

**Original citation:**

Chimienti, Milena and Solomos, John. (2016) How do international human rights influence national healthcare provisions for irregular migrants? A case study in France and the United Kingdom. *Journal of Human Rights Practice*, 15 (2). pp. 208-228.

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<http://dx.doi.org/10.1080/14754835.2015.1032225>

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# **Are International Human Rights Really Promoting Rights? Irregular Migrants' Access to Healthcare in France and the UK**

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## **Abstract**

Debates about human rights have often questioned their potential for generating rights at national levels, highlighting the discrepancies between the normative grounding of human rights and their empirical reality. In this paper we use the case of irregular migrants' access to healthcare in the UK and France to explore the extent to which international human rights can be seen as promoting access to healthcare among irregular migrants at the nation-state level. We argue that although international human rights often have a largely symbolic role in nation-state jurisdiction, they may sometimes represent a force for change.

**Key words:** human rights, healthcare, irregular migration, France, United Kingdom

## **I. Introduction**

Most scholars in the social sciences think of human rights as socially constructed (see for example, Donnelly 1989; An'Naim 2002; Kurasawa 2007; Nash 2012; Somers 2008; Keck and Sikkink 1998; Goodale and Merry 2007). In other words they see human rights as varying according to their historical and geographical context and as a result of social negotiations (Nash 2012). This perception explains why scholars have been critical regarding the ability of human rights to translate into legal rights on the national level. The social construction of human rights is considered the root of the discrepancy between 'normative ideals and their empirical reality' (Morris 2009: 217). Why does the social construction of

human rights necessarily create a discrepancy between human rights principles and practice? Some authors argue that it is due to the legalisation of rights, as to reach this level of formalisation a certain 'consensus' needs to be established from which minorities' voices are barred (Rancière 2004: 306, see also Hagan and Levi 2007). Another key explanation of this conflicting relationship between norm and practice can be found in the opposition between the trans-national purposes of international human rights and the national conditions of their implementation (Habermas 2001). In other words, there is a conflict between the idea of rights awarded on account of one's humanity, as stipulated in the 1993 Vienna Declaration of Human Rights, and the idea of rights based on one's membership in a nation-state, i.e. citizenship rights (Donnelly 2007: 281; Donnelly 2008, Tambini 2001: 199).

Indeed several scholars have demonstrated that the implementation of human rights still depends in practice on nation-state jurisdiction (Stasiulis and Bakan 1997, Joppke 2007) and is restricted for many people as a result of their positioning within national belonging (Benhabib 2007, Nash 2009). This is intensified by the fact that nation-states' power is not only related to their legislative capacity, but also, as argued by Shafir and Brysk (2006), to the sense of belonging and solidarity they provide which has been seen as essential to social cohesion and functioning. As a consequence the realisation of human rights depends on their ability to fit within national frameworks and political realities (Shafir and Brysk 2006: 285).

These bodies of scholarship lead us to conclude that there are few ways for human rights to countermand nation-state decisions: the principle of subsidiarity gives greater autonomy to nation-states, and moreover the provision of rights does not and cannot diverge from nation-state policies. In this sense the tensions between international human rights and nation-states are seen by some as superficial. Yet these tensions are very real in the case of

non-citizens' rights. There are in fact several layers of complexity in implementing human rights in the case of irregular migrants.<sup>1</sup> First, their irregularity calls into question which state – the state of origin, any state where they have been living or the state where they are currently – is responsible for implementing their rights (Basok and Carasco 2010). Second, their legal, economic and social vulnerability makes them more subject to abuse. Third, this vulnerability also reduces their ability to claim and negotiate their rights (Bloch, Sigona and Zetter 2011, Chimienti and Solomos 2011, Chimienti 2011). Yet it has been well documented that agency is crucial in the development of rights (see among others Isin 2000), since rights must be claimed and negotiated by individuals or collectives to be effective (Basok and Carasco 2010: 344).

Despite these criticisms, scholars have also seen human rights as a key feature of our contemporary and global order, having the 'ability to create new worlds by continuously pushing and expanding the boundaries of society, identity, and law' (Douzinas 2000: 343). Some scholars have, for instance, shown that international human rights have made it possible to extend certain rights to non-citizens (Soysal 1994, Helton et al. 2000), sometimes highlighting the role of activists acting transnationally (Risse and Sikkink 1999) or locally (Basok 2009) in negotiating rights. As argued by Nash (2012: 7) although it 'is important not to assume that human rights are necessarily a progressive force for justice (...) if we treat "human rights" as nothing more than the empirical uses to which the term is put, we lose sight of the quasi-transcendental, moral value of human rights, which is what makes them politically distinctive and – at least in part – motivates those who are actively trying to extend and secure human rights'. In order to take into consideration both the social construction of human rights and their (putative) moral aspiration, Nash suggests we 'consider the positive law of international human rights as providing a universal framework against which any particular uses of human rights might be assessed. In this way 'human

rights' apparently become a neutral object of study (see, for example, Landman 2006: 5 in Nash 2012: 7). It is then the task of sociologists (and other scholars in the social sciences) to distinguish between the discrepancies and the ideals and to make sense of them, analyzing why and how a particular definition of human rights has been established at a given time and place.

This article builds on this body of scholarly work on human rights in order to explore the ability of international human rights to generate rights in nation states and expands it by looking at the specific case of healthcare and irregular migrants in two nation-states, namely France and the UK. The paper will examine, moreover, how the two countries studied interpret the right to health, 'translate international human rights law into acceptable practices' (Basok and Carasco 2010: 351) and the extent to which their definition is in agreement with international human rights. For instance, is asking irregular migrants to pay for primary healthcare in a tax-based health system such as the UK's an infringement of human rights and if so, on which grounds?

