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Citation: Cassidy, Kathryn (2018) Everyday bordering, healthcare, and the politics of belonging in contemporary Britain. In: Borderless Worlds for Whom? Ethics, Moralities and Mobilities. Border Regions Series . Taylor & Francis, London, pp. 78-92. ISBN 9780815360025

Published by: Taylor & Francis

URL: <https://doi.org/10.4324/9780203797549-4>  
<<https://doi.org/10.4324/9780203797549-4>>

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Please cite as: Cassidy K (2018, in press) 'Everyday bordering, healthcare and the politics of belonging in contemporary Britain' in Paasi A, Saarinen J, Zimmerbauer K and Prokkola E-K (eds.) *Borderless worlds – for whom?* Routledge: Abingdon, Oxon.

## **Everyday bordering, healthcare and the politics of belonging in contemporary Britain**

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### **Abstract**

At the same time as processes of globalisation were being operationalized to support claims surrounding the emergence of a 'borderless world', we have also seen the emergence of counter-narratives highlighting the proliferation of borders. In Britain and elsewhere de- and re-bordering processes involve the territorial displacement and relocation of borders, border controls and 'borderwork', which is increasingly being carried out by individual citizens. The UK 2014 and 2016 Immigration Acts expanded and potentially criminalized failures in border-guarding as well as unsanctioned border-crossing. In this chapter, I explore the differential ethical and moral positionings surrounding the incorporation and contestation of this 'borderwork' within Britain's National Health Service – often seen as unique in that it is founded upon principles of being free at the point of delivery and access is dependent upon clinical need not ability to pay. The chapter draws upon analysis of political and popular discourse, as well as narratives of the experiences of migrants and workers in the healthcare sector.

### **Introduction**

In this chapter, I argue that healthcare is not only a key emerging site of everyday bordering in the UK, but also that analysis of controls in access to healthcare for migrants offer an insight into the ethics and morality of Britain's geo-economics. Britain has long sought to 'maximise the benefits of labour migration without incurring its costs' (Poole and Adamson, 2008, p.33). Recent shifts in UK immigration policy have greatly extended the internal reach of the border(ing) regime (Yuval-Davis et al, 2017). This internalization has been advancing since the 1990s, but in 2010, the then Home Secretary Theresa May announced the intention to create 'a hostile environment' for so-called 'illegal immigrants'. This environment meant greater controls on access to a range of services, including employment, housing, healthcare, and education. Consequently, residents are being asked to reveal their immigration status in an increasing array of everyday encounters and more and more people are being required to check the status of others.

It is clear that as well as extending everyday bordering, these changes also

incorporate a considerable de-professionalisation of border(ing) regimes, shifting 'borderwork' not just informally onto citizen-detectives (Vaughan-Williams, 2008), but making it a formal requirement for those working in particular sectors. This borderwork is informed by the situated gaze (Stoetzler & Yuval-Davis, 2002) of the individuals involved, who will often make decisions based upon their own views of who belongs and who has the right to access state services. In this chapter, I will explore the proliferation of this borderwork within healthcare settings, where decisions surrounding rights to access healthcare not only impact upon individuals' health and wellbeing but could also be life-threatening. The chapter begins with a short theoretical framing, which explores everyday bordering and belonging, before presenting an overview of immigration checks in the National Health Service (NHS). After these introductory sections, I then draw upon a range of materials to analyse the political economy of bordering in healthcare and then its impacts. These materials were primarily drawn from ethnographic data collected in London/South East and on Tyneside as part of research projects on everyday borders, as well as from media (television, online press) and political (parliamentary debates, policy guidelines) sources in the period from 2013 to 2018.

### **Theoretical Background**

In Britain and elsewhere, everyday bordering has come to replace multiculturalism as the key technology through which states are approaching the governance of diversity (Yuval-Davis et al, 2017). In 2004, Etienne Balibar noted that '[t]he borders... are dispersed a little everywhere' (Balibar 2004, p. 1). Balibar was referring to the dispersal of border functions away from the traditional borderzones at the edge of nation-states into the heart of their territories, from airports to train stations. However, since Balibar noted this shift, we have seen a much more extensive de-territorialisation of borders or processes of de- and rebordering (Newman & Paasi 1998; Popescu 2012; Cassidy et al, 2018) that has moved them increasingly into everyday life. Alongside the internal reach of official border checkpoints, we have also seen a growth in immigration checks within a wide range of services (Yuval-Davis et al, 2017) and more and more people are being asked to undertake 'borderwork' (Vaughan-Williams, 2008) as part of their job or 'citizenship

