the quality of relationships, and to devote more time to patients. The persons selected have access to global assistance that can even last several years, and to lengthy medical consultations. The logic can be summarized as follows: fewer patients equals more quality.

In the SAMIFO, the principle is to guarantee universalism in providing assistance. Ensuring universalism means accepting as many people as possible who are in need of help. The reception of migrants is less structured and smoother than that at the COMEDE. Apparently, there is no real selection of patients to be admitted. In fact, migrants are received on the basis of arrival times, and their passage from one professional to another often occurs without involving a particular organization. The consequence is that the time to be devoted to each migrant is reduced, while the reception becomes person-dependent and changes according to the specific situation of each patient. The principle of administrative status helps SAMIFO members to guarantee a selection which is as rational as possible. Focusing on a particular population (asylum seekers) allows them to reduce subjectivity despite having never started a collective debate on this specific issue. But this administrative restriction cannot solve the problem of subjectivity. How can doctors or social workers determine which migrant they should devote more time to? Between an asylum seeker and a migrant requesting a humanitarian permit, who should be considered a priority case? As for the COMEDE, the answer to these questions is based on the individual subjectivity of the operators. But by contrast with the COMEDE, the normative principle used to hierarchize suffering and determine who should be allocated rare resources is the principle of merit. According to Jon Elster, this principle is 'a past-oriented criterion which prescribes to direct the rare resources primarily to those who have earned the right to receive them through their past actions' (1992: 18). Essentially this means that the members of the association make a subjective judgement about the trajectory (life history, past behaviour, etc.) of the migrant. Like the principle of need used by the COMEDE, merit is based on moral assessments, but in this case, the moral assessment rests on the behaviour of migrants. It is not enough for a migrant to need help to be well received at the SAMIFO; he must also adopt behaviours that conform to the status of a migrant in search of an asylum permit.

In both cases, there is a hierarchy of suffering, and local forms of vulnerability are created.

Conclusion

France and Italy are the only two countries in the European Union to have implemented, in 1998, legal measures that guarantee free access to the national health system to irregular migrants. This common political openness relies on health systems based respectively on the principle of equality and the principle of universalism. Due to the tightening of migration policies and the economic rationalization of health systems, France and Italy have for some time entrusted the reception of migrants to associations. Those organizations concerned with the health of migrants, however, receive less and less public funding and must cope with an increasing number of requests from migrants. The case study of the COMEDE and the SAMIFO shows that these associations are in a contradictory situation: on the one hand, they must guarantee the universalism or egalitarianism of health systems that are experiencing economic hardship, while on the other, they are forced, with limited economic and human resources, to decide which migrants are entitled to receive help.

Both associations use principles and criteria to identify migrants in urgent need to help them gain access to healthcare. The COMEDE has created vulnerability criteria for selecting migrants. The SAMIFO uses the principles of administrative status and order of arrival. The operation of these instruments can only be disrupted by medical emergencies. The ethical justifications for this selective reception are different. In the first case the principle is to guarantee equality. All patients have to face the selection process in order to become patients of the association. The selected ones have access to global, long-term and high-quality assistance, following the rationale that fewer patients means more quality. In the SAMIFO, the principle is universalism: accepting as many people as possible who are in need of help, but at the expense of the time that a doctor or social worker can devote to each.

In both cases, the triage practices, based on a hierarchy of suffering, participate in building specific and local forms of vulnerability.

In the first case, the most vulnerable is the one who does not have access to the common law system, who has no shelter or stable social networks, who suffers from a chronic disease or is in a specific social situation (pregnant woman, minor). In the second case, the most vulnerable is the person who applies for a residence permit because he has been a victim of violence or has escaped from a war. In the COMEDE, the normative principle used to hierarchize suffering and determine which person is to receive rare resources is the principle of need, a present-oriented principle based on the greatest vulnerability at that moment.

In the SAMIFO, by contrast, the normative principle is that of merit, a past-oriented principle based on evaluation of the migrant's past actions.

Analysing the practices of field actors makes it possible to observe the subtler local moral positions (deservingness) that undergird what legislation prescribes (enlightenment) (Willen 2012; see introduction by Sahraoui, this volume). From this perspective, associations are not limited to applying laws, but through their actions actively participate in the laws' construction and resolution of the laws' contradictions. They actually become producers of local forms of vulnerability.

Cecilia Santilli holds a PhD in social anthropology from the University of Aix-Marseille (SESSTIM UMR 912) and the University 'La Sapienza' in Rome. In her doctoral research, 'Access to Health Care and Migration Policies in Europe. The Journey of Sub-Saharan Migrants, Asylum Seekers Suffering from AIDS and Hepatitis B: A Comparative Analysis between France and Italy', she examines immigration and health public policies adopted in France and Italy for irregular migrants. She worked as a researcher for the INSERM (Institut National de la Santé et de la Recherche Médicale). Since 2014 she has been involved as a Research Assistant in projects focusing on crisis issues (LIVEWHAT, TRANSSOL) at CEVIPOF Centre de recherches politiques de Sciences Po in Paris. She is currently a Postdoctoral research assistant at the School of Social Work at the University of Lund.

Notes

1. The current literature on the welfare state influenced by Esping-Andersen's work describes the healthcare systems using the Bismarckian model and the Beveridge model. These models are used to classify healthcare systems from a comparative perspective. I used this classification in order to identify how the history and structure of the healthcare systems have different implications for the population's health in different contexts.
2. The Bismarck model is named for the Prussian Chancellor Otto von Bismarck, who invented the welfare state as part of the unification of Germany in the nineteenth century. Today, the Bismarck model is used in Germany, France, Switzerland, Belgium and the Netherlands.
3. The Beveridge system is named after William Henry Beveridge, who in 1942 presented a report to the British Parliament on social policy to create a comprehensive social insurance system. Today it is used in Denmark, Ireland, New Zealand, Italy and Spain.
4. From 2014, France and Italy are among the five European countries that have accepted the largest number of migrants.

References

Baglio, Giovanni, and Antonio Fortino. 2015. 'I migranti invisibili nelle città-ragnatela', *Salute Internazionale.info* 6. Accessed on 19 December 2019. http://www.saluteinternazionale.info/2015/06/i-migranti-invisibili-nelle-citta-ragnatela/.

Beneduce, Roberto, and Simona Taliani. 1999. 'Politiche della memoria e retoriche del trauma', *I Fogli di Oriss* 11–12: 110–18.

Bowling, Cynthia, and Margaret Ferguson. 2001. 'Divided Government, Interest Representation and Policy Difference: Competing Explanation of Gridlock in the Fifty States', *Journal of Politics* 63(1): 182–206.

Carde, Estelle. 2009. 'Les restrictions apportées au droit aux soins des étrangers sont-elles discriminatoires? La loi et l'illégitime', *Santé Publique* 3: 331–37.

Castaneda, Heide. 2009. 'Illegality as Risk Factor: A Survey of Unauthorized Migrant Patients in a Berlin Clinic', *Social Sciences & Medicine* 68(1): 1552–60.

Castel, Robert. 1999. *Les métamorphoses de la question sociale.* Paris: Gallimard.

Cattacin, Sandro and Milena Chimienti. 2009. 'Politique de migration et politique de santé en Europe: Des normes aux pratiques'. Rapport de recherche, UNIGE.

Chabanet, Didier. 2012. 'European Governance and Democracy', in Bernadette Andreosso-O'Callaghan and Frederic Royall (eds), *Economic and Political Change in Asia and Europe: Social Movement Analyses*. Dordrecht, Netherlands: Springer.

Cognet, Marguerite, Céline Gabarro and Emilie Adam-Vezina. 2009. 'Entre droit aux soins et qualité des soins', *Hommes et migrations* 1282: 54–65.

COMEDE. 2014. 'Demandeurs d'asile vulnérables, enjeux et dangers', *Maux d'exil* 44.

———. 2015. *La santé des exilés*. Rapport COMEDE 2014.

d'Halluin-Mabillon, Estelle. 2005. 'Vaincre la suspicion, entrer dans une intimité douloureuse: une intenable extériorité', in Florence Bouillon, Marion Fresia and Virginie Tallio (eds), *Terrain sensibles: Expériences actuelles de l'anthropologie*. Paris: CEA-EHESS.

———. 2012. *Les épreuves de l'asile*. Paris: Editions EHESS.

d'Halluin-Mabillon, Estelle, and Anne-Cecil Hoyez. 2012. 'L'initiative associative et les reconfigurations locales des dispositifs d'accès aux soins pour les migrants primo-arrivants', *Humanitaire*. Accessed on 19 December 2019. http://humanitaire.revues.org/1407.

Dubois, Vincent. 2012. 'Ethnographier l'action publique: Les transformations de l'État social au prisme de l'enquête de terrain', *Gouvernement et action publique* 1(1): 83–101. doi: 10.3917/gap.121.0083.

Elster, Jon. 1992. *Local Justice*. New York: Russell Sage Foundation.

Elster, Jon, and Nicolas Herpin. 1992. *Éthique des choix médicaux.* Arles: Actes Sud.

Esping-Andersen, Gøsta. 1990. *Les trois mondes de l'État-providence: Essai sur le capitalisme moderne*, trans. Noémie Martin. Paris: Presses Universitaires de France (Le Lien social).

Esping-Andersen, Gøsta, and Bruno Palier. 2008. *Trois leçons sur l'Etat-providence*, trans. Marianne Groulez. Paris: Editions Seuil.

Fassin, Didier. 1998. *Figures urbaines de la santé publique: Enquête sur les expériences locales*. Paris: La Découverte.

_____. 1999. 'L'indicible et l'impensé: la "question immigrée" dans les politiques du sida', *Sciences sociales et santé* 17: 5–35.

Geraci, Salvatore. 2006. *La sindrome di salgari: 20 anni dopo*. Rome: Janus.

_____. 2014. 'La dimensione regionale: prossimità o discriminazioni?', in Mario Affronti, Giovanni Baglio and Salvatore Geraci (eds), *Responsabilità ed equità per la salute dei migrani: un imegno da condividere*. Atti del XIII Congresso Nazionale SIMM-Agrigento, 14, 17 May 2014.

Gerbier-Aublanc, Marjorie. 2017. 'Des capacités d'agir révélées par le vécu collectif de la maladie? Le cas des femmes dans les associations de lutte contre le VIH', in Annabel Desgrées du Loû and Françoise Lert (eds), *Parcours: Parcours de vie et de santé des Africains immigrés en France.* Paris: La Découverte.

Hoyez, Anne-Cecile. 2011. 'L'accès aux soins des migrants en France et la "culture de l'initiative locale": Une analyse des contextes locaux à l'épreuve des orientations nationales', *Cybergeo: European Journal of Geography*. Espace, Société, Territoire section. Accessed on 19 December 2019. http://cybergeo. revues.org/24796.

Huschke, S. 2014. 'Performing Deservingness: Humanitarian Health Care Provision for Migrants in Germany', *Social Science & Medicine* 120: 352–59.

Lachenal, Guillaume, Céline Lefeve and Vinh-Kim Nguyen. 2014. *La médecine du tri: Histoire, éthique, anthropologie*. Paris: Les Cahiers du Centre Georges Canguilhem, no. 6.

Maille, Didier, and Arnaud Veïsse. 2000. 'Exclus des soins à l'heure de la CMU: comment réintégrer le système de santé?', *La Revue du Praticien, médecine générale* 14(502): 1111–14.

Muehlebach, Andrea. 2012. *The Moral Neoliberal: Welfare and Citizenship in Italy.* Chicago: University of Chicago Press.

Musso, Sandrine. 2005. *Le 5ème H: De la question des femmes dans l'épidémie à celles des femmes étrangères ou immigrées face au sida en France.* Lettre d'information du CRIPS, 57ème Rencontre du CRIPS Ile-de-France – Femmes migrantes et VIH/ Sida dans le monde: une approche anthropologique. Accessed on 19 December 2019. http://www.lecrips-idf.net/lettre- info/lettre74/L74_0.htm.

_____. 2011. 'Les suds du nord: Mobilisations de personnes originaires du Maghreb face à l'épidémie de sida en France', in Fred Eboko, Christiphe Broqua and Fréderic Bourdier (eds), *Les suds face au sida: Quand la société civile se mobilise.* Paris: IRD Editions.

Nay, Olivier, Sophie Béjean, Daniel Benamouzig, Henri Bergeron, Patrick Castel and Bruno Ventelou. 2016. 'Achieving Universal Health Coverage in France: Policy Reforms and the Challenge of Inequalities', *The Lancet* 387 (2 May 2016), no.10034: 2236–49.

Nguyen, Vinh-Kim. 2009. 'Government-by-Exception: Enrolment and Experimentality in Mass HIV Treatment Programmes in Africa', *Social Theory & Health* 7(3): 196–217.

Palier, Bruno. 2007. 'Modèle social français', in Julian Mischi, Hélène Hatzfeld and Henri Rey (eds), *Dictionnaire de la gauche*. Paris: Editions Larousse.

_____. 2008. 'Un lungo addio a Bismarck? Le Riforme del welfare nell'Europa continentale', *La Rivista delle politiche sociali* 1: 41–55.

_____. 2009. 'L'Europe et le social', in Renaud Dehousse (ed.), *Politiques européennes*. Paris: Presses de Sciences Politiques.

Santilli, Cecilia. 2017a. 'Accès aux soins et Politiques migratoires en Europe: Le parcours de vie des migrants subsahariens vivant avec le VIH et l'hépatite b. Un regard croisé entre la France et l'Italie'. PhD dissertation, Aix-Marseille University.

_____. 2017b. 'Medical Care, Screening and Regularization of Sub-Saharan Irregular Migrants Affected by Hepatitis B in France and Italy', *Journal of Immigrant and Minority Health* (JOIH) 20(3): 668–73.

_____. 2018. *Le migrant mobile: le cas des déplacements des réfugiés subsahariens d'un pays à l'autre en Europe*, ed. Nathalie Ortar, Monika Salzbrunn and Mathis Stock (forthcoming). Marseille: Les Presses Universitaires de Provence, Sociétés contemporaines.

Van Aken, Marco. 2008. *Rifugio Milano: Vie di fuga e vita quotidiana dei richiedenti asilo.* Rome: Carta Meltemi.

Vidal, Laurent. 1996. *Le silence et le sens: essai d'anthropologie du sida en Afrique.* Paris: Anthropos.

Willen, Sarah. 2012. 'How is Health-Related "Deservingness" Reckoned? Perspectives from Unauthorized Im/Migrants in Tel Aviv', *Social Science & Medicine* 74(6): 812–21.

Chapter 8

Introducing Gender into the Theorization of Health-Related (Un)Deservingness

Ethnographic Insights from Athens and Melilla

Cynthia Malakasis and Nina Sahraoui

Introduction

> Why did you come to the hospital? They might tell you, 'I was shopping,' or, 'I was visiting a family relative …' 'Or were you here because you were hoping to go into labour and you came so that we attend to you in the hospital? Tell me the truth, don't make up a tale that you were shopping and went into labour.' They tell you some lies thinking that we might kick them out, but we don't refuse them; if they really need to stay, they'll stay, and we'll take care of them.

Lila,[1] a nurse working in the maternity ward, commented on the context in which Moroccan pregnant patients come to the public Spanish hospital in the city of Melilla, an autonomous enclave bordering Morocco. Her words reflected broadly shared perceptions among medical personnel in the hospital. To ensure the borderland's economic prosperity, local mobility between the border city and the neighbouring Moroccan region is facilitated. Many come to buy European goods, while others enter daily for work purposes. Among the 'cross-border' women seeking healthcare at the hospital, need for obstetric care is the most common motive of women's consultations.

