Bordering and Disordering in the National Health Service

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Abstract
Recent immigration legislation in the UK has extended the internal reach of the UK's border. The intensification of everyday bordering has introduced immigration checks into more and more everyday encounters and required more UK residents than ever before to check the immigration status of others (Yuval-Davis, Wemyss & Cassidy, 2019). In this paper, I begin by exploring what this shift has meant for the UK's National Health Service (NHS) and healthcare workers, arguing that it has disordered the delivery of healthcare services. I then move on to demonstrate that the advent of everyday bordering has also, however, opened up new spaces to resist and disorder processes and practices of bordering, as well as illustrating why health care has become a key site for the disordering of everyday bordering amongst a wide range of actors. In particular, I explore how the campaigning work of migrant support organisations and other groups intersects with mundane practices of everyday resistance by workers within the NHS itself.

Introduction: Bordering and Ordering Contemporary States

Since the 1990s, there has been a shift in the multi-disciplinary literature on borders (Brambilla, 2015), which has moved away from territorial borders and their assumed fixity, to more complex understandings of the myriad of processes and practices, which 'construct, reproduce and contest' them, known as bordering(s) (Yuval-Davis et al, 2019, p.1). This de-territorialisation of border studies has been accompanied by an attendant de- and re-territorialisation of state bordering itself; as more and more bordering practices, such as the issuing of visas and checks on immigration status, have shifted to within and without nationalised territories (Balibar, 2004). These borderings contribute significantly to and have been re-shaping the governance of contemporary political entities (Walters, 2006; Yuval-Davis et al, 2019).

Researchers have been particularly concerned with the dual processes of de- and rebordering (cf. Cassidy Yuval-Davis & Wemyss, 2018), for which the European Union (EU), has provided a key contemporary site of analysis. Specifically, this dualism is concerned with the ways in which the debordering of space for particular groups is accompanied by its rebordering elsewhere for others. For example, as the EU supposedly debordered the territory of many of its member and

associated states, particularly through the Schengen agreement, so we also saw rebordering at the edges of the EU through securitisation and the creation of Frontex, an EU border force (Vaughan-Williams, 2008). At the same time, this debordered space, has not been evenly experienced, with some minoritized communities continuing to be subjected to a range of bordering processes and practices that question their legitimacy and belonging within the debordered territory of the EU (Yuval-Davis, Wemyss & Cassidy, 2018; Cassidy et al, 2018). Whilst this dualism of de- and rebordering is analytically useful, I believe there is a much more fundamental dualism at the heart of debates on borderings: dis/order. Although there is a wealth of empirical work (cf. De Genova, 2017) that seemingly highlights the disorders created by borderings, the underlying theoretical assumption – driven by the work of van Houtum (van Houtum, Kramsch & Zierhofer, 2005; van Houtum & van Naersson, 2002) primarily – continues to focus on borderings as forms of ordering, i.e. b/ordering. For me, this underlying supposition presents a conceptual dilemma, in which we continue to underpin work on bordering with statist views of borders, even though such an approach has been widely critiqued (cf. Walters, 2006).

We need to understand borderings as an interplay of disorders and orders, i.e. as forms of dis/ordering. They not only disorder the everyday lives and wider structures of society, but they also disorder other state institutions and the delivery of state services. The introduction of new 'everyday bordering' policies which have encouraged a 'hostile environment' in the UK since 2012 (Yuval-Davis et al, 2018), has brought with it new intersections of dis/ordering. Unlike other theorisations of the (re)making of borders in everyday life, everyday bordering refers specifically to the introduction of immigration checks into more and more routine encounters, administered not by trained, paid border officials, but by other residents. These practices have been developing over a number of decades, but have intensified in recent years, and are paralleled in other countries in the Global North, such as the USA and Denmark (ibid). This intensification has shaped and disrupted the delivery of a range of services, which everyday bordering ostensibly seeks to secure for a majoritised population – including those delivered by the welfare state such as social security and healthcare

(Guentner, Lukes, Stanton, Vollmer & Wilding, 2016), as well as services provided in the private sector, e.g. bank accounts and rental accommodation.

