Politics of Hospitality in the NHS: Immigration Enforcement through the Provision of Healthcare in England.

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LIST OF ABBREVIATIONS

A&E	Accident & Emergency
BMA	British Medical Association
DotW	Doctors of the World
EU	European Union
EEA	European Economic Area
CRT	Critical Race Theory
GMC	General Medical Council
GP	General Practitioner
HCWV	Health and Care Worker Visa
HEI	Higher Education Institution
HIV	Human Immunodeficiency Virus
IHS	Immigration Health Surcharge
ILR	Indefinite Leave to Remain
JCWI	Joint Council for the Welfare of Immigrants
IOM	International Organisation for Migration
MoU	Memoradum of Understanding
NRPF	No Recourse to Public Funds
NGO	Non-governmental Organisation
NHS	National Health Service
NMC	Nursery and Midwifery Council
OVM	Overseas Visitors Manager
UK	United Kingdom
UKVI	UK Visas and Immigration
US	United States

Abstract

Healthcare provision by the NHS is framed by an ethical framework fleshed out in values and principles that should inform the service in everything it does. Values such as dignity and "everyone counts" as well as principles such as "healthcare based on clinical need, and not ability to pay" reveal a normative commitment to humanity and a sense of universal care on the basis of equal human worth. Not only is this ethics concerned with the delivery of improvements in the health and wellbeing of patients, but also with the provision of healthcare in a cordial and generous manner so that patients can feel welcomed into the service. In other words, the ethics underpinning the operation of the NHS construes healthcare provision as an offer of hospitality: The NHS constitutes the home which welcomes the "ill" by providing the "gifts" of curing bodies and alleviating suffering. This promise of hospitality, however, is troubled by healthcare provision for migrants. Data-sharing policies operating through the system for charging migrants for health services allow for the transfer of migrant patients' personal information to the Home Office for purposes of immigration enforcement. Hospitality, viewed in this light, blurs the boundaries between health enhancement and border control – and enables the enactment of hostility towards migrants under the care of clinical staff. In this thesis, I investigate what happens when migrants are welcomed into the NHS. In carrying out my analysis, I flesh out the argument that, once migrants are welcomed into the service, practices of hospitality which deliver improvements in their health and wellbeing also subject them to hostility by means of technologies of power which control borders through the provision of healthcare. In doing so, I examine how the welcome of migrants into the NHS brings about ethical dilemmas for healthcare workers which cannot be resolved by the mere application of the moral guidelines orienting the professional practice of medicine. In this vein, the thesis interrogates hospitality as an entirely benevolent act, as well as healthcare as an intrinsic good delivered through medical interventions.

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INTRODUCTION

In 2017, I found myself reflecting on issues surrounding health and immigration. A few months previously, I had completed my Master's degree in International Politics, and written my dissertation on HIV-related travel restrictions to international migration. Broadly speaking, it was a work that analysed how the bodies of HIV-positive migrants were inscribed with biological markers that determined their ability to enter and stay in the territory of foreign states. Engaging with such a research problem confronted me with a range of questions which intrigued me and, at times, left me with feelings of astonishment: What are the justifications provided by a state for refusing the entry of a migrant into its territory on the basis of their health status? How could these motives possibly accommodate the enjoyment of the universal right to health, enshrined in international human rights law, which does not differentiate between citizens and foreigners? What does the use of biological markers to regulate migration tell us about contemporary systems of government? Furthermore, while carrying out my research, I was prompted to realise that HIV-related restrictions to international migration are not only a matter of allowing foreigners to cross borders (or prohibiting them from doing so). It is also a question of how migrants come to have their medical necessities met once these borders are crossed.

It was with these issues in mind that I came across the news article published in British online newspaper, The Guardian, on 24th January 2017, which introduced me to the seminal ideas to be explored in my PhD. The article spoke of a memorandum of understanding which had been put in place between the National Health Service (NHS) – the United Kingdom (UK) Government-funded healthcare system – and the Home Office, the lead government department for passports and immigration, drugs policy, police, counter-terrorism, crime and fire (Home Office 2022). The arrangement set out the protocol under which the Home Office could make requests of the NHS so that the health service could provide migrant patients' confidential non-clinical information for purposes of immigration enforcement. In other words, the Memorandum of Understanding (MoU) explained the procedures for the NHS to transfer migrant patients' details to the Home Office (e.g. last known address, telephone number, date of birth) so that the department could trace immigration offenders. In doing so, the Government claimed to be curbing illegal immigration as well as preventing those without the right to live in the country from accessing healthcare at the expense of the UK taxpayer (Department of Health, Home Office and NHS Digital 2016). The policy described in the article prompted me to reflect on a problem to which I

had not attended before: How healthcare provision is deployed by governments across the globe to regulate migration and control borders.

While describing the issues brought to light by the MoU, the piece published by The Guardian also introduced me to arguments advanced by critics of the agreement. By blurring the boundaries between immigration enforcement and healthcare provision, the UK Government was deterring migrants from seeking healthcare, which could impact both individual and public health. Furthermore, there were challenges arising from potential conflicts between the data-sharing policy established by the arrangement and medical ethics, given that confidentiality is one of the cornerstones of clinical practice (Travis 2017). In my attempt to better understand the terms of such opposition, I came across a plethora of documents describing ways in which confrontation could be enacted, and the rationale underlying practices of resistance against the arrangement. One of the first documents that came to my attention was the "Safe Surgeries Toolkit", designed by Doctors of the World (DotW), an independent humanitarian movement working to facilitate healthcare access to vulnerable populations. The toolkit set out steps to be taken by healthcare workers to stand against the MoU while complying with official guidelines and laws (DotW 2017a: 3 – 6). The guidance provided me with a useful understanding of the position of clinical professional bodies and non-governmental organisations in respect to the agreement, but something else emphasised by the document particularly attracted my attention.

The Safe Surgeries Toolkit argued for a view of healthcare provision as hospitality. In one segment, the document explains that it constitutes "a toolkit for healthcare professionals and GP [General Practitioner] practices who want to provide confidential and *welcoming services* for all their patients including refugees, asylum seekers and undocumented migrants' (DotW 2017a: 1, emphasis added). In a similar vein, it encourages healthcare workers to stand against the data-sharing policy set out by the MoU by taking "concrete steps to stop a patient's address being shared and to make them feel *welcome*" (DotW 2017a: 3, emphasis added). While describing one of the procedures to prevent migrants' confidential non-clinical data from being transferred to the Home Office, the toolkit incentivised surgeries to put up signs on display, declaring that they are a safe space where migrant patients do not need to provide identity documents or proof of address in order to access health services (DotW 2017a: 4). It is interesting to note that the posters designed by DotW for that purpose also advanced the aforementioned view of healthcare as hospitality, with one of them telling migrants that "All are welcome! Your nationality or immigration status do not affect your right to register here" (DotW 2017b: 1).

My preliminary analysis of the MoU and the materials produced by DotW left me with some significant questions: First, why the appeal to hospitality in response to the MoU? And what does it tell us about the overall ethical framework orienting healthcare provision by the NHS? Secondly, what is the backdrop against which the data-sharing policy came to be implemented? Does the MoU constitute an isolated effort to control borders through healthcare, or does it find itself embedded in a broader set of practices aimed at enforcing immigration through the delivery of health services? These were the initial prompts leading me to the core ideas which are analysed throughout my PhD research. To understand these issues, it is first necessary to provide an overview of the political standing of the NHS, and of why it matters to a proper understanding of the control of borders through the provision of healthcare.

1. The political standing of the NHS and the politicisation of healthcare provision by the service

Inaugurated in 1948 amidst endeavours of the UK to build the British welfare state after the Second World War, the National Health Service (NHS) constitutes the state-funded healthcare system delivering improvements in health and wellbeing across the country. An introduction to the health service – however brief it is – cannot underplay the ways in which its political standing interferes with (and reflects in) its management and operation. It is important to note that I do not provide here a detailed explanation of the politics surrounding the NHS, nor do I intend to explicate the different approaches to healthcare adopted by politicians in the UK. Rather, I emphasise that the NHS enjoys a socio-political status that interferes with (and reverberates through) the way in which the health system operates. Furthermore, I remark that the politics in the backdrop of its operation has a decisive role in determining the goals to be pursued through the service. I begin this outline of the political standing of the NHS by drawing attention to a segment of its first pamphlet, in which the UK Government offers an explanation of the new health service to members of the public:

> Your new National Health Service begins 5th July. What is it? How do you get it? It will provide you with all medical, dental and nursing care. Everyone – rich or poor, man, woman or child – can use it or any part of it. There are no charges, except for a few special items. There are no insurance qualifications. But it is not a "charity". You are all paying for it, mainly as taxpayers, and it will relieve your money worries in time of illness" (Ministry of Health 1948: 1).

As the first NHS pamphlet reveals, the UK Government made it clear in its introduction to the service what would be deemed to be the distinctive features of the emerging health system: Comprehensive healthcare, free for all at the point of use, with costs being primarily covered through general taxation. To a large extent, the words of the leaflet reflected the three core principles of the service: That it meet the needs of everyone; that it be free at the point of delivery; that it be based on clinical need, not ability to pay (NHS Providers 2015: 5). From its inception, the "unusual characteristics" of the NHS have made it the object of international and national attention (Webster 2002: 1). At the moment of its establishment in the 1940s, the UK stood alone among other Western democracies in its mission to build a health system providing care free of charge for the entire population. Conceived as a form of socialised medicine by then Minister of Health Aneurin Bevan, the service began its operations against the backdrop of the Cold War – a historical moment where projects and ideas deemed to be leaning towards communism were seen with suspicion by capitalist countries.

In a recent episode, the NHS took on again the main stage of international and domestic politics when a potential trade deal between the UK and the United States (US) put the health service at the risk of privatisation. Former US President Donald Trump was quoted as saying that nothing would be "off the table", including the NHS, after talks with members of the Conservative government back in 2019 (Taylor 2019). Echoing concerns that a for-profit healthcare system would prioritise the interests of US insurance corporations and pharmaceutical companies, the public response was less than favourable. In 2020, medical doctor Jatinder Hayre published an article in British online newspaper The Independent where he expresses his strong opposition to the marketisation of the NHS through any UK-US trade deal. He contended that three quarters of the British public are against the agreement, and made the potent claim that by selling the NHS, the Government would be selling the nation's soul (Hayre 2020). Indeed, he was not making an unfounded assumption when he appealed to the public's esteem of the service to build his argument. The NHS is deemed to occupy "a unique place in public consciousness" (King's Fund 2017a), consisting of a health system that is considered the "jewel in the crown" of the welfare state. It finds itself at the top of the list of the reasons why members of the public are most proud to be British (Ipsos 2022), and the inauguration of the service is deemed to have paved the way for the establishment of a social institution providing a sense of moral foundation to society in the UK (Heath 2018: 1).

It is not the public and healthcare workers alone that acknowledge the constant presence of the NHS in Britain's everyday life and its notorious role as part of the UK's national fabric. Politicians across the ideological spectrum and administrations headed by both the Conservative and Labour parties have paid regard to the prominence of the service as an arena of political interest (Webster 2002). Referring to the first years following the inauguration of the NHS, Charles Webster (2002: 1) provides us with a helpful description of this scenario: "To a greater degree than elsewhere, funding and policy became the province of the politician and the civil servant. Everywhere else health care was subject to political intervention, but the UK was unusual in the extent to which politicians assumed command and took over the levers of control for the entire health care system." There is no doubt that such circumstances demanded great responsibility on the part of politicians and administrations running the country, but they also opened up the opportunity to make the NHS into a field of intense political dispute – a field where, for instance, prime ministers could affirm themselves as "good" politicians while their opponents contended that they were not.

What do these brief reflections on the political standing of the NHS bring to light? First, they illuminate how the NHS – since its inception – has constituted an arena of political dispute which articulates questions of domestic and international politics. Secondly, it prompts us to consider that the operation of the health service needs to be critically scrutinised if we seek to gain a better understanding of how it comes to be deployed as an instrument of border control. Such a critical endeavour undermines portrayals of the service as a mere set of organisations linked together to deliver improvements in the health and wellbeing of the population. This is a crucial component of the heath service, but the management and operation of the NHS cannot be reduced to the outcome of advances in expert knowledge applied to the healthcare sector. The political significance that the service displays among UK politicians, and the socio-political (and even affective) status that it enjoys among members of the public interferes with – and reflects in – the ways in which the health service has been designed, transformed and administrated.

In refusing to conceive healthcare provision as a depoliticised means of delivering health services, we are better equipped to understand that health policies can be articulated with specific political goals which lie beyond the scope of health enhancement (e.g. reducing net migration in the UK), and how discourses of danger can be mobilised in reference to the NHS in order to appeal to the public opinion (e.g. free healthcare for migrants puts at risk the sustainability of the NHS). The politicisation of healthcare provision also sheds light on ways in which particular views of the NHS can be framed, and how they can be deployed to justify specific political moves. For instance, it

illuminates the link between a view of the NHS as a national – and not an international health service – with the decision to charge migrants for their healthcare. In this thesis, I take into account the political standing of the NHS in order to examine immigration enforcement through the service, and draw on this politicised view of healthcare provision to orient my analysis of hospitality for migrants in the NHS.

2. The NHS as a space of hospitality

I now return to the first question that I was left with after my first encounter with the MoU and the response that DotW articulated to the arrangement through its Safe Surgeries Toolkit: Why the appeal to hospitality in responding to the data-sharing policy? Perhaps most people – myself included – hold the assumption that patients should not be treated with hostility by healthcare workers. If someone is ill and seeks health services, we are prompted to think that laws and ethical codes for healthcare professionals will advise them to offer patients the best possible care in a cordial manner if they want their conduct to be legal and morally valuable. This assumption is not without reason. Take, for instance, the guidance issued by the General Medical Council (GMC), the public body responsible for maintaining the official register of doctors in the UK, setting ethical standards for the practice of medicine as well as overseeing medical education and training (GMC 2022). Their guidelines state that doctors must make the care of their patients their first concern while being polite, considerate and respecting their dignity (GMC 2013: 16). But what DotW's toolkit brought to my attention is that – by fulfilling such professional duties – doctors are providing health services as an act of welcoming. In other words, they are providing healthcare through practices of hospitality.

My preliminary understanding that healthcare provision could be framed as a practice of hospitality proved to be right. A vast literature in healthcare studies reiterates the view that providing health services is not just about delivering improvements in health, but also entails a cordial reception of patients into healthcare systems – an act of welcoming which contributes to the healing of patients and their overall wellbeing (Holroyd, Kelly and Wright-St Clair 2018; Kelly, Losekoot & Wright-St Clair 2016; Hepple, Kipps and Thompson 1990; Renzenbrink 2011). This will be properly explained in the first chapter of this thesis, but – for the time being – it is important to remark that this understanding of healthcare as hospitality finds itself enshrined in the ethical framework underpinning the operation of the NHS: The NHS Constitution for England. The document sets out the principles and values governing the operation of the service as well as the rights and

responsibilities of NHS staff, patients and the general public in respect to the health system (Department of Health 2015a: 2)[1]. It does not constitute a legally-binding document in the sense that it does create novel rights – rather it sets out and explains existing legal provisions instantiating entitlements. Furthermore, all organisations and persons that are part of the health service are required by law to take into consideration the Constitution in their actions and decisions (DHSC 2019a: 3).

An overall analysis of the NHS Constitution makes it possible for us to observe how the ethical framework it establishes shapes healthcare provision as an act of hospitality. For instance, the values enshrined in the document mandates that the NHS be committed to the delivery of high quality care, aimed at improving the health and wellbeing of all patients. However, the mission of the service is beyond deploying expert knowledge to diagnose and treat diseases through professionalism and excellence in care. The Constitution establishes that patients should be treated with sensitivity and kindness. It literally states that "[t]he business of the NHS extends beyond providing clinical care and includes alleviating pain, distress and making people feel valued and that their concerns are important" (DHSC 2019a: 14). Two points are of particular note here: First, the Constitution implies that healthcare provision entails the fulfilment of moral obligations which attach to the service ethical responsibility. Secondly, this ethical responsibility constitutes a duty to deliver health services while amounting to patients' feelings of warmth, security and belonging when received into the service. In other words, patients should feel as "at home" as possible in their access to healthcare (Hepple, Kipps and Thompson 1990: 309).

Having briefly looked into the NHS Constitution, the healthcare literature and ethical codes of conduct for healthcare professionals, it then made sense to me why DotW had decided to frame their resistance against the MoU in terms of hospitality. Indeed, my preliminary exploration of such works and documents allowed me to realise that the ethical framework underpinning clinical practice in the UK constituted an ethics of hospitality. Hospitality here is conceived as "something" good, a practice which works to improve the process of cure and alleviation of suffering of those under the care of clinical staff. Putting it differently, being welcoming constitutes a crucial part of medical practice. From this perspective, there is simply no possibility of one's being a "good" healthcare professional – one that acts in an ethical manner – if they treat their

[1] As clarified by the Handbook to the NHS Constitution, '[t]he core principles of the NHS are shared across all parts of the United Kingdom. However, the NHS Constitution applies only to the NHS in England" (DHSC 2019a: 6).

patients with hostility. This view is aligned with a conceptualisation of hospitality framed "as a desirable attribute for all manner of social groups, from communities and cities to nation-states, all keen to project an image of the good and gracious host" (Darling, 2014: 162).