Drawing on ethnographic research conducted in Melilla, Spain and in Athens, Greece, this chapter investigates whether and under what conditions women crossing international borders through semi-regular

channels are perceived as deserving of maternity care. Bringing together two sets of ethnographic material collected in public maternity clinics in the Greek capital and in the Spanish border city, this chapter examines how discourses and practices about deservingness are articulated and performed in two sites where the free access to care legally instituted for 'vulnerable' persons, such as pregnant women on the move, belies the complexity of ground-level practices shaped by – among other factors – healthcare professionals' perceptions of these migrants' deservingness.

In our empirical and analytical context, 'deservingness' denotes the ways in which some patients, but not others, are considered worthy of healthcare, particularly in settings of a receding welfare state and diminished public investment (Castañeda 2008; Marrow 2012; Sargent 2012; Ticktin 2011; Yarris and Castañeda 2015; Willen 2012). The nurse cited above, Lila, observes the patients' fear that they will not be seen, but also feels offended by what she sees as obvious lies. Acknowledging the legitimacy of pregnant patients' claims to healthcare – 'if they really need to stay, they'll stay' – she also attributes to them a dishonesty that erodes the premise of deservingness. With a focus on healthcare interactions, we aim to examine the 'vernacular *moral* register that is situationally specific and context-dependent' (Willen and Cook 2016: 96, emphasis in the original) and that constitutes the background to the formation of deservingness judgements.

More specifically, in this chapter, we venture a comparative analysis of our ethnographic data in order to engage with the question of gendered deservingness in health settings. Literature on health-related deservingness has focused extensively on undocumented migrants' access to healthcare systems as a central context of analysis (for a review of the literature, see Willen and Cook 2016: 99). Yet gender remains under-explored within these inquiries. Our approach brings gender into the conversation, and rests on three pillars, identified in the literature as foundational in deservingness debates: stakeholders, contexts and their evaluative criteria (Willen and Cook 2016). Conceptions of deservingness in health settings are strongly contingent on the social and historical context (ibid.). In the relevant section, we provide information on the two sites that formed the contexts of our comparative study. Elements that constitute these contexts include each country's or locality's historical and contemporary experiences with migration and health inequities. Our discussion sets out two distinct borderlands, which are nevertheless rendered similar by historically low structural investment and contemporary regimes of austerity (Grotti et al. 2019; Knight and Stuart 2016). Although a state capital, Athens has for years – even before the episode of mass movement that started in 2015 – been a political and

legal borderland of sorts, where migrants face not physical barriers, but legal and administrative ones that hamper their planned movement to other European countries (Cabot 2014). In both these borderlands, then, we focus on the discourses of healthcare professionals with the most intimate contact with pregnant women on the move: healthcare personnel, whose perspectives draw on their professional capacity, their moral and practical exigencies, and their everyday contact with the migrants to whom they provide care. Further, health-related deservingness has been conceptualized in relation to a list of evaluative criteria: migration motive, legal status, moral character, vulnerability and social proximity (Willen and Cook 2016). Gender underlies all of these axes, but it also needs to be brought to the fore in a distinctive manner.

The second section discusses the literature on migrants' health-related deservingness, and argues for the necessity of an approach that foregrounds the gendered character of the interactions between professionals and patients in healthcare settings. We explain that our chapter further contributes to the relevant literature by comparing healthcare professionals' use of notions of deservingness as they applied to pregnant migrant women with diverse legal statuses and varied forms of access to healthcare. What is more, such access was usually instituted on a humanitarian rather than a rights-based logic. Our material therefore enables an in-depth investigation of the relationship between moral deservingness and juridical discourses and policies of formal equality (Willen 2012; Willen and Cook 2016). In the third section, we lay out the specifics of our research sites, and demonstrate the merits of our comparative approach. This discussion continues in the section on methodology. We then break the discussion of our findings in two conceptual sub-sections: the relational dimension of deservingness judgements in contexts of competing resources and the dialectic tension between racialized-cum-gendered processes of othering and empathy. Our final remarks emphasize the ambivalence of gendered representations expressed by healthcare professionals, at times exacerbating a process of othering, while in other contexts constructing cognitive pathways to empathy.

Theorizing Gender and Deservingness: Background and Contributions

In the introductory quote, Lila, the Melilla maternity nurse, expresses simultaneously frustration and understanding toward the pregnant Moroccan women that compose the majority of the hospital's maternity patients. The gendered assumptions that underlie Lila's ambivalent

approach are not immediately visible – yet we will demonstrate that her ambivalence between empathy and suspicion is immanent to the gendered character of healthcare interactions, particularly in the realm of reproduction (Castañeda 2008). Our chapter, therefore, contributes to the literature that has engaged with the topic of migrants' deservingness in the realm of health by focusing on the gendered aspect of health-related deservingness – an emphasis as yet missing from the relevant literature. Scholarship that has engaged with deservingness in the nexus of health and migration (Willen 2012; Willen and Cook 2016) has yet to explore the workings of gender within the dynamics it examines. Our empirical observations, however, demonstrate that gendered assumptions, particularly those centred around vulnerability and agency (see also Grotti et al. 2018), are central within care interactions in prenatal and perinatal healthcare and indeed a formative element of notions of patients' deservingness. It is therefore necessary to apply gendered lenses of analysis to the ways in which deservingness judgements are formed.

Our chapter further highlights the significance of the fact that the cohorts whose care we examined ethnographically were partially (Melilla) or fully (Athens) entitled legally to the maternity care they were receiving. The conceptually rich and critical work that has been done so far has focused on undocumented migrants (Chavez 2008; Grove and Zwi 2006; Horton 2004; Willen 2012, 2015), whose 'illegality' renders them an easy target of discourses that contest their deservingness, because of the widespread assumption that they do not contribute to social insurance funds, or because 'illegal' entry into the country's territory throws their overall morality into question (Malkki 1995). Our focus on a category of migrants without a secure or long-term legal status, yet often legally entitled to care, allows us a more nuanced and complex theorization of the relationship between deservingness and rights. The scholarship on which we draw has theorized deservingness as the flip side of rights (Willen 2012; Willen and Cook 2016). While the formal, juridical discourse of rights presumes everyone's equality before the law, moral conceptions of who deserves healthcare are gauged inter-subjectively and relationally, assessed against 'our own' deservingness and our social proximity to the migrants in question (ibid.).

Documentation and legal status aside, pregnant women are differently positioned on the moral map of migrants' health-related deservingness, due to their status as women and future mothers. This further enriches and nuances our contribution to the relationship between formal rules and moral conceptions regarding migrants' access to health. The pregnant women whose care we researched were entitled to it on a humanitarian

rather than rights-based logic, because their sex and pregnancy rendered them 'vulnerable subjects', not as political subjects with a right to healthcare. Our chapter therefore also contributes to literature that has pondered the logics and effects of humanitarian-based forms of inclusion (e.g. Fassin 2010; Ticktin 2006, 2011). It does so by demonstrating, through the analytical lens of deservingness, that even archetypally vulnerable categories, such as pregnant women, may be deemed undeserving within daily, mundane healthcare interactions, particularly in contexts of scarce resources and colonially infused gender norms that intersect with other forms of sociocultural hierarchies.

The ascription by healthcare professionals of quintessential vulnerability to our research participants allows us to theorize the gendered character of health-related deservingness in articulation with the victim-agent binary. Notions of pregnant migrants as either victimized and passive or cunning and opportunistic – or simultaneously so – permeated the discourses of professionals that we analyse in this chapter. We do not focus on the actual conditions that produce vulnerability, neither do we focus on how pregnant migrants resisted these structures and engaged in forms of agency that clashed with paternalistic norms (Butler and Athanasiou 2013; Butler, Gambetti and Sabsay 2016) of 'humanitarian reason' (Fassin 2010). Rather, we demonstrate that notions of migrants as either vulnerable victims or cunning agents co-exist, succeed each other, and are contingent on and mutually constitutive with structures and relations of healthcare. The ambivalence of healthcare professionals' discourses spoke to contrasting moral sentiments and deontological rules, i.e. the meso-level of analysis represented in Figure 0.1 of the Introduction to this volume. This chapter demonstrates that notions of undeservingness may be mitigated by healthcare workers' moral sentiments of inclusion. Conversely, structural constraints intensified by austerity measures may equally threaten such inclusive understandings of the medical personnel's obligations.

Their theoretical import aside, moral conceptions of migrants' deservingness to access health services are socially significant in two ways. First, they affect the way in which healthcare is accessed in practice, even within favourable legislative frameworks (Marrow 2012), such as the ones that govern the maternity care of migrant women in Athens and Melilla. Second, they shape the public debate on migrants' access to health, bearing a strong policy impact (for a review of this literature, see Willen and Cook 2016: 97). Social scientists engaging with the issue, therefore, must reveal the values and assumptions that underlie deservingness notions and discourses – values and assumptions that are often half-spoken and implicit (Willen and Cook 2016). An objective of critical

medical anthropology is to reveal the social and cultural embeddedness of access to care and of care interactions themselves (Fassin 2010; Willen et al. 2011). Our chapter joins the critique of exclusionary practices by revealing the specifically gendered aspects of care access and interactions.

A caveat is necessary before we proceed to the discussion. Our discussion of gendered dynamics in the realm of migrants' healthcare via the case of pregnant women does not mean to equate gender (and theoretical correlates such as the vulnerability-resistance and victim-agent binaries) with the experience of women. On the contrary, we understand gender as very much operative in the experience of male migrants as well, whose branding as dangerous or free-loading – to invoke two common stigmas – draws strongly on conceptions of masculinity. Therefore, we see our chapter as the beginning of a conversation on health-related deservingness in the realm of migration that will incorporate the workings of gender in its various and complex dimensions.

Lastly, migrants are but one group whose deservingness comes into question (Willen and Cook 2016). In our research, we caught glimpses of the contested deservingness of other racialized and socioeconomically marginalized cohorts; Roma patients in the public health system in Greece are a glaring example. Attention to the experience of groups other than pregnant migrant women is beyond the focus of the present chapter. The gendered emphasis of our analysis, however, brings our chapter in conversation with works that may analyse the gendered aspects of the health-related deservingness of other disadvantaged patients.

Ethnographic Contexts: Migration, Health and Maternity Care in Athens and Melilla

Since 2015, Greece, Italy and Spain, as the EU's Mediterranean borders, have received close to 1.7 million migrants, fleeing war, persecution and poverty, from a number of countries in the Middle East, South Asia, Northern Africa and sub-Saharan Africa (UNHCR 2018a, 2018b, 2018c). While Spain lagged significantly behind the other two until 2017, its combined sea and land arrivals are the highest in 2018; against a background of staggering 63% and 25% drops from 2016 and 2017 respectively in the overall number of arrivals.

Migration to both our research sites did not start with the post-2015 episode of arrivals, dubbed Europe's 'refugee crisis' in mainstream discourses.[2] Migration to Greece in significant numbers started after the collapse of the Communist Bloc, particularly from neighbouring Albania and countries of the former Soviet Union, raising the

Table 8.1. Sea and land arrivals to Southern European countries, 2015–2018.

	Greece		Italy	Spain	
	Sea	Land	Sea Arrivals	Sea	Land
2015	856,723	4,907	153,842	5,823	10,980
2016	173,450	3,784	181,436	8,162	5,932
2017	29,718	6,592	119,369	22,103	6,246
2018	32,497	18,014	23,370	58,569	6,814

Source: UNHCR 2018a, 2018b, 2018c.

country's foreign-born population from less than 1% in 1991 to more than 11% in 2010, with Albanians forming some 70% of the foreign-born (Triandafyllidou and Maroukis 2010). Further, since 2010, when Greece joined the EU's Schengen Area of control-free movement, it has been the site of 'transit migration' (Papadopoulou 2004: 167) from Asia and Africa toward northern and western Europe, with migrants often stuck in the country in legal limbo for years on end (Cabot 2014; Papadopoulou 2004). In 2015, however, and in direct relationship to the flight from war-torn Syria, arrivals soared to some 850,000, from the previous year's 30,000 (UNHCR 2018a). Our research in Athens focused on the care of Syrian refugees, and it is primarily these ethnographic observations that inform this chapter.

The city of Melilla, an enclave in northern Africa and a former colonial Spanish outpost, witnessed, over the centuries, warfare and bordering as well as intense trade and social porosity (Soto Bermant 2014). With Spain joining the EEC in 1986 and Schengen in 1991, this Spanish borderland became at once a much more international border (Soto Bermant 2017). Since the 1990s, the physical border has been undergoing an ever-growing 'securitization' (Andersson 2015) through additional fences, barbed wire and patrols. Moroccan citizens registered as residing in the neighbouring region of Nador (but not other Moroccans) have the right to enter the enclave for the day, but not to stay overnight. To ensure the borderland's economic prosperity, local mobility between the Spanish border city and the neighbouring Moroccan region is facilitated. This fosters an intense local mobility which is essential to the city's economy. This special mobility regime is designed to accommodate the region's peculiar geopolitical situation and economic needs. Many Moroccans come to buy European goods in the enclave's supermarkets, others enter daily for work purposes. Yet, in return, the international border is reproduced between the enclave and mainland Spain, and one needs to go through police check points to leave the enclave. The focus in this chapter is on undocumented

Moroccan women who either reside in Melilla or cross the border to Melilla but reside in Morocco. Estimating the size of these cohorts is particularly difficult since they do not possess Spanish documents.

At the Spanish public hospital in Melilla, the need for obstetric care is the most common motive of these women's consultations. On a side note, the Spanish southern enclave is also on international migration trails for migrants from sub-Saharan and Middle Eastern countries. These migrants reach Melilla on their journey to Europe, yet their aim is to continue to either mainland Spain or other European countries. A few hundred to a few thousand migrants are accommodated in the migrants' centre at a time, while they wait for their administrative situation to be processed by Spanish authorities. Syrian refugees, in particular, started arriving in Melilla a few years after the war started.

In Greece, despite the decimation of its public health system since 2010 due to austerity measures (Economou et al. 2017; Kentikelenis et al. 2014), pregnant women are entitled to free, non-emergency maternity care throughout their pregnancy irrespective of political or legal status. Universal access to maternity care was instituted in April 2016 with Law 4368/2016. Until then, only labour, considered an emergency, was available free of charge. This law was well in effect at the time of our ethnographic research in Athens; our findings, therefore, reflect this context of legally universal access to healthcare.

In Melilla, the border context makes the situation slightly more complex. While pregnant women regardless of legal status are theoretically entitled to free maternity care, access to it hinges on the condition of residency, an implicit given in mainland Spain but a fact that needs to be demonstrated in the border city. The Moroccan women seeking care in Melilla belong to three legal categories, with distinct types of access to maternity care, that may well overlap within women's trajectories. Legal and undocumented residents are entitled to free maternity care, whereas women who cross the border from Morocco on an ad hoc basis are only entitled to emergency care. Residents of the city of Melilla, even if undocumented, are entitled to regular maternity care, unlike the border-crossing women. Yet, the difference often remains unclear at the time of accessing healthcare, because undocumented residents of Melilla may have no way of proving, administratively, that they reside in the city. Further, the adjective 'migrant' does not describe adequately the experiences of Moroccan 'border-crossers' (*transfronterizas*), since they do not intend either to stay in Melilla or to travel further to Europe. While in mainland Spain all pregnant women are entitled to maternity care (residency is assumed on the basis of their presence), the border context of the enclave has led health administrators to emphasize the conditionality of

this entitlement on residency and thus to introduce additional administrative procedures for such access to be granted.

Methodology

The two researchers co-authoring this chapter conducted research in Athens, Greece and Melilla, Spain, in spaces where migrant women – on various positions along the documented-undocumented spectrum, as the previous section explicated – received medical care. Data for this chapter derives from research in a major Athens public maternity clinic from March to August 2017 and, in Melilla, from research in the local public hospital and with various NGOs involved in migrants' medical care from August to October 2016 and during a follow-up visit in early 2017. In Athens, Cynthia Malakasis, a Greek speaker and national, conducted ethnographic fieldwork and semi-structured interviews with midwives and obstetricians in the public clinic's outpatient department, maternity triage area and labour ward. In Melilla, Nina Sahraoui, a Spanish speaker, conducted semi-structured interviews and focus groups with midwives, nurses and, to a lesser degree, obstetricians, in the maternity ward of the public hospital. Fieldwork in Melilla also entailed participant observation and interviews with three local and international NGOs.