duties'. Whilst this process stretches back to the 1971 Immigration Act in Britain, the 2014 and 2016 Immigration Acts marked a clear intensification of this trend by extending and strengthening checks in employment, housing, health, banking, and education. Such processes not only bring the negotiation of political projects of belonging into everyday encounters, but also present particular ethical and moral dilemmas for healthcare professionals, who are required to turn away patients in need of treatment on the basis of immigration status. As Martin Luther King (as cited in Loyd, 2014, p. vii) stated '[o]f all forms of inequality, injustice in health is the most shocking and inhumane'. For this reason, checks in healthcare settings have been widely contested in Britain and a number of campaign groups have emerged, as well as legal challenges.

The UK government's current political project of belonging is geo-economic as well as geo-political. It is framed in public and political discourse that seeks to filter out certain types of migrants (Rumford, 2008), who are framed as being dangerous, 'undesirable' or just redundant to the country's economic needs. This geo-economic element has been present in UK immigration legislation since it first began to systematically attempt to control immigration in 1905 (Wray, 2006), and, therefore, represents continuity rather than change, in spite of wider shifts in social attitudes. Such framings seek to create a sense of not only who has the right to share 'the home', but who has rightful access to the services offered by the state. A connection is created between everyday borderwork and keeping the home as a 'safe' space (Ignatieff, 2001). Through everyday practices and social relations (Blunt, 2005), belonging becomes naturalized (Fenster, 2004). Borderwork and territorial integrity relate to geo-political and geo-economic stability. As Nayak (2011) has highlighted, the political is emotional and fears surrounding the security of one's state are often bound up in feelings of personal insecurity (Ahmed, 2014).

Political projects construct not only particular collectivity/ies, which are themselves being assembled in these projects, but also create and maintain boundaries. As such, they are spatial/territorial (Antonsich, 2010) or geo-political. The technologies of controlling territory and citizens that are based upon particular politics of belonging are supposedly aimed at making people feel safe by keeping those who do not belong out, but can end up undermining these feelings of safety and raising instead a

sense of precarity. This is particularly true for minority groups, who are the most likely to be challenged by others to prove their right to belong and access services in their everyday interactions (Jones et al 2017). Some felt 'reassured' by the extension of the state into different arenas to prevent 'illegal immigration', others 'felt concerned that some people were treated with unnecessary suspicion in everyday situations' (Jones et al 2017: 46). Therefore, such processes are differentially experienced (Yuval-Davis et al, forthcoming).

### **Everyday Bordering in the NHS: An overview**

It is incorrect to speak of a National Health Service in the UK, as since 1999, each of the constituent countries operates their own health service, yet bordering regimes and immigration controls reach across the four separate services. Decisions regarding the governance of the services and their funding are organized differently. In Scotland, 14 different regional boards are responsible for planning and delivering healthcare services and the 32 local authorities provide social care; in Wales there are seven local boards responsible for hospital and community services; and in Northern Ireland there are five regional trusts, which provide secondary and tertiary care and manage contracts for primary care. In this chapter, I refer primarily to the situation in England, where since April 2013 (under the provisions of the 2012 Health and Social Care Act) clinical commissioning groups (CCGs), of which there were initially 211, became responsible for commissioning and providing services for their local areas. So, healthcare in the UK, but also in England in particular, is geographically differentiated.

At the same time as being locally fractured and differentiated, the NHS is also dependent upon large numbers of workers from outside the UK. In September 2017, 12.5% of workers in the NHS (for whom nationality was known – nationality was not reported for 6.6% of staff) were not British nationals (Baker, 2018). 5.6% of these overseas workers – 62,000 people - were from the European Union (EU). Amongst clinical staff, these figures are higher: 10% of doctors and 7% of nurses are from the EU and a further 12% of doctors and 6% of nurses are of Asian nationality. In total 36% of doctors gained their medical qualifications from outside the UK (ibid). However, diversity and the transnational make-up of the NHS' workforce are also

not recent developments, but were embedded in the development of the NHS from its inception. The creation of the service in 1946 led to demand for 42,000 new members of staff, which could not be met by the depleted population of post-war Britain (Snow and Jones, 2010). The greatest shortages were in nursing professions and many of the gaps were filled by workers recruited from the Caribbean and Ireland (Ali et al, 2013). Therefore, Britain's NHS is more accurately understood as both transnational in its dependence on labour and skills, as well as local, in its differentiated organization and commissioning of services.