One of the main implications of acknowledging healthcare provision as an act of hospitality is that the NHS does not simply constitute a health service aimed at delivering improvements in the health and wellbeing of the population. It is not just a site where patients undergo clinical interventions designed to cure their bodies. The service constitutes a homely space. And how can one possibly conceptualise the NHS as home? Initially, it could be argued that such a conceptualisation simply relies on a metaphor: The British healthcare system being regarded as representative or symbolic of the homely space. This portrayal of the health service does not, in itself, constitute a misconception which undermines the possibility of hospitality in the spaces where healthcare is provided for migrants. Indeed, against this backdrop, the delivery of health services can be conceived as a gift of hospitality offered to the foreigner who crosses the territorial borders of the UK – framed, from this perspective – as the actual home.

However, I take issue with the view above for two main reasons. Firstly, the appeal to a metaphorical understanding of the NHS as home does little to challenge the limited – and limiting – perception that decisions around hospitality intersect with the government of migration at the territorial border of the sovereign state alone. In other words, this view fits neatly into the traditional comprehension of the nation-station as the home and foreigners as the guests who experience a more or less welcoming reception under the state jurisdiction. However, it pays little regard to the role of sites – within but at the same time other than the nation-state – in the implementation of and resistance against exclusionary immigration policies (Bhattacharyya 2017: 96).

One of the main implications of the lack of attention paid to role of the aforementioned spaces in framing reactions to immigration enforcement consists of a failure to shed light on the mundane interactions and places of everyday life where compliance to – and confrontation of – anti-immigration discourses and practices shape the hospitality offered to the foreigner. This argument is in direct conversation with my second critique of a metaphorical understanding of the NHS as home. Appeals to this metaphor might imply that the "real" borders are those demarcating the spatial boundaries of the state – i.e. the ones which actually matter to the experience of hospitality as the reception of the other. In doing so, it underplays the shift in focus – strongly emphasised

by the UK Government – "from the external, territorial border to the internal border, incorporating technologies of everyday bordering in which ordinary citizens are demanded to become either border-guards and/or suspected illegitimate border crossers" (Cassidy, Wemyss and Yuval-Davis 2018: 228). Such an internalisation of borders will be critically analysed throughout this thesis, as I explore the ways in which verification of eligibility and healthcare provision for migrants constitute bordering practices.

While I have made the case for interrogating the aforementioned metaphorical comprehension, there remains the question as to why the NHS can be conceived as the materialisation itself of the physicality and affective component of that which is thought of as home. To begin with, it is crucial not to conflate the notions of home and house. Home is not simply the place of dwelling. While the home incorporates the matter out of which it is made, it also entails an imaginary imbued with feelings which are attached to the physical structure of the homely space (Blunt and Dowling 2006: 2 – 3). These could be feelings of belonging and inclusion, but also exclusion and alienation because there is nothing intrinsically "good" or "benign" in respect to the home. The content of the "being-at-home" cannot be aprioristic determined. It is worth noting here that my challenging of a metaphorical conceptualisation of the NHS as home does not contradict my view that the home has an imaginative dimension. This is because metaphors – as explained above – refer to something which is representative or symbolic of something else. The argument that I advance in this thesis is not that we look at the NHS *as if* it constituted a home. Rather, I propose that we conceive of the health service as home itself – one which is composed by its materiality and feelings attached to it.

Starting from the perspective above, we could argue that the idea of a material and imaginative conceptualisation of the homely space allows for the framing of the NHS as home: It is the space composed by the infrastructures which constitute the sites of healthcare provision; places where migrant patients can experience feelings of warmth and wellbeing as health services are delivered, but also fear and exclusion in the shadow of immigration enforcement. Furthermore, the healthcare system works as a homely space for other two fundamental reasons. Drawing from a "critical geography of home", we can argue that home can occur in and through multiple scales (Blunt and Dowling 2006: 29). Feelings of being-at-home – whatever they may be – and the interplay between hosts and guests are not limited to the house or any particular space of dwelling: Home can be states, cities, neighbourhoods, private accommodations, and healthcare systems where patients look for the cure of their bodies and alleviation of their suffering. Secondly, the

construction of the home finds itself linked to relations of power and the constitution of identities (Blunt and Dowling 2006: 6). Power relations operating through hospitality for migrants in the NHS will be explored in the second chapter of this thesis, but it worth highlighting at this point how the MoU allowed for the exercise of the sovereign power to exclude "immigration offenders" from the UK. (Unstable) Identities of hosts and guests are also produced through home-making practices. In the NHS, this particularly perceived as healthcare staff take on the task of welcoming migrant patients into the service.

Having provided an explanation of how the NHS functions as home, we can shift attention to some important questions relating to its operation: How is it that border control came to be entangled in the provision of health services by the NHS despite the ethics of hospitality governing its management? What political context gave rise to the implementation of a data-sharing policy which turns healthcare provision into an instrument of inflicting pain on migrant patients with unlawful residence in the UK? Against which backdrop can one explain the exclusion of migrants from the NHS by virtue of their immigration status? This is particularly significant if one considers that the first NHS principle advances a sense of equity and universalism in the provision of healthcare, which does not discriminate on the basis of nationality, ethnic or national origins (DHSC 2019a: 14; Equality and Human Rights Commission 2022)[2]. The question as to whether immigration enforcement can be reconciled with the ethics of hospitality governing the operation of the NHS is a relevant one. So is the question as to whether it is possible to conceive of a way for healthcare workers to enforce immigration through the service while maintaining their integrity as ethical subjects. These will be explored throughout this thesis. What I provide now is an explanation of the political context within which immigration enforcement came to be embedded in the provision of healthcare.

3. The hostile environment and immigration enforcement in the UK

As I previously mentioned, my first encounter with the MoU and the materials produced by DotW to respond to the arrangement prompted me to investigate the backdrop against which the data-sharing policy was operating. I was intrigued to examine the political context within which practices of border control came to be embedded in healthcare provision by the NHS – a health system governed by an ethical framework committed to a welcoming reception of patients into the service. Not long after that, I came across what would become a constant object of analysis

[2] Values and principles underpinning the operation of the NHS will be properly explored in Chapter One.

in my studies over the following years: The hostile environment policies. But what do they consist of? Putting it simply, the hostile environment refers to a set of restrictive immigration policies and practices of border control embedded in everyday interactions of migrants living in the UK. They also constitute procedures set out to establish immigration status in order to determine migrants' entitlement to a host of services, benefits and enjoyment of rights. A range of questions arise from this definition: How does hostility operate in this context? By whom is it enacted? Who are the targets – or, more precisely, who ends up being targeted – by the hostile environment? Housing can be a helpful illustration at this point.

The Immigration Act 2014 established that private landlords are required to check tenants' immigration status before renting to them. The procedure is mandatory in order to determine whether the potential tenant has the "right to rent" in the UK – i.e. that they are not disqualified from doing so by virtue of their immigration status. Those with unlawful residence in the country are deemed disqualified from renting. Following up on the aforementioned legislation, the Immigration Act 2016 criminalised the conduct of landlords who knowingly permit that a disqualified person occupy a rented property, and they were also given power to evict tenants if they are found not to have the right to rent. In addition to criminal sanctions, landlords who do not perform the required immigration checks are liable to the payment of fines (Liberty 2019: 33). The practical consequence of these restrictive measures is that migrants are pushed out of the regular housing market, and are more likely to experience homelessness or subjection to abusive practices (e.g. overpriced rents, unsafe accommodation). Landlords, in their turn, are incentivised to rent to British citizens only for pragmatic reasons. In this anti-immigration scenario, they are also encouraged to carry out acts of racial profiling, and to avoid renting to those marked by features of perceived foreignness – British or not (Liberty 2019: 34)[3].

What does the example of housing tell us about the operation of the hostile environment? To begin with, it highlights how the hostile environment relies not only on public servants and private sector workers to carry out the functions of immigration checks. Enforcing immigration constitutes a task to be shared with individuals and organisations whose primary interest does not lie in the control of borders. For instance, that is why banks are required to regularly check the

[3] It is important to note with Kathryn Cassidy (2018: 79) that while the process of embedding immigration checks within a range of services relating to everyday life "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."

status of migrants who hold a current account with them, and report to the Home Office those found to be illegal in the UK (Liberty 2019: 29). Secondly, as the example above reveals, hostility operates in such an environment by banning migrants from accessing benefits, services and the enjoyment of rights which are essential for them to carry out the basic acts of everyday life. Under certain circumstances, they can even find themselves criminalised for doing what they need to do to survive. For example, a destitute immigrant with unlawful residence in the UK is committing a criminal offense if they claim public funds (e.g. housing and homelessness assistance) (Yeo 2019).

The scenario described above reveals that immigration status consists of a life-defining issue under the circumstances imposed by the hostile environment. It delimits and restrains the ways in which migrants can experience everyday life while living in the UK. There remains the question as to who makes up the foreign population targeted by the hostility engendered by these policies. At first, it might seem that only those with unlawful residence in the country constitute their object. After all, such policies are generally traced back to former Home Secretary Theresa May's declared intent to create in the UK a hostile environment for "illegal immigrants"(Grierson 2018). However, their consequences can be as encompassing as to affect those with regular status in the country and even British citizens. As the case of housing reveals, landlords may choose to rent for British tenants alone in order to avoid the bureaucracy of carrying out immigration checks. Furthermore, racial profiling practices may lead them to assume that British citizens with foreign names and/or non-white phenotype – without the documents to prove their citizenship – are migrants who do not hold the right to rent.

Finally, it is also worth noting how the implementation of the hostile environment policies allows for a particular type of bordering by the UK. While opposing the operation of such policies in a report published in 2019, civil rights organisation Liberty described them as "a sprawling web of immigration controls embedded in the heart of our public services and communities" (Liberty 2019: 7). The description seems to be accurate, and highlights an important component of the control of borders under the hostile environment. Against this backdrop, we are confronted with "[b]orders that operate by attaching to individual subjects wherever they go rather than bounding off a defined physical area; borders that are internal to the nation that has already been entered" Keenan 2019: 79). Certainly, the effects of the hostile environment can be experienced by those who have not yet entered the UK. Take the payment of ever-increasing visa fees or the points-based immigration system, which facilitates the entry of so-called "high-skilled" workers while offering no immigration route for those deemed "low-skilled" (Home Office 2020a). However, it

is indeed the internalisation of borders and their removal from the territorial limits of the UK that is the most prominent feature of immigration enforcement in the hostile environment.

4. The hostile environment in the NHS

Similarly to housing, banking, education and other sectors of everyday life, healthcare provision by the NHS has also been impacted by the hostile environment policies. A helpful way to introduce their operation is by drawing attention to the lived experiences of migrants affected by the hostility engendered by such policies. We could begin by taking as an example the story of failed asylum seeker Simba Mujakachi, a personal trainer who was refused healthcare, and ended up having a stroke that left him in a coma and paralysed on his left side. Simba was a Zimbabwean national who had been living in the UK since he was a child after his father became wanted by the government of his country for speaking out against then president Robert Mugabe (Vinter 2021). Because of his immigration status, Simba was not entitled to free NHS care, including a relatively inexpensive medication for a blood clotting condition which could have prevented the life-threatening experience that he went through. After his stroke, Simba was taken to the Accident & Emergency department (A&E), where he was provided with hospital treatment. He was later handed a bill of more than £100,000 for the care he received. As a failed asylum seeker, he did not have the right to work in the UK nor was he entitled to disability support (Vinter 2021). After 11 years of appeals, Simba was finally granted the status of refugee in 2022, and had his NHS debt cancelled. However, as he explains, there is little to celebrate as his stroke – from which he still recovers – left him in a rather precarious physical, psychological and financial position (Vinter 2022).

What can the story of Simba tell us about the operation of the hostile environment in the NHS? A few observations can be made at this point. Firstly, certain health services are free of charge while other health services are chargeable. Secondly, immigration status is a decisive factor in determining eligibility for healthcare. For example, failed asylum seekers and migrants with unlawful residence in the UK are ineligible, irrespective of how long they have lived in the country. Thirdly, the system for charging migrants for health services allows for the blurring of boundaries between healthcare provision and immigration enforcement. In Chapter Two, I will provide a detailed explication of the charging regime, and how it works to allow for border control to occur through the NHS. However, drawing on the story of Simba to make a few preliminary considerations might be helpful to set the context for the issues that I will be exploring in this

thesis. In this vein, the first area of intersection between healthcare provision and immigration enforcement on which his story sheds light is delimited by the data-sharing policies between the Home Office and the NHS. These policies are significant since they play an important part in determining whether or not a migrant patient – such as Simba – is eligible for free health services.

The NHS is required to verify migrants' eligibility for healthcare if the service being provided is chargeable. The process entails sharing migrant patients' non-clinical information with the Home Office, which can provide details on their immigration status and, therefore, entitlement (or not) to free NHS care. In doing so, the department can also maintain storage of this data and use it for purposes of immigration enforcement (Medact 2019). It is important to note that this requirement is set out by the main piece of legislation grounding the charging regime: the NHS (Charges to Overseas Visitors) Regulations (the Charging Regulations) which came into force in 2015. Not that charging migrants for healthcare constitutes a new practice in the UK (Galaso et. al 2021). However, the Charging Regulations 2015 and their subsequent amendments constitute "the latest and the toughest application of rules for overseas visitors using the NHS" (McHale and Speakman 2020: 575). This is one of the principal reasons why this research is concerned with immigration enforcement through the NHS commencing from the enactment of this legislative benchmark[4].

Prior to having a stroke, Simba was receiving specialised care to treat his blood clotting condition. While going through his nearly fatal experience, he was taken to A&E for urgent medical treatment. He was then accepted as an inpatient to receive hospital care. All things considered, what services was he charged for? Under the charging regime, emergency services provided by A&E are exempt from charges, but care provided after the patient is admitted for hospital treatment is not. Specialised treatment does not constitute an exempt service either – that is why Simba was charged for his blood clotting condition. In fact, an amendment to the Charging Regulations in 2017 stipulates that they must be paid in full and upfront at rate of 150% of the national NHS tariff unless treatments are urgent or immediately necessary. In that case, they cannot be withheld or withdrawn but payment must be secured after the services are provided (DHSC 2021). Due exploration of this exception will be made in Chapter Two, but, for the time being, it is important to explain that urgent treatment is that which cannot wait until the person can be reasonably expected to leave the UK. Immediately necessary services, in their turn, are those which

[4] A chronology of the development of the charging regime is beyond the remit of this thesis. A useful timeline is provided by the Institute of Race Relations (2018) and by McHale and Speakman (2020).

are promptly required to save the patient's life, prevent permanent serious damage to the person, or avoiding a condition from becoming immediately life-threatening (DHSC 2021: 69 – 70).

It is worth offering an overview of the types of care provided by the NHS since it is a decisive factor for purposes of chargeability: Primary, secondary and tertiary care, in addition to community health services (NHS England 2022). Primary care refers to general practice, community pharmacy as well as primary dental and ophthalmic services. They are the first point of contact in the health system, and fall outside the scope of the charging regime. Secondary care entails planned/elective services (e.g. cataract operations, chemotherapy, radiotherapy, and kidney dialysis), mental health as well as urgent and emergency services. Tertiary care encompasses highly specialised services, such as neurosurgery and transplants. Community health services refer to those aimed at supporting people with complex health needs to live independently for as long as possible (e.g. community physiotherapy and cardiac rehabilitation). They include health promotion services involving partnerships across health and care teams, and can be delivered in a range of settings (e.g. hospitals, clinics, schools) as well as in a patient's home – including care homes (NHS England 2022). Except for primary care, all of the above constitute chargeable services unless an exemption applies. For instance, services provided by A&E are a type of secondary care but they are exempt from charges.

An interesting point of significance for data-sharing policies is that relating to what healthcare providers are required by law to verify migrants' eligibility for relevant services (i.e. those which are chargeable). Since 23rd October 2017, when the first amendment to the Charging Regulations came into effect, all providers of relevant services have been required to establish whether the person is a migrant patient to whom charges apply. Prior to the amendment, this legal obligation applied only to NHS trusts, NHS foundation trusts and local authorities exercising public health functions (DHSC 2021: 8)[5]. The requirement has now been extended to apply also to (NHS-funded) non-NHS organisations supplying relevant services, be it from the private or voluntary sector. The legislative alteration has been particularly impacting for destitute migrants who are now

[5] A brief note on the differences between NHS Trusts and Foundation Trusts. The former refer to "public sector bodies established by parliamentary order by the secretary of state for health to provide healthcare services to the NHS" (NHS Providers 2015: 7). In due course, they were expected to become Foundation Trusts, which, after a rigorous process of approval, are given greater independence than Trusts to "work with their local communities and design their services around local needs" (NHS Providers 2015: 7). Foundation trusts are deemed to constitute a "unique model of accountable autonomy" with the possibility of local residents, staff, patients and service users becoming members or elected governors who monitor their performance and represent the interests of the local community (NHS Providers 2015: 7).

in a position to be charged – and have their data shared with the Home Office – even if they are users of health services provided by a voluntary organisation[6].