The case of irregular migration is particularly useful for exploring the potential of international human rights for generating rights in nation states, since one might expect that the illegality of stay of irregular migrants automatically excludes them from citizenship rights. Human rights (here the right to health) and citizenship rights thus conflict in the case of irregular migrants. How can healthcare be provided to irregular migrants without violating citizenship rights? And how can immigration policies, according to which an irregular migrant risks being deported if they go to hospital, be respected without violating human rights? How can this antithetical agenda be solved? Karl-Trummer, Novak-Zezula, and Metzler (2009) offer some potential answers. They argue that a 'functional ignorance' between departments which must follow antithetical demands makes it possible to open up

a 'paradox-free space' and so doing ensure irregular migrants' access to healthcare without their risking deportation. As we will show this 'functional ignorance' is only possible when there exists a certain level of independence between immigration and health policy. Whilst Noll (2011) and others state that welfare and immigration jurisdictions are indivisible, we will argue that such jurisdictions have in the past followed divergent pathways regarding irregular migrants.

The lens of healthcare is also significant in terms of the role of international human rights: as health is a fundamental need, one might expect that the right to health promoted by international human rights bodies would not be contested at the national level. As argued by Fassin and Memmi, the (sick) body could give irregular migrants social recognition when all other arguments seem to have lost their legitimacy (Fassin and Memmi 2004: 240). Whilst the influence of path dependency on health policy has already been well documented (see among others Cattacin, Chimienti and Björgren 2006, Schierup, Hansen and Castles 2006), the influence of international human rights on national policies has been less examined. As we will show, although international human rights represent a force for change, they need a favourable national context in order to gain traction.<sup>2</sup>

The comparison between the UK and France is furthermore interesting as these countries are often portrayed as opposites despite their similarities. On the one hand these countries have comparable socio-economic structures and have one of the highest gross domestic products (GDP) in the world; they are among the most important destination countries and host a large number of irregular migrants, and they have declared themselves committed to international human rights. On the other hand these countries are seen as different with regard to citizenship and health policies so that their legal responses to irregular migrants' healthcare differ significantly (Cattacin, Chimienti and Björgren 2006, Cattacin, Chimienti,

Hachimi Alaoui *et al.* 2009, Da Lomba 2010, Karl-Trummer and Novak-Zezula 2011). These differences may highlight nation state sovereignty and therefore a lack of national harmonisation despite the influence of international and human rights bodies.

This paper is based among others sources on twenty semi-structured interviews with health professionals, social workers and representatives of advocacy NGOs of migrants' rights in Paris and London conducted between 2008 and 2009.<sup>3</sup> It builds on a number of documents (laws, NGOs briefs and reports<sup>4</sup> etc.) and the findings of recent research relating to healthcare for migrants in an irregular situation.<sup>5</sup>

The paper is organised in five sections. The next section explores the role of international human rights in relation to health and their rationale. The third and fourth sections focus on the French and UK cases respectively. For each case we will consider first irregular migrants' rights to healthcare and how these rights have been implemented. We shall then explore the extent to which there are discrepancies between national policies and international human rights. The concluding section provides an overview of the key questions raised by this paper.

## **2. International human rights to healthcare for irregular migrants**

Health and human rights are often associated with each other because they are seen as 'complementary approaches to the central problem of defining and advancing human well-being' (Mann, Gostin, Gruskin *et al.* 1994: 14). The right to health is frequently equated with the right to life and is therefore covered first by the general covenants of human rights.<sup>6</sup> In this sense, the right to health is dependent upon the recognition of other rights, and vice versa (Hervey 2003: 195-6). Although migrants (with or without a legal permit of stay) are in principle protected by these fundamental rights, these do not seem sufficient to promote

the right to healthcare for the most vulnerable, which may explain why a range of specific treaties and conventions have been ratified since 2000.

The aim of these accords is to acknowledge health as 'a right, not just a service and not a charity, commodity or privilege'.<sup>7</sup> They tend to make the right to health not only a negative but also a positive obligation for states, meaning that they should ensure both the provision of healthcare and access to it. For instance Article 13 (1) of the European Social Charter (ESC)/revised European Social Charter (rev ESC) declares that states have the duty both to ensure adequate healthcare and to ensure that everyone has access to it, including those without resources. In May 2000, the UN Committee on Economic, Social and Cultural Rights (CESCR) also published a document which specifies the obligations that should be fulfilled by each state in order to secure this right, and indicators for monitoring their achievement (General Comment No. 14). In 2002 a UN Special Rapporteur was put in place to evaluate governments' progress in achieving the right to health.<sup>8</sup>

These treaties also specify that healthcare is a right independent of the lawfulness of a person's situation of stay. For instance the Charter of Fundamental Rights of the European Union (EUCFR) specifies in two articles in particular that access to health should be independent from immigration matters. It does so first in Article 35 on healthcare, which mentions that 'everyone has the right of access to preventive healthcare and the right to benefit from medical treatment under the conditions established by national laws and practices' (EUCFR). This provision highlights first that the right to health is translated into the right to healthcare, which entails both 'preventive healthcare' and 'medical treatment'. Second, it underlines the 'individual entitlement' to this right, which means that is not based on one's membership in a nation-state, but on one's humanity (Hervey 2003: 202).

In addition to this, Article 3 of the European Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR) of the Council of Europe, which states that 'No one shall be subjected to torture or to inhuman or degrading treatment or punishment', makes it possible to stop the removal of a foreigner if that person suffers from a severe illness. The European Court of Human Rights (ECHR) monitors states compliance with ECHR, which is legally binding. Following this Convention, most European countries have implemented specific permits of residence for seriously ill irregular migrants which protect them from expulsion. For some migrants these temporary or indefinite residence permits for medical reasons represent the last resort in terms of staying (legally) in a country. The ECHR and the European Committee of Social Rights (ECSR) of the Council of Europe have managed to put pressure on those member states who violate human rights (as we show below with the abrogation of the *ticket modérateur* in France), for instance with the obligation of member states to refrain from expulsion either based on the international legal principle of *non-refoulement* of the Geneva Convention Relating to the Status of Refugees,<sup>9</sup> or on Article 3 of the ECHR.