All data used for this chapter have been anonymized, and we use pseudonyms for the selected quotations. Our methodologies were approved by the European Research Council Executive Agency (ERCEA) Ethical Assessment Committee. Oral informed consent was sought prior to the start of the research from participants, who were also ensured that they reserved the right to withdraw their participation at any point (for additional discussion of our methodological approach, see Grotti et al. 2018, 2019).

From Relational to Gendered Deservingness

Relational Deservingness in a Context of Competing Resources

> The middle-aged maternity ward attendant eyed me with what I perceived as wary annoyance, both at my request and at my presence in the ward. An anthropologist conducting ethnographic fieldwork on the maternity care of migrant patients in Athens, I had just accompanied a near-term pregnant migrant to her room, and I was now acting as her interpreter and intermediary.

It was another hour to lunchtime, but the pregnant woman, who had been admitted for observation after coming to the hospital with abdominal pain, had had nothing to eat that day. Therefore, she was feeling faint. She and I decided that I would ask the ward attendant to serve her lunch early.

As soon as she heard I was researching the maternity care of migrant patients, the ward attendant bristled. Why do you not do any research on the plight of Greeks, she asked me. She said she was an ethnic Greek from the former Soviet Union and that she had moved to Greece with her family with the post-1980s cohort.[3] Her 27-year-old son, she told me, is unemployed and has no insurance. Why do migrants get free care? More to the case, why do these foreign migrants, with no ethnic or cultural ties to Greece, receive more care than people like her? 'What has the state done for us?'

As she ranted against the injustice she felt that she had suffered, the ward attendant rose from her desk, in a small office facing the ward's wide, central corridor, flanked by patient rooms on both sides. She walked toward the ward's entrance and disappeared into a room. I returned to the bedside of Maya, the French-speaking, pregnant woman from Cameroon. I told her that it seemed that she would not be getting her lunch early. Should I go get her a banana, to raise her energy levels until lunchtime? Moments later, the ward attendant re-emerged, carrying a tray with Maya's lunch. Her indignation aside, she would not let a pregnant woman stay hungry.

This incident took place in March 2017, in one of Athens' major public maternity clinics. The 'I' in the vignette corresponds to Cynthia Malakasis, who conducted research there. The insights it reveals regarding healthcare professionals' notions of deservingness verify these notions' relational character, as opposed to juridical perceptions of formal equality before the law (Willen and Cook 2016). As a matter of fact, the same April 2016 law that gave pregnant migrants access to free care also made healthcare free for uninsured Greek citizens of no means, such as the ward attendant's son. Yet the fact that the law granted them equal access did not prevent the ward attendant from pitting the two categories of healthcare receivers – pregnant migrants and uninsured Greek nationals – against each other, evaluating their deservingness to access healthcare on the basis of their ethno-national ties to the political unit. Her social proximity to her son and to the wider category of ethnic Greeks neglected by their national state prompted her to rank them as more deserving of the state's resources than these newcomers, who seemed to be hogging everyone's, including the researcher's, attention. Yet, as much as she complained, the ward attendant did bend the rules, and brought the pregnant woman's lunch early. She did so without verbal commentary that would allow the researcher to identify her precise motivations. Was she putting on a performance of humane behaviour for the benefit of the researcher-observer?

It sounds unlikely, given her unrestrained rant moments before. Was she extending *bona fide* humane treatment to a person in a vulnerable situation? Or was she empathizing with the refugee patient on the basis of shared womanhood and motherhood? There are two points to be made with certainty here. The midwife's social proximity to ethnic Greeks made her more attuned to their socioeconomic plight and need. Deservingness, then, was gauged on the basis of perceived need, whose estimation, in turn, hinged on social proximity. To wit, the ward attendant contrasted her son's unemployment, whose effects she experienced first-hand, to the supposed preferential treatment the state gave to refugees, from whose hardship she was emotionally and physically removed. Yet, while the ward attendant deemed the migrant woman undeserving of her legally instituted access to healthcare, she nevertheless extended healthcare to her that transcended the formal framework of the law. The contradictions and ambiguities in the healthcare professional's words and actions offer a telling picture of the layered views, sentiments and social identifications that come together to form moral judgements of deservingness.

Perception of need, or lack thereof, was equally central in the formation of judgements by Melilla healthcare professionals. What is more, this perception developed out of constrained interactions due to the language barrier – an issue that was central in the Athens context as well, as we demonstrate in the following section. Often midwives and nurses could not converse with the Moroccan patients, who either spoke little or no Spanish. Due to the significant share of Moroccan women among the patients, most healthcare professionals had come to master some phrases of the local dialect, Shelkha. Yet the few professionals able to conduct a fluent conversation were the professionals of Moroccan origin, and there might be no such person within the team in charge in many shifts. The language barrier affected the care interaction in destructive ways for both parties involved. It took its toll on the emotional labour performed by midwives by increasing levels of stress and constraining possible rewards (e.g. patients expressing their gratitude). It is in the context of such limited verbal interactions that a midwife shared the following view during a group discussion:

> There are others that you don't feel sorry for them, those who come with all their gold, all their jewels, their teeth with braces, and they come here, so these people they could give birth somewhere else, I don't know, but I don't feel sorry for them, it's different isn't it? It's not the same as the woman that arrives, and you can see that she has no means. Or at least you know she [the woman with means] could monitor her pregnancy in good conditions, so you think … it's like this, the physical appearance tells you more or less what their socio-economic level is. Here the poor ones who come from the field … who

come with the skin damaged by the sun, with workers' hands … you know? These women you see them, you know that they are poor. And there are the ones whom you asked, 'and you haven't been to a doctor in nine months?' Maybe we're judging them, I don't know, but it makes you think.

This midwife, then, departed from the premise of a general empathy to carve out exceptions on the basis of an assessment of the financial means patients possessed. Patients perceived as able to pay for regular prenatal monitoring but who nevertheless attend the public hospital's emergency ward (and are directed to a midwife or obstetrician after triage), are deemed less deserving of care in this setting since 'they could give birth somewhere else'. The articulation of such deservingness judgements undoubtedly varies from one interaction to the other. As illustrated by the previous vignette set in the Athens public hospital, a healthcare professional might very well form a judgement of undeservingness and provide compassionate care at the same time. Deviating briefly from our focus on the ideas and practices of healthcare professionals, it is worth noting that these judgements were heard and sensed by the patients. Among the women interviewed, an undocumented Moroccan woman recounted how a healthcare professional challenged her for wearing braces. Though it remains unclear whether it was her case that inspired the situation in the quote above, Soraya's words sound like a response that she was not able to voice at the time when the allegation was made:

> When I went to see the obstetrician: 'you, you have money, you wear braces' … but these braces I got them before my husband went to prison and on top of that I have the cheapest in the region. You know how much? A hundred euros. She told me: 'your husband, he has money?' … But we lived normally, and, after he went to prison, I didn't have anything left.

Perceptions of wealth versus need are embedded in a set of social codes, and many can turn out to be misleading. The formation of deservingness judgements is mediated by culturally determined assumptions, yet such judgements can have material implications in the way in which healthcare is delivered. Back in the Athens hospital, the daily shortage of beds in the maternity wards fostered the impression of an undeserved channelling of resources to racialized patients. On a June 2017 summer morning, seated at a desk in the centre of the labour ward, one of the midwives on duty spent what seemed like her entire shift on the phone, inquiring about the availability of beds in the hospital's maternity wards. The number of beds in the hospital, she and other midwives said, is not enough to accommodate the number of women giving birth there. In the end, the labour ward's head midwife instructed the one making calls to

tell the staff in charge to stop scheduling so many C-sections. This was not an infrequent occurrence. On another morning when this happened, a midwife on duty expressed her dismay about the space that refugee and Roma women take up – space that should be available to insured, paying Greek women. She said that a woman with insurance – usually a Greek woman – has the right to ask for a specific type of room and co-pay the difference. Yet the Greek woman who has requested and is able to afford a, for example, two-bed room, will be forced – because of the bed shortage – to go to a five-bed one with 'gyspies' and refugees.

This discourse of refugee women coming to the hospital in droves mainly reflects the harried personnel's perception of the situation – yet numbers also show that the percentage of births by foreign-born women exceeded their percentage in the general population. The incidents described above both took place in June 2017. According to the labour ward's official records, tabulated by Cynthia Malakasis from the labour ward's records book, in that month, Syrian and Afghan women – the two main groups that constitute 'refugees' in the popular perception – delivered 28 babies; that is, 8% of the total of 356 live babies born in the hospital. Meanwhile, refugees from these two national groups present in Greece at the time made up about 0.5 percent of its population. Migrant women of all other nationalities[4] except for Albanian, delivered 43 babies, or 12% of the total. Albanian women delivered 30 babies, or 8% of the total. The remaining 259 babies, or 73% of the total, were born to Greek nationals, including members of the Roma minority.

While highly specialized scientifically and often linked to medical schools, Greek public maternity clinics have lost many of their middle-class Greek maternity patients, who since the 1990s have been increasingly giving birth in private facilities (Mosialos et al. 2005), with the exception of high-risk pregnancies that private facilities are less equipped to assist. Combined with the context of austerity, it seems that notions of migrants' deservingness are embedded in an existing context of struggles and hierarchies. To wit, pregnant migrants are seen as encroaching on resources that are scarce and disproportionately allocated to healthy people coming there to give birth for free at the expense of the specialized medical services the hospital is supposed to provide, as a senior obstetrician, Stefania, noted. A midwife in the maternity triage area, Anna, in her effort to explain to me her frustration with the frequent advent of Roma and, to a lesser degree, migrant women during the hospital's on-call hours for what she described as minor pains and bleedings, also argued that their presence there and the care they received violated the hospital's primary purpose of providing highly specialized, tertiary care. The formation of notions of deservingness, then, is not only highly relational – it

also should be placed within the specific context of structural underin-vestment in the public sector.

A context of diminishing resources in peripheral regions of the EU – as can be said about both austerity-stricken Greece and the Spanish bor-derland of Melilla – could only foster the resentment that underpins judgements of undeservingness. The border city presented the additional particularity that the comings and goings of Moroccan women had long become a usual feature of the hospital's patient base, while there was no sign of budgetary expansion. The local maternity ward, modest in both size and personnel, generated an intense workload for healthcare work-ers, so much so that the experience gained by Melilla-trained midwives came to be acknowledged in the wider professional circles extending to mainland healthcare facilities. Yet, this exceptionalism came at a price. In their daily work, many Melilla midwives lamented the lack of material resources, starting – very much like in Athens – with the number of beds:

> This hospital jams up because of births from Morocco. … It happened that for planned surgeries, people from Melilla that need an operation have to wait for another moment, though they're residents, because there's no room, it's jammed up, almost all the time. Because this hospital is meant to attend to the needs of the population that lives in Melilla, it's small.

Much like the dismay expressed by the Greek midwife in the sec-tion's opening vignette, competing claims to healthcare are gauged against one's legitimacy as a local; i.e. a resident of Melilla. A tension at the heart of the deservingness problematic, undocumented Moroccan women – who, therefore, appear as uninsured to the hospital administra-tion – are here depicted as illegitimate Others, whose needs encroach on the needs of the residents of Melilla. Unlike the Greek context, the share of uninsured patients in this Spanish maternity ward revolved around 60% in 2016, thus the healthcare professionals' take on the competition that arises between local and Moroccan women is hardly surprising. Yet, the lump category of Moroccan women needs to be unpacked, as it remains unclear whether these women are *transfronterizas* or local, yet undocumented, residents of Melilla. In the absence of a thorough inquiry into this distinction on the part of the hospital administration, it is yet to be determined how many are 'births from Morocco' and how many 'local undocumented births'.

In this section, then, we provided the overall context of how notions of migrants' health-related deservingness are formed in the inherently gendered realm of maternity care in the two sites where we conducted research. The section placed emphasis on the complex and interdepend-ent relationship between juridical notions of formal equality and moral

conceptions of deservingness. Literature on migrants' health-related deservingness has emphasized 'illegality' as a factor that produces negative moral judgements. Our participants, however, were, in their majority, formally entitled to care. Yet they were still seen as undeserving, on the basis of their perceived need, which was deemed to be less pressing than the need of other, local cohorts. What is more, their legal entitlement to care was seen precisely as encroaching on the needs of locals, who had stronger ties of belonging to the city or the nation. Our analysis further highlighted that structural underinvestment exacerbates perceptions of Others – people with no immediate claims to the moral community of the nation or the locality – as undeserving of its resources. Having laid this ground, gender takes centre stage in our next section. To wit, we demonstrate that relational notions of deservingness arising from a context of limited resources are mutually constituted with gendered and racialized perceptions of pregnant women on the move.

Gendered Deservingness between Othering and Empathy: Shades of Compassion

At the Athens maternity clinic, obstetricians and midwives – primarily those staffing the outpatient department, where the entry process of migrant patients into the hospital system took place and was the most evident – oscillated between anger at migrants perceived as demanding and insouciant toward the hospital's rules and constraints and pity for women seen as mistreated, oppressed and robbed of agency and initiative. That is, the issue of competition for scarce resources set out in the previous section was compounded by an additional dimension: the healthcare personnel's culturally mediated perceptions of migrants' gender norms. The two discourses went hand-in-hand during formal interviews and informal conversations with healthcare staff.

During a semi-structured interview in Athens in July 2017, a senior obstetrician, Mirsini, lamented the fact that most refugee women visited the hospital for the first time when they were close to term, in order to schedule their delivery. 'They come without appointments, and they demand to be seen by priority', the doctor said, yet also blaming the medical NGOs that had monitored pregnancies up to that point.[5] They come in 'violently', disregarding normal procedure, and thus causing a strain on personnel and equipment, and forcing the hospital to offer 'discounted' services to women who come in through regular appointments.

Yet Mirsini argued that the impact of this demanding and disruptive behaviour was alleviated, at least in part, by a different behavioural tendency of migrant patients: their culturally conditioned behaviour to obey

authority figures. 'But they are young women', the senior obstetrician continued, 'and they cooperate as much as they can. Their faces are dispassionate masks, afraid, and they cooperate, because this is what they know, they have learned, they have become from home and from their religion'. 'They treat them like dogs', she said, referring to the women's husbands. 'Women do not say a word, when their husbands are present'.

The formation of judgement of undeservingness relies on gendered and racialized processes of othering. In both contexts under study here, the patients against whom these judgements were formed were constructed as alien to the local culture owing to several identity features, not least religion. Women emerged as voiceless, because the perceived gendered norms of their 'culture' allegedly did not allow them to speak. Yet they were also literally speechless, because of a strongly adverse structural condition in the healthcare context: the lack of linguistic interpretation, which widened the perceived distance and facilitated processes of othering.

'We can't elicit their medical histories', the Athens senior obstetrician, Mirsini, said, alluding to the fact that the hospital did not employ interpreters, and most pregnant migrants did not speak Greek (or enough English) to communicate with healthcare personnel. At the outpatient department, residents on duty often employed culturalist explanations for the inability of women to communicate their medical information. Looking over the file of a young Syrian who had recently arrived in Athens from an island of first reception, an obstetrics resident on duty, Archontia, blamed the limited information she had on the pregnant woman's medical history on the latter's passivity and backwardness. 'They don't know anything', the resident said, referring to refugee women in general. 'The man knows everything. When they have their period; when they are giving birth'. The obstetrics resident did not clarify who 'they' were – yet for all present, it was clear enough that she was referring to migrant and refugee women from Middle Eastern and Islamic backgrounds, who constituted the vast majority of the post-2015 arrivals. In Melilla too, this was the cohort to whom health professionals referred with racialized condescendence – yet with empathy as well.