The 1949 NHS (Amendment) Act created powers – now contained in Section 175 of the 2006 NHS Act – to charge people not 'ordinarily resident' in Great Britain for health services. The powers were first used in 1982 to create regulations on eligibility for NHS hospital treatment (now consolidated as the NHS (Charges to Overseas Visitors) Regulations 2011). Historically these charges were only made in hospitals or by hospital employed or directed staff. This meant that primary care and community care remained free 'by default', as well as treatment carried out under the NHS in private hospitals. The regulations define an overseas visitor as someone who is not ordinarily resident in the UK but the term is not defined, either in the 2006 NHS Act or in the regulations. It is, in fact, the Department of Health that defines ordinarily resident as:

A person is ordinarily resident if they are normally residing in the UK (apart from temporary or occasional absences), and their residence here has been adopted voluntarily and for settled purposes as part of the regular order of their life for the time being, whether for short or long duration (Department of Health, 2017).

The 2014 and 2016 Immigration Acts reduced the entitlements to welfare benefits of EU citizens and compelled NHS employees to carry out ID checks to identify migrants from outside the EU who must pay for most non-emergency or primary care NHS treatments. Previously, hospitals had discretion in charging 'overseas visitors'. A health surcharge for non-EEA citizens staying in the UK for over six-months was also introduced with other extensions of charging planned across the NHS, extending everyday bordering roles to increasing numbers of NHS staff.

The surcharge of £200 for those from outside the European Economic Area (EEA) is paid during the visa application stage. Those who come to the UK on tourist visas are not required to pay the levy, but will be fully liable for the costs of any NHS treatment they receive. There has also been a change in the definition of 'ordinarily resident', which is used for accessing the NHS (Grove-White, 2014). Prior to the 2014 Act's implementation, entitlement to free NHS treatment was based on being 'ordinarily resident' in the UK, which was decided upon whether an individual was living here lawfully, rather than upon any minimum time requirement. The 2014 Act changed this definition, so that 'ordinarily resident' would require indefinite leave to remain, which is contingent on five years' residency in the UK. This move clearly removed the right to freely access healthcare for certain sections of the population. In 2014, the Migration Observatory released a briefing giving an overview on the health of migrants in the UK. It found that, whilst it was currently difficult to gain a comprehensive account of the health of migrants, but evidence suggested that health amongst migrants was generally poorer overall compared to UK born individuals (Jayaweera, 2014). There were already numerous barriers to accessing healthcare for migrants, such as lack of information, language and transport. Keith and van Ginneken (2015) have argued that particularly in the UK, migrants' right to life is continuously challenged by limited access to healthcare.

### **The (geo)political economy of healthcare charging**

In general, debates surrounding healthcare charges focus on health tourism, framing it as problematic and an issue to be addressed. The health tourism 'imaginary' (Buerkner, 2018) is based on the assumption that only those who are resident in the UK will have made a contribution through their taxes and, therefore, should be entitled to access the services provided.

[It] is only fair to the millions of hard-working people who pay into the NHS through their taxes that somebody who comes here to live for a period of time should be asked to contribute (Theresa May, Home Secretary, HC Deb 22 Oct 2013, col. 165).

There is an inherent contradiction in such arguments. The logic is economic, i.e. based upon a moral economy (in this case fairness) of providing support to those

who have paid into the system, yet the focus of the restrictions is upon a different group – non-EEA migrants (with certain exceptions). This moral economy is set to appeal to shared social and cultural values, in particular, associated with notions of ‘reasonable prices’ and ‘just needs’ among the rural and urban poor (after Scott, 1976 and Thompson, 1971). However, advice on the government’s own website refutes the narrative of the debates in the press and in the House of Commons.

Within England, free NHS hospital treatment is provided on the basis of someone being ‘ordinarily resident’. It is not dependent upon nationality, payment of UK taxes, national insurance contributions, being registered with a GP, having an NHS number or owning property in the UK (Department of Health and Social Care, 2017).