To ensure the implementation of these international human rights, the Council of Europe has recommended that member states should allow medical personnel the right not to share with immigration authorities the identity of their patients who are irregular migrant (Resolution 1509 para. 16.4). As noted by Sövig (2011: 50): 'the rationale is that irregular migrants might not claim their rights through fear of identification as irregular migrants and fear of expulsion'.

Despite the influence of international human rights, their weakness in relation to nation states' power is apparent even in their formulation. For instance the Charter of Fundamental Rights of the European Union (EUCFR) highlights the subsidiarity of states by

specifying that these rights are to be implemented according to national conditions. Besides, the nature and extent of so-called humanitarian permits varies between countries. The fact that these permits are allocated through administrative decisions and are in many cases discretionary further increases discrepancies among the beneficiaries and the risk of arbitrary treatment (Health for Undocumented Migrants and Asylum Seekers Network 2009: 20). In practice it is therefore not surprising to find that the number of allocated humanitarian permits remains very limited (Platform for International Cooperation on Undocumented Migrants 2009).

We can see the limits of human rights within nation-states in the case of irregular migrants, since none of these treaties challenge the right of a nation-state to expel non-citizens from its territory. Since granting a residence permit to seriously ill migrants is still left to member states' discretion (Platform for International Cooperation on Undocumented Migrants 2009: 42), the practical significance of these international rights is limited, and even more so when it is a question of irregular migrants whose rights conflict with the unlawfulness of their residence. Besides, as highlighted by some scholars (see Nash 2012: 6) the emphasis of human rights practices on individual rights entails the risk that observing them might 'exacerbate the individualizing effects of neo-liberalism (Beck 2006; Bauman 1999) and undermine still further the experiences of national solidarity on which policies of redistribution through the welfare state have depended (Turner 2002)'. Each right being granted on a case-by-case basis, international rights are more likely to be called into question (as highlighted by the case of *N. v the UK* or in France with the attempt to abrogate the humanitarian permit, both explored below).

In the next section we show that despite nation-states' subsidiary power over international human rights, both the UK and France have put in place specific measures to ensure

healthcare access for irregular migrants. The next section will examine the extent to which these measures correspond to international human rights, looking at the healthcare norms and practices for irregular migrants in the UK first and then in France.

### **3. United Kingdom – from inclusive NHS access to economic differentiation**

The UK has had until recently a very inclusive healthcare system which aims to provide similar but limited provision to all residents. To access NHS services, all residents must register with a General Practitioner (GP). GPs are responsible for primary care and are gatekeepers to secondary care (Health for Undocumented Migrants and Asylum Seekers Network 2009: 3). The National Health Service (NHS), which provides the majority of health services in the UK, is funded by taxation. This system makes those considered 'ordinarily resident' automatically entitled to free primary and secondary care (Department of Health 2011: 3). Those patients who are not ordinarily resident in the UK, such as tourists and those living in the country without a permit of stay (irregular migrants), are deemed 'overseas visitors' (Department of Health 2011: 3). Before April 2004 'overseas visitors' could access primary and secondary (hospital treatment) care free of charge independently of the legality of their situation of stay. Thus access to healthcare in the UK was universal without any distinction of citizenship, nationality, or even lawfulness of residence. In this sense, health policy conflicted with UK immigration policy, which considered irregular migrants outside the common law. This system of access to healthcare corresponded to international human rights, but was not a consequence of the formation of human rights dating from the Second World War. Rather, this system arose from the national social welfare system put in place after the Beveridge report in 1942. This universality, however, has since been challenged, curtailing healthcare access for the most vulnerable.

Besides the successive reforms that created a two-tier health system with the expansion of private health insurance and provision in addition to the NHS (Laing and Buisson, 2001), irregular migrants and failed asylum seekers (and their children) have been excluded since April 2004 from free-of-charge hospital treatment and diagnosis including secondary care, treatments considered as 'non-urgent', ante and postnatal care, medicines and antiretroviral treatment. In order to implement these measures the Department of Health initiated the new administrative role of 'overseas visitors manager', whose job is to decide who is entitled to receive free-of-charge NHS services by monitoring the immigration status of service users. This activity is typical of the diversification of modes of surveillance of (irregular) migrants put in place in recent years by European countries, which tend to delegate this control to transport agencies, employers, service providers and even private citizens.

In addition in 2004 the UK government proposed an amendment to the health regulations to further restrict access to free-of-charge primary care for irregular migrants. This proposal was offered for consultation in the same year and was abandoned after the consultation took place (Health for Undocumented Migrants and Asylum Seekers Network 2009: 3). Therefore there is so far no legislation or case law in the UK that would permit the exclusion of residents from free-of-charge primary care. However, irregular migrants' access to healthcare still depends on the General Practitioners' decision as to whether or not to register a 'non resident' (Migrant Rights Network 2011). NGOs state that in some cases GPs are advised by Primary Care Trusts (PCTs) to refuse to register people because of their immigration status, which is an infringement of the current regulations (see quote below).

Another consultation was launched in February 2010 by the Department of Health to clarify this kind of problem, this time in collaboration with the Home Office.<sup>10</sup> The government's response to the consultation was partly to change the practices in place in the period since April 2004. On the one hand health services became more inclusive in line with international and human rights criteria, returning to the pre-2004 practice of exempting failed asylum seekers from charges for both primary and secondary care. This change came into force in the spring of 2011. On the other hand, the practice remains unchanged for irregular migrants, i.e. an exemption for primary care only; or becomes more restrictive with the implementation by UK Border Agency of new Immigration Rules in October 2011 which refuse entry or the extension of stay in the UK to those who fail to 'discharge debts to the NHS of or in excess of £1,000'. For this purpose, the NHS has agreed to provide the required information to the UK Border Agency.