At a certain point during the treatment of his blood clotting condition, Simba stopped attending his medical appointments out of fear that his increasing debt would interfere with his application for asylum in the UK (Vinter 2021). In theory, NHS debts must not reflect in the assessment of such claims. In the end, Simba's application was refused, and he was never informed if his outstanding debt had a part to play in the process. Whether or not the Home Office acted according to the law remains uncertain. However, one thing is for sure: Simba's concerns were not without reason because NHS debts and immigration enforcement are linked together in the charging regime. The Charging Regulations stipulate that that the NHS is required to inform the Home Office of unpaid debts of £500 or more outstanding for at least 2 months. Inability to pay these debts can constitute grounds for refusing a visa application (Galaso et. al 2021). As a consequence, owing NHS debts, migrants are prevented from regularising their immigration status through one of the visa routes established by the UK Government.

Lastly, I reiterate that Simba entered the UK as an asylum seeker. Why does it matter for charging relating to healthcare? At least for two main reasons. First, because asylum seekers – as well as refugees – cannot be charged for NHS services. Simba ended up being charged because his claim for asylum was refused by the Home Office[7]. Secondly, by entering the UK as an asylum seeker, Simba was not required to pay the Immigration Health Surcharge (IHS), a fee introduced by the Immigration Act 2014. Since April 2015, the IHS has been payable by migrants subject to immigration control applying to enter the UK for more than six months or to extend their leave to remain in the country for any period of time (e.g. temporary workers, international students) (DHSC 2021: 35). The IHS must be paid to the Home Office during the visa application process unless it is waived or if the migrant is exempt in their own right (e.g. victims of modern slavery). The fee currently stands at £624 per annum, with a discounted fee of £470 for certain visa holders (e.g. students and their dependents). Inability to pay the IHS will result in the refusal of the visa application. Migrants who have paid the fee are granted access to free NHS care, with a few exceptions set out by the Charging Regulations (DHSC 2021: 35)[8]. Critics of the IHS have stressed

[6] Having said that, for purposes of practicality, when citing the NHS in this thesis, I am referring to both NHS bodies and non-NHS service providers supplying relevant services.

[7] An explanation of exempt persons will be provided in Chapter Two.

[8] Exceptions include assisted conception services, termination of pregnancy and services which – in general – are chargeable for all, including UK citizens (DHSC 2021: 38).

how the surcharge works as a means to prevent "unwanted" migrants (e.g. low paid workers) from coming to the UK or pushing people into illegality by pricing them out of regularising their immigration status (Medact 2019: 11).

It is worth explaining that the aforementioned hostile environment policies operating in the NHS refer to immigration enforcement through healthcare in England – and not in all the four nations of the UK. The devolved administrations in Scotland, Wales and Northern Ireland are responsible for developing their own health policies, which may not be aligned with that implemented in England (DHSC 2019a: 6). As a consequence, the approach to healthcare provision for migrants in one nation may differ from the way health services are provided for non-nationals in another. This is the case, for instance, of the treatment conferred to failed asylum seekers in England and Scotland. In the former, people who have been refused asylum are generally not entitled to free healthcare while, in the latter, they are fully exempt from charging (Equality and Human Rights Commission 2018: 12). This research addresses health entitlements associated with immigration status in England only as a means to provide a more detailed analysis of the issue at hand.

At this point, it is helpful to address the UK Government's justification for charging migrants, such as Simba, for health services. In their view, the main reason for the charging regime is to ensure the financial sustainability of the NHS. Arguments that the NHS can only be sustained as a national – and not an international – health service, and that migrants must "make a fair contribution" if they wish to access NHS care have been prominent in policy-relevant documents justifying the need for the charging regime (Department of Health 2015b). The UK Government explains that – because the NHS is a residency-based health system – only those living in the country and financially contributing to the service should access NHS care free of charge (Department of Health 2017a). This justification constitutes a debatable argument for a few reasons: First, around 80% of the NHS budget is made up of general taxation, followed by a supplement of nearly 20% deriving from National Insurance contributions. Only a small percentage of its budget is funded by patients' charges, including those paid by UK citizens (Full Fact 2020; King's Fund 2021a).

Moreover, the argument that migrants need to pay for their healthcare because they are not living in the country – and therefore not making a financial contribution to the NHS as UK residents are – requires further scrutiny. Take the example of a British citizen who has been living abroad for decades. The Charging Regulations set out that they can be eligible for free NHS care from the

day of their arrival in the country as long as they have, from that moment, taken up settled residence (DHSC 2021: 28). However, an international student, legally residing in the country for a few years and contributing to the system through general taxation, is not entitled to free NHS care. The same applies for workers who do not have permanent leave to remain in the UK, and contribute to the health service through general taxation and National Insurance. This scenario has raised criticism against the Charging Regulations for constituting a form of double taxation for migrants (Ramadan 2020). In addition to that, the justification for the charging regime is further problematised in relation to the costs involved in the administration of the system (BMA 2019; McHale and Speakman 2020). This is relevant given that charges already constitute a minor fraction of the NHS budget. In this vein, opponents of the Charging Regulations have therefore contended that the system works more like a mechanism to reduce net migration, and make it difficult for lower paid and "illegal immigrants" to remain in the UK (Institute of Race Relations 2018; Medact 2019).

5. Hospitality for migrants in the NHS as a research problem

In light of the above, this thesis is motivated by the following research question:

What happens when migrants are welcomed into the NHS?

In response to this question, I argue that, once migrants are welcomed into the health service, practices of hospitality which deliver improvements in their health and wellbeing also subject them to hostility by means of technologies of power which control borders through the provision of healthcare.

Before going further, a few clarifications are paramount. The first point that merits attention concerns my focus on migrant patients. Who are the migrants to whom I am referring in this thesis? From the outset, it is important to note that the term "migrant" is a broad and contested concept. The vast scope of the category is properly captured by the definition provided by the International Organisation for Migration (IOM): "An umbrella term, not defined under international law, reflecting the common lay understanding of a person who moves away from his or her place of usual residence, whether within a country or across an international border, temporarily or permanently, and for a variety of reasons" (IOM 2019: 132). The definition is a useful starting point, and most will agree that it is not inaccurate – although it certainly does not

stress that the term is value-laden, that it does not attach equally to every person in movement, and that it might even attach to those who have indeed never moved (Guild 2009). Yet the above definition does not tell us enough about the people that I am drawing attention to in my work.

In this thesis, I am analysing hospitality in the NHS centred on two specific migrant populations. First, I am focussing on migrants with temporary leave to remain in the UK. This first group comprises a variety of individuals ranging from international students and tourists to foreign workers and their dependants. The reason for this delimitation is very simple. As explained above, the main stage for the enforcement of immigration through the NHS consists of the system for charging migrants for healthcare – and migrants on temporary visas are foreigners to whom the Charging Regulations apply. Having said that, my research takes into account, but is not concerned with exploring the case of migrants with Indefinite Leave to Remain (ILR) in the country, an immigration status which prevents migrants from being subject to immigration controls. Similarly, I do not provide an analysis of the situation of non-UK nationals covered by specific reciprocal healthcare agreements that allow them to make use of the NHS on the same (or similar) basis as someone who is not liable to pay charges. That includes, for example, European Union (EU) and Switzerland nationals holding a European Health Insurance Card (EHIC) in their temporary visits to the UK as well as Irish nationals irrespective of the length of their stay (DHSC 2021). Likewise, this thesis does not centre its attention on the experience of EU nationals (and their family members) who moved to the country before it left the political-economic bloc (i.e. on or before 31 December 2020) and applied to remain in the UK through the EU settlement scheme, a plan that allowed them to continue to access healthcare in the country free of charge (DHSC 2022a).

The other group of migrants affected by the Charging Regulations – and therefore placed in the scope of my analysis – are those with unlawful residence in the UK. At this point, it is worth clarifying my use of expressions such as "illegal immigrants" or "immigration offenders" in the thesis. The terminology is deployed in a range of policy-relevant documents published by the UK Government, and I have used them when analysing these official documents. However, I am aware that this terminology can carry a criminal connotation and may amount to the use of dehumanizing terms associated with migration. In this vein, it has been argued that expressions such as "migrants in an irregular situation" should be favoured over alarmist terms in an attempt to reshape negative perceptions of migrants' realities (IOM 2019: 102). While I agree with the view that it is inaccurate to refer to a person as "illegal", I also believe this terminology can be used strategically in order to confront the very rationality that it asserts. In my view, this strategic use highlights the violence

that lies with the Government's choice of words, and avoids the suggestion that we can find terms such as "migrants in an irregular situation" in policy-relevant documents. When using this terminology, I place quotation marks around the relevant terms in order to remark my strategic use of these expressions, but also my critical view of their employment.

Finally, still clarifying my focus on migrant patients, it is important to note that the Charging Regulations do not refer to chargeable NHS users from abroad as migrants. Rather, "overseas visitors" is the expression deployed by the UK Government in the rules of the charging regime (DHSC 2021). The point being made is that the Charging Regulations can apply even to certain UK citizens (i.e. those who do not live in the country on an ordinary basis). As the NHS consists of a residence-based healthcare system, UK citizenship would not constitute a relevant factor in determining eligibility for free health services. However, in my research, I do not address the case of UK citizens returning to the country from overseas. There are two main reasons for that. First, they are indeed migrants but they are not foreigners in the sense of not being part of the political community constituted by the British state (e.g. they are not subject to immigration controls). Secondly, I dispute the argument that UK citizenship is not a relevant factor to determine entitlement to free healthcare. UK citizens are not subject to the same level of scrutiny as non-citizens in regard to access to the NHS. As I mentioned before, they can be eligible for free health services upon arrival in the UK even if they have lived overseas for many decades, and settle back in the country. Therefore, when I refer to migrants in this this thesis, UK citizens are not included.

Another aspect of my research question which merits clarification concerns the use of the expression "technologies of power". The term "technology" is frequently deployed to refer to the outcome of developments in scientific knowledge applied to produce technical progress. In this sense, artificial intelligence, robotics and the Internet of Things, to name just a few, are all considered new technologies resulting from the technical advancements arising from the Fourth Industrial Revolution. My use of the expression "technology" instead derives from the works of French philosopher Michel Foucault in his writings about the operation of power (1984; 2003). According to Michael C. Behrent (2013: 55), the use of the term by Foucault "refers to the ways in which modern social and political systems control, supervise, and manipulate populations as well as individuals." However, one should not be misled to the conclusion that technologies of power are simply a means of subjugation. They also constitute a productive force that triggers behaviours, stimulates actions and shapes the conduct of those to whom these technologies are applied (Behrent 2013: 60).

It is important to note that the conceptualisation of "technologies" explained above is in line with an understanding of the operation of power according to which it not only excludes, coerces, represses or conceals – in other words, its effects cannot be simply conceived in negative terms. Power also bears within itself the potential to generate behaviour, maximize forces and produce truths about reality (Foucault 1995: 194). From this perspective, banning a migrant from healthcare by virtue of their immigration status can be conceptualised as the deployment of a technology of power. Likewise, providing free health services for a foreigner irrespective of the lawfulness of their residence in the receiving state can also be conceived as the manifestation of a power technology. These examples illustrate how technologies can operate to exclude and include, to ban unhealthy migrants from health systems, but also to produce healthy bodies irrespective of the reasons for doing so. This is the usage of technologies that I am drawing upon to investigate hospitality for migrants in the NHS. The term "technique" is also deployed in the thesis in the same way, following Foucault's interchangeable use of the expressions (Behrent 2013: 59).

Having clarified my use of the terms "migrants" and "technologies of power", I address now the type of "hostility" enacted towards migrant patients which this thesis explores. In this regard, it is important to note that this research advances the view that hospitality as healthcare does not constitute *per se* a health-enhancing act of welcoming migrants into the NHS. Once health services are provided as hospitality, migrants can be subject to different forms and degrees of hostility. There are two underlying assumptions in this argument: First, not every act of hospitality as healthcare actually delivers improvements in migrants' health and wellbeing. From a clinical perspective, one can take the case of medical errors and negligence leading to the deterioration of patients' health and/or to their death. Secondly, there can always be a certain level of hostility when health services are delivered: Healthcare provision can involve pain, discomfort and even the disfigurement of the body that one seeks to cure (Summers 2019: 42). In my research, I am looking into a specific type of hostility enacted towards migrant patients – i.e. that which is exercised as practices of border control.

6. Research contribution to International Politics

This thesis examines the practices of hospitality operating technologies of power which subject migrant patients to different forms and degrees of hostility in their access to the NHS. In doing so, my research offers a number of contributions to the broad field of International Politics. My

primary contribution is to draw on the lens of hospitality in order to investigate immigration enforcement through healthcare provision. Studies on international ethics have used concepts of hospitality to explore ethical duties and moral responsibility in respect to the foreigner in a range of scenarios. Roxanne Lynn Doty (2006) argues for the possibility of enacting unconditional hospitality through the life-saving practice of providing water to migrants risking their lives as they cross the Arizona and California deserts to enter the US. In a different vein, Gillian McFadyen (2016; 2020) explores how practices of hospitality and labelling have been articulated to produce the British response to the so-called refugee crisis. In doing so she examines what she terms an "externalised hospitality of humanitarianism" operating alongside the construction of an idealised figure of the genuine refugee produced by British policies (McFadyen 2020: 8).

Dan Bulley (2013; 2015; 2017) examines how practices of hospitality work to produce spaces of belonging and exclusion beyond (and other than) the nation-state, and the different types of power which operate once the threshold of the homely space is crossed. In doing so, he questions the centrality of the state as the primary space and agent of hospitality, and investigates how a non-state centric perspective impacts on the production of hosts and guests as ethical subjects (Bulley 2017: 4). For instance, he analyses how the refugee camp is produced as a "temporary home" through technologies of care and control employed by international agencies, which articulate an ethos of "humanitarian hospitality" (Bulley 2015: 195). Shifting attention to issues of postcolonial migration, Ida Danewid (2017) interrogates whether hospitality constitutes an adequate response to the Mediterranean crisis on the part of European states, given that it promotes the erasure of the colonial past connecting Europe to the migrants seeking refuge in the continent, and for the replacement of questions of responsibility and structural reform with matters of empathy and hospitality (Danewid 2017: 11).

The aforementioned scholarly works demonstrate the relevance of drawing on hospitality to investigate problems of ethics in International Politics. However, the literature in the field has not thus far explored how hospitality for migrants has been offered in the context of health systems. Drawing on hospitality to approach issues of immigration enforcement in the healthcare setting seems to be a useful theoretical tool, given that hospitality has assumed a prominent role in academic works on healthcare (Holroyd, Kelly and Wright-St Clair 2018; Kelly, Losekoot and Wright-St Clair 2016; Hepple, Kipps and Thompson 1990; Renzenbrink 2011). However, the way I explore hospitality in health systems are not the same as most works in healthcare studies. From this perspective, hospitality is conceived as a means to delivery improvements in patients' health

and wellbeing by offering them a welcoming reception. That the welcome of patients into a health system can have the very opposite effect of health enhancement – especially if they are not a citizen of the state where healthcare is being provided – remains unexplored in the field. In my thesis, I interrogate the offer of hospitality as healthcare as an intrinsic good and the role of medical practice as the instrument for delivering it. In doing so, I also offer a contribution to the field of the Global Politics of Medicine which is concerned with prompting us "to rethink the global dimension of medical authority […] and the ways in which medicine is not a priori 'innocent' but rather always implicated in strategic relations of power and force globally" (Howell 2014: 987).

My second main contribution consists of my exploration of hospitality through the lens of the dispositif (Foucault 1980). It is true that hospitality does not allow for a stable definition since it is forever torn between complete openness and different degrees of closure (Bulley 2015: 187). It does not follow, however, that we cannot conceive of conceptual and methodological tools to examine the constitution of the subject positions of the host and the guest, and their lived experience of hosting and guesting. In this vein, I propose an articulation of Jacques Derrida's (2002) notion of the welcoming apparatus with Foucault's (1980) concept of the dispositif in order to construct a framework for the analysis of hospitality. My suggestion is that the welcoming apparatus (or dispositif of hospitality) consists of a heterogeneous assemblage of discursive and material elements which are linked together to construct a system for responding to the arrival of the foreigner. Viewed in this light, the workings of the welcoming apparatus define the form of hospitality to which the guest is subject in their interplay with the host in the space of the home.