Further analysis reveals different underlying motivations for the introduction of the surcharge, including the inefficacy of current arrangements to recoup costs from overseas visitors, as well as a desire to use the charge as a means by which to filter immigrants and discourage lower paid economic migrants. In 2012, the Department of Health carried out a review of the overseas visitor charging policy, which specifically referenced a lack of detailed evidence relating to the use of the NHS by non-residents, as well as to the costs of this use to the NHS. This was supported by observations made by a worker in a clinic in East London – run by an international charity – in 2015 and also an employee of a large inner London NHS trust, who worked in the Overseas Visitors’ Office and took part in an episode of the BBC documentary *Hospital* in 2016, which was aired in 2017.

Most of the patients we deal with I would not define as health tourists. They’re not here specifically for...to access free medical treatment. They’re here on holiday usually and they have fallen ill or they have an accident (Hospital, 2017).

The Department for Health report highlighted inefficiencies in the current arrangements for recouping these costs. At the time of the report, the NHS was recouping around £15-25 million annually, which equated to only 20% of chargeable costs. There were two key reasons given for this: firstly, they estimated that only between 30 and 45% of chargeable costs were being identified; secondly, of the costs identified, 60% were not being recovered. Administering the system was



estimated to be costing the NHS £15million annually, meaning that potentially, no net gain was being made at all in the recovery of these costs. The inefficiencies were also stressed by the same worker in the London trust's Overseas Visitors' Office, who referred to the laws and regulations as 'fruitless' (Hospital, 2017).

In 2013, the government commissioned a further report, which showed that EEA visitors and non-residents cost the NHS £305million (less than 0.3% of the total NHS budget) in 2012/13, of which £220million was recoverable under the European Health Insurance Card (EHIC) scheme (Prederi, 2013). £50million of the £220million was recovered, compared to £173million paid out to other countries by the UK under the EHIC scheme for British visitors to EEA states (ibid). In one of the debates in the House of Commons surrounding the health surcharge in 2013 on the then Immigration Bill, Diane Abbott, the deputy leader of the oppositional Labour Party argued that there was existing legislation to recoup these costs and that new legislation was not necessary (HC Deb 22 Oct 2013, col. 222).

However, after the introduction of the surcharge, the economic benefits to the UK Treasury quickly became apparent. In the first year the charge was in operation (2015-16), it raised an additional £164million for the NHS (National Audit Office, 2016). This was more than the £85million, which the 2014 government report had estimated that overseas visitors cost the NHS in 2012/3. Questions remained about the inequalities relating to the surcharge, particularly certain exemptions. The most controversial related to the ways in which particular groups of migrants were being constructed as more beneficial to the UK because of their potential (not actual) earning capacity. Mark Harper (the then immigration minister) reflected on why the government had extended exemption from the surcharge to information and communication technology (ICT) professionals.

We made a judgment to exempt them, based on their value to the UK economy (HC Deb 7 November 2013, col. 288).

The exemption has since been removed (in 2017), but the principle is of exemption based upon 'their value to the UK economy'. In contrast with ICT workers, employees in the NHS, particularly those not engaged in senior clinical roles, not only paid the charge, but actually struggled to be united with their families. In an interview with a senior employee in Human Resources at a North-East England NHS

trust in 2016, I was told that the trust had just hired 92 nurses from the Philippines. He commented that the upfront costs per nurse were in the region of £4500, which included over £1000 for the objective structured clinical examination (OSCE), visas, three years of the health surcharge (£600) and costs for accommodation. The trust pays these monies but they are then recovered from the nurses. However there were distinctions being made between how they supported workers from overseas; whereas they would sponsor spousal visas for consultants and even offer work to spouses in some cases, the manager clearly stated they did not get involved in even offering immigration advice to the nurses.

So we have a number of them [certificate of sponsorship] allocated, so we can just use them when we need them. We keep them predominantly for the doctor roles because – no disrespect to the band 5 nurses but we've got 4,000 plus walking around the hospital whereas a specialist doctor who we might need in to go through the process could be a lot quicker. So with the nursing ones we apply for certificates of sponsorship separately.