This overview of healthcare regulations shows that the curtailing of healthcare access in the last decade essentially takes an economic form in the UK. This means that irregular migrants can be charged for secondary care, but if they are able to pay medical bills, they cannot be denied access to it.<sup>11</sup> The restriction of entry or extension of stay for people with a pending debt to the NHS is formally also an economic restriction. Given the health costs and precarious living conditions of irregular migrants, these economic restrictions still represent a major barrier for this category of people and as such could be interpreted as a breach of human rights. This is also a major change in the philosophy of healthcare in the UK, which had been 'based on clinical need, not the ability to pay' (Department of Health 2011: 2). Yet according to the Department of Health these restrictions do not represent an infringement to international and human rights laws, since the NHS is advised not to deny urgent and immediately necessary treatment even if the unentitled patient cannot pay in advance, and debts are often written off if the person is unable to pay (Department of Health 2011: 12).

Besides, in refusing to continue to charge any failed asylum seekers, the Department of Health has softened its initial stance.

The context of these changes is both common to all European countries in relation to the present economic climate and particular to the UK in relation to its universal healthcare system. In the UK the presence of irregular migrants has only recently been problematised (Jordan and Duvell 2002). These migrants became an issue with the fear that their number would increase, making it difficult for the labour market to assimilate all of them and representing a potential cost for the welfare system. In the UK this fear – which is not yet based on any evidence<sup>12</sup> – was probably increased by the rise of healthcare as a share of gross domestic product (GDP) since 2000 to reach the average EU level in 2004, whereas it was 10% less than the Organisation for Economic Co-operation and Development average in 1997 (Organisation for Economic Co-operation and Development 2010).

Whereas so far the British healthcare system aimed to provide similar but limited benefits to all residents, it now aims to be less inclusive and to differentiate its beneficiaries. This desired selectivity went together with an increase in the budget of the British healthcare system in order to improve its services and provisions. This investment seemed to have sparked in the public discourse the fear of ‘health tourism’, i.e. the fear that foreigners would migrate to the UK in search for medical treatment. The recession that started in 2008 increased this fear whilst the government tried to reduce its health budget along with other large public deficits (Organisation for Economic Co-operation and Development 2010: 106); a trend that has been exacerbated by the NHS reforms launched by the Conservative-Liberal Democrat Coalition Government in 2010. This curtailing of universal access to healthcare is correlated with the convergence of health and immigration policies

as well as the individualisation of healthcare attribution, as we will discuss in the next sections.

### **The convergence of health and immigration policies**

One of the consequences of curtailing access to the NHS has been the collaboration it has created between the Department of Health and the Home Office, since, as noted above, health policy previously contradicted UK immigration policy by not using nationality or permission to stay as a criterion for exclusion. This curtailing and the bringing together of these two departments conjures up quasi simultaneously a third actor: new and ongoing NGOs.

As showed by Basok and Carasco (2010), local migrant rights groups play a crucial role in engendering policy change. In this case, they have used a variety of means to denounce the lack of healthcare access of irregular migrants: creating new organisations, employing a variety of public fora and using litigation. One of the measures put in place by local migrant rights groups is the launch of a project to provide free healthcare. In response to the 2004 restrictions, two years later the Doctors of the World association developed a unit in London to help irregular migrants. Those in charge of this project insist that their main aim is to help irregular migrants (and any people in a situation of vulnerability) to access health services, and not to replace mainstream healthcare, although they provide short-term healthcare.<sup>13</sup> Except for this initiative, almost all the existing NGOs (among others Migrants' Rights Network, Medact, African HIV Policy Network) focus on advocacy and social work rather than on providing healthcare directly.<sup>14</sup>

These migrants' rights groups have also used a variety of public fora to pressure the government to change its policy. They created coalitions in order to help as many individuals and organisations as possible to respond to the Department of Health

consultation on the health policy,<sup>15</sup> and also published several briefs to inform the population as widely as possible. As showed by Basok and Carasco (2010), the use of litigation by these local migrants' rights groups has been also crucial in engendering policy change. In March 2009, the Court of Appeal judgement in Regina(A) v West Middlesex University Hospital NHS Trust decided in favour of the claimant, concluding that it was unlawful to charge failed asylum seekers.<sup>16</sup> It also suggested that 'trusts should make an assessment of when an individual can reasonably be expected to return home before denying them treatment that is not "immediately necessary"'.<sup>17</sup>

One difference between the UK and France is that in the UK, NGOs based their arguments more on national legislation and public health grounds than on international and human rights discourses, as illustrated by a recent briefing paper co-authored by two NGOs (Migrants' Rights Network and Doctors of the World) and a firm of solicitors (Pierce Glynn). The briefing paper argues that to exclude irregular migrants from free-of-charge primary healthcare is: 'unlawful' according to the national policy in that it breaches both the current health regulations and the 2010 Equalities Act provisions regarding indirect discrimination in the UK; that it is 'uneconomic' as prevention costs less than cure, and the control of immigration status will represent increased costs in terms of bureaucracy; that it is 'unhealthy', putting at risk the rest of the population by not screening or treating communicable diseases and risking the creation of 'backstreet health services' that abuse the vulnerable; that it is 'disproportionate', since irregular migrants are small consumers of healthcare because they are mostly young and therefore in good health, or because they already face many barriers that reduce their access, in contrast to prejudices regarding 'health tourism'; and finally that it is 'unethical', contradicting the World Medical Assembly Declaration on the Rights of the Patient, but also establishing a culture of suspicion,

institutional racism and a breach of social cohesion which then could be extended to other categories of vulnerable people (Migrant Rights Network 2011).

Emotional arguments<sup>18</sup> or a human rights rationale are only used as last resort. This focus on national legislation, an economic rationale, public health grounds and only minimally on ethics is thought to be more effective, as highlighted by this social worker:

We are not trying to make public campaigns because it's counter-productive. We are always sent back to the argument of "My granny's hip": we cannot respond to such arguments, there is no time so we gave up. We're talking about health, not migrants because combining the two cannot do justice to either ... our most effective lobbying is done by caregivers: Royal College of GPs, Royal College of Paediatricians. It is a powerful argument because it is not political, it's not linked to immigration. The current discourse of *government* is that of fairness: 'I paid for the NHS, so I have right to it; then why people should who have not paid be entitled? (Social worker, medical NGO, London, UK quoted in Hachimi Aloui and Nacu 2009: 146, translated by us).