Among the migrant patient basis in Melilla, few of the women wore burkas. Indeed, patients in burkas represented a marginal share of the patients assumed to be Muslim, and as recounted by midwives, most of them grew up in Melilla and presented a sociologically different profile than the *transfronteriza*s. Yet, their care created gendered tensions, when the women refused to be attended by male professionals. Midwives struggled to build a sense of empathy with these women, all the more so when their religiously motivated decisions went against medical advice. For example, healthcare professionals would relay, with mixed feelings

of sadness and anger, episodes of women in labour having left the hospital instead of giving birth there and returning to the hospital after a stillbirth. A midwife reflected on the impact of such feelings on the care delivered to some patients:

> There are many workers in the hospital who are suffering from burnout and they say, 'and another one from Morocco, and another one …' you know. So, you can see they're not treating them the same. It's true for example that, if the family is Spanish, they want to enter, they enter, and maybe the husband of the woman with a burka he doesn't enter. It's not the woman's fault, but she bears the consequences. The truth is that it happens …

The fact that the husband of a woman wearing a burka would be less likely to be allowed in the delivery room illustrates here a gendered-cum-racialized form of othering resulting in a discriminatory practice. Some women's refusal to be seen by male medical professionals, unacceptable in the hospital, created an unease that might explain the healthcare personnel's reluctance to let their husbands in. Men were blamed for the lack of care that some of these women suffered and for the life-threatening dangers to which they were exposed. Hence, because of the perception of men's behaviour as going against the prevailing obligations of the medical profession, to which strong moral sentiments are attached, some of midwives' practices contradicted the customary norm of letting in at least one accompanying person in the labour room. This example illustrates the complexity of the racialized and gendered aspects of the formation of deservingness judgements, one stirring empathy and the other distancing.

The ethnographic information provided so far in this section has highlighted the gendered components of notions of undeservingness. Yet empathy also surfaced centrally within these narratives. Melilla midwives actively imagined their own potential reaction to circumstances similar to those faced by 'cross-border' Moroccan patients. Countless were the declarations stating, essentially, that 'I would do the same', as in the example that follows:

> Many come because they're well treated, others come because they don't have to pay, and I'll tell you something, if I'm sincere, I would do the same. If I don't have social security, and they tell me that on the other side there's a hospital and that everyone goes there and doesn't pay, I would do the same. We have to be sincere, and you would do the same, and that's how it is.

Implicit in such statements often shared in group discussions of healthcare professionals, with only women around the table on most days, was the addition: as a woman, 'I would do the same'. Healthcare professionals, in their majority women, shared with their patients the challenges of

reproductive health. They relayed what they had heard about the public hospital on the other side of the border with horror, coming to the conclusion that it was, after all, not a surprise that some women decided to cross the border and access safer care for themselves and their newborns. Some midwives, in one-on-one conversations, elaborated further on their understanding of what the Moroccan women from across the border were facing. In the following quote, Teresa makes the point that the fear of being unwelcome increased patients' stress:

> The women who come, the majority come with pregnancies that are not monitored so they arrive, especially when it's a first pregnancy, they arrive frightened, with fear of what they don't know, and on top of that they arrive in an environment hostile to them because they don't know anyone, they think they'll be received as 'cross-border patients' that are not supposed to come and that add to our workload, they think they won't be treated well … so they arrive very frightened, and this fear makes them ask for caesareans, you know … because they're in pain and they're screaming and everything.

Displaying empathy by putting herself in these women's shoes, Teresa described the emotional state that most of these women might find themselves in. She explained the patients' screams, an element that was often invoked in less empathetic terms, depicting the foreign patients as coming unprepared to give birth, in contrast to local women portrayed as enduring pain more discreetly. The combination of statements of deservingness and undeservingness, often in the context of the same group discussions, revealed the highly ambivalent character of the processes that underpin the formation of deservingness judgements.

Conclusion

This chapter's ethnographic focus on care interactions demonstrated the strongly relational dimension of notions of migrants' health-related deservingness. With the focus not on access per se but rather healthcare interactions and the medical personnel's discourses around these interactions, our insights converge with the conclusion to which Perez, Rodríguez-Newey and Petel-Rochette arrive in this volume as to the relational nature of the right to healthcare. Healthcare access and interactions are mediated by moral judgements. Qualitative attention to these judgements is key to understanding practices of inclusion as well as exclusion of non-nationals, or marginalized cohorts more broadly, within healthcare provision.

Our chapter demonstrated that the criteria involved in this relationality, such as social proximity or perceptions of need, as well as the

humanitarian element inherent in the legal and moral dimensions of pregnant migrants' healthcare, held a deeply gendered component. Indeed, pregnant migrant women are specifically situated on the moral register of deservingness judgements. Our chapter highlighted how gender plays out in healthcare interactions, at times exacerbating processes of othering, and in other instances facilitating empathy. Our insights confirmed that the assumptions of passivity and victimhood tend to foster a perception of deservingness (Jensen and Petersen 2017); overall, however, assumptions of cunning and opportunism alternated with assumptions of passivity and victimhood to form shifting understandings of deservingness. The formation of deservingness judgements included processes of racialization, which worked toward othering, and of gendered racialization, which paradoxically appeared to be mobilized as a discursive practice both for distancing and for the articulation of empathy. This ambivalence, if anything, emphasizes the importance of theorizing the place of gender within health-related deservingness.

Cynthia Malakasis is a cultural anthropologist interested in nationalism, ethnicity, race, post-colonial dynamics with an emphasis on intra-European hierarchies, citizenship rights, the social media and Greece. Her doctoral project, at the Department of Global and Sociocultural Studies at Florida International University, examined whether and how post-1989 mass immigration to Greece challenged the country's nationalist norms of collective belonging. In April 2016, she joined the Robert Schuman Centre for Advanced Studies as a postdoctoral research associate at the ERC-funded EU Border Care project. EU Border Care examines the politics of migrant maternity care in four European borderlands; from September 2016 to September 2017, Cynthia conducted ethnographic research on the maternity care of Syrian refugees in Athens, Greece.

Nina Sahraoui is Postdoctoral Researcher at the Paris Centre for Sociological and Political Research (CRESPPA), CNRS. Nina is also affiliated with the Chair 'Exile and Migrations' at the Collège d'études mondiales in Paris (FMSH). Previously, Nina was Post-doctoral Research Associate at the European University Institute within the EU Border Care project and conducted research on the politics of maternity care among undocumented migrants on the peripheries of the European Union. Nina completed her PhD in the framework of a Marie Sklodowska-Curie Fellowship at London Metropolitan University and published this research as a monograph: *Racialised Workers and European Older-Age Care: From Care Labour to Care Ethics* (with Palgrave Macmillan, 2019).

Notes

1. Names have been changed to protect the anonymity of research participants.
2. We understand the so-called 'crisis' as a crisis of reception, rather than one that depletes the receiving nations' resources and presents them with an unmanageable challenge (Christopoulos 2017; Grotti et al. 2019).
3. Ethnic Greeks from the areas of the former Soviet Union moved to Greece in the 1920s as Ottoman subjects and then again after 1989 and were granted nationality per Greece's regime of almost unconditional *jus sanguinis* (Christopoulos 2012). Their swift political integration, however, was not met with measures adequately ensuring their socioeconomic prospects.
4. This includes countries of the former Communist Bloc, Africa and the Middle East.
5. The dynamics of the de facto, if not always willing, collaboration between the public and the NGO health sectors in the care of migrants since 2015 is beyond the scope of this chapter. For a detailed analysis, see Grotti et al. 2018, 2019.

References

Andersson, Ruben. 2015. 'Hardwiring the Frontier? The Politics of Security Technology in Europe's "Fight Against Illegal Migration"', *Security Dialogue*: 1–18.

Butler, Judith and Athena Athanasiou. 2013. *Dispossession: The Performative in the Political*. Cambridge, UK and Malden, MA: Polity Press.

Butler, Judith, Zeynep Gambetti and Leticia Sabsay. 2016. 'Introduction', in Judith Butler, Zeynep Gambetti, and Leticia Sabsay (eds), *Vulnerability in Resistance*. Durham, NC: Duke University Press.

Cabot, Heath. 2014. *On the Doorstep of Europe: Asylum and Citizenship in Greece*. Philadelphia: University of Pennsylvania Press.

Castañeda, Heide. 2008. 'Illegal Migration, Gender and Health Care: Perspectives from Germany and the United States', in Marlou Schrover, Joanne van der Leun, Leo Lucassen and Chris Quispel (eds), *Illegal Migration and Gender in a Global and Historical Perspective*. Imiscoe: Amsterdam University Press.

Chavez, L.R. 2008. *The Latino Threat.* Stanford: Stanford University Press.

Christopoulos, Dimitris. 2012. *Ποιος Είναι Έλληνας Πολίτης;* [*Who is a Greek citizen?*]. Athens: Vivliorama.

———. 2017. 'Human Rights in a State of Perpetual Emergency', Open Democracy, 5 January. https://www.opendemocracy.net/en/can-europe-make-it/human-rights-in-state-of-perpetual-emergency/.

Economou, Charalampos, Daphne Kaitelidou, Marina Karanikolos and Anna Maresso. 2017. 'Greece: Health System Review.' *Health Systems in Transition* 19(5): 1–192.

Fassin, Didier, 2010. 'Inequality of Lives, Hierarchies of Humanity: Moral Commitments and Ethical Dilemmas of Humanitarianism', in Ilana Fledman and Miriam Ticktin (eds), *In the Name of Humanity: The Government of Threat and Care*. Durham, NC and London: Duke University Press.

Grotti, Vanessa, Cynthia Malakasis, Chiara Quagliariello and Nina Sahraoui. 2018. 'Shifting Vulnerabilities: Gender and Reproductive Care on the Migrant Trail to Europe', *Comparative Migration Studies* 6(23): 1–18.

———. 2019. 'Temporalities of Emergency: Migrant Pregnancy and Healthcare Networks in Southern European Borderlands', *Social Science & Medicine* 222: 11–19.

Grove, N.J., and A.B. Zwi. 2006. 'Our Health and Theirs: Forced Migration, Othering, and Public Health', *Social Science & Medicine* 62: 1931–42.

Horton, S. 2004. 'Different Subjects', *Medical Anthropology Quarterly* 18: 472–89.

Jensen, Carsten, and Michael Bang Petersen. 2017. 'The Deservingness Heuristic and the Politics of Health Care', *American Journal of Political Science* 61(1): 68–83.

Kentikelenis, Alexandros, Marina Karanikolos, Aaron Reeves, Martin McKee and David Stuckler. 2014. 'Greece's Health Crisis: From Austerity to Denialism', *The Lancet* 383 (9918): 748–53.

Knight, Daniel M., and Charles Stewart. 2016. 'Ethnographies of Austerity: Temporality, Crisis and Affect in Southern Europe', *History and Anthropology* 27(1): 1–18.

Malkki, Liisa. 1995. 'Refugees and Exile: from "Refugee Studies" to the National Order of Things', *Annual Review of Anthropology*. 24: 495–523.

Marrow, Helen. 2012. 'Deserving to a Point: Unauthorized Immigrants in San Francisco's Universal Access Healthcare Model", *Social Science and Medicine* 74(6): 846–854.

Mosialos, E., S. Allin, K. Karras and K. Davaki. 2005. 'An Investigation of Caesarean Sections in Three Greek Hospitals: The Impact of Financial Incentives and Convenience.' *European Journal of Public Health* 15(3): 288–295.

Papadopoulou, Aspasia. 2004. 'Smuggling into Europe: Transit Migrants in Greece', *Journal of Refugee Studies* 17(2): 167–84.

Sargent, Carolyn. 2012. '"Deservingess" and the Politics of Healthcare', *Social Science and Medicine* 74(6): 855–857.

Soto Bermant, Laia. 2014. 'Consuming Europe: The Moral Significance of Mobility and Exchange at the Spanish–Moroccan Border of Melilla', *The Journal of North African Studies* 19(1): 110–29.

———. 2017. 'The Mediterranean Question: Europe and Its Predicament in the Southern Peripheries', in N. De Genova (ed.), *The Borders of 'Europe': Autonomy of Migration, Tactics of Bordering*. Durham, NC: Duke University Press.

Ticktin, Miriam. 2006. 'Where Ethics and Politics Meet', *American Ethnologist* 33(1): 33–49.

———. 2011. 'The Gendered Human of Humanitarianism: Medicalising and Politicising Sexual Violence', *Gender & History*. 23(2): 250–65.

Triandafyllidou, Anna, and Thanos Maroukis. 2010. *Immigration to Greece of the 21st Century*. Athens: Kritiki.

UNHCR. 2018a. 'Operational Portal, Refugee Situations, Mediterranean Situations, Greece'. Accessed on 7 February 2019. https://data2.unhcr.org/en/situations/mediterranean/location/5179.

———. 2018b. 'Operational Portal, Refugee Situations, Mediterranean Situations, Italy'. Accessed on 7 February 2019. https://data2.unhcr.org/en/situations/mediterranean/location/5205.

_____. 2018c. 'Operational Portal, Refugee Situations, Mediterranean Situations, Spain'. Accessed on 7 February 2019. https://data2.unhcr.org/en/country/esp.

Willen, Sarah S. 2012. 'How Is Health-Related "Deservingness" Reckoned? Perspectives from Unauthorized Im/migrants in Tel Aviv', *Social Science & Medicine* 74(6): 812–21.

_____. 2015. 'Lightning Rods in the Local Moral Economy: Debating Unauthorized Migrants' Deservingness in Israel', *International Migration* 53(3).

Willen, Sarah S., Jessica Mulligan and Heide Castañeda. 2011. 'Take a Stand Commentary: How Can Medical Anthropologists Contribute to Contemporary Conversations on "Illegal" Im/migration and Health?' *Medical Anthropology Quarterly* 25(3): 331–356.

Willen, Sarah S., and Jennifer Cook. 2016. 'Health-Related Deservingness', in Felicity Thomas (ed.), *Handbook of Migration and Health.* Cheltenham: Edward Elgar Publishing.

Yarris, Kristin and Heide Castañeda. 2015. 'Introduction, Special Issue Discourses of Displacement and Deservingness: Interrogating Distinctions between "Economic" and "Forced" Migration', *International Migration* 53(3).

Chapter 9

Moral Economy of Exclusion
Cases of Childbirth on the Margins of Regularity
in the EU

Olena Fedyuk

Public discourses on human mobility in Europe have for decades been overshadowed by the dichotomy of the legal ('good') vs the illegal ('criminal') migrant. Terms like 'welfare tourism' marked an economic turn by giving a name to the undefined public paranoia surrounding the image of 'an immigrant'. On the one hand, these discursive tags reflected only a small part of the regularity/irregularity dichotomy that grasped the public imagination, in which regulated migration was seen as a model, while irregular, undocumented migration was criminalized and was to be punished. On the other, it reflected the economic logic whereby the deservingness of a mobile human being is assumed to be measurable and to have a material value equivalent to his/her economic contribution and ability to generate income (Bonizzoni 2018). And yet, research into the effects of legal status on the lives of mobile people has shown that the state of full regularity is difficult, and in many cases impossible, to achieve, with mobile individuals often being consigned to states of fragmented regularity in which they secure some form of documentation while lacking various others (Kubal 2013). In many cases, it is not lack of will on the part of the mobile person, but regulatory dead ends, the slow pace of the state bureaucratic machinery which fails to update status on time, or changes in legislation, that render an individual irregular or undocumented. The effects of such status fluctuations, although they only reflect the relation of an individual vis-à-vis a receiving state, often have a profound impact on individuals' access to geographic mobility, employment, social mobility and family life (Menjivar 2006). Therefore, periods of various forms of irregularity

are episodes (at least temporary) in many biographies, and as such represent a significant part of the experience of mobile people. Although non-political in nature, the lived complexities of such irregularities can be interpreted as a challenge to the black-and-white bureaucratic logic of regulated migration and a larger political challenge to the legitimacy of state control of human mobility (Casas-Cortes et al. 2015; Papadopoulos and Tsianos 2013).