Whilst the number of tier 2 visas<sup>1</sup> for health and social care staff increased from 2,921 in 2010 to 5,287 in 2016 (ibid), the number of spousal and dependent visas being issued fell by 73% in the decade up to 2017 (ibid).

In attempting to tackle inefficiencies in recouping costs from overseas visitors and countries in the EEA, the government has adopted a system of incentives and also sanctions. NHS trusts are permitted to charge up to 150% of the cost of treatment for overseas visitors and a financial incentive is also offered for identifying and better reporting of EHIC patients. The latter scheme has led to a doubling of reporting of patients covered under the EHIC scheme, but the incentive for overseas visitors has had little impact (National Audit Office, 2016). As part of the most recent changes to guidelines, introduced in April 2017, sanctions have been introduced via clinical commissioning groups (CCGs) to withhold monies from trusts failing to identify overseas visitors.

The extension of the UK's border(ing) regime into healthcare needs to be understood in political-economic context. The surcharge acts as a further barrier to

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<sup>1</sup> Tier 2 visas are issued to those with the offer of a skilled job in the UK.

travelling to the UK legally for lower income migrants, but it also reflects an approach predicated on tackling health tourism, which is highly not only not supported by the government's own research but is also inefficient. Overseas visitors who fall ill whilst they are in the UK are not health tourists but simply tourists. They have been issued with a visa because of the perceived economic benefit that their tourism brings, but if they do not pay the healthcare costs, they may be refused permission to enter the UK in the future. This suggests that the UK's border(ing) regime is not limited to solely maximising the benefits of labour migration without incurring its costs, as proposed by Poole and Adamson (2008), but also extends to maximising the benefits of tourism as well. In fact, figures emerging from even the first year show a clear government intention to profit from the surcharge, with incomes much higher than estimated spend on treatment for non-EEA overseas visitors.

### **The impacts of bordering in healthcare**

In this section I explore the ways in which everyday bordering in healthcare impacts upon patients and staff in the NHS. I focus on three key areas emerging from the research: firstly, I posit that clinical decision-making itself has become borderwork, which is impacting upon doctor-patient relationships; secondly, I present arguments relating to the ways in which immigration checks within health care settings increase the need for urgent care; and finally, I explore the difficulties of administering the border for employees attempting to re-coup costs from overseas visitors.

### ***Clinical decision-making as borderwork***

Under the new legislation, doctors must determine whether care is urgent or not. In cases where the care is deemed urgent, treatment is provided and then the hospital must seek to recoup the costs. Where care is deemed non-urgent, payment from overseas visitors not exempt from charges is sought in advance. Many NHS trusts are now requesting that patients whose status is unknown or unclear complete 'pre-attendance' letters prior to routine treatment, so that their details can be checked with the Home Office. In October 2017, the case of a pregnant British woman who had taken her husband's Polish surname was reported in the press. The letter from

the hospital due to provide her care suggested that she would not receive treatment due to a 'failure to provide proof of identification and residence' (Pasha-Robinson, 2017). The couple accused the NHS bosses of racial profiling and claimed to have been singled out solely on the basis of the surname. Of course, the fact that this particular woman's case was reported owed more to the fact that she was white and British. Such checks and threats have become commonplace for minority and migrant communities in the UK (Jones et al, 2017).

One of the key areas for borderwork in the NHS is the role of clinicians in determining whether care is urgent or not. More importantly, the urgent/non-urgent distinction effectively turns clinical decision-making into borderwork and gives new meaning to cases in which this distinction is not always entirely clear. Many organisations and individuals highlighted this as a particular area of concern, as it could impact on the relationship between healthcare professionals and their patients. Indeed, this was debated in the House of Commons before the 2014 Immigration Act was passed. Clare Gerada, the Chair of the Council of the Royal College of General Practitioners (2010–2013), raised practitioners' concerns in a committee debate

We do not want to turn GPs[general practitioners] into border agents. That is absolutely clear[...] We should not turn people away at the front door because of their inability to pay. (HC Deb 29 Oct 2013).

Yet in making the decision to demand upfront payment effectively a clinical one, i.e. urgent/non-urgent care, the government has, in fact made doctors into border agents. The charity worker in the London clinic was particularly concerned about the impact of bordering on these relationships.