Moreover, by not limiting the debate to the case of irregular migrants, and instead showing that the curtailing of healthcare could affect any vulnerable person, these groups aim to increase people's support. This rationale based on the 'unlawfulness' of the current practice, based on national legislation, also aims to encourage legal action by the persons concerned (see Joint Committee Human Rights, 2007).

Besides the convergence of health and immigration policies another consequence of the breach of universality of the NHS concerns the increase of individualisation in the determination of who is or is not entitled to free treatment as we will discuss in the next section.

### **Individualisation of healthcare**

The economic closure created the obligation for the caregivers to determine of who is or is not entitled to free treatment on case-by-case basis. Since then caregivers feel pressured to follow immigration rules and choose their patients according to immigration status:

We discover that medical doctors do not have the same freedom to do what they want, the administrative power in the hospitals is stronger... (Social worker, medical NGO, London, UK, quoted in (Hachimi and Nacu 2010: 169, translated by us).

According among others to the NGO *Migrants' Rights Network*, this pressure does not only affect secondary care, but also GPs who, unlike doctors working in hospitals, have complete discretion to choose whom to register. Although such rules do not apply to GPs, they seem to be influenced by this new rule and some decide therefore to not register irregular migrants as argued by *Migrants' Rights Network*:

Over two thirds of PCT's in London have issued guidance to GPs that is incompatible with their legal obligations. Many PCT's advise GP's they should only register people living legally in the UK for more than six months, but this is wrong as the 'ordinarily resident' test applies only to hospital services (...) Based on poor guidance from their PCT's many GP practices demand proof of immigration status along with proof of residence before they will register some patients (*Migrant Rights Network 2011: 2*).

It is indisputable that the delegation of decision-making about who is entitled to free healthcare to hospital administrators (overseas visitors managers) or GPs increases these functionaries' responsibility and goes beyond their competence as caregivers. Health professionals often do not know how to make such judgments, given the complexity of the status of irregular migrants and failed asylum seekers. They tend to take a decision based on subjective judgment, which leads to important discrepancies between caregivers and creates arbitrary decision making.

Moreover, this delegation of control increases the responsibility of health professionals. They must accept or refuse to treat patients, knowing that if they refuse a patient who does not have the required documents, that person might not be able to get treatment elsewhere. This places the health professional in an ethical dilemma and requires him/her to take a position on health policy. If s/he decides to infringe the policy, s/he can decide that the person is at risk and needs 'urgent and immediately necessary treatment' - which is not denied if a person not entitled to healthcare cannot pay in advance - or s/he can avoid

checking the patient's documents, as still happens in many hospitals, and thus avoid demanding reimbursement, as highlighted by this interviewee:

The situation is very different from one hospital to another. Some hospitals chose not to charge irregular migrants (...) others decide to write off the debts if the person is unable to pay. But now, more and more hospitals use debt collection agencies to recover debts from irregular migrants (Social worker, NGO defence irregular migrants, London, UK).

The definition of who has the right to healthcare is assessed case by case under this 'administrative guardianship' (Hachimi and Nacu 2010). It means that a non-national without a permit of stay might be deported if her/his illness is not judged serious enough to require treatment. This is what happened in the case of *N v. the UK*.<sup>19</sup> Ms N, an Ugandan national entered in the UK in 1998 and was diagnosed as HIV positive and 'seriously ill'. After her asylum demand was refused, she appealed to remain in the UK in order to receive anti-retroviral treatment according to Articles 3 (prohibition of torture) and 8 (Right to respect for private and family life) of the European Convention on Human Rights (ECHR). The European Court of Human Rights rejected her claim.

The European Court of Human Rights found that for ill-treatment to fall within the scope of Article 3, it must attain a minimum level of severity that is relative and dependent on all the circumstances of the case, including the duration of treatment, its physical and mental effects and, in some cases, the sex, age and state of health of the victim.<sup>20</sup>

This case marked a turning point, making it possible to deport someone who was seriously ill 'in spite of the immediate effect this may have on their life expectancy'. If such a person decided then to stay illegally in the UK, she would be refused treatment officially not in the name of irregularity of stay but because she could not pay for it. This legal pirouette allows the UK not to breach (formally at least) human rights.

In the UK, it is more the fear of not being able to finance medical costs than of being denounced to the immigration authorities that constitutes the main barrier to going to

hospital:

We have cases of persons who come to see us after they have been treated in hospitals and charged. They cannot pay the bills. They are frightened to return to hospital. We have to insist and explain that it is their right (Social worker, medical NGO, London, UK).

The UK case shows that economic closure in the health system can lead to more restrictive immigration rules and, in so doing, bring together health and immigration policies. Since this change, the UK is seen as offering only partial access to healthcare for irregular migrants (Karl-Trumer, Novak-Zezula and Metzler 2010). The government argues that this economic closure does not represent an infringement of international and human rights as everybody can be treated independently of his/her situation of stay if they can pay, and if they cannot, urgent and immediately necessary treatment will still not be denied. This economic closure, however, breaks down the universality of the British health system. This breach called for a counter-power embodied by NGOs which launched measures to fulfil the gaps in state services. Because of their discretionary power, it also requires health professionals to take a position on health and immigration policies. As we have argued, however, this discretionary power can lead to arbitrariness and discrepancies in treatment.

This case also shows that the government refers to international human rights whilst NGOs try to avoid this discourse or use it as a last resort. The UK government made these changes acceptable by arguing they fit with the international human rights definition (Department of Health 2011). Yet the economic closure and the individualisation of healthcare that go together are an illustration of the risk entailed in human rights discourse of a decrease in social welfare (Beck 2006; Bauman 1999; Turner 2002). This might explain why NGOs are reluctant to refer to human rights to defend their case.