Everyday bordering in the UK has necessitated increasingly complex regulations to determine access for non-citizens to healthcare, education and state support. Decisions on eligibility for healthcare, social security and education are being made by other UK residents—citizens and non-citizens. These checks restrict access for those with uncertain immigration status, other non-citizens, as well as settled populations, who are unable to prove their status (Yuval-Davis et al, 2019). However, everyday bordering and its dis/orders have been widely resisted, with healthcare and its delivery proving to be a particularly important focus for this resistance.

People have historically come together to challenge bordering in a range of different ways (Gill et al, 2014; Askins, 2015). The advent of everyday bordering and internalization of bordering regimes has opened up new spaces to resist the processes and practices of bordering and create alternative securities (Koopman, 2011). These spaces include both established existing migrant support organisations (e.g. the Joint Council for the Welfare of Immigrants) but also a range of new campaigning and advocacy groups like Docs not Cops (Potter, 2018). Some more visible and well-established initiatives have been or are the focus of ongoing research, e.g. open borders (Paasi, 2018; Bauder, 2018) and cities of sanctuary (Bagelman, 2016). However, research has primarily highlighted the dis/ordering of everyday bordering (Cassidy, 2018), with little analysis of how this is being resisted by more mundane practices of 'quiet politics' (Askins, 2014). As Sarah Hughes (2019) has been exploring in her recent paper on 'resistance' – our view of resistance in human geography has not kept pace with the more emergent and fractured understandings of the political and power.

> [A] framing of resistance as emergent prevents a foreclosure of emergent forces into predetermined forms (e.g. of activist, intentional subject, protest, tactic or dispute), and thereby keeps open the category of resistance to other subjects, materials, spaces and temporalities which do not always cohere to an (expected) resistant form and yet condition the possibility for future claims to be made. (Hughes, 2019, p.3).

I argue that analyses of the disorders of bordering need to explore this resistance as a form of dis/b/ordering, incorporating a wide array of different approaches to challenging and disrupting everyday bordering processes and practices *in situ*. The question is not only of who should be bordered and who should not, but also where and by whom borderwork should be undertaken (Rumford, 2008, 2013; Vaughan-Williams, 2008). The analysis of dis/b/ordering involves capturing a range of different attempts to disrupt contemporary bordering, but it is particularly attendant to everyday mundane acts— the healthcare worker who treats a patient without first establishing their immigration status, the advocacy worker who helps an individual entitled to access a service to gain that access. In addition, it is concerned with how in everyday life different residents challenge the underlying b/orders that support bordering, for example through befriending schemes between local residents and newly-arrived asylum seekers and refugees (Askins, 2014; Askins, 2015).

The purpose of this paper is to present examples of how we might analyse the confluence of orders and disorders in relation to everyday bordering in the NHS. I begin with a very brief overview of everyday bordering in the NHS before moving to some examples of the ways in which we might understand bordering as disordering the delivery of healthcare, and finally, I present some examples of resistance or efforts to dis/b/order the NHS.

Everyday Bordering in the NHS: An overview

The organisation we refer to as the National Health Service is, in fact, a far cry from being national; it is geographically differentiated within the UK but remains dependent on resourcing from outside the UK (Cassidy, 2018). Therefore, Britain's NHS is more accurately understood as both transnational, in its dependence on labour, skills and other resources, as well as local, in its differentiated organization and commissioning of services.

Bordering within the NHS hinges on a term that was created in the 1949 NHS (Amendment) Act, which designated the power to charge people not 'ordinarily resident' in Great Britain for health services. However, this power was not meaningfully operationalised until 1982 when regulations on

eligibility for NHS hospital treatment were created. Charges for care were initially only made in hospitals and primary care and community care remained free 'by default'. The key legislation that introduced everyday bordering into the UK was the 2014 Immigration Act. Prior to the 2014 Act's implementation, being 'ordinarily resident' in the UK was based upon whether an individual was living here lawfully, rather than upon any minimum time requirement.

> 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 Act changed this definition, so that 'ordinarily resident' would require indefinite leave to remain, which is contingent on five years' residency in the UK (Grove-White, 2014). This move removed the right to freely access healthcare for certain sections of the population and further undermined migrants' right to life (Keith and van Ginneken, 2015) by increasing barriers to healthcare and failing to make adequate provision to protect the lives of all UK residents. Those who are not 'ordinarily resident' are expected to pay up-front for non-urgent care, whilst urgent care is provided but the costs are then recouped by hospitals' overseas visitor offices.