In proposing a distinct path for the examination of hospitality, I make a contribution to two particular literatures in International Politics. To begin with, I engage with scholarly works which provide original theorisations of the practice. As mentioned above, many have used the lens of hospitality to analyse issues relating to the interplay of hosts and guests, and the breaching of borders between the home and the away. But certainly not as many have put forward a conceptual or methodological framework to explore problems in respect to the welcome of the other. The most prominent study in this regard is that of Bulley (2015: 188; 2017: 7) where he argues that hospitality consists of a "spatial relational practice with affective dimensions." My research will add to this literature by contending that we draw on the welcoming apparatus to investigate factors and contingencies shaping the reception of the foreigner into the homely space. Furthermore, my thesis adds to a branch of works from a Foucauldian-inspired literature which refer to the dispositif in order to examine issues of international politics (Aradau and Van Munster 2007; Barder and

Debrix 2009; Herschinger 2015; Salter 2008; Thomas 2014). Because none of them use the apparatus as a methodological tool to analyse hospitality for migrants, my work makes an original contribution to the field in this regard.

7. Reading hospitality for migrants in the NHS: Some methodological notes

7.1. A deconstructive line of inquiry to the analysis of hospitality for migrants in the NHS

In this thesis, I deploy a "deconstructive line of questioning" in order to offer a critique of hospitality for migrants in the NHS (Derrida 1992: 8). My reference to deconstruction as an approach to reading texts is worthy of note here and requires further elaboration. To begin with, what is meant by the deployment of a deconstructive line of inquiry to reading texts? Jonathan Culler (1982: 86) provides a helpful starting point: "to deconstruct a discourse is to show how it undermines the philosophy it asserts, or the hierarchical oppositions on which it relies, by identifying in the text the rhetorical operations that produce the supposed ground of argument, the key concept or premise." The definition alludes to the ways in which deconstruction operates that do not constitute entirely dissociate processes but rather styles that complement each other. As Derrida himself (1992: 21) explains, "[d]econstruction is generally practiced in two ways or styles, although it most often grafts one on to the other. One takes on the demonstrative and apparently ahistorical allure of logico-formal paradoxes. The other, more historical or anamnesic, seems to proceed through reading of texts, meticulous interpretations and genealogies."

The first style referred to by Derrida is properly captured by the two steps involved in the deconstruction of hierarchical dichotomies which can be produced in the writing of a text. Derrida (1981: 41) notes that, in these binary oppositions, one element occupies a dominant position, and is valued more highly than its opposite. And, "as long as such a distinction is tightly held in place the whole system can function effectively" (Eagleton 1996: 115). Deconstructing the dichotomy requires a "double gesture" of reversal of the classical opposition and an overall displacement of the system (Derrida 1981: 41). As Eagleton (1996: 115 – 116) asserts, "[d]econstruction tries to show how such oppositions, in order to hold themselves in place, are sometimes betrayed into inverting or collapsing themselves, or need to banish to the text's margins certain niggling details which can be made to return and plague them." The question that I approach now is: How is this critical operation deployed in my analysis of hospitality for migrants in the NHS? In other words,

in what ways does a deconstructive line of inquiry help me unpack the issues surrounding immigration enforcement through the provision of healthcare? The case of resistance against border control in the delivery of health services constitutes a helpful illustration in this regard.

Contestation of immigration enforcement through the NHS is commonly rooted in the argument that providing healthcare alleviates pain and suffering while not providing health services amounts to the deterioration of one's health and wellbeing. Putting it simply, healthcare provision is something "good" because it avoids (or mitigates) harm to one's health and wellbeing while not providing health services is something "bad" because it causes suffering and pain. In setting up this dichotomy, healthcare provision is valued more highly than its negative counterpart. This is particularly illustrated in Chapter Three, where I explain how the ethical guidance issued by the British Medical Association (BMA) tells doctors that healthcare should be provided irrespective of migrant patients' chargeable status or ability to pay (BMA 2021a). But the issue is far from simple, and the hierarchical dichotomy on which the argument relies finds itself on unstable grounds. For instance, while providing healthcare to migrant pregnant women, midwives turned out to subject them to the violence of immigration enforcement (Maternity Action 2019). Similarly, General Practitioners (GPs) providing primary care to migrants with unlawful residence in the UK under the MoU (2016) allowed for the transfer of their non-clinical information to the Home Office as well as their subjection to practices of border control.

To deconstruct the aforementioned dichotomy – an enterprise with which I task myself in this thesis – is not to argue that healthcare provision is "bad" while refusing health services is something "good". That would simply maintain the hierarchical opposition in place albeit on different terms. It entails demonstrating that healthcare provision can cause pain and suffering while not providing health services can avoid the subjection of migrants to forms of violence underlying immigration enforcement through the NHS. From this perspective, healthcare provision has no intrinsic superior status, and the system which relies on such an assumption turns out to collapse and embarrass itself. In addition to the "double gesture" of reversal and displacement, it is worth explaining how a deconstruction line of inquiry relies on a careful and meticulous process of reading texts – referred to by Derrida as the second style of deconstruction. In this vein, "texts" do not simply refer to written discourse and are not "distinct from or opposed to action" (Derrida 1999a: 65). That is why practices of dissent and resistance against the hostile environment can be examined as a "text" as I suggest in Chapter Two.

Furthermore, while analysing the operation of a deconstructive critique, one should keep an attendant eye to the way in which "reading" is deployed from a Derridean perspective. For Derrida, to read a text does not equate to the activity of deciphering the meaning of a written piece of work, but rather to "read events, to analyze the situation, to criticize the media, to listen to the rhetoric of the demagogues, that's close reading, and it is required more today than ever" (Derrida 1999a: 67). This process of reading is well-described by Barbara Johnson (1995: 46) when she explains that

> "reading", for Derrida, involves following the "other" logics of structures of signification inscribed in writing that may or may not be in conformity with traditional logics of meaning, identity, consciousness, or intention. It involves taking seriously the elements that a standard reading disregards, overlooks, or edits out. Just as Freud rendered dreams and slips of the tongue readable rather than dismissing them as mere nonsense or error, so Derrida sees signifying force in the gaps, margins, figures, echoes, digressions, discontinuities, contradictions, and ambiguities of a text. When one writes, one writes more than (or less than, or other than) one thinks. The reader's task is to read what is written rather than simply attempt to intuit what might have been meant.

This way of reading texts is of particular relevance for my analysis of hospitality for migrants in the NHS. A helpful example of how this operation is deployed in my research concerns the argument advanced by the Department of Health & Social Care (DHSC) in regard to the system for charging migrants for health services. As is especially highlighted in Chapter Two, the charging regime is justified on the basis of ensuring the sustainability of the NHS (Department of Health 2017a: 5). In this vein, the DHSC contends that migrants must "make a fair contribution" to service, and only those who are living in the UK and contributing financially should be entitled to receive free healthcare (Department of Health 2017a: 7). The imperative to prioritise the health needs of the "British taxpayer" is embedded in this argument, and is well-captured by the claim that for the Government to continue to improve the NHS, "it can only be sustained as a National, not an international health service" (DH 2015b: 5).

A few issues are of particular note here. First, the argument that migrants will make a fair contribution to the NHS by covering the costs of their healthcare effaces from the "text" the fact that "overseas visitors" contribute financially to the funding of the NHS through general taxation, National Insurance contributions (if they are workers) or the IHS, if applicable. In other words, the argument disregards the fact that non-permanent residence or unlawful status in the UK does not imply lack of financial contribution to the sustainability of the health service. Secondly, the claim that the NHS can only be sustained as a national – and not an international health service – puts to the margins of the "text" the reliance of the NHS on healthcare workers from overseas, as

I particularly highlight in Chapter Four while addressing the context of the COVID-19 pandemic. In fact, the emphasis put by the DHSC on the "national" character of the NHS contradicts the very discourse of the UK Government when it seeks to portray the service as open and welcoming to staff from all over the world.

While "reading" hospitality for migrants in the NHS, I draw out these effacements, contradictions, gaps and ambiguities embedded in the argument for charging migrants for healthcare as a means to ensure the sustainability of the service. This hermeneutic effort speaks to issues around the power of hospitality – to which I shift attention in Chapter Two – in that sense that "[i]f each text is seen as presenting a major claim that attempts to dominate, erase, or distort various 'other' claims (whose traces nevertheless remain detectable to a reader who goes against the grain of the dominant claim), then 'reading' in its extended sense is deeply involved in questions of authority and power" (Johnson 1995: 46). In this thesis, I am oriented by this broader sense of "reading" (and writing) which remarks how such practices are always already imbricated in power relations in that they work to (re) produce authority, exclusions, confrontation and dissent. This is particularly the case when I analyse UK Government documents advancing the defense of the charging regime, but also when I examine materials published by critics of the system for charging migrants for healthcare.

7.2. Drawing on the grey literature to investigate immigration enforcement through the NHS

In my research, data collection was primarily centered on the reading of the grey literature cutting across the themes of healthcare provision and immigration enforcement. In this regard, I paid particular attention to policy-relevant documents published by the UK Government through its departments and non-departmental bodies. The analysis of these materials fulfilled two main purposes. To begin with, it equipped me with the tools to understand the framework within which the NHS operates (i.e. its organisation, objectives and the ways through which these are pursued by the service). In this respect, the NHS Constitution for England was central for the reflections in this thesis for setting out the values and principles underpinning the operation of the service (Department of Health 2015a). A document of particular use to understand the provisions of the Constitution is the accompanying handbook, which provides details of the legal sources of the rights and pledges that it enshrines as well as the role which all stakeholders are expected to play

in the protection and development of the NHS (DHSC 2019). The handbook, too, was a key document examined in my research to comprehend the operation of the service.

The analysis of policy-relevant documents published by the UK Government also allowed me to grasp how immigration enforcement is embedded in healthcare provision through laws, administrative arrangements and official declarations by its members. Furthermore, the reading of these materials allowed me to identify the rationale underlying arguments in favour of immigration enforcement through the NHS (e.g. securing the sustainability of the service through the charging of migrants). A few documents are of particular note. To start with, the analysis of the MoU between the Home Office and the NHS was particularly useful in my research given that it laid bare the Government's view that healthcare provision should work to identify "illegal immigrants" and reduce the alleged burden they place on the health service (Department of Health, Home Office and NHS Digital 2016). This rationality underlies the provisions of another key document for this research: "The Guidance on implementing the overseas visitor charging regulations" (DHSC 2021), which provides a detailed explanation of the rules comprising the system for charging migrants for their healthcare.

This thesis is primarily concerned with questions of ethics around the delivery of health services. In this regard, as previously mentioned, the NHS Constitution was fundamental to my research as it establishes the ethical framework orienting the provision of healthcare by the service. Furthermore, two other documents were of relevance for my analysis: "The Code", elaborated by the Nursery and Midwifery Council (NMC 2018), and "Good Medical Practice", the guidance designed by the GMC (2013). Both documents are designed to set out the professional standards of practice and behaviour for their respective healthcare workers while bringing to light the ethical commitments which are deemed to be fundamental to the referred professions. On this note, the ethical guidance issued by the BMA was also of particular significance for my research given that it was designed by the organisation to advise doctors on legal and ethical issues that they may encounter in their professional practice (BMA 2012; 2013). Ethical decision-making is a topic cutting across all chapters in this thesis so the aforementioned documents are of primary importance to my analysis of immigration enforcement through the NHS.

Equally important for the present research is the literature produced by non-governmental organisations which contest the enforcement of the Charging Regulations (e.g. blog posts, briefings, newsletters, reports, news articles). These are significantly helpful in my analysis of

hospitality for migrants in the NHS in the sense that it constitutes what Alison Howell (2013: 300) terms "low" or "niche" sources of information, i.e. they describe the "messy actualities of governing" that go beyond widespread narratives scripted by official documents while providing the researcher with a more detailed view of how "people on the ground" are experiencing the problems they are confronted with, how they tackle particular institutional cultures, and how they enact micro-practices of alliance and resistance. In doing so, they constitute useful tools to scrutinise narratives embedded in policy-relevant documents and other "high" sources (Howell 2013: 300). Decisions about the suitability of the material to be considered were based on whether they approached the issue of NHS healthcare provision for migrants against the backdrop of the hostile environment in England. Priority was given to those sources which relied on primary data collection to generate their findings.

The use of reports exemplifies how "low" sources constituted a helpful methodological tool in the development of my research. To name just a few, "Patients Not Passports: Challenging healthcare charging in the NHS", published by Medact (2019), a non-governmental organisation (NGO) working to support healthcare professionals to implement the right to health; "Duty of Care? The impact on midwives of NHS charging for maternity care", published by UK-based maternity rights charity Maternity Action (2019); and "Delays & Destitution: An Audit of Doctors of the World's Hospital Access Project (July 2018-20)", issued by DotW (2020). The analysis of these materials was essential to bring to my attention to the plethora of issues arising from immigration enforcement through healthcare provision, and how they can impact hospitality for migrants in the NHS. For instance, the report published by Medact helped me to map out the broader context within which the Charging Regulations operate; the one issued by Maternity Action allowed me to better understand the ethical dilemmas arising from clinical practice when healthcare provision for migrants is at stake. The one published by DotW provided me with an account of the lived experience of migrants who had been refused healthcare on the basis of their immigration status.

7.3. Reading stories of migrants to problematise immigration enforcement through the provision of healthcare

In addition to illuminating the main issues surrounding immigration enforcement through healthcare and how they impact on hospitality for migrants in the NHS, the aforementioned low sources of information were of particular significance for my research in that they allowed me to examine stories of migrants in their struggles to access health services. Migrants have provided

accounts of their experiences in a range of contexts and media. They have spoken to journalists who have published their stories in editorials, news articles and books. They have provided oral testimonies which have been written down and published in briefings, blog posts and newsletters released by charities and think-tanks. They have also shared their stories in interviews carried out by NGOs, many of which have served as the basis for the elaboration of reports and scholarly articles. This thesis presents stories that I explored while reading news articles, reports, briefings and other low sources of information where migrants shared their lived experience of navigating the NHS. A few questions are worth addressing at this point: Why turn to stories in my analysis of hospitality for migrants through the healthcare system? And how did stories open up avenues for my research?

In the social sciences, the use of stories as a research tool has been has been justified by a range of reasons. Basbøll and Gelman (2014) assert that stories serve the purpose of motivation and illustration because they are attention-grabbers which facilitate the explanation of ideas. Furthermore, they contend that stories work not only to "sell ideas" to others but also to "provide information for real-world inference" (Basbøll and Gelman 2014: 550). In this sense, they contribute to the illustration of theories (broadly speaking) as well as for their development, justification and contestation. To put it differently, the argument is that stories are "central to learning and theorizing about the world" (Basbøll and Gelman 2014: 553). To a large extent, those are the roles that stories play in my investigation of hospitality for migrants in the NHS. For instance, in Chapter Three, I examine the story of Saloum, a migrant with unlawful residence in the UK who died after being refused NHS care required to treat his two brain tumors and lung cancer (DotW 2020). His story helps me analyse how an ethics of healthcare as hospitality – constructed by reference to the moral norms set out in the NHS Constitution and in the codes of conduct for healthcare workers in the UK – is troubled by the charging of migrants who are not entitled to free health services.

Another aspect of the use of stories in this thesis merits attention. My reflection here is inspired by the discussion introduced by Jenny Edkins (2011) in her book "Missing: Persons and Politics", where she draws our attention to the enactment of a "politics that misses the person", i.e. a form of politics which objectifies and instrumentalises the person by forgetting them in its focus on order and security (Edkins 2011: 2). This is the case when state authorities respond to people going missing in a way that treats the person as a mere equivalent to another of the same type. What is crucial to note here is how people turn out to be produced simply as objects to be governed

with the aim of securing populations as a whole (Edkins 2011: viii). In contrast to the response by the official systems of administration, relatives of missing people demand action in a spirit that highlights the singularity and distinctiveness of those gone missing, breaking with the conceptualisation of the person as an interchangeable object of political governance. For Edkins (2011: 2), this form of demand for action calls for a "politics of the person as missing", i.e. one that recognises "persons-as-such, singular lives, political in their uniqueness and irreplaceability" (Edkins 2011: xix).

In this thesis, I draw on stories of migrants in their struggles to access NHS care in an effort to counter the "politics that misses the person" underlying immigration enforcement through the NHS. When referring to the necessity of charging migrants for healthcare in order to ensure the sustainability of the service, or when justifying the identification of "immigration offenders" through their contact with healthcare providers, the UK Government advances a narrative that effaces the suffering experienced by those to whom healthcare is refused by virtue of their immigration status. Stories such as that of Simba, to which I previously drew attention in this introduction, are not addressed in official policy-relevant documents, and they find little (if any) prominence in the Government's justifications for the system for charging migrants for healthcare. The singularity of the stories of migrants struggling to access healthcare dissipates in a politics for which their existence is conceived in terms of cost-benefit, and their health needs are instrumentalised. Migrant bodies constitute interchangeable objects of political governance aimed at controlling borders and promoting security as an optimised state of health for the British taxpayer. By bringing migrants' stories into this thesis, I attempt to corroborate a politics that recognises the foreigner as a "person-as-such" by refusing to neglect the distinctiveness of their experiences in my analysis of hospitality for migrants in the NHS.

