The Ethics of Migration Policy Dilemmas

CSO healthcare provision as exception – undermining a rights-based approach to health and obscuring the political economy of irregularity. A response to Piccoli and Perna (2024)

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In their new paper, Lorenzo Piccoli and Roberta Perna (2024) provide a conceptual framework that helps to better understand and systematically analyse the highly ambiguous and morally challenging position of civil society organisations (CSOs) engaged in healthcare provision for irregularised migrants. Rather than criticising their work, we would like to pinpoint yet another aspect of the dilemma that CSOs are facing, which we call "exceptionalism". By "exceptionalism", we mean the framing of irregularised migrants' exclusion from public healthcare and their relegation to other, parallel systems of healthcare provision as an exceptional phenomenon affecting only a few "Others". We argue that, only if portrayed as an exception, migrants' exclusion and reliance on CSO healthcare provision becomes reconcilable with the idea that there currently is a public healthcare system that offers universal and equitable health coverage for all deserving persons. In our view, such framing – which CSOs may run the risk of (intentionally or unintentionally) subscribing to – is problematic for at least two reasons: It risks undermining rights-based approaches toward universal health coverage (as also argued by Piccoli and Perna); and it obscures the fact that our liberalised economies rely heavily on irregularised migrant workers. Indeed, in some sectors and industries, they are part of the "new normal" rather than an exception (Karatzas 2024).

First, if it genuinely was an exceptional solution (used only in few and extraordinary cases), CSO healthcare provision would prove an otherwise different rule: that the welfare state takes responsibility for the health and access to healthcare of all persons living under its governance. This rule is also known as the right to health. However, the deferral of responsibility from the state to non-state, private actors – and thus de facto privatisation - of migrant healthcare may often presage rather the opposite of a consolidation of the right to health: namely, the continued singling out of more and more groups of undeserving

Others, and further restrictions of their health rights. (This danger is also noted by Piccoli and Perna, and the three possible relationships between CSOs and the State they describe – complementarity, substitution, and supplementarity – suggest different degrees of "exceptionalism".) Why does the referral of responsibility undermine the right to health? Because delegating responsibilities for health from the state to CSOs reflects a conceptual shift away from a rights-based approach and toward an approach where the health of some persons or groups becomes a matter of charity (Gottlieb et al. 2020). Rather than remaining an exception, policy moves that restrict, outsource, or privatise the healthcare of one marginalised group are frequently followed by policy moves to apply similar measures to other marginalised social categories such as the poor or the unemployed. As such, they often form part of a broader political agenda that combines Othering and exclusion with welfare retrenchment; while at the same time garnering public support – not least among those who are impacted by such policies - by scapegoating a marginalised Other (Falkenbach and Greer 2021; Gottlieb et al. 2024). The exclusion of one marginalised group from health rights thus typically serves as a precedent for the gradual and fundamental dismantling of the right to health, which works its way from the margins of society inward (Gottlieb 2015; Ong 2006).

Various examples have been described where healthcare privatisation initiatives facilitated neoliberal welfare retrenchment and undermined approaches to improve population health through action on its structural determinants such as social justice and equitable access to resources; e.g. in Spain (Acerete et al. 2011, 2015; Comendeiro-Maaløe et al. 2019), the UK (Hellowell and Ralston 2016; Reynolds and Mckee 2012; Shaw 2003), Israel (Filc et al. 2020; Filc & Davidovitch 2016), and for Global Health generally (Acerete et al. 2012; Ruckert & Labonté 2014) as well as with specific regard to Covid-19 vaccines (Storeng et al. 2023). Across European countries, CSOs that started out offering healthcare for irregularised migrants find themselves more and more providing services for uninsured citizens who have fallen outside the welfare safety nets (Gottlieb 2015). Right now, we are seeing many examples for populist attacks against migrants' belonging and deservingness, often mobilising health-related issues to rally for exclusionary policies that ultimately serve broader neoliberal agendas. For example, the German parliament recently confirmed further restrictions on asylum-seekers' (already limited) social and health benefits, including the dispensation of their monthly allowances not in cash but in form of a debit-card. Asylum-seekers' healthcare utilisation was among the main topics mobilised by conservative and right-wing politicians to rally support for these restrictions (AP News 2023). While their statements were counterfactual or unfounded at best (Bozorgmehr et al. 2024), they proved effective in pushing through anti-migrant legislation. It did not take long before demands were made to extend the same restrictions to welfare recipients and unemployed persons (see, e.g., Schlagenhaufer 2024).