The GP-patient relationship should be based on trust, privacy and in the end it should be productive. [...] You can't have a conversation if you're worried that the person you're talking to might be telling the border police about you or your immigration status. That fundamentally breaks the doctor-patient relationship and this will not end in a healthy situation for the patient and will not end in a healthy situation for society.

The situation has been exacerbated by the memorandum of understanding (MoU) between NHS Digital, the Home Office and the Department of Health. The MoU

came into effect at the beginning of 2017 and sets out the terms under which the Home Office can request information from NHS Digital.

Confidentiality is the cornerstone of doctor-patient relationship [...] With that broken, I don't think you can carry on to have such a good relationship... I don't think [the government] has considered enough the damage to public trust that has been done. (Lucinda Hiam, GP with Doctors of the World, cited in Hill, 2018)

One asylum seeker in the North-East of England showed me a pre-attendance letter from a local NHS Trust that sought to establish her eligibility for free treatment prior to even scheduling an appointment. The letter clearly explains the sharing of data with the Home Office and that failure to pay for treatment could impact on a future immigration application. The woman to whom it was addressed told me that she was not going to go ahead with the necessary medical procedure, even though she was entitled to free treatment, because of concerns around personal information being shared with the Home Office. The letter makes the specific connection between accessing healthcare and 'national security'; that non-belonging means certain migrants pose a threat to the UK's territorial integrity and this is a key element of everyday bordering. For asylum seekers, who regularly have negative interactions with the Home Office and experience the violence of forced dispersal across the country (Darling, 2011), the threat of such data sharing clearly serves to discourage attendance at hospital. The incorporation of clinical decisions into borderwork and the memorandum of understanding have begun to disrupt patient-doctor relationships, and this has implications for vulnerable groups, who are discouraged from getting timely medical care, which I will explore in the next section.

### ***Bordering in the NHS increases the need for urgent care***

Concerns over the impact on the health of individuals, but also on minority groups as a whole had been at the heart of the debates surrounding the new legislation in 2013 and 2014. Baroness Manzoor presented these concerns in a debate in the House of Lords in February 2014.

[...]having a two-tiered system will create confusion, and could delay and discourage people seeking the most appropriate help... This clearly has implications regarding public health (HL Deb 10 Feb 2014).

As the asylum seeker's comments in the previous section show, there is growing evidence that even those entitled to access free healthcare are choosing not to do so as a result of the changes. Healthcare workers highlighted not only were people risking their lives because the uncertainty of their status was deterring them from accessing healthcare, but that this was ineffective for the NHS itself, as it meant people often accessed acute services when the problem became critical.

This is a concern not just for the patient who is then not going to access care until they're much more acutely ill [...] but also that's a significantly greater cost for the health system.

Here we see those opposing everyday bordering in the NHS attempting to frame the debate in the same economic terms presented in political and popular discourse. In doing so, however, the argument is shifted from an ethical or moral basis to an economic rationale, not a moral economy of the public discourses based on fairness, but an economic decision to simply save the UK government money through timely treatment. The problem with such argumentation is that it normalises economic rationale for decision-making in healthcare, rather than that of individual needs and rights.

### ***Administering the UK's political project of belonging in the NHS***

The new system has incorporated greater numbers of clinical and administrative staff within the NHS into borderwork. As I have highlighted elsewhere with colleagues (Yuval-Davis et al, 2017 and Yuval-Davis et al, forthcoming), many of these new borderworkers feel insufficiently knowledgeable and lacking in the training needed to make decisions surrounding entitlements to access healthcare. In a meeting with midwives and health visitors in 2016, many admitted that they were not only unfamiliar with the new regulations coming into force but were also opposed to having to implement and carry out such checks. The list of exemptions was particularly troubling, as it seemed that administrators often had no understanding of who was exempt from the surcharge and classed as an overseas

visitor. This was a trend, which charity workers in the clinic in East London had been observing prior to the recent changes in legislation.

Frontline staff are ill-informed, are unaware of what patients' rights are and patients themselves are unaware of their own rights. And so what we see is frontline staff turning patients away from healthcare which that patient has the full right to access.

These observations related to regulations on overseas visitors prior to 2014, and there were calls to support bodies within the NHS in administering the border following the changes in legislation in 2014 and 2016.