8. Thesis outline

In Chapter One, I demonstrate that the ethical framework governing the operation of the NHS consists of an ethics of hospitality. In doing so, I explain the main provisions of the NHS Constitution for England and the rules contained in the codes setting professional standards of practice and behaviour for healthcare workers in the UK. Then, I go on to argue that healthcare provision for migrants challenges hospitality as an entirely benevolent act of welcoming by analysing the MoU put in place between the Home Office and the NHS. As previously explained, the agreement set out the protocol under which the health service should transfer migrant's data

to the Home Office for purposes of immigration enforcement. The point that I emphasise in the chapter is the way in which hospitality as the provision of free health services for migrants turned out to subject them to different forms and degrees of hostility articulated by practices of border control. It is against this backdrop that I argue for the usefulness of the concept of hospitality as elaborated in the works of Derrida, given that it highlights the ways in which practices of hospitality are inhabited by the opposite of welcoming, and always-already marked by the trace of hostility towards the guest.

Still in Chapter One, I highlight that although Derrida's thought on hospitality provides a helpful theoretical tool to analyse healthcare provision for migrants in the NHS, it is necessary to go beyond his contributions in order to examine immigration enforcement through the health service. In this regard, I explain how Dan Bulley's (2015; 2016) further elaboration on the concept allows me to explore immigration enforcement through the service. Three are the main contributions of his thought in this regard. First, his emphasis on the affective dimensions of hospitality. Secondly, his articulation of Derrida's thought on hospitality with the works of Michel Foucault in order to investigate what other forms of power are exercised after the threshold of the home has been crossed. Third, the attention he pays to the ways in which sites – other than the traditional space of the nation-state – can be "created as homes through everyday practices of international hospitality" (Bulley 2015: 186).

In Chapter Two, I investigate technologies of exclusion, surveillance and care operating through hospitality for migrants in the NHS. In doing so, I argue that the power of hospitality enacted through healthcare provision for foreigners is exercised as a form of governmentality. My analysis is centred on the examination of the system for charging migrants for healthcare instantiated by the Charging Regulations 2015 and its subsequent amendments. A few points are of particular note to an appropriate comprehension of this chapter. To begin with, my use of the term "governmentality" (Foucault 2001) refers to "the different ways in which security practices combine sovereign, disciplinary and biopolitical technologies" (Aradau and Munster 2010: 77). In this vein, I draw inspiration from Foucault's (1984) analytics of power in order to explain how the technologies of exclusion, surveillance and care enabled by the charging regime work to secure security as an optimised state of health and wellbeing for ordinary residents in the UK. Governmentality also provides a useful framework to analyse the operation of the charging regime in the sense that it is concerned with the question of how economy is introduced into political

practice and the management of the state in a way that the biological features of the population become relevant elements for its economic administration (Foucault 2001: 92).

In Chapter Three, I investigate the limits of the harmlessness of the ethics of hospitality governing the operation of the NHS by interrogating its capacity to avoid the subjection of migrants to different forms and degrees of hostility. Putting it differently, I analyse the argument that providing healthcare constitutes the "right thing to do", and examine the ways in which "ethical" decision-making is troubled by immigration enforcement through the NHS. I explicate how the application of principles devised in the abstract to concrete situations of "real life" does not prevent the enactment of hostility towards migrant patients, and does not resolve the ethical dilemmas that healthcare workers are faced with by attempting to avoid the causation of harm. While illuminating the limits of the principles approach in the practice of modern medicine (Beauchamp and Childress 2013), I further a view of ethics as the interminable negotiation between conflicting – but equally compelling – imperatives emerging from medical dilemmas. From this perspective, hospitality does not "fail" as an ethics. Rather, it is because we are confronted with the undecidable, i.e. circumstances where "the two determined solutions are as justifiable as one another" (Derrida 1999a: 66) that we can speak of ethical responsibility in the first place.

In Chapter Four, I look into the ways in which foreign staff working for the NHS prompt us to reconceptualise traditional understandings of the role of guests and hosts in practices of international hospitality. In doing so, I demonstrate how these overseas workers disrupt conventional power relations that operate in the dynamics between these two subject positions. My analysis is centred on the investigation of COVID-19-related measures addressing the recruitment of foreign healthcare workers to aid in the fight against the pandemic in the UK. By referring to the concept of 'hostipitality' (Derrida 2000: 3), I explain how NHS staff from overseas carry out the material acts of welcoming while subjecting migrant patients to hostility through the implementation of the charging regime in the health service. The notion of the hôte (Derrida 1999b) is also deployed in my analysis given that it allows for the investigation of the role of foreign NHS staff both as indispensable hosts and acceptable guests who are subject to forms and degrees of hostility similar to those experienced by migrants who access the service in the sole position of guests. This chapter also addresses the instantiation of a "hierarchy of deservingness" among low-paid workers and their high-paid counterparts through the lens of the conceptual tool of the (g)host (Bulley 2013; 2016). Finally, I explore how foreign NHS staff help script the health service

as a space of hospitality and the ways in which this narrative can efface parallel accounts of its operation.

In Chapter Five, I address the question as to how we can map out and comprehend the factors and contingencies shaping the reception of the foreigner into the homely space. In doing so, I articulate the concept of the dispositif as elaborated by Foucault (1980) with the notion of the welcoming apparatus as conceived by Derrida (2002a). My argument is that – by connecting these two conceptual tools – we are able to build up a framework to understand the constitution and operation of the welcoming apparatus or dispositif of hospitality: A heterogeneous assemblage of discursive and material elements which are linked together to construct a system for responding to the arrival of the foreigner. Viewed in this light, the welcoming apparatus defines the form of hospitality to which the guest is subject in their interplay with the host in the space of the home. And it does so by shaping the constitution of the subject positions of the host and the guest while framing their experience of hosting and guesting. In the chapter, my investigation of immigration enforcement through the NHS illustrates the use of the dispositif as a methodological device to approach hospitality.

In the conclusion, I address the main points of inquiry in my research to reiterate my argument that – when migrants are welcomed into the NHS – practices of hospitality which deliver improvements in their health and wellbeing also subject them to hostility by means of power technologies that control borders through healthcare provision. Next, I explain how gender, race and postcolonialism constitute fruitful areas for further investigation. I then revisit some of the contributions that I make by carrying out this research. I identify three points of relevance in this regard: First, the analysis of a healthcare system as a space of international hospitality; secondly, the use of the welcoming apparatus (dispositif of hospitality) to map out and understand the factors and contingencies shaping the reception of the foreigner into the homely space; third, the investigation of immigration enforcement through the NHS to demonstrate how the inner biological processes of migrant bodies are turned into the object of security policies. In my final remarks, I offer a brief reflection on the ways in which my PhD research allowed me to reconceptualise my own position as a migrant in light of the hostility embedded within the UK immigration system.

CHAPTER ONE:

MIGRANT PATIENTS OR "IMMIGRATION OFFENDERS"? THE ETHICS OF HOSPITALITY IN THE PROVISION OF HEALTHCARE BY THE NATIONAL HEALTH SERVICE

1. Introduction

Healthcare provision by the NHS is framed by an ethical framework fleshed out in values and principles that should inform the service in everything it does (DHSC 2019a: 14). Values such as dignity, compassion and "everyone counts", as well as principles such as "services free at the point of delivery" and "healthcare based on clinical need, and not ability to pay" reveal a normative commitment to humanity and a sense of universal care on the basis of equal human worth. This ethical framework is primarily concerned with the question as to how to welcome the ill into the NHS while providing a "road map" towards the "right" way of delivering health services. In telling healthcare providers how to proceed in the welcome of patients, this ethics suggests that healthcare is offered as an act of hospitality. After all, in its most general formulation, hospitality is concerned with "the quality of receiving strangers in a warm, friendly and generous manner" (Brown 2010: 309). Similarly, the ethics of the NHS is concerned with the welcome of patients into the health system; it addresses the most caring ways to provide health services, and it sets standards to orientate the conduct of those receiving the ill. From this perspective, the NHS is portrayed as the "home" whose hosts deliver the "gifts" of curing bodies and alleviating suffering in a hospitable manner.

However, the ethos advanced by the moral framework underpinning the operation of the NHS seems to be troubled by healthcare provision for migrants. The analysis of the Memorandum of Understanding (MoU), which set out the protocol under which the NHS should transfer migrant patients' non-clinical data to the Home Office, is particularly illustrative in this regard. By virtue of the agreement, as "immigration offenders" provided their personal details in the best interest of their health (e.g. while registering or consulting with a general practitioner), their information (e.g. name, address, telephone number) could be handed over to the Home Office for purposes of arrest, detention and deportation. It is worth stressing that this data-sharing policy was largely reliant on migrants' access to primary healthcare provided by the NHS, which is free for all, irrespective of nationality, place of residence or immigration status. Despite the ethical

commitment to compassion and benevolence in the welcome of "illegal immigrants" into the service, healthcare workers ended up inflicting pain on their migrant patients while attempting to alleviate their suffering and cure their bodies.

What the example I referred to above suggests is that hospitality for migrants in the NHS is far from entirely benign or benevolent. It is true that offering hospitality as health services enables a welcome: How can one claim that enhancing health is not an act of care towards migrants in need of medical treatment? However, in articulating a welcome, acts of hospitality in the NHS can also enact hostility towards migrant patients seeking healthcare provided by the service. And this is of particular note in the case of migrants with unlawful residence in the UK, and those who are legally in the country but ineligible to comprehensive free NHS care (i.e. migrants with temporary leave to remain). This ambivalence in acts of hospitality is helpfully captured by Jacques Derrida's theorization of the concept. For Derrida (2002a: 359) that which works hospitality like a labour, which settles within it, like a promise as much as like a threat, is indeed a contradiction of welcoming itself. This conceptualisation is a useful platform to explore how an ethics of hospitality – in extending to the guests the gifts of the home – can operate different forms and degrees of hostility.

In this chapter, I argue that healthcare provision for migrants challenges hospitality in the NHS as an entirely compassionate and benevolent practice. In this vein, I contend that acts of hospitality in the delivery of health services enables a welcome of migrant patients into the service, but also enacts different forms and degrees of hostility. My argument is theoretically informed by Derrida's (2000, 2001, 2002a, 2005a, 2005b) thought on hospitality which interrogates understandings of the practice as a simply benevolent reception of the guest in a cordial and generous manner. In order to illustrate my argument, I examine the MoU established by the NHS and the Home Office, and focus attention on the case of migrants with unlawful residence in the UK, given that this migrant population was specifically target by the aforementioned agreement.

This chapter is organised as follows: In the next section, I argue that the ethics orienting healthcare provision by the NHS is framed in terms of hospitality. I draw on healthcare studies to demonstrate that hospitality as a welcome of patients into health systems constitutes the predominant view in the field, and show how that applies to healthcare provision in the NHS. In doing so, I focus attention on the ethical framework underpinning the delivery of healthcare by the service: The NHS Constitution for England, which sets out the values and principles that

governs its operation. I also approach the main provisions enshrined in the ethical codes setting professional standards of practice and behaviour for healthcare workers in the UK. In the following section, I examine the data-sharing policy set out by the MoU established by the NHS and the Home Office. My aim here is to show how healthcare provision for "immigration offenders" challenges conceptualisations of hospitality as entirely benevolent or simply benign welcome of migrant patients into the service. In the next section, I explain how the Derridean notion of hospitality offers a useful theoretical framework to capture the ambivalence of hospitality for migrants in the NHS. In my final remarks, I underline how Dan Bulley's (2013; 2015; 2017) further elaboration on Derrida's thought helpfully highlights important aspects of hospitality as healthcare for migrants in the health service.

2. Healthcare as hospitality: The ethical framework governing healthcare provision by the NHS

What does it mean to provide healthcare? Is it simply the act of delivering health services to diagnose and treat illnesses? Or are there moral questions around how healthcare should be provided? From the Hippocratic Oath dating back to ancient Greece to contemporary professional codes of conduct for healthcare workers, it has been widely recognised that there is a normative basis underlying the use of medicine to attend to a patient's needs (Summers 2019: 3). In other words, the "art of healing" has been long conceptualised as subscribing to values, principles and rules that govern the "right" course of action for particular situations in the healthcare context. From this perspective, we can certainly speak of an ethics of healthcare in that ethics is concerned with what we ought to do, with clarifying what is deemed to be a morally justifiable conduct, as well as providing explanations for why certain principles of right behaviour may operate as guidelines for individuals and groups (Fieser and Pojman 2012: 3).

That healthcare is rooted in ethical grounds seems to be an indisputable claim, but the question remains as to whether we can conceptualise such moral imperatives as an ethics of hospitality. In healthcare studies, there prevails the view that healthcare providers should adopt principles which enable a cordial reception of patients, allowing for an understanding that healthcare provision and the offer of hospitality should be conceived as "two sides of a same coin", which work to enhance the healing of patients through their welcome into health systems (Holroyd, Kelly and Wright-St Clair 2018; Kelly, Losekoot and Wright-St Clair 2016; Hepple, Kipps and Thompson 1990; Renzenbrink 2011). Of particular note here is the commonality shared by healthcare and

hospitality: They are both framed as intrinsically "good"; they are conceptualised as practices which bear within themselves something of worth that is to be shared to those in need. For medicine, "health" is the human benefit it pursues, and providing healthcare constitutes its goal (Zaklaki 2019: 56). However, health services are not to be provided in just *any* manner: Their provision must amount to the creation of a welcoming environment for patients.

In line with the view outlined above, Irene Renzenbrink (2011: 27) explores narratives of illnesses in order to make the case for hospitals becoming more "hospitable" rather than simply aiming to work as "factories" for curing the ill. In her understanding, "[a]n alienating hospital environment where staff focus on technical tasks and functions can drive patients and family members into a state of deep isolation and disconnectedness just when they need compassion and understanding." This perspective resonates with that of Jill Hepple, Michael Kipps and James Thompson (1990: 309) who propose a working definition of hospitality for hospital settings: "that the individual patient should feel as 'at home' as possible during their hospital stay." In this view, the phrase "at home" denotes what they refer to as "a standard of security and psychological comfort which the patient knows and is satisfied with" (Hepple, Kipps and Thompson 1990: 309). Similarly, Rosalind Kelly, Erwin Losekoot and Valerie A. Wright-St Clair (2016: 125) stress how healthcare as an act of hospitality contributes to patients' overall healing and enhance their lives, "within a context of respect recognised at once as subtle moments of warmth, sincerity, and feeling acknowledged." Along similar lines, Eleanor Holroyd, Rosalind Kelly and Valerie A. Wright-St Clair (2018: 1903) argue that hospitality evokes "a special moment which leads to feelings of great comfort and feelings of being truly cared about. When hospitality is received, patients feel a connection; they begin to trust and their healing begins."

It is worth noting how "care" in "healthcare" assumes two distinct, but inter-related meanings which link with both the practicalities (concrete material practices) and affective dimension of offering hospitality: On the one hand, to provide healthcare implies caring *about* patients – i.e. engaging "both thought and feeling, including awareness and attentiveness, concern about and feelings of responsibility for meeting another's needs" (Glenn 2000: 86). On the other, healthcare provision entails caring *for* patients which refers to activities aimed at "providing for the [physical and emotional] needs or well-being of another person" (Glenn 2000: 86-87). Healthcare provision therefore is embedded within a conceptualisation of hospitality that is aligned with a notion of reception of the other (i.e. the act of opening up the home to the guest), but also doing so in a

generous and friendly manner (Brown 2010: 309). In other words, a welcome of patients entails the enactment of both the material and affective component of being hospitable.

In line with the ethos advanced by the aforementioned healthcare studies, the NHS is committed to providing healthcare on ethical grounds, accompanying the contemporary Western tradition that the practice of medicine should be rooted in curing bodies and alleviating suffering, while creating an environment of warmth, security and comfort for patients. As previously mentioned, the ethics of the service is enshrined in the NHS Constitution for England, which states that its main goal consists of safeguarding the enduring principles and values of the NHS (DHSC 2019a: 3). At this point, one issue requires particular attention: Is the imperative of curing bodies and alleviating suffering in a welcoming manner mirrored in such ethical guidelines contained in the NHS Constitution? Putting it differently, do these guidelines advance a conceptualisation of hospitality as a welcoming reception of patients into the service?