It is from this latter perspective that this chapter investigates the experience of three third-country national women who gave birth on the margins of regularity in the EU. The chapter also gives insight into women's interaction with the police, their employers, friends and colleagues in those instances where the women's immigration status was concerned. The goal of the chapter is twofold – on the one hand it focuses on the women's strategies, when, facing childbirth and planning the reproductive life of their families, they patched together all available resources to secure access to the necessary medical and social care. On the other hand, the chapter explores the moral economy (Thompson 1971, see also discussion in the Introduction to this volume) behind these women's decisions, as choices motivated not only by economic logic but also by moral judgement as to what is just, even if it goes against the logic of the regulatory immigration regimes of their host countries. Accordingly, I explore women's perceptions of their status and choice of strategies as a critique of the stifling regulatory regimes they encountered. This latter focus is politically charged; I here stand together with all mobile people who on a daily basis contribute to the lives of their host societies with little hope of receiving the support they and their families need. I also stand with all those medical professionals, as well as those state and local officials, who, despite restrictive migratory regimes, in their daily professional practice support their clients irrespective of the latter's immigration status (for more discussion see chapters by Pérez, Rodríguez-Newey and Petel-Rochette and by Perna, in this volume).

The three cases are drawn from research conducted in segments between 2011 and 2015, which looked into the effects of migration status on migrants' life trajectories. At the core of this cross-country comparative research was a qualitative method, consisting mostly of life-story and semi-structured interviews with twenty-two research participants. Ethical considerations relevant to this chapter prevent me from giving more details of the location or origins of the women discussed here. Apart from protecting the research participants' identities and personal details, I am mainly concerned with revealing specifics of the strategies that women resort to in the course of their mobility. To avoid exposure of their tactics, which, as my research suggests, are commonly used

where the regulations fail to provide safe access to the most basic rights, I rebuild the life-stories of three women as generic, archetypal narratives.

The chapter proceeds to an overview of the notion of (ir)regularity and the managed migration debate in the literature. I then turn to a narration of the life trajectories of three women, from the start of their mobility to the moment of childbirth. I discuss the choices they made in the light of their mobility and their future plans as a map of the moral economy of mobility, that provides a fruitful political critique of the state's mobility regulations. Next I discuss how their stories and situational practices challenge the logic of the irregularity which they inhabit, allowing us to see the vulnerabilities the state creates and how their irregularity is managed at turning points in their biographies, such as childbirth.

The Politics of Mobility and the Fiction of the Regulatory Dichotomy

Critical migration research has repeatedly pointed out that, despite policy-makers' obsession with the regulatory migration regimes that give rise to the 'legal/illegal' dichotomy, fully regulated migration has been a historical fiction that hardly exists in empirical reality (for the debate on this, see Ambrosini 2017, 2018; Menjivar 2006; Bonizzoni 2017, 2018). Multiple studies have pointed out the messiness of lived experiences of human mobility and the incoherence of regulatory structures that cannot contain the diversity of ever-changing mobility patterns and practices (De Genova 2002; Papadopoulos and Tsianos 2013; see also the discussion in the Introduction to this volume). Similarly, it has been pointed out that the definition of illegal migration does not exist; migration regulatory policies define what is legal, de facto casting as illegal any deviation from the legal (Kubal 2013). If anything, the term has come to denote, rather, a political position of those who employ it: 'illegal' indicating intolerance towards immigration, and 'irregular' or 'undocumented' signalling a move towards a more inclusive perspective. In this chapter, I use the term '(ir)regular' as the most generic concept, indicating a certain inconsistency in the legal status of mobile individuals. I will make this generic concept more nuanced by introducing the notion of a moral economy, to explore how irregularity is experienced, narrated and made sense of by those with fragmented regularity status. Irregularity is often a (temporal) aspect of mobility, as diverse and fluid as mobility patterns themselves. Without understanding and fully considering experiences of irregularity, we are in danger of falling into the 'fraught politics of irregular migration' (Squire 2011: 3) in which an emphasis on immigration invokes a

state-centric perspective, while an emphasis on illegality criminalizes migrants (Squire 2011: 4).

Multiple critical perspectives examine multifaceted features and functions of irregularity as a valid, critical state, ripe with political potential that is too often disregarded. These studies point to the general feature of irregularity that can be summarized in four broad points. First, irregularity has no one face or form but comes in many diverse forms, evoking the conceptual struggle to define it. Some scholars, accepting the definitional challenge, have spoken of 'liminal legality' (Menjivar 2006), 'semi-legality' (Kubal 2013), or 'clandestine immigrant workers' (Düvell 2008). Second, irregularity is often partial and can be defined only in relation to particular regulatory regimes (see the discussion in the Introduction to this volume). For instance, Ruhs and Anderson (2010) make a convincing case for the great diversity of irregular practices. They describe how many mobile workers in the UK have engaged in such economic activities as working long hours or doing types of work that exceed the limits of their visa status, while their entry and stay were perfectly in accordance with their travel documents. Third, regularity is not static, but fluid, fluctuating and temporal; 'with or without formal changes in the law, people may move between different statuses with varying degrees of agency and expedience' (Kubal 2013: 560). This reminds us that one and the same person can shift between documented and undocumented states, at times due to their own decisions, at times due to a change in the regulations which can deem them irregular. Fourth, despite the common perception, irregularity is not produced by the illegitimate behaviour of a mobile individual. Irregularity is 'a condition that is produced through various processes of (ir)regularization' (Squire 2011: 5). This critical point allows us to shift the focus from mobile people towards the states which define the grounds of (ir)regularity. Moreover, it provides a space for questioning the legitimacy of these definitions and the logics behind them. It thus leaves scope to question whose interests managed migration represents, and what the goals are of delegitimizing one form of mobility but not the other.

Scholarly debate that has emerged around the ambiguity of regularity and legitimacy has developed mostly in the spheres of citizenship and membership (Soysal 1994; Isin and Saward 2013), the nature of borders and border controls (Mezzadra and Neilson 2013), inclusion based on (un)deservingness (Bonizzoni 2018; De Genova 2013), or – as in the autonomy of migration (AoM) approach – the legitimacy of national claims to regulate human mobility (Casas-Cortes et al. 2015). The last approach offers two particularly valuable perspectives from which to understand the choices and reasons guiding the women in this chapter. For one thing, AoM allows us to explore the political challenge that mobility presents

to the logic of state-controlled migration. It foregrounds the idea that migration is not primarily a movement defined by claims of institutional power. It rather indicates that the movement itself becomes a political and a social movement. In this important analytical distinction, the practice of human mobility is seen as a political act, calling into question institutional attempts at control, even when such mobility is devoid of an articulated or unified political claim.

Second, the AoM thesis calls on us to dissect the power struggles between human mobility and various institutional claims to the management or control of these movements. It highlights the social and subjective aspects of mobility rather than its control:

> Mobility drives control not the other way round. This does not of course mean that mobility operates independently of control. … Migration grapples with the harsh, often deadly, realities of control. However, the point is migration is not just responding to them. Rather it creates new realities which allow for migrants to exercise their own mobility against or beyond existing control. (Papadopoulos and Tsianos 2013)

Vicky Squire, building on the AoM approach, calls for 'a more dynamic politics of mobility' (2011: 5) reading, in which irregularity is to be 'contested, resisted, appropriated and re-appropriated through a series of political struggles' (2011: 5). I argue that the three women whose stories will be discussed in the chapter, via their choices and practice, articulate a political critique of the limitations of their status, as experienced in their host countries.

Finally, my focus on the decisions and motivations of the three women aims to demonstrate that, besides the economic motive that in some ways triggered their mobility, the women in many respects pursued non-economic goals like the chance of personal happiness, the vision of the proper family unit, and ideas about the right timing for motherhood. Their decisions are driven by their moral and cultural judgements of what is right, which at times clashed with the state logic of borders and immigration regimes. Here, the concept of 'moral economy' (Thompson 1971; Kofti 2016), as a framework allowing us to see the moral judgement on which the economic decisions are based, comes in useful. Building on E.P. Thompson's original concept, which he uses to present moral norms as a type of informal contract that binds those in power to those dependent on them, Kofti uses 'moral economy' as a set of values that guide economic and political choices beyond formal regulations in the context of workers' mobilization or lack of it. Kofti argues: 'Moral economy may offer an analytical lens to study the dynamic relations of values, ideas, and political and economic practices' (Kofti 2016: 434). In this chapter, the

moral economy approach allows an exploration of the motivations of the three women, as they act against and despite the state logic controlling their mobility. The chapter thus aims to see beyond the economic motives for mobility, and into the realm of moral decisions challenging the logic of state controls. It also enables us to read such a challenge as vested with political potential, even when the protagonists do not articulate any straightforward political claims.

Three Women: Birthing on the Margins of Regularity

Valentina: Solving an Administrative Puzzle with Missing Pieces

Valentina sounds composed and confident. We have an interview on Skype call, without video, so I am only left to imagine a confident woman in her early 30s, whose voice is calm, and whose answers to my questions are lengthy and detailed, as if they are not about her own life, but about a professional field in which she is an expert. Like many migrants from the post-Soviet states, she has a high level of education but no work experience in her field of study. Migration was her first professional step. She is a lawyer by training, and after being offered a 'professional practice abroad' by her university for the 'modest' sum of 4000 USD, she went abroad to pick fruit together with other graduates of her course. Valentina said that she was not bothered by the skill mismatch; she had just finished university and before plunging into a job search at home she wanted to see the world and try life abroad. After a job at a strawberry farm she found another job and gave herself a year to experience life away from home, but it has been over ten years now since she left her home.

 As for many mobile people, Valentina's migration story started with very different expectations and motivations. She went abroad in a fully regularized manner, matched by her university professor at home with a foreign work agent who organized all the paperwork, work permits and contracts. However, Valentina very soon realized that jobs were easy to find, while her youthful ambition to see the world and the initial price of a journey (4000 USD in her case) were strong enough incentives for her to move on without proper authorization for work. She changed cities, following job offers along the informal but ever-strong network of 'friends of friends' and experiencing a certain growth in her professional migrant career. She worked at various jobs, in fields including agriculture, cleaning and geriatric care. Meanwhile her steady upgrade required her to resolve her deficient regularity status in whatever ways were available. Since her host country provided no amnesty procedures for irregular

migrants, and a trip home would probably entail an investment of thousands of dollars in order to then make another trip abroad, Valentina did not risk a return home but preferred to stay on with expired documents. By that time the expansion of the EU eastward in 2004 brought a solution to her situation: she bought a passport and a local tax number from one of the new accession country nationals and re-entered the European labour market under a different name, but in what Valentina feels was a more honest way – as a full-fledged taxpayer.

At that point Valentina moved yet again and started to work as a geriatric carer in a local family, whom she came to see as her best friends and guardians. When she started in the job, she introduced herself by her adopted name, inventing a story about her place of origin but mixing in all the main biographical details of her own life. Valentina said that the family received her with a great deal of respect and appreciated her work, and when they realized that she had a college degree they encouraged her to seek a job that would be better suited to her educational background. This encouragement and the documents which allowed Valentina to become a contributing citizen, although not under her own name, gave her, in her own words, that moral legitimacy that she lacked while working without paying taxes. She looked for jobs in a local paper and soon became a manager in a local supermarket. Even though the job was far from what she had trained for at university, it gave her a sense of professional upward mobility compared to her previous jobs in cleaning, caring and agriculture.

When Valentina and her partner, a fellow countryman with a similarly irregular status, got together, she admits that she felt under a lot of pressure from her family back home. They did not appreciate Valentina's living in a civil union without being married. But her national passport had expired and she could not get married in the Embassy. When she became pregnant, a return home became even more problematic; Valentina feared the uncertainty of moving back without work or savings, and facing the even more proximate pressure of her family. She sought advice from a lawyer from her country of origin, but left with a sense of helplessness and of having been cheated after paying three hundred euros for a visit. She then gathered the courage to go to a local lawyer, who, after hearing her story, recommended a course of action and charged only one hundred euros.

Valentina describes the administrative challenge surrounding childbirth with irregular status as a puzzle that she needed all her strength to put together. First she registered for prenatal care in a small town next to the city where she worked, using the name on her purchased documents – the same name she was known under at her workplace. In

due course she obtained, in her adopted name, a twelve-week pregnancy note for her workplace, making her eligible for six months of maternity leave. When she was about to give birth, she went to another hospital under her real name, cooking up a story that she was just visiting her boyfriend for a while. Her baby girl received a local birth certificate stating the real names of both parents, but no other documentation or rights. Valentina never received any child benefits but was able to stay at home and have her job held open for six months, based on her twelve weeks of pregnancy certificate.

When I ask Valentina about the emotional cost of these arrangements, she brushes aside my sympathetic tone: she is very grateful to be able to receive full prenatal and birth-giving medical care. She says she feels good about being able to contribute to the system through her taxes, and also to be able to use it, at least partially. She explains that this gives her a sense of proper European citizenship, unlike the situation back at home, where even if she paid tax, she would have to pay even more in bribes and gratitude payments at the time of birth. She is happy that her daughter was born where she was, and is proud that she is now friends with the grandchildren of the local family where she originally worked as a caregiver. Valentina's voice shakes only once, when I ask if she plans to tell her daughter about her 'double identity':

> I just won't. We will go back before she is old enough to ask. I can't bear the thought that after years of friendship I've never told this family where I'm really from or my real name. I don't want my daughter, who is now friends with their children, to be a part of this . … in some cases I wish we had a way to regularize, marry, have normal documents … after all, their lawyer helped us, many people at work could realize my story doesn't add up but they don't ask questions. I pay tax, I work well, I don't know why we have to leave or who will win from this.

Valentina's account offers a picture of irregularity that suggests a viewpoint varying from the mainstream, which often paints irregular migrants as perpetrators. From the start, she felt that her motives for mobility were reasonable – as a young graduate she wanted to see the world, learn a language and experience life in a different country, which, due to her national passport, was very difficult to achieve. She thus turned to some readily available commercial intermediaries who organized her mobility, and once abroad put her mind to figuring out the legislative regulatory system on her own, without having to pay intermediaries. She also justifies her actions by a plain economic logic of contribution and benefit: she feels that, by paying her tax, it is only just that she should get state support for her maternity.

In her mobility Valentina does not break any ground, but rather uses well-established formal and informal channels of mobility; she paid for recruitment to her first job (using an intermediary network involving her home-country university professor and a recruiter abroad), she purchased tax documents from readily available networks, she obtained advice from a local lawyer on how to receive maternity entitlements. If anything, she challenges the stereotype of a 'welfare tourist', as she purchased documents that allow her to pay tax, while lacking the other documents needed for access to full social benefits. Valentina even suggests that people at her workplace might be aware of her 'secret', yet her whole experience indicates the contrast between, on the one hand, their benevolence, and on the other, the precarious position she occupies on a state level. She feels that the real price for this flexibility is one that she pays alone – through compromising her sense of integrity and honesty in the relationship with her friends. Valentina thus does not live in fear of expulsion; she rather questions why there is a need for such pretence and, ultimately, who benefits from her insecurity: 'I don't know why we have to leave or who will win from this'.