[...] it can be difficult to identify which patients should be charged. Trusts were told there would be further support to implement these changes. We look forward to seeing the full range of measures that will be made available. (Phillippa Hentsch, head of analysis at NHS Providers, cited in Donnelly, 2017).

This lack of clarity surrounding the details of the charges was not limited to the new measures, but was also evident in how the Overseas Visitors Offices would approach the right to cancel. This right applied to certain groups, e.g. refugees, asylum seekers, victims of modern slavery or female genital mutilation (FGM), however, in the guidelines for trusts, there are also details on debts being written off, for cases where someone has died, they have no means to pay, or every effort has been made to recover the debt without success (Department of Health, 2017). The latter does not constitute a cancellation of the debt and the guidance specifically states that such debts could be pursued by relevant bodies in the future. For those administering the invoices and payments in the Overseas Visitors Offices there were options to reduce costs of treatment, but these were often presented to vulnerable patients in confusing terms. The below is a conversation between an overseas visitors' office employee and a woman from Nigeria from the BBC *Hospital* documentary. The woman had given birth to her quadruplets in a London hospital after going into labour on a flight back from the US to Nigeria, via London. One child did not survive and the three others were in an intensive care unit at the time of the conversation and the mother, Priscilla, was also still an in-patient

**Terry** “I’ve got not great news I’m afraid because I’ve had to raise some invoices for you. [...] That’s giving birth and then your time here, OK? And then these are the invoices for the three children. Those are quite high, Priscilla.”

**Priscilla** “Is it negotiable?”

**Terry** “I’m afraid they are not negotiable, no. The Trust really does not have a mandate to either cancel. [...] I will say this, you know, if a patient is showing willing and is able to make a payment then that could help in reducing the charges.” (Hospital, 2017).

So, here we see that in response to Priscilla’s enquiry about negotiating regarding the bill, the employee states the invoices are not negotiable, but then immediately suggests that if she is willing to make a payment then the charges could be reduced. Nicholas de Genova (2013) has argued that such spectacles enact a ‘scene of exclusion’. Here it is not an immigration offence that shapes this ‘illegality’ spectacle (ibid), but instead the inability to pay for life-saving health care. The performance does not involve an immigration official, but a hospital worker. Nonetheless, the worker sets what he does within the wider economic rationale evident in political discourses surrounding health tourism.

I recognise it is a small part in terms of money we recoup but it’s a pie, it’s an important part and you have to look at it well – what would four million pounds provide in terms of treatments? It’s a no-brainer?

Here the wider scene setting is focused on legal border-crossing, which is based upon a supposition of zero-cost to the British state. It is this assumption, which leads frontline staff to turn away those that don’t have settled status in the UK, such as asylum seekers, even when they do have the rights to access health care.

## **Conclusions**

In this chapter, I have explored the impact of the extension of the UK’s bordering regime into healthcare, where it presents very particular moral and ethical dilemmas for those increasingly being asked to undertake border work, including healthcare professionals and specifically-appointed administrators. I have argued that for the UK government the health surcharge was predicated on the imaginary of health



tourism, which although it has been prominent in public and political discourses on the topic, is not supported by clear evidence. However, the introduction of a surcharge has very quickly produced a revenue stream for the UK government, which exceeds previous estimates of the costs to the NHS for overseas patients and with plans to already double the charge, it is clear that this has become an extra tax on non-EEA nationals visiting the UK for more than six months.

A number of impacts emerge from the introduction of the checks within healthcare settings. Firstly, clinicians effectively determine the border, by having to make decisions regarding urgent or non-urgent care and I have shown that this is not only impacting upon the doctor-patient relationship but that this is compounding existing barriers to healthcare for vulnerable groups. In response to the political-economic arguments raised in relation to health tourism, a number of organisations have developed economic arguments surrounding refusing urgent care as ultimately leading to higher costs for the NHS in the longer term. However, such framings move the debate away from a moral or ethical question of whether it is right for a state to refuse an ill person treatment on the basis of their immigration status, and re-produce rather than challenging the dominance of the economic rationale. What is becoming apparent is that even when urgent care is offered, in hospitals we find scenes of exclusion in which some people are being approached and asked to make payments that few could and can afford. These scenes are framed by a wider geo-economic positioning in the UK, which not only seeks to ensure that migrant labour but also tourism can be fully exploited and any related costs minimized, if not complete eliminated.

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