As we witness the rise of the populist right across Europe and in various countries around the world, it becomes all the more important that the medical and public health community, including CSO and other healthcare providers, make sure their actions do not unintentionally subscribe to xenophobic narratives and instead take a clear stand for equitable inclusion and solidarity (Gottlieb et al. 2024).

As the second point of our commentary, we would like to draw attention to yet another problem with "exceptionalism": that it conceals the political economy of irregularised migration. This point is rooted in our joint research on irregularity and migrant labour in farm-to-fork industries across eight EU and associated countries, within the framework of the EU-funded project DignityFIRM. This project conceptualises "irregularity" as a "non-binary, multifaceted and dynamic" (Schweitzer 2024, 4) phenomenon shaped not only by migrants' agency and employer preferences but also various structural drivers such as immigration and labour market policies and geopolitical dynamics. More specifically, preliminary findings from this project and from pre-existing research highlight that "irregularity" is an asset for industries operating in globalised and liberalised economies: Many studies have shown that "irregularity and the underlying processes of illegalisation can be understood as a particular form of control over not only the mobility but also the labour of migrants" (Schweitzer 2024, 7). These processes are instrumental for supplying liberal economies with cheap and flexible labour (Calavita 2003; Jordan and Düvell 2002; Menz & Caviedes 2010; Pastore 2014; Sassen-Koob 1981; Van der Leun and Kloosterman 2006), inter alia by creating power differentials (i.e., reducing the negotiating power of the workers), and by effectively excluding workers from employment rights and social and health benefits, thus externalising the costs of social reproduction (Vosko et al. 2022).

For instance, Aris Escarcena (2022, 8) describes how "[migrant] camps have become a reservoir of precarious or irregular migrant labour for the agricultural industry" in Italy. In this context, even governmental regularisation campaigns were hollowed out by practices of collusion of employers, police and bureaucrats, which thus maintained the irregularisation of migrants to serve corporate interests (Aris Escarcena 2022, 6). In the North American context, it has long been argued that "illegality" does not actually aim at removing migrants without legal status but at establishing their "deportability", which, in turn, secures the subordination and exploitability of their labour (de Genova 2013; Paret 2014).

What does this have to do with CSO healthcare provision for irregular migrants, and with Piccoli and Perna's framework? We maintain that CSOs, whether they are 'complementing', 'substituting', or 'supplementing' the public healthcare system, by accepting framings of their healthcare provision for marginalised groups as being an exceptional phenomenon, may unwillingly help obscure a crucial fact: that precarity and irregularity are not exceptional circumstances, but built-in and necessary features of liberalised economies. De-contextualising migrants' lives and work within our societies, such framings bend a reality in which irregularity is not at all an exception but part and parcel of the business model of many industries that satisfy our most basic daily needs, including the food on our plates.

On a more practical level, too, CSO healthcare provision – as an "exceptional" parallel system - runs the risk of perpetuating the invisibility of irregularised migrants, as it removes their health risks and needs from the public's and the medical community's eye. Consequently, they also remain excluded from health information systems and routine health monitoring mechanisms. The lack of systematic data on migrant health has long been recognised as a key challenge for research and policymaking (Abubakar et al. 2018; Bozorgmehr et al. 2019, 2023), not least because a lack of data tends to be mistaken for a lack of problems (Krieger 1992). As one example from the DignityFIRM project, we note that agricultural policies and

food system transformations for greater sustainability are currently high on the political agenda across EU member states. Curiously absent from all related debates, including the recent farmers' protests, are seasonal and migrant farmworkers – not least because they do not appear in the relevant statistics (Gottlieb 2023; Karatzas 2024).

To sum up the above two points: Our commentary adds to the dilemmas that Piccoli and Perna have described in that we argue that CSO healthcare provision for irregularised migrants runs the risk of reproducing narratives that not only undermine rights-based approaches to health, but also obscure the political economy of (producing and maintaining) irregularity. Importantly, this is not to condemn CSO healthcare provision for migrants as wrong or harmful as such. Rather, we want to highlight the importance of constant vigilance and critical self-reflection for CSOs and other healthcare providers operating in contexts of social and health inequities, to ensure that their actions align with their values (Gottlieb et al. 2011; Schweitzer 2019) and that they do not unintentionally become part of a system of domination, oppression and exploitation (Fanon 1965).

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