Valentina's question adds to the critique based on the well-documented abuses of the human and working rights of undocumented and mobile citizens. As we see increasingly, accusations of irregularity often overshadow cases of abuse and labour exploitation; consider how, very often, the victims of labour exploitation are deported on grounds of unlawful stay before they can press charges against their exploitative employers (Apostolova 2018; Greer et al. 2011). Migration literature that warns against 'cataloguing of migrants' shows that many factors, such as age, race, gender, health, social status and, above all, capacity to generate income, often play a role, earning migrants 'points' in migratory regimes (De Somer 2012). The EU has repeatedly articulated its need for high-skilled migrants, so that

> [t]he distinction between regular and irregular migration that informs neo-liberal 'managed migration' policies is now familiar. On the one hand, the 'legitimate' movement of people across borders has been approached as a productive force to be harnessed or managed while, on the other hand, the 'illegitimate' movement of people across borders has been approached as a destructive force to be controlled or restricted. (Squire 2011: 3)

Migration trajectories like Valentina's reveal that the extent of control and management between the national labour markets and migration is rather incomplete, as migrating individuals and employers challenge this control through practices of both unsanctioned migration and informal employment. While the AoM perspective invites us to read such practices

as unarticulated critiques of the malfunctioning migratory and employment regimes, I would like to point out that these practices heighten power struggles and vulnerabilities, often pushing the price of insecurity onto the shoulders of individuals with lower levels of regular protection, i.e. in most cases a migrant worker.

Alina: Personal Cost of Irregularity

Alina is thirty-six and she experienced her mobility as not only a spatial but also a tremendous social and emotional journey. A graduate of a pedagogical university with English and German linguistics as her major, she left her home country two years after graduation, along with her husband, who was fifteen years older than herself and who was by that time an experienced labour migrant. Using his contacts in the countries where he had worked before, he purchased EU passports for both of them in order to make a move further westward. When they first arrived in their destination country, he worked in construction and later even started a shop of his own, where Alina worked informally as a sales assistant without any documents. After three years their marriage fell apart in what Alina describes as a 'disaster': her husband escaped back to their country of origin, leaving Alina behind to sort out his failed business and debts. From a position of full dependency and reliance on her husband, Alina suddenly found herself all alone, starting from scratch. She said that a return home was impossible; her husband was there and he had everything, while she had nothing. In order to get access to employment she purchased a tax number from an acquaintance, a citizen of a new EU-8 accession country, who was returning home on the wave of the 2008 economic crisis. Alina kept in touch with that person and stepped into her shoes as a taxpayer and social benefit contributor, paying, among other things, the other person's pension contributions. However, the solution was not ideal, as her acquaintance was forever urging her to drop the use of the number: whether from an attack of remorse, from fear, or in an attempt to make Alina pay again, Alina couldn't tell.

Alina described the biggest challenge of her status caused by the split in her personal life: 'I was renting a room in a house share, with local students, and for the contract I had to give my ID. So they know me as Edit. But over time we became friends; they have me on Facebook under my real name. They never asked questions, but I felt so guilty'. Alina met her partner, a local man, on a dating site. She recalls that she managed to tell her own story to him over the next year, in small bits, working through it almost as if she were in therapy:

> It's just so difficult, how do you start to say all this? I had to tell him that I was married and not divorced and not from the country I said I was, and my name is not what I said it was … . I mean, and I wanted to tell him that despite all that I am not a criminal, I am just a normal person, I am here to work that's all … . And also that he can trust me … . The more I was postponing saying it the less possible it becomes to ever mention it. I don't even know how I manage to tell all this to him. … It happened slowly, I don't even remember how I told him.

Alina got pregnant a year into her relationship but had a miscarriage at an early stage. This experience brought her even closer to her partner and she recalls knowing that she wanted to try again. When she became pregnant with her daughter she kept her job as a barista at a university cafeteria until fourteen weeks into the pregnancy and then quit without telling anyone about her pregnancy. Alina speaks with an air of great relief over that step, and when I ask her whether she considered claiming benefits, since she had paid tax for at least four years prior to the pregnancy, she exclaims: 'I was so relieved I could leave that life behind! I cut all my contacts, I didn't want to continue with this double identity. I think I was mostly relieved to finally be myself and not have to be someone else. I would give up anything for that!'

For prenatal care Alina was asked to provide her residence documents and ID, but instead she showed up the next time with her partner and, in her words, 'No-one ever asked more questions'. She was registered under his social security number and their baby was registered under Alina's maiden name (which was not the name on her expired national passport). Because Alina had no valid documents (her national passport being in her husband's last name and expired), they had to secure parenthood through the court. Their daughter is registered with the local GP in the name of Alina's partner. When I ask Alina the provocative question of whether she feels secure and what might happen to her and the child if her relationship should take a turn for the worse, she pauses, seeming to look inside herself for an honest answer:

> I can always turn to his parents. When I got pregnant his mother called me and showed me her new will – imagine, she included me in her will. She said I can always count on her. The kindness these people are capable of … so hard to imagine. I don't know if I would be able to do it [like her] if I was in her place. To trust someone, a foreigner … but I really am just an honest person. I am not afraid at all, to tell you the truth. I am not doing anything wrong. I simply came here like the others to earn some money, to see the world, to live like a normal human being.

Since the birth of her child, Alina has been hoping to obtain regularization based on the fact that she is the mother of a citizen. It is a slow process because, with her national passport having expired, she has no valid documents. She would need to return to her country of origin and apply for a family reunification visa; but for that she would need to obtain a divorce back home. Knowing her husband, she suspects that she will need to buy her way into an easy divorce. Additionally, with a small baby and all the complications of this situation, she does not want to risk going home yet, knowing that it would be painful for her partner to miss out on the period of early childhood in the life of their daughter.

Alina's account seems to bring home what is only hinted at in Valentina's more organized and affirmative story: the emotional and social cost of irregularity for individuals. Although it is fragmented and activated in relation to particular authorities and regulatory regimes, irregularity generally describes the relation between the mobile individual and the receiving state. As Kubal points out in her critical dissection of the notion of semi-regularity, the relationship to a state is only one sphere, which does not need to override all other spheres of a migrant's social and economic life. And yet, in Alina's case, she feels that her very personal integrity is overshadowed by this relationship to the state, and by the guilt she feels without having committed a crime. Alina argues: 'I am not doing anything wrong. I simply came here like the others to earn some money, to see the world, to live like a normal human being'. And yet, she is under constant threat of being exposed, or of losing the trust of people who are dear to her.

Isolation is the price of irregularity for Alina, pushing her into various forms of dependency. Thus, the pressure she is under from the person who sold her the documents, and to whose social benefit account she was contributing on a daily basis, together with what she feels is an 'immoral' double identity, makes her shy away from forming strong social ties and taking steps towards fuller integration with the host society. I read her account as full of strength and vulnerability at the same time; while she challenges her fear by getting into a relationship despite her status, and braving pregnancy and childbirth, her feeling of gratitude to her partner and his family can potentially push her to internalize her guilt. Also, because of her situation she has not developed any independent mechanisms of support for herself and her daughter in case her relationship should deteriorate; the mother of her partner made an act of commitment by including Alina in her will, but even this action is outside Alina's own power to control. Thus, while Alina repeatedly emphasizes that she does not see her actions as criminal or immoral but a mere migration strategy in the context of an unforgiving migration regime, she still internalizes

the guilt and shame attached to it. The keen sense of shame stems from how Alina believes her situation must look to citizen onlookers, and again brings to the fore the personal and emotional price of irregular status for its bearers.

As I will discuss further, her undocumented status weighs heavily on the shoulders of each woman in this chapter. Thus, in Alina's case, she simply 'doesn't remember' how she managed to tell her partner, indicating a psychological block on the very memory, which is too traumatic to recover. The status also interferes with the women's relationship with their young children; none of the three women intended to explain to their children why they were called one name within the family and another by their friends. It is a heavy burden for all my respondents, and one which they plan to resolve by ending economically beneficial migration. Valentina says that after over ten years in the receiving country, she plans to go home before she needs to 'come out' about her double identity to her child. Her biggest fear is that she will need to tell a local family with whom she has been very close friends that she had to lie to them about her origin and status. And yet, the sense of a right moral decision is strongly present in all the women's narratives, since they view their tax and contribution payments as fair, just and concrete actions. Alina comments: 'For all these years I have been paying taxes and contributing to the pension of this person, who is back at home, can come back and claim these contributions any time. I will never claim them. In the meanwhile, I am not getting younger, and it would be nice to deserve a pension for my contributions'.

All three women in my research articulate the tension between their sense of guilt over their 'immoral double identity' and 'being honest', as proved by their participation in the labour market and even contributing to social benefits without significantly claiming them. I see this as the tension between the two regimes of moral economy operating in the lives of my protagonists. One is the discursive legitimation of the state-controlled legal categories that define access to resources (social benefits, work, healthcare) and, increasingly, entailing legal or criminal responsibility for irregularity. The other regime is the moral economy of mobility, which from the beginning poses the question of the fairness and legitimacy of the rules set up by national governments. This latter regime builds strongly on the notions of deservingness, which are linked to morality, rather than on a political critique of the state. As also discussed in the chapter by Perna in this volume, it is not only mobile people, but also street level bureaucrats, health and social workers interacting with mobile people who often act upon the moral values determining who deserves help, thus making the assessment of deservingness the subject

of continuous negotiation (Perna, in this volume). Conceptualizing these continuous situational negotiations as a moral economy of mobility allows us to link the economic to the moral and the moral to the political, as an 'unarticulated challenge' that the practices of irregular migration present to the nation-state's claims to the control and management of mobility (Papadopoulos and Tsianos 2013).

Edina: The Open Secret of Irregularity

Edina set out on the move by joining her boyfriend, on a promise by his family to finance their initial migration and find them their first jobs. Moving as a couple was a big thing: his family sponsored them with 3000 euros each, and their visas and work permits were organized through an intermediary. Like the two women previously discussed in this chapter, Edina and her boyfriend had valid permits to stay and work, but with the expansion of the EU eastward and the economic crisis came a tightening of migration and regularization opportunities for third-country nationals. The opportunities for regularization seemed to shrink for Edina, driving her and her boyfriend to patch up their increasingly irregularized stay. Through the black market channels offering IDs and tax numbers of the new accession countries, they both became taxpayers under new identities, while Edina's boyfriend also applied for regularization with his original documents, 'just in case'. At one point immigration police raided their home, and because Edina kept her adopted and real documents together, their situation was exposed. When I asked her whether she was scared, she quickly replied 'No, these are all open secrets!' Indeed, the guards merely confiscated her purchased documents and returned her original ones, mildly telling her off. 'It is not so dangerous, but just incredibly time and energy consuming to obtain various documents, just endless tangled messy business', remarks Edina.

Meanwhile Edina's partner, Oleg, used his original visa and work permit to obtain a tax number in his own name, but by then his occupation as a manual worker had for many years caused him to be deemed unsuitable for renewal of his work permit, despite available job offers and previous permission to work. Thus, three years prior to our conversation, he had taken the opportunity to apply for an amnesty with his documents, and he was still waiting for the response, which was supposed to have arrived within a year of his application. This waiting, which originally was to last for a year, but due to the bureaucratic backlog was taking much longer, plus Edina's family's pressure on her to have a baby soon, made her feel trapped; accordingly, getting pregnant constituted the dynamics that defined Edina's story. At twenty-six, with

a vocational education, Edina had little in the way of career expectations; her job as a cleaner was becoming very boring after years of doing it and she keenly felt her reproductive clock ticking: 'We should have waited for the documents, but we waited for so long, and it was so uncertain how much we still needed to wait … . But a baby is a baby, right? It comes when it comes, right? One should just be happy'.

Edina gave birth under her real name and associated documents, referring the costs to the social security entitlements of her partner who was still waiting for the decision on his amnesty. When I ask her whether it is difficult to deal with irregularity, she bursts out with the words:

> What do you mean, irregularity?! Irregular for whom? How do you define that? OK, maybe I do not have a document to enter, maybe border guards can consider me illegal, but ever since I am in [here] I pay all taxes every day. OK, I do it under a different name but what does that matter? I pay back everything! I don't ask anything back. In this sense I think I am more legal citizen than those local people who spend all their lives on social benefits never contributing anything.

Of all the three women in this chapter, Edina was the one who cared the least about staying. In fact, she was very bored with her job and wanted to return home to make a fresh start in life. She felt that the long wait for her partner's documents dragged them into a state of constant fatigue:

> Anything is better than this waiting. I wish they would just tell us 'yes' or 'no'. Anything is better, at least we could move on. This waiting is inhumane. I feel we need to plan our future, I want to marry my partner, plan a future for my girl. But it would be very stupid, after all we went through, to leave without getting a response from the authorities.

Edina's story is a clear case of irregularization of mobile individuals through the bureaucratic failure of the state to meet its own regulatory standards. Due to lack of resources and personnel, an amnesty application was taking three years and counting, instead of the one year stipulated in the procedure's description. These three years prolong the period of irregularity not only for her partner but for Edina as well. Although unable to give up the hope of regularization and unwilling to leave without an answer from the immigration authorities, Edina refuses to base her whole life on the mercy of that decision and goes ahead with the risks of pregnancy and childbirth in this legally highly vulnerable position. Edina's case brings forward the critique of managed migration, in which the mobile individuals' status constructs them as irregular, illegalizing them through a failure of the state's bureaucratic machine or a change

in its regulations and policies. Similar situations arose in several cases in the larger framework of the project from which I chose the three stories for this chapter; participants in the research described periods in their mobility history when, due simply to the overburdened condition of the state apparatus, they remained undocumented for periods of time varying from months to years. These conditions often had serious impacts on their family rights, transnational mobility and possibilities of professional development.

Another important element that is to some degree present in all three stories here is the indirect incorporation of the women's irregular status into the institutions and socioeconomic canvas of their host countries (localities), as indicated in their direct interaction with aspects of the state – such as immigration control, health services and workplaces. Edina's story speaks most prominently of what Valentina and Alina refer to as the 'known secret' – the fact of their irregular presence in the receiving country. In Edina's case, when the immigration police themselves ignore her possession of purchased identity documents, they send Edina the message that the rules of the immigration game exist not in the written regulations but in the moral economy of mobility. It also opens up an issue that, as is discussed in greater detail elsewhere in this volume (see Perna), state policies should not be equated with their implementation, inasmuch as street-level state servants (like police or immigration officers) are not passive recipients and implementers of the state's regulations. Instead, they engage in active processes of justification whereby various identities can gain prominence and different regimes of moral justice can dominate their decisions.

Reinhard Schweitzer (2017), in his eye-opening dissertation on public service provision for immigration enforcement in London and Barcelona, develops a concept of 'micro-management of migrant irregularity', as a way of grasping the contradictions and local day-to-day implementation of the national immigration regimes. Schweitzer explains how the implementation of the policies depends not only on local resources but also on local translation of the logic of the policies: 'the responsible agents of the respective state have to consolidate a distinct logic of exclusion towards irregular migrants with the highly context-dependent logics of inclusion and exclusion that normally underpin the entitlement and access of local residents, patients, students or welfare recipients' (Schweitzer 2017: 7).

In the lives of my three protagonists, the logic of the restrictive national policy, denying legalization or amnesty, is compromised by the very citizens of the host countries, and the very authorities who are supposed to implement the restrictive immigration controls. Many of the women's encounters with immigration authorities, medical services, colleagues,

neighbours and partners' families confirm their observation that their presence is an open secret, not only tolerated but often valued.

> They [authorities] know that there are many people like us [irregular]. They would have no money to deport us all. (Edina, interview)

> I wish [they] would regularize local migrants, those who work here. That would be the right thing to do. This way we could work normally. (Valentina, interview)

Thus, from the case of Edina, who gets away with a small rebuke in an encounter with the immigration police, to that of Valentina, who gets advice from a local lawyer on how to obtain maternity benefits, the women's experience repeatedly shows them that their presence is not entirely unwanted: that it is what De Genova calls a 'dirty secret of migration' – integration through reliance on irregular labour (De Genova 2013; Wills et al. 2010; Squire 2011). It is to this open secret that all three women appeal as legitimizing their presence in the host countries, and through this secret that woman address their critique of the state which deliberately ignores the hardships and dependency that such irregularity imposes on the women's personal and professional lives. They also critique it as an 'unfair' status quo, within which, even if they have lived in their host countries, contributed to their social systems with their taxes and work, and become what Valentina so eloquently calls 'local migrants', they see themselves as both excluded from and yet incorporated into the system through their dependent state of irregularity.