Prior to the new regulations, hospitals had discretion in charging 'overseas visitors'. However, after 2014 NHS employees were compelled to carry out ID checks and identify migrants from outside the EU who must pay for most non-emergency or primary care NHS treatments. In addition, a health surcharge for non-EEA citizens staying in the UK for over six months was introduced in April 2015. The initial cost was £200/year (£150/year for students and young people on Tier 4 and 5 visas), rising to £400/year (reduced rate of £300/year) in January 2019, with plans to further extend the charge to £624/year (reduced rate of £470/year) in October 2020. The surcharge has to be paid upfront for all years of the visa, e.g. £1200 for a 3-year visa. 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.

The dis/orders of everyday bordering in the NHS

In this section, I highlight examples of the ways in which everyday bordering might be understood as disordering the delivery of healthcare in the NHS (for more details see Cassidy, 2018). Firstly, the new legislation dis/orders relationships between healthcare professionals and patients, which disrupts the delivery of care. This was a concern for professional bodies, migrants' rights and support organisations, and other groups and individuals from when the plans for the everyday bordering in the NHS emerged in 2013.

> 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. (Clare Gerada[1], HC Deb, 29 October 2013)

Yet in making the decision to demand upfront payment a clinical one (in other words whether requiring urgent or non-urgent care) doctors are now effectively having to make such decisions. Maternity Action's 2019 report 'Duty of Care' based upon data from interviews with midwives highlights exactly the type of impacts on professional practice and relationships with patients that were raised during debates on the new legislation. In particular, some NHS trusts have been asking midwives to check immigration status and provide information about the possibility of charging for ante-natal care in the first full appointment they have with an expectant mother—known as the booking appointment.

> Overall, midwives' considered that charging had an adverse impact on their professional practice, increasing barriers to good relationships between midwives and women. (Maternity Action, 2019, p.2).

In an interview in the north-east of England in February 2020, one junior doctor, illustrated how the changes had impacted her relationship with and treatment of one patient.

> I particularly remember a man who was from South East Asia or of South East Asian origin […] I think he'd been in the UK for quite a long time actually, but didn't have clear status, and pretty much everything I proposed, investigation or treatment, he would sort of ask me whether he was going to have to pay for that. So, it sort of changes the nature of the conversation a little bit. It sort of makes your conversation a bit more stilted, and you're more aware of their anxiety, not just about their own health but about their financial status

[1] Chair of the Council of the Royal College of General Practitioners (2010–2013).

> as well. And it gave, it actually probably made me more aware, that he might be a sort of [a] vulnerable person in various senses, which I might have been less aware of otherwise.

The situation has also been exacerbated by a memorandum of understanding (MoU) between NHS Digital, the Home Office and the Department of Health (Doctors of the World, 2017). The MoU came into effect at the beginning of 2017 and set out the terms under which the Home Office could request information from NHS Digital[2].

> 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[3] cited in Hill, 2018)

Fear of the sharing of information with the Home Office not only disordered the professional-patient relationship that is central to the delivery of health care, but was also one of the reasons why some patients entitled to free care did not always seek or receive care in a timely manner. I consider this to be a second, further, way in which everyday bordering in the NHS has disrupted healthcare, by increasing the need for urgent care. Everyday bordering reduces opportunities for preventive care and early treatment and diagnosis, thus disordering key principles of effective healthcare systems by shifting resource needs to more acute and 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.

> … 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. (Baroness Manzoor, HL Deb, 10 February 2014)

There was already clear evidence from a Doctors of the World's clinic in East London prior to 2015 that some from migrant and minoritized backgrounds were failing to seek healthcare in a timely manner because of concerns about their entitlement to free care (Wemyss & Nava, 2015).

> This is a concern not just for the patient who is going to not access care at that point then until they're much more acutely ill and often then will access care through A & E, which

[2] The MoU was partially suspended in May 2018 and withdrawn at the end of January 2019 (Bowcott, 2018).
[3] General Practitioner, Doctors of the World.