There are seven principles set out in the NHS Constitution which are deemed to be the enduring "high-level rules" that govern the operation of the service, and define how the NHS aims to achieve its purpose (DHSC 2019a: 14). These principles are underpinned by six core values which are considered to be paramount to "creating a culture where patients come first in everything the NHS does" (DHSC 2019a: 12).[9] Therefore, principles and values are in constant conversation, establishing the moral grounds on which the service operates. While examining this ethical framework, what comes to the fore is how these ethical guidelines further a normative commitment to humanity and a sense of universal care on the basis of equal human worth in the delivery of health services. This sense of equity and universality in the provision of healthcare, I contend, translates into an ethics of hospitality conceptualised as a welcoming reception of patients into the NHS. The analysis of the first principle is particularly illustrative of my claim, and merits full quotation:

> The NHS provides a comprehensive service, available to all irrespective of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity, or marital or civil partnership status. The service is designed to improve, prevent, diagnose and treat both physical and mental health problems with equal regard. It has a duty to each and every individual that it serves and must respect their human rights. At the same time, it has a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where

[9] My purpose here is not to provide a thorough explanation of the meaning of each principle and value underpinning the operation of the NHS, but to demonstrate how they corroborate the view that the service provides healthcare as hospitality. Therefore, I am focusing my analysis in this section on specific principles and values which exemplify the ethos of hospitality advanced by the aforementioned set of guidelines as a whole.

> improvements in health and life expectancy are not keeping pace with the rest of the population (DHSC 2019a: 14).

A few points are especially important in the analysis of the first principle. To begin with, this commandment reveals a commitment to comprehensiveness, both in terms of who the recipients of health services are, and the type of services that are available to them (e.g. prevention, diagnosis and treatment of physical and mental health issues). It establishes the so-called "protected characteristics" on the basis of which no one should be discriminated against in the provision of healthcare[10]. In addition to that, the appeal to universality, equity and inclusiveness advanced by the principle should be manifest both at the individual and collective level. In other words, when delivering health services, the NHS should attend to individual patients' human rights, as well as providing healthcare as a means of minimising disparities in respect to health in society (e.g. those relating to the wider socioeconomic determinants of health).

The first principle has its foundations in at least two values that underpin the operation of the NHS. To begin with, one should note the inspiration it draws from "respect and dignity", which aims to ensure that everyone who is served by NHS providers be treated as individuals whose different needs, aspirations and priorities must be valued and respected, while fostering "a spirit of candour and a culture of humility, openness and honesty, where staff communicate clearly and openly with patients, relatives and carers" (DHSC 2019a: 12). The principle also finds its basis in "compassion" which seeks to safeguard sensitivity and kindness in the delivery of health services, while stressing that "[t]he business of the NHS extends beyond providing clinical care and includes alleviating pain, distress and making people feel valued and that their concerns are important" (DHSC 2019: 13).

The analysis of the first NHS principle and the core values in which it is grounded corroborates the view that the ethics of the NHS is not exclusively concerned with *what* healthcare should be provided (e.g. physical and mental health services), but also with *how* NHS staff should provide such healthcare. This perspective is aligned with the understanding that healthcare providers should aim to care *for* and *about* patients while designing and implementing health services. Respectively, they should conceive of ways in which they should meet patients' physical and mental

[10] These characteristics are the same enshrined in the Equality Act 2010, the UK legal framework which aims to protect individuals from discriminatory and unfair treatment, as well as promoting equality of opportunity (Equality and Human Rights Commission 2019).

health needs, but they should also be concerned with the thoughts and feelings experienced by those under their care. On the basis of the predominant literature in healthcare studies, this ethos in healthcare provision translates itself into an ethics of hospitality, which works to promote patients' health and wellbeing while providing them with health services in a welcoming manner. One that furthers the healing of those being looked after in the health systems, while amounting to feelings of security, comfort and warmth, commonly associated with the "being-at-home".

It is worth noting that the rules contained in the ethical codes setting professional standards of practice and behaviour for healthcare workers in the UK commonly overlap with those enshrined in the NHS Constitution, and corroborate the view that health professionals must not only attend to patients' clinical needs, but also do so in a way that fosters a welcoming reception of these patients into healthcare settings. In regard to doctors, the General Medical Council (GMC) - the regulatory body of medics – sets out its ethical guidelines in the document termed "Good Medical Practice", which covers issues ranging from respect for patients and trust in the doctor-patient relationship to the training of doctors registered with the council (GMC 2013). At the core of the GMC's ethical guidance is the notion that "good" doctors make the care of their patients their primary concern, and ensure that all patients receive appropriate services according to their needs (GMC 2013: 4). However, issues revolve not only around what health services should be provided, but also around how to provide them: The guidance establishes that doctors must treat their patients politely and considerately, listen and respond to their preferences and concerns, in addition to making every effort to avoid that their safety, dignity or comfort be compromised (GMC 2013: 2).

The professional practice of nurses, midwives and nursing assistants working in the UK is governed by rather similar imperatives. Their ethical guidance is enshrined in "The Code", established by the Nursing & Midwifery Council (NMC), which constitutes the regulatory body of the aforementioned healthcare workers. In one of its provisions, the Code highlights their duty to assess and respond to patients' physical, social and psychological needs, as well as the obligation to provide medicines or treatment to those under their care within the limits of their knowledge and attributions (NMC 2018: 7; 16). And similarly to the guidance provided for doctors, these health professionals must fulfil these duties by treating people with kindness, respect and compassion, while creating an environment of welcome, e.g. by taking steps to meet patients' communication needs and considering cultural sensitivities in their approach (NMC 2018: 9). Healthcare provision therefore should pursue the cure of bodies and alleviation of suffering by

means of offering a hospitable encounter between patients and healthcare staff, where the former are entitled to the promotion of their health and wellbeing through a welcoming reception into the NHS, while the latter have the duty to provide clinical care in a sensitive and kind manner.

The question I raise at this point is: To what extent does the ethos of healthcare as hospitality remain unsettled when healthcare provision for migrants is taken into account? I do not seek to draw attention to particular acts of specific doctors, nurses or other NHS staff members that may be considered to be rude, impolite or hostile, which obviously might happen and deserve serious consideration. Nevertheless, my focus here is to explore the following point of inquiry: When healthcare is provided for migrants who are not eligible for free health services, does such healthcare provision simply equate to the cure of bodies and alleviation of suffering in a welcoming manner? Or does healthcare provision for these migrants challenge this view of hospitality in the NHS? The examination of the MoU established by the health service and the Home Office, in 2016, is a fruitful starting point to address these questions since it draws attention to healthcare provision for "illegal immigrants" – one type of migrant with no entitlement to NHS care free of charge. This is the analysis I am carrying out in the following section of this chapter.

3. Tracking down "immigration offenders" through healthcare provision: Data sharing between the Home Office and the NHS

In England, certain health services are free for all irrespective of any specific character or qualification of the individual in need of healthcare provided by the NHS. I emphasise that "certain" health services are free for all because – despite being governed by an ethics of hospitality that advances universality, equity and inclusiveness – only a specific set of individuals and services are exempt from charges (DHSC 2021: 13). All in all, free health services for everyone reiterates the normative commitment to humanity and the sense of universal care on the basis of equal human worth embedded in the NHS Constitution, i.e. it reinforces its promise of "not leaving anyone behind" when it comes to healthcare provision. This is particularly revealed in the analysis of values such as "respect and dignity" and "compassion" (as explained in the previous section), but also in other ethical guidelines such as "everyone counts", which advances the message that "[n]obody should be discriminated or disadvantaged, and everyone should be treated with equal respect and importance" (DHSC 2019a: 13).

That certain health services are free for all also constitutes a relevant point for the understanding of the operation of the MoU since it targets "immigration offenders", who are entitled to such free healthcare despite their irregular immigration status in the UK. The MoU sets out the administrative arrangements on the sharing of migrant patients' non-clinical data in support of immigration enforcement (NHS Digital 2018: 1). It formalises and clarifies the circumstances in which the Home Office can make requests of NHS Digital for tracing "immigration offenders", how such requests should be made, and what information can be provided in return. As the Department of Health (2017b: 2) explains, "the MoU is about locating immigrants who have lost touch with the Home Office, in order to re-establish contact and either remove them from the UK or otherwise regularise their stay." Two main justifications are provided by the Government in favour of the arrangement.

First, the MoU enables the Home Office to remove "dangerous" migrants who are in breach of immigration rules. In the Government's view, this "dangerousness" stems from the fact that "those who have lost contact with the Home Office have committed immigration offences that are serious enough to result in their removal from the UK" (DHSC & Home Office 2018: 4). In this vein, the Home Office explains the "dangerousness" of "immigration offenders" by tracing a potential connection between the breaching of immigration law and criminality, as the anecdote provided by the department reveals:

> By way of illustration, a Pakistani national overstayed a visitor visa and an out of time application for leave to remain was refused in 2013, after which the individual ceased contact with the Home Office. Home Office tracing activity using other sources was unsuccessful. An NHS Digital trace in 2017 identified a new address for the individual. The Home Office visited the address and arrested the individual, a convicted sex offender, who is now complying with the Home Office and will leave the UK (DHSC & Home Office 2018: 4).

The second justification for the implementation of the MoU is concerned with the alleged harm "immigration offenders" cause to the economic wellbeing of the UK (Department of Health, Home Office and NHS Digital 2016: 7). By enforcing immigration through the NHS, the Government argues that it is protecting limited UK resources and public services from unnecessary financial pressures caused by illegal immigration. As "immigration offenders" contribute to excessive demands on the service, it is mandatory to trace such individuals and remove them from the country. The justification seems to be in line with the view that the NHS can only be sustained as "a national, not an international health service" (Department of Health

2015b: 5), with "immigration offenders" being portrayed as illegitimate users of the service who pose a "threat" to its financial sustainability.

In procedural terms, on a case-by-case basis, the Home Office discloses data to NHS Digital on individuals where it suspects an immigration offense has been committed. NHS Digital then matches this data against its records and, in response, transfers to the department migrant patients' non-clinical information (Department of Health, Home Office and NHS Digital 2016: 16). The data required is limited to demographic/administrative details covering name (change of name, if applicable), last known address, nationality, date of birth, gender and date of registration with the NHS. In all cases, tracing requests are deemed to be a last-resort instrument to locate "immigration offenders", meaning that requests should only be "triggered when other avenues available to the authorities to locate the individual have been unsuccessful" (Department of Health 2017b: 2).

Consisting of the national information, data and IT provider to the NHS, the role played by NHS Digital in the data-sharing policy set out by the MoU seems to conflict with its mission, which the organisation announces as supporting NHS staff carry out their duties, help people obtain the best healthcare, as well as using the "nation's health data to drive research and transform services" (NHS Digital 2021). As a public body sponsored by the DHSC, NHS Digital finds itself subject to the NHS Constitution and the ethical provisions that it enshrines. As established by the Constitution itself, "the Secretary of State for Health, all NHS bodies, private and voluntary sector providers supplying NHS services, and local authorities in the exercise of their public health functions are required by law to take account of this Constitution in their decisions and actions" (Department of Health 2015a: 2). Even though the Constitution furthers a sense of inclusiveness of all patients, regardless of nationality or citizenship, the MoU seems to propose a reconceptualisation of the role of NHS Digital by stating that its purpose is "to improve health and social care in England by putting technology and information to work in the interests of *citizens*" (Department of Health, Home Office and NHS Digital 2016: 5, emphasis added), and apparently not those of migrants in breach of immigration law.

Following the rationality of the data-sharing policy, "illegal immigrants" would potentially seek health services provided by the NHS, handing over their personal details in the relevant healthcare bodies (e.g. GP practices and hospitals), which could then be deployed for purposes of immigration enforcement. For instance, registration and consultation with a GP is free for all, irrespective of proof of identity, residence or immigration status. In other words, a patient cannot

be refused registration or appointments because they do not have proof of address, identification or lawful residence at hand, and that applies to asylum seekers, refugees and migrants with unlawful residence in the UK. For purposes of clarification, it is important to stress that GP practices cannot refuse healthcare on the basis of migrants not providing the aforementioned documents, but it does not mean that registration with a GP is carried out without migrants providing personal non-clinical details (e.g. name, address, telephone number). This is relevant for healthcare administration (e.g. sharing migrants' data between two different GP practices), and works to enhance the delivery of health services in favour of patients; however, at the same time, it has a crucial role to play in the data-sharing policy established by the MoU[11].

It could be argued that confidentiality of administrative/demographic data should be protected, given that this information had been shared by migrants within an expected relationship of trust between doctors and patients – which is a cornerstone of medical practice (BMA 2018: 2). However, it is the UK Government's understanding that administrative information is not subject to the established rules of medical confidentiality, and "falls at the less intrusive end of the privacy spectrum, making disclosure easier to justify as the public interest in tracing immigration offenders outweighs the public interest in non-disclosure" (NHS Digital 2018: 4). In this vein, where an individual is suspected to have committed an immigration offense, even if it is missing an appointment with the Home Office (DotW 2018: 2), it is in the public interest that the Home Office make a request of NHS Digital for tracing such an "immigration offender", as 'the public policy objective of maintaining the effective enforcement of the UK's immigration laws is a thoroughly important one" (DHSC & Home Office 2018: 3).

On a final note, it is important to clarify that the MoU was suspended in May 2018, with NHS Digital withdrawing from the arrangement in November of the same year, following a legal challenge by charity Migrants' Rights Network (Liberty 2018). Nevertheless, the termination of the agreement does not make the analysis of its provisions less useful or relevant. For one thing, the MoU reveals a rationality that still underpins ongoing discourses and practices linking together immigration enforcement and healthcare in the UK through the operation of the hostile environment policies. For another, NHS Digital and the Home Office have announced that a

[11] Despite the NHS policy being clear that GP practices must not refuse registration in circumstances where patients cannot provide proof of identity, residence or immigration status, most surgeries refuse to register undocumented migrants (Bureau of Investigative Journalism 2021). This breach of the law by such primary care providers worked to facilitate the operation of the data-sharing policy set out by the MoU.

revision plan is underway, with NHS Digital placing current requests from the Home Office in a "queue" until a revised memorandum of understanding is agreed (NHS Digital 2018).

As demonstrated above, if one seeks to interrogate hospitality for foreigners in the NHS, conceptualised as a benevolent welcome of migrant patients into the service, the analysis of the MoU seems to be a helpful tool to illuminate the conflicting aspects inhabiting acts of welcoming carried out by the health system. This is not because the MoU simply disregards the NHS Constitution, and converts hospitality in the NHS into hostility enacted towards migrants in need of medicine. As I previously explained, even when the MoU was in effect (from January 2017 to November 2018), certain health services remained free for all, irrespective of migrants' nationality, place of residence or immigration status. And it is certainly arguable that acts of healing the ill, especially if provided by healthcare staff in a cordial way, reflected an understanding of healthcare as hospitality aligned with the ethical framework underpinning the operation of the NHS. However, free healthcare provision – even if health services are delivered in a welcoming manner – does imply that hospitality can prevent hostility from being enacted towards migrant patients. Under the MoU, as "illegal immigrants" provided their non-clinical information in the best interest of their health, their data could be transferred to the Home Office for purposes of arrest, detention and deportation. This is why I suggest that we look at hospitality not simply as an entirely benevolent act, but also as a practice that carries the very opposite of welcoming within itself. The notion of hospitality advanced by Derrida incorporates the ambivalence to which I am drawing attention, and will be discussed in the following section.

4. 'Hostipitality': Hospitality and hostility in the reception of the other

How should we welcome the foreigner that seeks to cross the threshold of our home, be it a house, a community, a state, or even a healthcare system? This question interrogates our sense of the "foreignness" of the other, and positions hospitality at the core of debates around the meaning of openness and closure towards the "stranger". Although current issues – such as fining non-governmental organisations (NGOs) for rescuing migrants stranded at sea or banning migrants from healthcare due to their immigration status – rightly stress the significance of the concept for contemporary debates, the significance of hospitality for reflections upon the reception of the foreigner can be traced back to a longstanding tradition in Western thought. In this regard, the philosophical legacy of Immanuel Kant is particularly relevant, given its influence on current understandings of the concept (Brown 2010: 309). For Kant (2006: 82), hospitality means

> […] the right of a stranger not to be treated in a hostile manner by another upon his arrival on the other's territory. If it can be done without causing his death, the stranger can be turned away, yet as long as the stranger behaves peacefully where he happens to be, his host may not treat him with hostility. It is not the right of a guest that the stranger has a claim to (which would require a special, charitable contract stipulating that he be made a member of the household for a certain period of time), but rather a right to visit, to which all human beings have a claim, to present oneself to society by virtue of the right of common possession of the surface of the earth.

This approach to hospitality introduced by Kant has inspired voices in the field of International Politics, which have advocated for the relevance of Kantian political theory as a "reasonable ethical foundation for an international society" (Brown 2006: 661), and elaborated on Kant's thought to ground a right of foreigners to political membership (Benhabib 2004: 38). On the other hand, the Kantian legacy has also set the scene for significant contestation. Critics of Kant-inspired understandings of hospitality have pointed out their links to colonialism and practices of racialisation, as well as the ways in which scholars drawing on Kant's thought maintain the erasure of race in their studies (Gani 2017: 445 – 446). The Kantian tradition has also constituted an object of scrutiny for Derrida (Derrida 2000; 2005a). For the French philosopher, Kant's formulation of hospitality is centred on its construction as a right, and as defining conditions for the foreigner to enter a state of which they are not a citizen. It is a right therefore "determined in its relation to citizenship, the state, the subject of the state, even if it is a world state […]" (Derrida 2000: 3).