#### **4. France – towards the inclusion of irregular migrants in the common law**

France has in a sense seen an opposite trend to that of the UK, becoming more inclusive towards irregular migrants since the 2000s. Before this date the French healthcare system was not only based on insurance, but the access to health insurance was limited to the regularity of the permit of stay of the beneficiary.<sup>21</sup> After several social struggles different reforms led to what is called the *Couverture Maladie Universelle / CMU* (Universal healthcare) in 1999. This law transformed the French health system to a more universal and inclusive one, allowing any permanent and regular resident in France who earns less than a certain amount to benefit from free social security and healthcare. The universality of the CMU system has been questioned, however, as it does not include irregular migrants. Several organisations for the defence of migrants including healthcare professionals and hospitals, which paid the cost of those not insured, claimed that irregular migrants should be included in the CMU. This protest led the government of Lionel Jospin<sup>22</sup> to create another system in January 2000, known as *Aide médicale d'Etat/AME* (State Medical Aid).

##### **State Medical Aid: a breach in immigration policy ?**

State Medical Aid (hereafter AME) offers free access to healthcare to irregular migrants and similar treatment to that of nationals. In other words, this system allows irregular migrants to be dealt with under the common law. AME seems to represent great progress in the recognition of irregular migrants' right to health. Yet this system still excludes those who do not have a residency permit from universal healthcare (health insurance or CMU), creating a different category of 'care receivers'. This distinction between 'regular' and 'irregular' migrants has been criticised by many organisations for the defence of migrants, who based their rationale on the principle of equality of treatment and international human rights treaties or conventions signed by the French government, but without success as the distinction remains until now.<sup>23</sup> Those who fought against this two-tier system (CMU –

AME) feared that the distinction would become more than symbolic and lead to curtailing the healthcare rights of the most vulnerable persons. Their fear has been proved right as there have been several changes in the law since then to reduce access.

The government attempted with the *Loi de finances rectificative pour 2002* to require irregular migrants to contribute to the costs of their healthcare. This contribution is called the *ticket modérateur*. A large number of NGOs, beyond the issue of migration (among others the associations for Improving the Condition of the Poor and those supporting people living with HIV) and healthcare professionals (GISTI 2003) have fought the *ticket modérateur*.

The case was judged after a claim made by the International Federation of Human Rights Leagues in collaboration with two French NGO (Groupe d'information et de soutien des immigrés / GISTI and Ligue des droits de l'Homme / LDH) against France (FIDH v. France). The European Committee for Social Rights concluded that the *ticket modérateur* for irregular migrants had 'violated the right to medical assistance' according to Article 13(4) ESC/revESC. In response to the decision, the French Government changed its policy and the *ticket modérateur* has not been implemented for irregular migrants.<sup>24</sup> However in 2003 the government managed to put in place additional requirements for the AME: since then someone must have been in France for at least three months, have proof of his/her identity and earn less than a certain amount. Since 2008 associations have also been required to refuse demands from irregular migrants to serve as a private address if they have not been there in the last three months; in the same year the State Medical Aid used admission documents that could not be copied, including laminated cards as of 2009, in order to prevent their transfer between individuals. In 2011 The *Loi de finances rectificative* again attempted to put an end to the free access to healthcare, requiring the annual contribution of 30 euros per person to benefit from the AME. Although this contribution could seem

affordable, several NGOs and health professionals have again fought it as it represents an additional barrier to healthcare access for those who already have difficulty. The same year the government repealed the temporary permit of stay for health issues. The former law regarding financial contribution has been already abrogated by the new (socialist) government of François Holland, but not the second. Each time the rationale for these attempts to limit irregular migrants' access has been based, as in the UK, on the fear of abuse of the system by those who should not be entitled and of health tourism, although several studies prove that the demand of permission of stay for health issues did not raise during the last years (Chauvin, Parizot and Simonnot 2009).

As the AME remains free, the main problem in France in access to healthcare for irregular migrants is having proof of three consecutive months' residence. As in other countries many irregular migrants are homeless in France and use therefore migrants' rights associations as a private address. The State Medical Aid is provided by the Social Security agency. In contrast to the UK, healthcare professionals are therefore not (or less) directly linked to an assessment of who is entitled or not to (free) care, and to what is considered a suitable document, as illustrated by the following quote:

The proof of residence, this is awful! From one area to another it changes. To give you an example: in the 93 [area] the orange card [which is a tube/bus pass] is considered as a proof of residence in France, whereas it is not the case in Paris. We must find the proofs that are accepted by the social security agency, which is really uncertain: this is assessed individually, it depends on the social security agency [...]  
(Social assistant from a Parisian Hospital quoted in Hachimi and Nacu 2010: 165).

This organisation protects the independence of health professionals and allows them to focus more on their medical role than those working in the UK, as argued by Hachimi and Nacu (2010). However it also has to take a position in the case of irregular migrants who are not entitled to State Medical Aid. In some cases health professionals are pushed to leave their medical position and become more involved in their patients' lives. For instance when

the lack of regularisation through asylum threatens the life of their patients, some health professionals advise them to use their poor health as a mode of regularisation instead of political issues related to their situation in their country of origin. This highlights Fassin's point regarding the bio-legitimacy of health: pathology becomes a source of social recognition stronger than political asylum (Fassin and Memmi 2004). One of our interviewees made this point clear, sharing his dilemma with us :

Recently I advised one of my patients to ask for a temporary permit of stay for medical reasons. I thought he had no chance of being granted asylum for political reasons and therefore I thought that his health issues could help him to stay at least temporarily. It is a difficult decision and I am not sure I would take it again because if I am wrong, my advice could have an important impact on my patient's life (Health professional, Hospital, Paris, France).