> means they've got to a stage where their condition is much more serious so it's obviously more concerning for them. But also, that's a significantly greater cost to the health system. We're not saving resources if all we're doing is pushing people towards using already over-stretched accident and emergency services. (Phil Murwill[4] in Wemyss & Nava, 2015)

This was apparent after the introduction of the new regulations in January 2017, when a female asylum seeker showed me a pre-attendance letter from an NHS Trust that sought to establish her eligibility for free treatment prior to even scheduling an appointment. The letter explained that failure to pay for treatment and data sharing with the Home Office could impact a future immigration application. The woman said that on this basis she had decided not to have the necessary medical procedure, even though she was entitled to free treatment, due to concerns that personal information could be shared with the Home Office and impact on her asylum application.

Finally, in addition to disordering healthcare delivery by increasing the need for acute care, everyday bordering in the NHS has also disordered the administration of the NHS itself by increasing resources dedicated to identifying and recovering costs from patients who are 'chargeable' (Department of Health and Social Care, 2019), and changing the ways in which healthcare staff record and administer patient care.

> I've been actually asked to be involved in the paperwork for actually asking someone to pay. […] I remember they had a sort of sheet on the front of their notes saying, you know, this patient is gonna be charged, so you know, make sure you document what you've done with them, or something to that effect. Which, again, […] I found quite difficult, […] and I therefore spent quite a bit of time with that person trying to understand whether they actually did fit the criteria for charging or not and see whether they could register with a GP. So, I guess it's quite a use of health professionals' time which, I feel could be better spent doing other things. (Junior Doctor, North-East England, February 2020)

The consequences of these practices are evident not only in the growth of routine administration relating to the recording of treatment, but also in concerns about whether patients really were chargeable that drove extra investigation tasks and bureaucratic work that took healthcare staff away from other duties. Midwives also reported having to support women and relay messages between Overseas Visitors Offices and their patients to try to and ensure they weren't charge for

[4] UK Programme Officer, Doctors of the World.

care they were entitled to, or to have erroneously issued invoices cancelled (Maternity Action, 2019). In some cases, like in mental health trusts and community-based services, no clear policies were in place.

> So recently, we have had, like, lots of emails from management, asking us to, like, clarify, what I'm going to do with patients who have got, like say, no settled status. And what are we going to do? Are we going to give them a service? Which is actually a question which we hadn't encountered, like, 3-4 years ago. […]And it's all like, very opaque. And this is the thing, and this is becoming more and more common in the NHS, you know like, they want you to discharge people. They want to, but there's not clear cut guidance. But then there's pressure at the ground level to discharge. And I'm supervising a junior doctor at the moment, and I've just heard that the manager is going to sit in a clinic with the junior doctor, and watch him while [he] discharges the patient because the patient does not have a settled status. (Consultant, Community Mental Health Team, London, March 2020)

Rather than dealing with questions of chargeability, it is clear in these cases that healthcare staff were under pressure to discharge patients before they were clinically fit, and this interviewee also stated that tensions were emerging between administrative/managerial staff and clinicians as a result. In this section I have elucidated some of the ways in which everyday bordering is disordering healthcare delivery within the NHS. In the final section of this paper, I seek to balance such a top-down account of dis/ordering with insights drawn from efforts to disrupt everyday bordering within the NHS.

4. Dis/b/ordering health care

There have been concerns about access to healthcare for mobilised peoples with different statuses for many years in the UK. Some of these include organisations such as Doctors of the World, who as well as operating emergency and long-term healthcare to displaced people around the world, also offer care to vulnerable people experiencing barriers to accessing healthcare in the Global North as well. Many of these organisations developed specific responses to the introduction of everyday bordering policies, some of which were policy-orientated, but others focused on supporting healthcare staff to understand the new legislation (Doctors of the World, 2015; Maternity Action,

2019). The latter were based upon existing concerns that those entitled to healthcare, such as asylum seekers, were already experiencing difficulties in accessing healthcare and that the introduction of the new policies would lead to more people being turned away because of uncertainties on the part of healthcare staff. Doctors of the World were, therefore, outspoken in their criticism of the hostile environment from the beginning.

However, in addition to the resistance of these existing organisations that support migrants and racialised minorities, resistance has also emerged within professional bodies for health care, such as the British Medical Association and the royal colleges of surgeons, general practitioners, nursing and midwives.