Challenging the Politics of Control

First and foremost, the three cases in this chapter turn the 'welfare tourist' stereotype upside down, with a migrant turning to black market intermediaries in order to purchase a chance to pay tax and social contributions, without much hope of receiving various forms of benefits. If anything, we have three stories of women contributing to the system despite their irregular status. Cecilia Menjivar, exploring the question of how mobile people's uncertain statuses affect diverse aspects of their lives, argues that 'legal status shapes who they are' (2006: 1000), having a paramount effect on every sphere from employment to social integration, from health and well-being to vulnerability to violence. Her proposed concept of 'liminal legality' seems to fit the complicated arrangements of the three protagonists in this chapter; without owning the proper work permits and visas, they purchased identities under which they

could access the labour market and pay the full tax, social and pension contributions of real people, who at that time were located in a different EU country. What these stories also importantly testify to is a system in place that protects itself from taking responsibility for these women by maintaining the 'open secret' of their irregularity.

And yet, from a certain perspective the concept of liminal legality seems too small for the experience of the women I write about; it evokes a static liminal space, which, although it can be fluid, is hardly shaped by the agency of those inhabiting it. Instead, the experiences of the three protagonists in this chapter are thoroughly shaped by their will for mobility, their resourcefulness in overcoming the limitations of the migratory regimes they operate within (or which operate on them), and their own unflagging sense of moral judgement about the right thing to do in their situation. It is on these three components – the will to mobility, the moral judgement as to what is right, and action upon this judgement against and despite the national regulations – that I would like to focus in my discussion.

The focus on moral judgement and action as a moral economy of migration guiding the three women in my research is instrumental in unpacking the unspoken political critique that is articulated in their mobility. Although their movement falls into the classification of labour or economic migration (as none of them had fled their home country, asked for asylum, or joined in an act of family reunification), the women's stories point to many non-economic motives that drove them in making their practical decisions. Thus, all three women were prompted by reasons beyond the economic in their decision to migrate. For Alina and Edina it was a larger family project in which joining their partners was a step that was expected of them to keep their families together. For Valentina, the motivation was to see the world, learn and experience a different life before committing to a career path. And although none of the women speaks of or articulates her actions as political, I see their actions as an unnamed political critique of the regulatory limitations in their host countries, which women dismiss as unjust and as limiting their rights to movement and the pursuit of personal happiness. Repeatedly, all three women referred to their status regulations as 'unjust' and 'unfair'. Alina points out in an earlier quoted episode 'I really am just an honest person. I am not afraid at all, to tell you the truth. I am not doing anything wrong. I simply came here like the others to earn some money, to see the world, to live like a normal human being' (Alina, interview). Their commentaries and choices of strategies position mobility as a basic aspect of human experience, while state controls, by contrast, as only temporary and to be overcome.

It is in such subtle non-compliance, in the strength to challenge the legitimacy of the national migratory regulations and bend the practice of the immigration law, that Squire (2011) locates a truly political potential of irregular migration. Indeed, the women in my research reject that logic that denies them mobility, juxtaposing to it their own moral logic as contributing members of the host societies. In fact, they contribute despite the regulations limiting them; as Edina boldly puts it, she sees herself as a more deserving citizen than those local citizens whom she views as a burden on the social benefit system: 'I think I am more legal citizen than those local people who spend all their lives on social benefits, never contributing anything' (Edina, interview). The logic of a deserving citizen, as much as the stigma of an undeserving one, is adopted from the same logic that deems them irregular, and yet, in a proactive step, the women redeem their own status within their own moral logic, if not in the eyes of the law. Notably, all three women, while not posing any political critique per se, question who it is that gains from their status, and why they are cut off from any straightforward way to regularize their presence. All three women see their presence as an open secret (known to the state authorities but also possibly to colleagues and medical personnel) and their contribution as valued (none of the women loses her job and becomes unemployed), despite the persistent denial of their opportunity to regularize.

With this awareness, and particularly in the face of birthing and a moral right to bring a new life into this world in safety, the women refuse to accept the discursive label of their status. Valentina, with a help of a local lawyer, braves the process of taking maternity leave, basing the justice of this claim on the fact of being a faithful taxpayer. Alina shies away from asking for healthcare in her adopted name, relying instead on her partner's support. Although this puts her in a situation of almost complete dependence on him, her confidence in him gives her a chance to simply leave her double identity behind. Alina sees her relinquishment of state support as a symbolic 'price' that she can afford to pay for breaking away from the irregularity in which she has had to function for years. In Edina's case, she refuses to offer up the cycle of her personal and reproductive life on the altar of regulatory experiences that require her husband to wait for his regularization, and goes ahead with pregnancy and childbirth in a legal limbo. In all three cases, the women bring in several moral value systems which they navigate and which gain prominence and determine their migratory choices; Edina and Valentina keenly feel the pressure of their extended families back home to formalize their relationships through marriage and to hurry up with child-bearing. Interestingly, it is these pressures, rather than

migratory restrictions, that determine their choices, yet their relation to the state determines the limits of the support they can receive on the path to motherhood, which in turn directly translate into the quality of their family life (e.g. Valentina's need to go back to work after six months).

Conclusion

In all three cases, the women had some aspects of regularity – they worked officially, even though under a different name, and paid tax and social contributions throughout their employment history. This last fact gave all three women specific moral justification in their own eyes, when in the light of upcoming childbirth they found that the state made no provision for straightforward, fully regularized pre- and postnatal care. Each woman resorted to a particular way of circumventing her partial irregularity, appealing to the economic logic of her contributions; if she had contributed with tax and social security payments for years, albeit not under her real name, was she not entitled to receive care in such a pivotal moment of her biography as childbirth? And yet, as their interviews demonstrate, these decisions came at a great personal price in private insecurity and guilt (for Valentina and Alina), personal sacrifice (for all three women, the inability to have their children within a legally registered marriage), and what my respondents refer to as 'just incredibly time and energy consuming' administrative puzzles (Edina, interview).

The cases of the three women presented in this chapter are specifically selected to speak to both the moral and the economic logic of the dichotomy of regularity, and come from a larger project that looks into the individual costs of regularized status for mobile individuals. Irregular migration, far from being the antonym of 'regular' migration, is a space of revisionary potential that can challenge not only the practice but the very logic of the increasingly restrictive national and supranational migratory regimes in the EU. Irregularity, as a lived experience rather than a bureaucratic category, contains practices of resistance to such categorization, a critique of unrealistic regulatory expectations, and an (unarticulated) political critique of the right of nation-states to manage human mobility.

And yet, this perspective allows us to see migrants not as passive objects of the state politics of control, which often change along with changes in policy or government and can render more or less legal people who are already practising mobility. Their story opens up space for the necessary investigation of the motives that guide migrants in

their choices and practices. It also transcends the simplified perspective of migrants as free-will agents operating within a fully informed and deterministic mindset. Instead, it allows us to imagine 'a more dynamic politics of mobility' (Squire 2011: 5): a more politicized and egalitarian frame in which states are involved in a politics of control while migrants exercise the politics of mobility.

Olena Fedyuk obtained her PhD degree from the department of Sociology and Social Anthropology at the Central European University, Budapest. Her dissertation is an ethnographic examination of transnational moral economies and distant motherhood through the cases of Ukrainian female labour migrants to Italy. Her recent work deals with transnational labour migration, overlap of gendered employment and migration policies as well as transformations in care and labour regimes. Since 2012 Olena has directed two documentary films: 'Road of a migrant' (2015) deals with the role of the church in migrants' lives and 'Olha's Italian Diary' (2018), which is a sneak peek into a life of a sole female migrant. Olena's most recent action-based research brings together migration and industrial relations perspectives by exploring the growing field of temporary work agency in employing third-country nationals in the EU.

References

Ambrosini, M. 2017. 'Why Irregular Migrants Arrive and Remain: The Role of Intermediaries', *Journal of Ethnic and Migration Studies* 43(11): 1813.
———. 2018. 'Irregular Migration: Beyond Common Wisdom, Irregular Immigration in Southern Europe', *Irregular Immigration in Southern Europe* 1–31. https://doi.org/10.1007/978-3-319-70518-7_1.
Apostolova. 2018. 'Obstacles Before Struggles: Freedom of Movement and the Conditioning of Collective Response', in Olena Fedyuk and Paul Stewart (eds), *Inclusion and Exclusion in Europe: Migration, Work and Employment Perspectives.* London and New York: Rowman & Littlefield International.
Bonizzoni, P. 2017. 'The Shifting Boundaries of (Un)Documentedness: A Gendered Understanding of Migrants' Employment-Based Legalization Pathways in Italy', *Ethnic and Racial Studies* 40(10): 1643.
———. 2018. 'Looking for the Best and Brightest? Deservingness Regimes in Italian Labour Migration Management', *International Migration* 56(4): 47−62.
Casas-Cortes, M., S. Cobarrubias and J. Pickles. 2015. 'Riding Routes and Itinerant Borders: Autonomy of Migration and Border Externalization', *Antipode*, 27 March. https://doi.org/10.1111/anti.12148.

De Genova, N. 2002. 'Migrant "Illegality" and Deportability in Everyday Life', *Annual Review of Anthropology* 31: 419–47.

———. 2013. 'Spectacles of Migrant "Illegality": The Scene of Exclusion, the Obscene of Inclusion', *Ethnic and Racial Studies* 36(7): 1–19.

De Somer, M. 2012. 'Trends and Gaps in the Academic Literature on EU Labour Migration Policies'. NEUJOBS: state of the art report no. 5. Accessed on 6 February 2015. http://www.neujobs.eu/sites/ default/files/publication/2012/12/ NEUJOBS%20D.18.1.pdf.

Düvell, F. 2008. 'Clandestine Migration in Europe', *Social Science Information* 47: 479–97.

Greer, I., Z. Ciupijus, and N. Lillie. 2011. 'The European Migrant Workers Union and the Barriers to Transnational Industrial Citizenship' [Electronic version]. Retrieved 22 January 2020 from Cornell University, ILR School site: http:// digitalcommons.ilr.cornell.edu/articles/974.

Isin, E., and M. Saward (eds). 2013. *Enacting European Citizenship*. Cambridge: Cambridge University Press. https://doi.org/ 10.1017/CBO9781139524025.

Kofti, D. 2016. 'Moral Economy of Flexible Production: Fabricating Precarity between the Conveyor Belt and the Household', *Anthropological Theory* 16(4): 433–53.

Kubal, A. 2013. 'Conceptualizing Semi-Legality in Migration Research', *Law and Society Review* 47(3): 555–87.

Menjívar, C. 2006. 'Liminal Legality: Salvadoran and Guatemalan Immigrants' Lives in the United States', *American Journal of Sociology* 111(4): 999–1037.

Mezzadra, S., and B. Neilson. 2013. *Border as Method, or, the Multiplication of Labor*. Durham, NC: Duke University Press Books.

Papadopoulos, D., and V.S. Tsianos. 2013. 'After Citizenship: Autonomy of Migration, Organisational Ontology and Mobile Commons', *Citizenship Studies* 17(2): 178–96.

Ruhs, M., and B. Anderson. 2010. 'Semi-Compliance and Illegality in Migrant Labour Markets: An Analysis of Migrants, Employers and the State in the UK', *Population, Space and Place* 16: 195–211.

Schweitzer, R. 2017. 'The Micro-Management of Migrant Irregularity and Its Control: A Qualitative Study of the Intersection of Public Service Provision with Immigration Enforcement in London and Barcelona'. PhD thesis in Migration Studies, University of Sussex, submitted in December 2017. Available online via Sussex Research Online: http://sro.sussex.ac.uk/

Squire, V. 2011, 'The Contested Politics of Mobility: Politicizing Mobility', in Vicki Squire (ed.), *The Contested Politics of Mobility: Borderzones and Irregularity*. Abingdon: Routledge.

Soysal, Y.N. 1994. *Limits of Citizenship: Migrants and Postnational Membership in Europe.* Chicago: University of Chicago Press.

Thompson, E.P. 1971. 'The Moral Economy of the English Crowd in the Eighteenth Century', *Past & Present* 50: 76–136.

Wills, J., K. Datta, Y. Evans, J. Herbert, J. May and C. McIlwaine. 2010. *Global Cities at Work: New Migrant Divisions of Labour*. London: Pluto Press.

Conclusion

Nina Sahraoui

Although each chapter provides a rich case study in itself, bringing the volume's ethnographies together illuminates the crucial dimension of the healthcare/migration nexus in shaping contemporary moral economies. In the aftermath of the highly mediatized migrant arrivals of 2015, a stiff political backlash manifested itself through restrictive immigration legislations, stigmatizing media and popular discourses, and the increasing criminalization of humanitarian rescue in the Mediterranean. Four years on, the prevailing politics of deterrence tinted with biopolitical humanitarianism have mutated into a post-humanitarian politics of exclusion, aggravating lethal consequences in the Mediterranean: a migration governance that anthropologist Maurizio Albahari names 'crimes of peace' (2015). Although these ruptures are symptoms of profound changes within migration governance, it would be misleading to conclude to a unidirectional tendency to exclude migrants from accessing healthcare.

Caught between the biopolitical reason of public health ideologies and the growing repression of migration, actors in the field navigate competing discursive frames and carry out ambivalent practices. The methodology chosen in this volume intends to unpack the complex dynamics at work at the crossroads of migration and healthcare against the background of broader shifts in the 'ethic of contemporary states', to quote Didier Fassin again (2005: 366).

Resorting to the analytical lens of a multi-level moral economy of healthcare and migration foregrounds the growing importance of the formation of deservingness judgements in the provision of healthcare to migrants with precarious legal statuses. What is more, the range of case

studies explored across the European space uncovers the constant re-assessment of dominant norms and sentiments among healthcare actors in the light of changing discursive frames. Findings presented in several chapters hint in this regard at the unmaking of the public health frame through the generalization of individual as well as collective deserving-ness assessments against the background of recurrent phases of welfare state contraction. The qualitative enquiries brought together thus reveal decisive shifts within the moral economy of healthcare and migration, with situated assessments of deservingness undermining an inclusive understanding of the universal right to healthcare.

In the concluding remarks to this volume, I bring to the fore how all the chapters speak to the scalar perspective of the moral economy of healthcare and migration proposed in the Introduction and emphasize what the ethnographic insights reveal as to how these levels relate to each other.

At the Macro Level: Exploring the Contested Values That Sustain Discursive Framings and Practices on Healthcare and Migration

The systematic review of undocumented migrants' access to health-care services in six European countries presented in the first chapter argues that France, Greece, Italy and Spain offer more than most basic rights while Germany and the United Kingdom pertain to the cluster that ensures only minimal rights. The authors, Danielle da Costa Leite Borges and Caterina Francesca Guidi, further find that all these countries, but one, remained in the same cluster between 2011 and 2018. Spain witnessed increased restrictions, partly discarded in 2018 (yet, as docu-mented in chapter 5, on the ground many restrictions were maintained or even reinforced), and Greece was the only country to change clusters, with the widening of the existing healthcare coverage for undocumented migrants. This legal analysis indicates that the right to access healthcare as a human right, inscribed into international conventions, continues to possess both legal and moral weight in relation to national legislations in this field.