This brief overview shows that in contrast to the British healthcare system, the French one has become in a sense more inclusive even for irregular migrants. It is classed as one of the countries offering full access to healthcare to irregular migrants (Karl-Trumer, Novak-Zezula and Metzler 2010). However this inclusivity does not mean universal access to healthcare: instead it has created separate systems. To benefit from AME, irregular migrants have to fulfil several bureaucratic requirements. Another difference between the UK and France concerns the use of human rights discourses. Whereas French NGOs use them to support their claims (as illustrated by the collaboration between the International Federation of Human Rights Leagues and two French NGOs), in the UK NGOs justify their demands with the current national legislation. We also note that the back and forth of the health policy was related to a change in government. Each time the problematisation of migration was used for political ends to mark an opposition between the two main political forces. In this sense the abrogation of the *ticket modérateur* or of the 30 euro participation fee to benefit from AME especially seem to have been influenced more by a national political party's willingness to change the previous policies to mark its difference than by

international human rights. Finally, health professionals in France seem more independent from immigration policy and more able to focus on their medical duties than in the UK, as the decision about who is entitled to healthcare or not is done by others (the Social Security agency).

## **5. Conclusion**

This paper has explored the extent to which international human rights generate rights at the level of nation states, by looking at the particular case of irregular migrants' healthcare in France and the UK. It has used the situation of irregular migrants to exemplify the tension between international human rights and citizenship rights. These tensions are illustrated by the contradictory roles of national immigration and health policy. Whilst immigration policy tends to criminalise irregular migrants and therefore curtail their rights, the aim of health policy is to cure and care for anyone independently of legality of their stay – as symbolised by the Hippocratic Oath taken by healthcare professionals. Today, in theory irregular migrants have free access to primary healthcare in both the UK and France. Yet these states have increased the barriers to exercising this right so that immigration and health policies are increasingly converging. In the UK, whilst health policy has followed an independent path from immigration policy until recently by treating irregular migrants the same as residents with a permit of stay, these policies are no longer discordant. In France the trend is somehow inverted: health policy seems now to be more independent of immigration policy with the 'state medical aid' created specifically for irregular migrants. However this openness in the French healthcare system so far exists only on paper, as irregular migrants still face several barriers in accessing healthcare.

The independence of the health system from migration policy is also curtailed because in both countries the right to healthcare for irregular migrants seems less influenced by international human rights discourses and bodies than by historical traditions of immigration

and welfare policies in particular countries (Cattacin, Chimienti and Björgren 2006). Since health policy is more influenced by path dependency in nation states than by international human rights, this means that policy is likely to change according to national contingencies. In the UK, for example, universal access to healthcare was formerly based on liberal healthcare and immigration policies which sought to provide egalitarian access to welfare for everybody but offered minimal benefits. In the context of an increase in irregular migrants in the UK, combined with the wider economic crisis, their access to healthcare has been reduced. The French system is based on health insurance, which creates categorical access to healthcare, distinguishing the insured from the uninsured and those who have private insurance from those who pay for minimal benefits. The creation of universal healthcare and then State Medical Aid in 2000 followed mobilisations by organisations concerned with the welfare of migrants, often supporting their claims by reference to international human rights discourses. But if access to healthcare for those who cannot pay for insurance has introduced a universal dimension to healthcare, these measures also perpetuate the categorical logic of the French healthcare system by constructing a two-tier system that blocks a category of resident, namely irregular migrants, from universal healthcare.

Despite these different trends, both countries have tried to exclude irregular migrants from their national spaces, in a context where we have seen a growing problematisation of migration in the political discourse and in the media, along with the crisis of the welfare state (Schierup, Hansen and Castles 2006). In this context international human rights are used as a last resource to change the law when an infringement takes place, and have only limited impact, as illustrated by the AME in France or the case of *N. v. the UK*. The various attempts to block the AME in France occurred mostly when a change in the government took place. The AME was implemented by a left-wing government, which might explain why a right-wing government tried to end it, wanting to mark a distinction from the preceding

administration. To judge whether this distinction is feigned or genuine goes beyond the point of this paper. Our point here is that the recent abrogation of an annual fee of 30 euros to benefit from the AME is more related to a favourable political context towards a change of governance than to the pressure of international human rights. This favourable context allowed a certain amount of independence regarding health policy and immigration policy, which Karl-Trummer, Novak-Zezula, and Metzler (2009) call 'paradox-free spaces for action'. At the same time, this also allows more recourse to the human rights discourse. In the UK, this favourable context for irregular migrants' rights was missing, and this helps to explain why NGOs have tried to raise social and political awareness more by building on national legislation than on international human rights.

What these French and UK cases show is that although the international human rights tools provide a legitimating framework to support irregular migrants' claims for access to healthcare, this framework alone is not sufficient. The enforcement of international human rights depends on a political and social 'reception' for them at the national level. This confirms and illustrates what Honneth has argued more generally in relation to social justice (2005 [1995]) and what Shafir and Brysk have discussed in comparing citizenship rights and human rights (2006). Although international human rights can act as a force for change, they are framed in terms of national interest 'rather than in terms of global citizenship or universal morality' (Nash 2012).

The second question raised by this paper is what constitutes an infringement of the international human right to healthcare. Although both the UK and France limit irregular migrants' access to healthcare the governments of both countries argue that they do not infringe international human rights since irregular migrants are allowed access to emergency treatment even if they are not entitled to State Medical Aid in France or if they cannot pay

in advance in the UK. Are these governments right to argue this?

As argued by Sövig (2011) and Hachimi and Nacu (2010), among others, the definition of what constitutes an emergency is problematic. It requires an interpretation from caregivers and therefore forces them to take responsibility for issues that go beyond the question of health, i.e. technocratic and immigration matters. Moreover, the obligation to distinguish between what is an emergency and what is necessary for a patient's well-being seems incompatible with their role as caregivers.