In challenging the openness towards the foreigner advocated by Kant, Derrida argues that responsibilities and decisions concerning hospitality must be taken between the following two figures of hospitality: unconditional or pure hospitality, and conditional hospitality or hospitality by right (Derrida 2005b: 6). These are respectively associated, as Derrida contends, with two heterogeneous but indissociable regimes of law: the regime of the *law* of hospitality and that of the *laws* of hospitality. But to begin with, what does Derrida mean by the law of absolute, unconditional, hyperbolical hospitality? Putting it simply, "[p]ure and unconditional hospitality, hospitality itself, opens or is in advance open to someone who is neither expected nor invited, to whoever arrives as an absolutely foreign visitor, as a new arrival, non-identifiable and unforeseeable, in short, the wholly other" (Derrida 2003: 128 – 129).

It is worth reflecting at this point on whether free health services for all, irrespective of nationality, place of residence or immigration status consists of an instance of unconditional hospitality. For example, as mentioned in the previous section, registration and consultations with a GP are not chargeable, and GP practices cannot refuse registration and appointments for migrant patients on

the basis of their not having proof of their identity or lawful residence in the UK. It is true that practices can ask for non-clinical personal data (e.g. name, address, telephone number) of migrant patients for purposes of healthcare administration, which would seemingly undermine the possibility of unconditional hospitality be taking place. However, as Derrida (2005b: 7) explains

> Pure hospitality consists in welcoming whoever arrives before imposing any conditions on him, before knowing and asking anything at all, be it a name or an identity "paper". But it supposes also that one addresses him, singularly, that he be called therefore, and that he be understood to have a proper name: "You, what is your name?" Hospitality consists in doing everything to address the other, to accord him, even to ask him his name, while keeping this question from becoming a "condition", a police inquisition, a blacklist or a simple border control. This difference is at once subtle and fundamental, it is a question which is asked on the threshold of the "home" and at the threshold between two inflections. An art and a poetics, but an entire politics depends on it, an entire ethics is decided by it.

Apparently, it seems reasonable to argue that free healthcare for all consists of an instance of unconditional hospitality. After all, asking a migrant patient (e.g. one with unlawful residence in the UK) their name would not erase such a possibility. However, opening up the home to the non-identifiable and non-expected other, the unforeseeable foreigner whose origin and identity cannot be required, does not mean that free NHS care instantiates the "unconditional" in the reception of migrants into the service. This is because if we are speaking of unconditional hospitality, it should be granted not to the extent that we retain the mastery of the home. On the contrary, pure hospitality demands giving up on our sovereignty, allowing the foreigner to take our place as hosts (Derrida 1999a: 70). Providing free healthcare for "immigration offenders" certainly does not imply NHS staff are giving up mastery of the home, or that such migrant patients are taking their place as "masters" of the healthcare system. This could unquestionably be argued under the MoU, but still remains valid nowadays, after the termination of the agreement.

Furthermore, unconditional hospitality is conceived as a "law without a law" (Derrida and Dufourmantelle 2000: 83): it should be offered without a duty inscribed by a rule (i.e. if hospitality is governed by a duty, it is not absolute), and it resists attempts to be organised or legislated for because, as soon as it is arranged and predetermined, it loses its unpredictability and unconditionality (Fagan 2013: 85). This amounts to the argument that it is not unconditional hospitality that we are looking at when we speak of free healthcare for migrants irrespective of their immigration status. Rules determining the provision of free health services for all have been enshrined in legislation as a "right" as well as a duty to be carried out by NHS staff (DHSC 2019a). Not that I am arguing that this is a predicament nor that there should not be administrative and

legal frameworks in place to regulate free healthcare provision. On the contrary, I follow Derrida when he contends that what remains unconditional risks being nothing at all if not inscribed into rules that allows the host to give something concrete and determinate (Derrida 2003: 129).

The imperative command of the *law* of unconditional hospitality is in contrast with the *laws* of hospitality, "namely, the conditions, the norms, the rights and the duties that are imposed on hosts and hostesses, on the men and women who give a welcome as well as the men or women who receive it" (Derrida and Dufourmantelle 2000: 77). In other words, the host puts in place a set of conditions to be met for hospitality to be offered. There is a filtering and choosing of guests because not everyone is welcome to cross the threshold of the home. This point is particularly interesting when analysing the first principle enshrined in the NHS Constitution, i.e. that "the NHS provides a comprehensive service, available to all, irrespective of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status" (Department of Health 2015a: 3).

As previously explained, no one should be deprived of health services on the basis of the protected characteristics cited above. Despite the sense of inclusiveness underlying the first NHS principle – in line with the values that underpin it (e.g. "everyone counts") – immigration status is not mentioned in the referred set of characteristics. It is important to note that term "race" (as included in the principle) comprises colour, ethnic origin and nationality. However, nationality does not equate to immigration status. In this regard, the UK Supreme Court (2016) has established that mistreatment stemming from precarious immigration status does not amount to discrimination on grounds of nationality. In other words, discrimination based on immigration status does not violate the Equality Act 2010. It is true that the NHS Constitution does not contain any prescriptions stating that patients can be refused healthcare if they are not legally residing in the UK – in fact, most of the guidelines set out in the document convey otherwise (Mitchell C & Reynolds 2019: 499). Nevertheless, the fact that "immigration status" does not appear as a protected characteristic in the NHS Constitution (which, in this regard, replicate the Equality Act 2010) suggests that some filtering and choosing has been enshrined in its provisions.

Furthermore, in conditional hospitality, not all gifts are to be offered: The host must choose to give "this" and not "that". In this form of hospitality by right, sovereignty over the home remains, and we welcome the other "to the extent that he/she learns and speaks the language, adjusts to the order of the house, respects the orderer, in more common terms, assimilates" (Doty 2006: 65).

For Derrida (1999a: 69), this gesture of hospitality is inscribed "within a circle in which the guest should give back to the host […]", deriving from reciprocity and exchange. When it comes to healthcare provision, this notion of reciprocity and exchange echoes one of the justifications for the MoU, which still orients immigration policies in the UK[12]: that immigration enforcement through the NHS is paramount to prevent "immigration offenders" from harming the economic wellbeing of the country by accessing public services, such as healthcare (Department of Health, Home Office and NHS Digital 2016: 7). From this perspective, those migrants with unlawful residence in the UK amounts to unnecessary pressures on national resources and risk the financial sustainability of the NHS by not making a "fair contribution" to the health service (Department of Health 2017a). As suggested by this narrative, there is a break in the circle of reciprocity and exchange because the conditionalities of hospitality have not been observed by the foreigner (i.e. they have not paid for the healthcare which they received).

In addressing the regimes of law prescribed by absolute hospitality and hospitality by right, Derrida lays bare that such regimes are "both contradictory, antinomic, and inseparable. They both imply and exclude each other, simultaneously" (Derrida and Dufourmantelle 2000: 81). In other words, these regimes are at the one and same time marked by a perpetual heterogeneity and indissociability. They are heterogeneous regimes in that the law of unconditional hospitality demands from the host an absolute welcome of whoever may arrive, without asking them any questions, without imposing any conditions; the foreigner must come and disrupt our sovereignty over the home. The laws, on the other hand, impose conditions that must be met so that hospitality can be granted. They imply filtering and choosing who is to be welcomed, which gifts to be given, and the rules by which the guest must abide in order to cross the threshold of the home.

In spite of their heterogeneity, the regimes instantiated by the law and the laws are also inseparable. To begin with, the laws need the law because, without this reference, conditional laws would no longer be laws of hospitality in the first place, for lacking the guidance, inspiration and aspiration given by the principles of absolute hospitality (Derrida and Dufourmantelle 2000: 79). From a Derridean perspective, "[…] a politics that does not retain a reference to this principle of unconditional hospitality is a politics that loses its reference to justice", and cannot speak of it with any credibility (Derrida & Stiegler 2002: 17). Unconditional hospitality therefore works as a regulative pole of a "desire for perfectibility" of the laws, one that can amount to their

[12] I am referring here to the system for charging migrants for healthcare, which will explained in the following chapter.

transformation and improvement, because "there is an infinite progress to be performed, to be achieved in that respect" (Derrida 2001: 100).

In addition to that, there is inseparability between the regimes of the *law* and the *laws* because unconditional hospitality also demands its conditional counterpart. The laws are essential for hospitality to become effective and concrete, for it to be able to deliver something determinate (Derrida and Dufourmantelle 2000: 79). Without laws regulating the welcome of the other, i.e. putting in place a politics of hospitality, unconditionality will not be translated into concrete contexts and situations (Aradau 2010: 113), and runs the risk of remaining a vague illusion or utopia. The laws threaten and disrupt the law but this regime of hospitality that filters and chooses is the same which makes hospitality effective, that gives something determinate by re-inscribing the unconditional into conditions, because what remains unconditional risks being nothing at all, if conditions do not make something of it (Derrida 2003: 130).

Furthermore, by establishing conditions, the laws undermine "the perverse effects of an unlimited hospitality" (Derrida 2005b: 6) by securing the existence of the home and the integrity of the host, without which we cannot even speak of hospitality in the first place. In an unconditional welcome, there are not rules establishing who can cross the threshold of the home, and which gifts can be given. That implies accepting "the risk of the other coming and destroying the place, initiating a revolution, stealing everything, or killing everyone. That is the risk of pure hospitality and pure gift, because a pure gift might be terrible too" (Derrida 1999a: 71). The laws filter and selects guests, and which gifts to be offered, and in doing so, they tame the effects of the law, given that an unlimited welcome is "nothing short of life threatening" (Derrida 2003: 129).

The tensions between the *law* and the *laws* of hospitality illuminate the unresolvable contradictions which lie within the concept and practice of hospitality, i.e. the contradictions that arise every time we speak of hospitality, make it into or theme or offer it to our guests (Derrida 2002a: 360). For Derrida (2000: 3), hospitality carries its own contradiction within itself; it allows itself to be parasitised by the opposite of welcoming. Putting it differently, hospitality is inhabited by hostility, its undesirable guest that "haunts" the possibility of conceiving hospitality as an entirely benevolent practice. This dichotomy incorporated into the notion and acts of hospitality is what Derrida (2000: 3) terms "hostipitality" – by drawing attention to the dimensions of hospitality which are, at the same time, in competition and incompatible, but also intrinsically inseparable, in such a way that hospitality is neither simply a welcome nor hostility but, at the same time, it is both. Whether it is

conditional or unconditional, hospitality is marked by the trace of its opposite, meaning it cannot be separated from its ever-present hostility (Bulley 2006: 660).

The metaphor of the home can be useful at this point: For there to be hospitality, there must be a home. However, in establishing a home, "one is automatically erecting a border, demarcating what is inside and outside. In creating a home, you create a space with a border that is yours through a process of inclusion and exclusion" (McFadyen 2016: 601). This is aligned with the argument that for the host to offer hospitality, they must be assured of their sovereignty over the space and goods they provide to the guest, meaning that the host can only open up and offer hospitality by affirming "This is mine, I am at *my* home". In other words, hospitality constitutes, limits itself, and depends on the reaffirmation of the "mastery and being oneself in one's own home" (Derrida 2000: 14). As Bulley (2006: 652) explains, "[o]n a purely practical level, the possibility of my welcoming someone, of offering hospitality, is predicated on my having a home to welcome them into. My home is therefore both a way of unethically excluding others […], but also the very possibility of my acting ethically in welcoming someone in." This is a simple but useful explanation of the unresolvable tension that lies within hospitality or, in Derridean terms, its aporetic contradiction which cannot simply be effaced (Derrida, 2002a: 362 – 363).

It is inspired by this view of hospitality that I will carry out my analysis of immigration enforcement through the provision of healthcare by the NHS. In other words, it is this conceptualisation which will guide my exploration of how healthcare provision for migrants entails both their welcome into the service, but also different forms and degrees of hostility. In this vein, I am not disputing the value of or intentions underlying the NHS Constitution. In fact, my understanding is that the ethos enshrined in this framework does advance a normative commitment to providing patients with a welcoming reception by delivering health services in a cordial and friendly manner. In this regard, it is aligned with a view of hospitality as a desired gift to be delivered by healthcare workers while they are attending to their patients' clinical needs. However, as the case of the MoU reveals, this ethics does not capture the ambivalence at the core of healthcare provision for migrants who are not eligible for free health services – i.e. the delivery of improvements in their health and wellbeing, but also their subjection to arrest, detention and deportation through the sharing of their data. In my view, this ambivalence can be well-described and examined through the lens of hospitality as elaborated by Derrida and those inspired by his thought.

5. Conclusion: Pushing the boundaries of Derrida's thought on hospitality

In this chapter, I argued that hospitality as healthcare enables a welcome of migrants into the NHS, but it also subjects them to hostility in their access to health services. I illustrated my argument by analysing the data-sharing policy set out by the MoU in order to demonstrate how free healthcare for migrants with unlawful residence in the UK worked to enhance their health while subjecting them to border control. In doing so, I advanced the view that the ethics of hospitality operating through healthcare provision by the NHS cannot be conceptualised as an entirely benevolent welcome of patients, as suggested by the promise of universality, equity and inclusiveness underpinning the NHS Constitution. Rather, I drew on Derrida's thought to make the argument that this ethics of hospitality entails both the practice of welcoming and the enactment of hostility (i.e. hostipitality) when healthcare provision for migrants is taken into account.

While Derrida's conceptualisation of hospitality lies at the core of my analysis throughout this thesis, further elaboration on his ideas provides invaluable insights to illuminate important aspects of hospitality for migrants in the NHS. More precisely, I am referring to Dan Bulley's (2013; 2015; 2016) contribution, which pushes the boundaries of Derrida's thought to remark that we ought to be "clearer than he allows in separating actual practices of hospitality from other potentially ethical conduct" as well as further exploring the relation between ethics and power embedded in these acts (Bulley 2015: 190). In regard to the difference between acts of hospitality and other types of ethical behaviour, Bulley stresses that the aim is not to offer a general definition, which seeks to stabilise the ever-present instability and tensions that come to the fore whenever we thematise and enact hospitality. Rather, what he provides is a "minimalist taming [which] wards off an expansionist approach in which hospitality comes to encompass any social relation or responsibility-taking" (Bulley 2016: 7). But what does it consist of?

For Bulley (2016: 7), hospitality consists of "a spatial relational practice with affective dimensions." First, hospitality consists of a spatial practice because it requires the crossing of borders and thresholds, separating the home and the away, delimitating what belongs to the host, but not to the guest. This is a point of particular relevance to differentiate hospitality from other types of ethical responsibility in light of Derrida's often-cited claim that "ethics is hospitality" (Derrida 2005a: 17). As Bulley (2015: 188) explains, the argument that "ethics is hospitality" can be conceived in the abstract sense of the term as it broadly refers to the ethos and its relation to the other. The concrete practice of hospitality, however, requires that attention be paid to spatiality,

as suggested by his definition. To follow up on the crossing of borders, it worth noting that, in practices of hospitality, the boundaries of the home are always already porous and bound to be transgressed by the other that comes expectedly or unannounced. Putting it differently, what hospitality operates in respect to its spatiality is not to build the home as an impenetrable fortress, but to produce and generate the home as sphere of coexistence by welcoming, rejecting, filtering and regulating trajectories and circulations (Bulley 2016: 7).

Furthermore, the focus on the crossing of borders and thresholds draws our attention to the aforementioned affective dimensions of hospitality. This is because, when it comes to practices of hospitality, one does not witness the transgression of non-meaningful boundaries. As Bulley (2015: 189) explains, these boundaries "constitute lines between feelings of belonging and non-belonging, comfort and discomfort, security and insecurity, ease and awkwardness." However, it is worth noting that centring attention on the affective dimension of practices of hospitality does not imply an attempt to romanticise the home as a "safe and pure space of belonging" (Bulley 2016: 9). The point here is to highlight that this affective component constitutes the home, makes the home a product of it, but without suggesting that once its threshold is crossed all the guest experiences is "the sense of ease and comfort from being-at-home-with-oneself" (Bulley 2015: 189). Indeed, this is what hospitality both enables and disrupts (Bulley 2016: 9).

The contributions made by Bulley while building up on the thought of Derrida highlight important aspects relating to the offer of hospitality to migrants in the NHS. First, they help us perceive that practices of hospitality produce the NHS as the home, delimiting a space for the provision of healthcare where some foreigners will be welcomed while others will not – or even a space where a welcome of foreigners may implicate their very exclusion through the enforcement of immigration. The data-sharing policy set out by the MoU provides a useful example in this regard, given that healthcare provision for "illegal migrants" enabled their subjection to border control. By setting the boundaries which constitute the NHS as the home, hospitality also works to demarcate limits that separate the national and the international, legality and illegality, the British citizen and the foreigner. These dichotomies are hierarchical, value-laden and determinative of who is to be welcome into the service as well as of the extent to which certain "gifts" of hospitality are to be granted. For instance, as an "illegal immigrant", a foreigner may register with a GP and access primary care, but not undergo cancer treatment free of charge.