> The BMA called on the government to publish the findings of its own review into the effects of migrant charging, which it launched back in 2017, but this request has been denied. We can only assume that this is because the results confirm what clinicians at the front line already know—that mistakes, injustice, and avoidable suffering have been caused not for financial benefit, but merely to help the government look tough on immigration. As doctors, we must continue to speak out against this policy, which harms us all: vulnerable people are denied care, public health is compromised, and the founding ethos of the NHS is undermined. (Salisbury, 2019: n.p.).

> As a midwife I entered my profession to care for all women and their babies, with compassion. It breaks my heart that women will not get the treatment that they need, that they can no longer trust me because a booking appointment ends up as an immigration check. […] Britain's leading doctors, nurses and midwives all say that this is a risk to individual and public health. […] Midwives become midwives to care for women, not to act as border guards as part of a 'hostile environment' immigration policy. (Rigby, 2019: n.p.).

Within these statements, we see the use of professional identities and their ethics as the basis of resistance. The question is not only of who should be bordered and who should not, but also where and by whom borderwork (Rumford, 2008) should be undertaken. As well as the development of resistance through and with professional bodies, one group of doctors also established a new campaign group, Docs not Cops, which used campaigning and direct action to challenge everyday bordering in the NHS.

> Healthcare workers are trapped by these policies, forced to undermine their duty of care to patients and threatened with fraud if they do not uphold the regulations. Knowingly or unknowingly, we are now complicit in the detention and deportation of the people we are supposed to be caring for. This is distressing to say the least and as the NHS becomes

> increasingly linked with immigration control, many healthcare workers have nowhere else to turn for advice on how to support their patients. I have spent hours on the phone to doctors who want to advocate for their patients. One told me they were pressurised by hospital management and senior colleagues to discharge someone so unwell they would die without treatment, simply because they could not prove their legal entitlement to care. (Dr. Jess Potter, Docs not Cops, 5th July, 2019)

In Potter's account, we also see the emphasis of healthcare professionals as being differentially positioned in relation to hospital management, who are seen as enacting everyday bordering on behalf of the state. Elements of these tensions are also present in the accounts given by the consultant with the community mental health team in London discussed earlier in this paper. Whereas s/he and the junior doctor from the North-East of England sought to disorder everyday bordering through mundane actions within their workplaces, members of Docs not Cops were spurred on by a sense that the scale of the problem required a collective response.

> [S]o right from the offset I sort of found myself in a way of challenging charging that felt appropriate to the kind of scale of the problem and how things were coming out, and I suppose that being that the work we were doing was focused on trying to challenge the hostile environment in its *entirety* as a policy in the way it is being enacted in the NHS. (Member of Docs not Cops, March 2020 – *emphasis added*)

Resistance, therefore, also becomes internal to the NHS, the hospital itself, as well as to the system as a whole and might be understood as contributing to a more general disorder of healthcare delivery that emerges from efforts to both border and dis/b/order emanating from everyday bordering and opposition to it.

5. Conclusions

In this paper, I have briefly sought to introduce key aspects of everyday bordering in the NHS, by focusing on some of the ideas supporting the introduction of new legislation in 2014 and 2016. I have shown that the imaginary of a 'national' health service has centred on the NHS as a key site of control for government as it has increased the internal surveillance of populations (Yuval-Davis et al, 2019). I have argued that everyday bordering is disordering the NHS by: (re)shaping relationships

between healthcare workers and their patients; changing healthcare delivery by reducing opportunities for preventive interventions and early treatment and increasing the need for urgent/acute care; and by introducing new administrative work both into the NHS as a whole, particularly in relation to cost recovery, but also into the roles of healthcare workers themselves.

However, the introduction of everyday bordering has also been subject to resistance as it has made visible to more and more residents the slow violence of border securitization. This resistance has been particularly strong within health care and has garnered support not only amongst well-established groups but also professional societies and organisations, as well as healthcare professionals themselves. Some healthcare professionals have sought to expand more mundane acts of resistance by individual healthcare workers through the development of direct action initiatives. Overall, I have argued that border studies as a multidisciplinary endeavour has frequently highlighted the disorders of bordering processes and practices, but it has failed to shift the underlying theoretical assumption of the link between bordering and ordering – b/ordering. By centring dis/order rather than order, I argue we can more effectively shift border studies beyond the state (Walters, 2006).

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