The argument that those whose health issues are not considered an emergency could pay for treatment raises further questions, including how to deal with those who are not able to pay because they are children. Whilst the UN Convention on the Rights of the Child (CRC) requires that irregular children have the same access to healthcare as children with a legal permit of stay or nationals, the legal situation is unclear and there are national variations (Sövig 2011). Several NGOs also argue that this rule is discriminatory not only because it would treat residents of the same country differently, but also because it would make irregular migrants pay twice for healthcare, i.e. both through taxes and consumption (as do legal residents) and then also for non-emergency care. In both countries, access to healthcare for irregular migrants on a case-by-case basis did not correspond to an increase in rights as such. Instead it led to a decrease in the meaning of health rights (Da Lomba 2010). For all these reasons, if the restrictions that these states place on irregular migrants' access to healthcare are not formally a violation of human rights (especially of Article 12 of the ICESCR), they do however tend to de-humanise irregular migrants.

## **Acknowledgments**

To add\*\*\*

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<sup>1</sup> By irregular migrants we mean people who do not have a permit of stay. This broad definition include those who entered legally but lost later their permit of stay or those who entered illegally.

<sup>2</sup> As Honneth (2005 [1995]), has shown social justice needs a favourable objective and subjective context in order to take place (which he identifies as the affective, socio-economic and legal spheres of recognition).

<sup>3</sup> Name of researchers involved to add\*\*\*

<sup>4</sup> In particular the following: FRA 2011, HUMA 2009, Médecins du Monde 2009, PICUM 2007.

<sup>5</sup> Among others: Cattacin, Chimienti and Björgren 2006, Cattacin, Chimienti, Hachimi Alaoui et al. 2009, Da Lomba 2010, Karl-Trummer and Novak-Zezula 2011, Sövig 2011.

<sup>6</sup> The 1948 UN Universal Declaration of Human Rights states: 'Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including . . . medical care . . . and the right to security in the event of . . . sickness, disability . . . ' (Article 25.1). The International Covenant on Economic, Social and Cultural Rights (ICESCR is the most important in terms of the right to health. The Article 12 (1) of the ICESCR, ratified by all 27 EU Member States, which recognizes 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'. There is also the Article 21 of the Charter of Fundamental Rights of the European Union (EUCFR) on non-discrimination which specifies that 'any discrimination based on any ground such as (...) shall be prohibited', implying with the phrase 'on any ground such as' that other suspect grounds not mentioned in the article 'such as for instance citizenship or nationality might also found a complaint of discrimination' (Hervey 2003: 203).

<sup>7</sup> [www.ifhhro.org/health-a-human-rights/the-right-to-health](http://www.ifhhro.org/health-a-human-rights/the-right-to-health), last consulted 15/04/2011

<sup>8</sup> [www.ifhhro.org/health-a-human-rights/the-right-to-health](http://www.ifhhro.org/health-a-human-rights/the-right-to-health), last consulted 15/04/2011

<sup>9</sup> Article 33 (1) of the 1951 Geneva Convention Relating to the Status of Refugees provides that 'no Contracting State shall expel or return ("refouler") a refugee against his or her will in any manner whatsoever, to a territory where his or her life or freedom would be threatened on account of his or her race, religion, nationality, membership of a particular social group or political opinion'.

<sup>10</sup> [www.ukba.homeoffice.gov.uk/sitecontent/documents/policyandlaw/consultations/nhs-debtors/](http://www.ukba.homeoffice.gov.uk/sitecontent/documents/policyandlaw/consultations/nhs-debtors/)

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<sup>11</sup> Unlike some countries such as Germany, where the Asylum Law (*Asylbewerberleistungsgesetz* / AuslG) stipulates that any member of an official board has a ‘duty to denounce’ irregular migrants voluntarily at the risk of being penalised if they do not (Article 76), and that anyone who helps an individual without a regular residence permit can be fined or detained for up to five years (AuslG, Article 92a).

<sup>12</sup> Kymlicka and Banting 2004; Chauvin *et al*, 2009.

<sup>13</sup> [www.doctorsoftheworld.org.uk/lib/docs/124249-projectlondonleaflet2009.pdf](http://www.doctorsoftheworld.org.uk/lib/docs/124249-projectlondonleaflet2009.pdf)

<sup>14</sup> Doctors of the World and the Helen Bamber Foundation are the only two migrants rights NGOs at that time providing (free) health care provision.

<sup>15</sup> See for instance the website created by the NGO Medact,

[http://www.medact.org/article\\_refugee.php?articleID=911](http://www.medact.org/article_refugee.php?articleID=911)

<sup>16</sup> *Regina(A) v West Middlesex University Hospital NHS Trust* [2008] EWHC 855 (Admin), paragraph 27, page 11

<sup>17</sup> Medact Briefing Document, 21 May 2010, page 2

<sup>18</sup> Such as ‘Is having the wrong passport or visa such a heinous crime that doctors should treat perpetrators worse than they would a mass murderer?’ (Migrant Rights Network 2011: 7)

<sup>19</sup> See the Case of N v. The United Kingdom, [http://www.escr-net.org/docs/i/case\\_of\\_N\\_v.\\_the\\_united\\_kingdom](http://www.escr-net.org/docs/i/case_of_N_v._the_united_kingdom)

<sup>20</sup> [http://www.escr-net.org/docs/i/case\\_of\\_N\\_v.\\_the\\_united\\_kingdom](http://www.escr-net.org/docs/i/case_of_N_v._the_united_kingdom)

<sup>21</sup> Based on the so-called ‘Pasqua law’ who was in 1993 the French Home Secretary and enforced this law in August 1993.

<sup>22</sup> The government was at that time composed of a left-right wing cohabitation with socialist Ministers (among others the Prime Minister Lionel Jospin) and the President Jacques Chirac from the neo-Gaullist group, the Rally for the Republic / RPR (*Rassemblement pour la République*).

<sup>23</sup> Among others the Article 3 of the European Convention, <http://www.odse.eu.org/Plate-forme-des-revendications-de>.

<sup>24</sup> See International Federation of Human Rights Leagues (FIDH) v. France, Complaint No. 13/2003, European Committee on Social Rights <http://www.escr-net.org/docs/i/400976>