Yet beyond the legislative field, several chapters capture dominant discourses that stigmatize undocumented migrants as illegitimate and undeserving. The case study by Séverine Carillon and Anne Gosselin points out in this regard how the prevailing hostile environment that precarious migrants face on a daily basis amounts to a significant barrier to healthcare services. Chapter 5 by Marta Pérez, Irene Rodríguez-Newey

and Nicolas Petel-Rochette and chapter 6 by Roberta Perna refer respectively in their analysis to the discourse on 'healthcare tourism' and 'medical tourism' to describe a similar framing. In the Spanish case, the authors illustrate how this discursive line is part and parcel of a hegemonic public discourse which blames 'the Other' for excessive welfare expenditures. In a similar vein, the medical tourism allegation in the Italian context serves to stigmatize migrants as posing a threat to the sustainability of the welfare state altogether. The comparative insights that Cynthia Malakasis and I bring together in chapter 8, highlight how the stigmatization of migrants is not only racialized but equally gendered. The gendered processes of othering analysed in our chapter relate to popular representations of Muslim women as victims deprived of agency. Chapter 4 by Caterina Rohde-Abuba likewise complexifies our understanding of the values at play in the racialized and gendered space of discursive formations. Her critical discourse analysis reveals how the figure of the Muslim refugee man, whose racialization is deeply entangled with assumptions about Muslim men's masculinity, gives way to a reversed othering within some media, based on family values and tradition, owing to the care industry's labour needs.

Overall, two patterns emerge across these chapters with relation to the dominant discourses around migration and healthcare. First, to various degrees, the neoliberal management of healthcare exacerbates cost-cutting pressures and fosters the multiplication of deservingness judgements, across levels of analysis. Second, actors in the field operate increasingly on the premises of patients' biological needs rather than legal entitlements, as previously identified in the literature on humanitarianism (Redfield 2005; Fassin 2007; Ticktin 2011), with the effect of producing hierarchies of deservingness within the moral economy of the healthcare and migration nexus.

At the Meso Level: Understanding Stability/Malleability Dynamics in Institutionalized Norms and Collective Moral Sentiments

In the scalar perspective of the moral economy of migration and healthcare, two strands form the meso level of analysis. On the one hand, dominant moral sentiments are convictions shared in specific social groups such as a profession or a religious community. These collective feelings of a sort feed into a local culture equally defined by norms and obligations. These are institutionalized ideas about what actors' appropriate conduct should be. Norms differ from moral sentiments in their degree

of malleability, yet both are sandwiched between the performativity of predominant values and the variability of individual emotions.

A series of tensions appears at this level of scrutiny in how practices are produced by both formal norms and informal moral sentiments. Chapter 5 brilliantly examines the creation of para-norms by admission workers at healthcare facilities. The authors trace how street-level healthcare bureaucrats (Lipsky 2010) determine migrant patients' access through differential treatment. Such gatekeeping practices are shaped by both media and political discourses on migration and healthcare, yet they are not immune to individual emotions, positive or negative, which can determine street-level actors' attitudes towards specific persons and social groups. Particularly interesting in this regard is the finding foregrounded in chapter 6, whereby practices by administrative and medical personnel are better accounted for through the common category of healthcare workers. This case demonstrates how healthcare providers at times create local institutional cultures across professions, beyond potential differences between medical deontology and administrative rationale. On a similar level of enquiry, Majorie Gerbier-Aublanc sheds light on the resilience of a public hospital facing the challenge of providing healthcare in a humanitarian setting at the French northern border. Her ethnography illustrates how healthcare workers' moral sentiments, expressed in a humanitarian ethic, drive change within healthcare management and delivery. Likewise, some of the healthcare professionals met by Roberta Perna insisted on their professional commitment to universal care, rejecting external injunctions to act as gatekeepers.

This collection of chapters thus hints at some of the ways in which norms come to be instituted and also how they can shift under the influence of changing moral sentiments. In chapter 7, Cécilia Santilli traces how two medical NGOs, in France and Italy, come to define different vulnerability criteria drawing on the broader value-laden frames of universalism and egalitarianism. In a different humanitarian setting in Italy (chapter 6), yet one facing a similar dilemma of unavoidable selection to access services, the author observes that the costlier the treatment, the more restrictive the admission practices of health workers were. Exclusion tended in these cases to be justified as a law-abiding attitude, which conceals, at the discursive level, the room for interpretation apparent across the range of situations studied. The mobilization of one (expenditure control) or the other (universal right to healthcare) of these over-arching discourses allowed actors on the ground to inscribe their practices in broader meaning-making processes. Yet, these were also affected by the daily interactions among medical and clerical personnel as well as between these two groups and the patients.

At the Micro Level: Accounting for Contrasted Emotions in Daily Interactions

The ethnographic endeavour of the contributors to this volume informs our understanding of the complex role of emotions within daily interactions in healthcare settings. Healthcare work is saturated with emotional labour, not least in the context of healthcare provision to migrants with precarious legal statuses. Descriptions and quotes along the eight ethnographic chapters of this collection testify to the relevance of an attention to emotions in socio-anthropological perspectives on the healthcare-migration nexus. These emotions, expressed and acted upon, reveal how tensions are resolved on the ground and what individual actors make of moral sentiments, institutional norms and dominant values. The sociological meanings of actors' emotions emerge by placing observed patterns in the context of a scalar analysis of the moral economy of migration and healthcare. For instance, the feeling of accomplishing 'meaningful work' experienced by hospital nurses in Calais constituted a driver for the structure's adaptation to a novel setting, akin to humanitarian work (chapter 2). The initiative and energy that doctors willing to implement the HIV prevention programme in the Paris area needed to demonstrate, while aiming at the completion of administrative and medical procedures, equally represented crucial emotional labour without which little could be achieved (chapter 3). The 'creativity' that doctors needed to display to ensure patients' continuity of care can be read as imbued with public health concerns pertaining to the profession's culture.

Micro-level interactions are also the site where conflicting norms and sentiments come to be embodied. Chapter 5 examines for instance how hospital doctors in the Spanish capital perform an inclusive attitude at an assembly protesting the privatization of public hospitals, by stating that no bills are sent following emergency care to patients without means given the principle of universal healthcare. The authors document, however, how reality catches up with the case of a young Bangladeshi man receiving a bill for heart surgery, uncovering the systematic practice of registering patients without means as 'private patients' who need to pay for emergency care. Were the doctors in the vignette unaware of administrative practices? Or were they merely performing moral sentiments in a public event to make a statement, notwithstanding bureaucratic intricacies? In any case, the emotions of all present in that assembly proved instrumental in triggering protest and shaping shared moral sentiments. In chapter 8, hospital midwives in two different southern European regions, Athens and Melilla, offer further insight into how apparently conflicting emotions can impregnate concrete healthcare

interactions. Although some articulated views about non-local women's undeservingness to access free healthcare, the observed practice aligned with standard practices of care, at times even going the extra mile to meet those patients' specific needs. The situations recounted in this comparative case study thus illustrate how a judgement of undeservingness drawing on dominant discourses is contested by a commitment to fulfil obligations on the one hand and, on the other, individual feelings of gendered empathy, that build on women's shared challenges in the face of reproductive health.

Turning our attention to the emotions of those accessing healthcare, chapter 9 by Olena Fedyuk explores the experiences of migrants, who, finding themselves with few or no formal entitlements, are forced to precariously navigate healthcare institutions. Her chapter offers rich insights into the feelings of undocumented pregnant women who, in spite of being employed and paying taxes, need to access perinatal care under a different identity. The ethnographic vignettes immerse the reader into the experiences of these three women, illuminating how all felt simultaneously a discomfort caused by their 'double identity' yet also a profound feeling of honesty as to their migration trajectories within which they happened to face barriers that forced them underground. The feeling of deservingness, shared by the three women, relied on the premise of formally contributing to society by paying taxes. At the same time, the chapter documents the feeling of isolation and perceived vulnerability that the absence of legal status produces at the particular time of childbearing.

Together, these chapters allow us to think about the relations between the micro, meso and macro levels of the moral economy of healthcare and migration. Reflecting on processes that produce the right to healthcare in situated settings also brings us to sketch out what it means to understand the right to healthcare as relational.

What a Relational Right to Healthcare Means and What It Reveals

Through its ethnographic commitment, this volume emphasizes the relational nature of individuals' access to healthcare facilities and thus the unescapable relational dimension of the right to healthcare. Thinking about this relational dimension offers three contributions to the conceptualization of the healthcare/migration nexus.

First, it brings to the fore the significant role of street-level healthcare workers composed of both medical and administrative personnel.

Examining the medical-administrative continuum and the types of relations that characterize these professional groups (cooperation, conflict, contingent collaboration, as illustrated along these chapters) determines how moral sentiments and norms are produced and acted upon. Second, the emphasis on the relational dimension of healthcare foregrounds the importance of the formation of deservingness judgements and it is no coincidence that deservingness is itself conceptualized in a relational fashion (Willen and Cook 2016). Adopting the broader perspective of the moral economy of healthcare and migration illuminates the growing importance and social implications of the multiplication of collective and individual deservingness judgements in contemporary expressions of the right to healthcare. Third, examining the manifestations of what a relational right to healthcare means leads us to identify crucial shifts in the dominant discourses around healthcare and migration. Case studies collected here hint at the diffusion of the humanitarian frame at the expense of the rights frame across public and non-governmental actors. The volume documents what is at stake in terms of inclusion and exclusion when such broader meaning-making frames (here rights vs. humanitarian deservingness) come to shift.

Bringing the Moral Economy of Healthcare and Migration to Political Theory on Migration Ethics

More research into the moral economy of healthcare and migration and health-related deservingness can only constitute a welcome development of an emerging field. However, on a final note I would like to briefly point in a different direction, which I believe deserves attention from the specific standpoint of social research around the migration-healthcare nexus. These insights can be fruitfully studied through, as well as feed into, the theoretical lens of migration ethics within political theory. Situated approaches of migrant experiences have yet to be taken on board by philosophers of migration ethics, to date dominated by universalist liberal political theory (Reed-Sandoval 2016). To be sure, the healthcare-migration nexus engages with questions of migration ethics in an acute and challenging manner. Unpacking how a moral economy of healthcare and migration is produced and with which implications bears the potential of renewing reflections on key questions of migration ethics addressing the 'should' dimension of migration debates. Fundamental human rights – such as the right to emigrate - feature at the heart of these debates, yet other fundamental rights, such as the right to healthcare, have so far been astonishingly overlooked. Several authors

have reflected on the ethical issues raised by the emigration of highly skilled workers from poorer to richer countries (Levatino and Pécoud 2012) that often concerns medical personnel. From a different perspective, I suggest here dedicating greater attention to the right to healthcare in normative considerations about migration ethics.

Although this endeavour lied beyond the scope of this volume, I see in the critical examination of how actors resolve the 'should' question at various levels of analysis, through different manifestations of deservingness judgements, an invitation to think about the place of the right to healthcare within migration ethics. The case for open borders within political theory (from Carens 1987 to Sager, forthcoming) revolves around central tenets of this scholarly tradition, namely: rights, justice and freedom. Specific arguments address questions of arbitrariness and coercion as well as social justice. Yet, as biopolitical governmentality (Foucault 1978/2004) is fundamentally racialized (Howell and Richter-Montpetit 2019), bearing large-scale lethal consequences, the right to healthcare needs to be part of contemporary reflections around migration ethics.

Nina Sahraoui is Postdoctoral Researcher at the Paris Centre for Sociological and Political Research (CRESPPA), CNRS. Nina is also affiliated with the Chair 'Exile and Migrations' at the Collège d'études mondiales in Paris (FMSH). Previously, Nina was Post-doctoral Research Associate at the European University Institute within the EU Border Care project and conducted research on the politics of maternity care among undocumented migrants on the peripheries of the European Union. Nina completed her PhD in the framework of a Marie Sklodowska-Curie Fellowship at London Metropolitan University and published this research as a monograph: *Racialised Workers and European Older-Age Care: From Care Labour to Care Ethics* (with Palgrave Macmillan, 2019).

References

Albahari, Maurizio. 2015. *Crimes of Peace: Mediterranean Migrations at the World's Deadliest Border*. Philadelphia: University of Pennsylvania Press.

Carens, Joseph, H. 1987. 'Aliens and Citizens: The Case for Open Borders'. *The Review of Politics* 49(2) (Spring, 1987): 251–73.

Fassin, Didier. 2005. 'Compassion and Repression: The Moral Economy of Immigration Policies in France', *Cultural Anthropology* 20(3): 362−87.

──── . 2007. 'Humanitarianism as a Politics of Life', *Public Culture* 19(3): 499−520.

Foucault, Michel. 1978/2004. *Naissance de la biopolitique: Cours au Collège de France 1978/1979.* Paris: Gallimard/Seuil.

Howell, Alison, and Melanie Richter-Montpetit. 2019. 'Racism in Foucauldian Security Studies: Biopolitics, Liberal War, and the Whitewashing of Colonial and Racial Violence', *International Political Sociology* 13: 2–19.

Levatino, A. and Pécoud A. 2012. 'Overcoming the Ethical Dilemmas of Skilled Migration? An Analysis of International Narratives on the "Brain Drain', *American Behavioral Scientist* 56(9): 1258–1276.

Lipsky, Michael. 2010. *Street-Level Bureaucracy: Dilemmas of the Individual in Public Service*. New York: Russell Sage Foundation.

Redfield, Peter. 2005. 'Doctors, Borders, and Life in Crisis', *Cultural Anthropology* 20(3): 328–61.

Reed-Sandoval, Amy. 2016. 'The New Open Borders Debate', in Alex Sager (ed.), *The Ethics and Politics of Immigration: Core Issues and Emerging Trends*. New York: Rowman & Littlefield.

Sager, Alex. Forthcoming (2020). *Against Borders: Why the World Needs Free Movement of People.* New York: Rowman & Littlefield.

Ticktin, Miriam. 2011. *Casualties of Care: Immigration and the Politics of Humanitarianism in France*. Berkeley: University of California Press.

Willen S.S., and J. Cook. 2016. 'Health-Related Deservingness', in F. Tomas (ed.), *Handbook of Migration and Health.* Cheltenham: Edward Elgar Publishing.

Index

A

admission practices, 215
  clerical worker, 13
arbitrariness, 114, 122, 219
austerity, 36, 108, 154, 169, 172, 175, 180, 181
autonomy of migration, 193

B

belonging, 117, 146, 154, 182, 186
biolegitimacy, 113, 114
border, 2, 11, 14, 16, 45, 46, 48, 55, 57, 109, 146, 168, 169, 174, 175, 181, 184, 185, 193, 204, 215
  borderland, 16, 168, 170, 174
bureaucracy, 31, 108, 109, 113, 116, 120, 122, 123
  street-level, 129, 202, 205, 215, 217

C

care, 1, 3, 7, 10, 11, 12, 13, 14, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 40, 42, 43, 44, 45, 46, 47, 48, 49, 50, 52, 53, 54, 55, 56, 57, 58, 59, 60, 63, 67, 68, 71, 73, 75, 79, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 107, 108, 109, 110, 111, 114, 115, 117, 118, 119, 120, 121, 129, 130, 131, 132, 134, 135, 137, 138, 139, 140, 143, 144, 145, 146, 150, 151, 152, 153, 154, 155, 157, 159, 160, 168, 169, 170, 171, 173, 174, 175, 176, 177, 178, 179, 180, 182, 183, 184, 185, 186, 187, 191, 195, 196, 197, 200, 209, 210, 213, 214, 215, 216, 217, 218
  care market, 90, 91, 95, 96, 97, 99
  care work, 12, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 217
childbirth, 132, 191, 192, 201, 204, 208, 209
citizenship, 22, 23, 39, 129, 143, 145, 186, 193, 197
crisis, 10, 17, 29, 30, 36, 62, 89, 114, 119, 133, 140, 154, 155, 164, 187, 199, 203

D

deservingness, 3, 5, 6, 7, 8, 9, 10, 13, 14, 15, 113, 122, 130, 136, 139, 143, 145, 146, 152, 155, 164, 169, 170, 171, 172, 173, 177, 178, 179, 180, 181, 182, 184, 185, 186, 190, 193, 202, 212, 213, 214, 217, 218
  deservingness judgements, 8, 9, 15, 169, 170, 179, 184, 185, 186, 212, 214, 218
  See also health-related deservingness
differential inclusion, 2, 108, 109, 114
discourse analysis, 9, 214
discretion, 33, 122, 140, 144