While contending that hospitality can be conceived as a spatial and affective relational practice, Bulley stresses the necessity to explore the interplay of ethics and power relations in acts of hospitality beyond the notion of sovereignty (Bulley, 2013; 2015; 2017; Bulley and Lisle 2012). The point here is not to limit analyses of the "power of hospitality" to the moment of crossing the threshold of the home; to the moment where the sovereign master decides whether to welcome or refuse the guest. In other words, the aim is to interrogate ourselves about what forms of power are exercised after the threshold is crossed. Again, the reflection proposed by Bulley speaks to issues surrounding hospitality for migrants in the NHS.

For instance, the MoU reveals not only a mechanism of inclusion and exclusion of "illegal immigrants" from the NHS (or from the UK), but also techniques deployed to constitute these migrants as the embodiment of personal data which could be used by the Home Office to secure borders and (allegedly) protect the health of citizens residing in the country. Therefore, this data-sharing policy is not exclusively about rejection or expulsion of "immigration offenders", but it is also largely concerned with the datafication of subjects for surveillance and the promotion of security as an optimised state of health and wellbeing. The issues surrounding the "power of hospitality" that I am raising here merit further consideration, and can be properly explored through an analysis that draws inspiration from Michel Foucault's analytics of power (Foucault 2003). This is the task that I will be carrying out in the following chapter of this thesis, as I shift attention to the system for charging migrants for healthcare provided by the NHS.

CHAPTER TWO:

THE POWER OF HOSPITALITY: EXCLUSION, SURVEILLANCE AND CARE IN THE CHARGING OF MIGRANTS FOR HEALTH SERVICES

1. Introduction

What does power have to do with hospitality? When writing about the encounter between citizens and strangers by virtue of their arrival in the territory of another state, Kant (2006: 82) spoke of the right of the foreigner to not be treated with hostility as long as they peacefully occupy their place in the foreign land. But – if on the one hand he theorises on the right of the foreigner not to be subjected to a hostile treatment upon their arrival – on the other, Kant refers to the power of the state to refuse the stranger if this can be done without causing their death. Hospitality, in this vein, is a matter of protecting the foreigner against gratuitous hostility as much as it is about the sovereignty of the state to control its borders. The power of hospitality has also been addressed by Derrida (Derrida and Dufourmatelle 2002: 53 – 55). When describing the sovereign power of the host over the home, he explains that there is a "necessity for the host, for the one who receives, of choosing, electing, filtering, selecting their invitees, visitors, or guests, those to whom they decide to grant asylum, the right of visiting, or hospitality" (Derrida and Dufourmatelle 2002: 55). Again, the interplay of hosts and guests constitutes a question of power: In the management of the home, the host makes the sovereign decision about who is allowed to cross its threshold and what gifts are to be granted after they are received.

Even though the logic of inclusion and exclusion constitutes a crucial component of hospitality, an analysis of its power cannot limit itself to such a dynamics. Derrida points us in this direction when he contends that "being at home with oneself […] supposes a reception or inclusion of the other which one seeks to *appropriate, control, and master according to different modalities of violence*" (Derrida 2005a: 17, emphasis added). But despite his suggestion that there is more to hospitality than determining who is allowed to cross the threshold of the home, Derrida does not offer us a further elaboration on how the power of hospitality operates once the guest is welcomed in. He does not investigate how power relations play out in the efforts of the host to appropriate and control the guest after the threshold has been crossed (Bulley 2015: 192). While pushing the boundaries of

Derrida's thought, Bulley (2015: 191) suggests that we interrogate what becomes of the power of hospitality after the moment of reception by questioning how it gets to be exercised "to manage and control the home", and how it works to "produce more or less inclusive exclusions and exclusive inclusions." The implications of this concern are significant: First, it encourages us to look beyond practices of exclusion when analysing how power is exercised in the administration of spaces of hospitality. Secondly, it highlights that guests are still subject to different types of hostility in spite of – and due to – their welcoming into the home.

In light of the above, this chapter explores the ways in which power is exercised through practices of hospitality for migrants in the NHS. I draw inspiration from Foucault's analytic of power to investigate the techniques of care, surveillance and exclusion of migrants which operate through healthcare provision by the service. In doing so, I demonstrate how healthcare is provided for migrants as a means to secure security for those deemed to be the legitimate users of the service while enabling different forms and degrees of hostility towards the foreigner. In this vein, I explain the main provisions of the NHS (Charges to Overseas Visitors) Regulations 2015 and its subsequent amendments (the Charging Regulations), which instantiate the system for charging migrants for their healthcare. The implementation of the charging regime, I claim, allows for the power of hospitality to be enacted as a form of "governmentality" (Foucault 1991: 102) in the sense that techniques of care, surveillance and exclusion are combined in order to secure security as an optimised state of health and wellbeing.

This chapter is organised as follows. In next section, I investigate techniques of exclusion enabled by the implementation of the charging regime. I draw attention to the lethal dimension of the politics of making live by emphasising the power to kill operating through the system for charging migrants for health services. In the following section, I analyse how unpaid NHS debts allow for the operation of techniques of surveillance enabled by data-sharing policies between the Home Office and the NHS. In my discussion, I explain that surveillance through the provision of chargeable healthcare enacts hostility towards migrant patients despite amounting to the cure of their bodies. In the subsequent section, I draw attention to the provision of free health services for migrants as a technique of care operating through the charging regime. In doing so, I interrogate whether free healthcare for migrants constitute a politics of benevolence and generosity in the government of migration through the NHS. In the following section, I contend that the charging regime enacts a logic of racism which functions as the prerequisite to render killing acceptable in an economy of biopower. In this vein, I highlight how hospitality for migrants in the

NHS reveals itself as racialised. In the conclusion, I add some final remarks on the operation of techniques of power enabled by the Charging Regulations from the perspective of practices of resistance and contestation.

2. Exclusion and death in the system for charging migrants for NHS care

When it comes to the system for charging migrants for NHS care, the operation of mechanisms of exclusion are paramount for the implementation of the regime. For instance, the Charging Regulations establish that refugees are eligible for free healthcare while determining that migrants with unlawful residence in the UK are not. Their provisions set out that diagnosis and treatment of sexually transmitted infections are free for all, but most secondary care (e.g. specialised care provided in a hospital setting) is chargeable – and inability to cover its costs upfront and in full can result in the refusal or withdrawal of health services (DHSC 2021). The Charging Regulations, as the UK Government puts it, constitutes a means of promoting health by ensuring the financial sustainability of the NHS. However, as the story of Simba Mujakachi – explored in the introduction to this thesis – reveals, the charging regime has implications that extend beyond the issues surrounding the NHS budget: It paves the way for the deterioration of migrants' health and increases their risk of dying.

We are then left here with a seemingly paradoxical realisation: On the one hand, the Charging Regulations enables the exercise of a power "that exerts a positive influence on life, that endeavours to administer, optimize, and multiply it, subjecting it to precise controls and comprehensive regulations" (Foucault 1984: 137). In other words, a biopower. On the other, the charging regime operates in a way that disallows (certain types of) life to the point of death. For Foucault (1984: 136), the explanation of this "paradox" is that the power of death in an economy of biopower constitutes "the reverse of the right of the social body to ensure, maintain, or develop its life." In this vein, it is justified to the extent that killing allows for the elimination of those who pose a biological danger to others (Foucault 1984: 138). Given that free healthcare provision for "overseas visitors" is framed by the Government as a threat to the sustainability of the NHS, excluding these migrants from the service is justified – even if that implies increasing their risks of dying. It is important to note here that "killing" does not only refer to murder itself, but also "every form of indirect murder: the fact of exposing someone to death, increasing the risk of death for some people, or, quite simply, political death, expulsion, rejection, and so on" (Foucault 2003: 256). Techniques of exclusion exercise the power of death through a charging regime that operates

a selection and filtering of health services on the basis of immigration status. The story of Eritrean asylum seeker Esayas Welday offers a helpful illustration in this regard.

In May 2018, Esayas Welday was relived to begin the first of five courses of chemotherapy for acute lymphoblastic leukaemia, a form of blood cancer he had been diagnosed with at age 29. Weeks into his treatment though, he was distraught to learn from staff at the Northwick Park Hospital in West London that his care would be discontinued unless he paid the £33,000 bill for the treatment he had been provided thus far. Despite his desperate protestations that he would be homeless again if discharged from the hospital, Welday was refused treatment and sent way onto the streets with the medication for his cancer in a plastic bag. In a statement, the London North West University Healthcare NHS trust, which runs Northwick Park, claimed that the patient was not eligible for free NHS treatment because he was a homeless refugee. The justification, nevertheless, was not accurate: Welday had not acquired refugee status by the time the care was refused. Furthermore, the trust added that his condition did not require urgent treatment. However, a few months later, Welday would fall seriously ill again and – as of January 2019 – would be waiting to have a stem cell transplant in the hopes of curing his leukaemia (Campbell 2019).

In a statement to The Guardian, which published details of his story in 2019, Welday was quoted as saying that staff at Northwick Park decided that they did not care about his life or his health by discharging him onto the street despite his state of destitution. Importantly, he shared a sorrowful – and rather significant – understanding of the treatment to which he had been submitted by Northwick Park staff: He thought they were killing him (Campbell 2019). Far from a simply resentful – but justified – metaphor deployed by Welday to describe the course of action adopted by the NHS trust, his words remark that – when it comes to withholding or withdrawing healthcare to patients in need – it is of killing that one is speaking. Echoing Foucault (2003: 256), we can make the claim that by increasing the risk of death for some patients – especially those severely ill and in precarious socioeconomic conditions – the charging regime articulates a form of indirect killing. The case at hand illustrates the manifestation of the function of murder operating in the regime of biopower: A power to kill which lets die by disallowing life to the point of death (Foulcault 2003: 254).

Welday was fortunate enough to find support in the work of charities and resume his medical treatment as well as obtaining leave to remain in the UK for two and a half years (Campbell 2019).

Nevertheless, his story is one among a range of life-threating experiences faced by migrants who struggle to obtain healthcare provided by the NHS. Against the backdrop of the hostile environment policies, hardship in migrant access to NHS services has been traced to the enforcement of the rules contained in the Charging Regulations, which instantiate the system for charging migrants for healthcare provided by the service in England. The description of the adversities encountered by Welday while navigating the NHS allows us, however unique his personal experience may be, to unpack the overall contents of the Charging Regulations as well as drawing attention to the techniques of exclusion operating through the enforcement of the system.

The initial question which must be tackled is: Why was Welday refused cancer treatment by Northwick Park in the first place? As mentioned above, the NHS trust running the aforementioned hospital justified its action by explaining that the patient was a homeless refugee, suggesting a connection between his immigration status and ineligibility for free health services. A few points are worthy of note here. To begin with, it is crucial to bear in mind that Welday was indeed an asylum seeker by the time he sought treatment at Northwick Park. Having said that, what the refusal of medical treatment by the NHS reveals is the frequently denounced lack of knowledge and misunderstanding of the complex and intricate provisions of the Charging Regulations by NHS staff (Medact, Migrants Organise and New Economics Foundation 2020: 11). This is because refugees, asylum seekers (with an active application or appeal) and even failed asylum seekers who receive support by the Home Office or a local authority are eligible for chargeable NHS care at no cost (e.g. the cancer treatment initially refused to Welday) (DHSC 2021: 16). In other words, being a homeless refugee or an asylum seeker would have entitled him to free health services, and could not therefore constitute a justification not to provide him with care.

The misunderstanding described above (assuming that all those involved were acting in good faith) begs the question: Does immigration status matter for determining someone's eligibility for free NHS care? The response to this query is affirmative, but further explanation is required at this point. To begin with, one must be aware that the NHS consists of a residency-based healthcare service, and eligibility for free health services is determined on a person's ability to pass the "ordinary residence test" (DHSC 2021: 25). What criteria must therefore be met in order for someone to be ordinarily resident in the UK? The relevant requirements consist of the following: a) they must be living lawfully in the country; b) their stay must be voluntary; and c) they must be properly settled in the UK for the time being (DHSC 2021: 26). The first requirement imposes severe consequences for those who have entered or remained in the country without legal

authorisation: Unless the specific health service is exempt in its own right, those with unlawful residence in the UK are not eligible for free NHS care. The second criterion is self-explanatory, sufficing to say that those living in the country should not be here against their will. Finally, meeting the "settled residence" requirement implies having an identifiable purpose for being in the country even if for a limited period of time (DHSC 2021: 25).

Further evidence that immigration status matters for purposes of passing the ordinary residence test – and therefore being entitled to free NHS care – is the requirement that needs to be met by certain categories of migrants. For European Union (EU), Iceland, Liechtenstein, Norway and Switzerland citizens living in the UK on or before 31st December 2020, they must have applied for (or have been granted) settled status by 30th June 2021 under the EU-UK Withdrawal Agreement[13]. In their turn, non-European Economic Area (EEA) citizens must hold the immigration status of Indefinite Leave to Remain (ILR) in order to be deemed ordinarily resident in the country (DHSC 2021: 26)[14]. Those who do not hold the "correct" immigration status for purposes of healthcare provision are considered "overseas visitors". That means they are liable to pay for their care at the rate of 150% of standard NHS tariff for the cost of any health services they receive, with payment being secured in full and prior to services being provided (DHSC 2021: 71; 83)[15]. Apart from the exemptions set out in the Regulations, the only way for "overseas visitors" to be eligible for NHS care is by paying the immigration health surcharge (IHS), the mandatory fee charged during the visa application process which entitles them to access the NHS on a similar basis to those ordinarily resident in the UK (DHSC 2021: 37).

One point made in the introduction to this thesis merits being revisited: At the heart of the Charging Regulations lies the argument that everyone who benefits from services provided by the NHS must "make a fair contribution to ensure it is sustainable, and only those who are living [in the UK] and contributing financially are entitled to receive free NHS care" (Department of Health 2017: 7). The premise here is that the healthcare system is "overly generous to those with only a temporary relationship with the UK" (Department of Health 2017: 7). However, length of stay and financial contribution does not constitute a prerequisite for establishing a person's eligibility

[13] For citizens of these countries who have to come in the UK after 31 December 2020, reciprocal agreements have been put in place comprising most relevant services, and allowing the UK to recover the costs of medical treatment where appropriate (DHSC 2021: 75).

[14] Certain non-EEA citizens are not subject to immigration control and therefore do not require ILR in order to be ordinarily resident in the UK (e.g. a diplomat posted to the UK, or someone who has a right of residence by virtue of their relationship with an EEA national who is resident in the country) (DHSC 2021: 28).

[15] Urgent and immediately necessary services fall outside the scope of this provision as will be explained below.

for NHS care. A migrant with unlawful residence in the UK, having lived here for many years, is not entitled to free health services despite financially contributing to service throughout the whole duration of their stay. On the other hand, for a British citizen who has lived abroad for many decades, "it is perfectly possible to be ordinarily resident here from the day of arrival, when it is clear that that person has, upon arrival, taken up settled residence" (DHSC 2021: 27). As previously explained, settled residence in the UK simply implies an identifiable purpose for being in the country irrespective of the duration of one's stay (DHSC 2021: 27).

What the ordinary residence test reveals is that the charging regime positions immigration status ahead of one's effective contribution to the sustainability of the service. While it is true that having British nationality or holding a British passport does not *per se* make someone an ordinarily resident in the UK, British citizenship is a key factor to establishing entitlement to free health services. It comes therefore as no surprise that the UK Government, at times, conflates financial contribution with British citizenship in their policy-relevant documents, e.g. when claiming that "overseas visitors" can use the NHS as long as they "make a fair contribution just as the British taxpayer does" (Department of Health 2017a: 5). But what about British citizens who do not pay taxes? Or non-British citizens who actually do? A plausible response to these questions cannot be found in the provisions enshrined in the Charging Regulations.

Recapitulating the struggles encountered by Welday while seeking healthcare in the NHS, it is worth remarking the argument advanced by the Joint Council for the Welfare of Immigrants (JCWI) in respect to Northwick Park's refusal to provide his cancer treatment. Specialising in offering support to migrants in the UK, the charity stressed that Welday should have been provided with healthcare not only because he was an asylum seeker (or, as the NHS trust had equivocally claimed, a homeless refugee), but also due to his treatment qualifying as urgent or immediately necessary (Campbell 2019). Why does it matter? Are urgent and immediately necessary health services free of charge, irrespective of immigration status, under the Charging Regulations? A few definitions are elucidative at this point. According to the Charging Regulations,

> immediately necessary treatment is that which a patient needs promptly: to save their life; or to prevent a condition from becoming immediately life-threatening; or to prevent permanent serious damage from occurring […]. Urgent treatment is that which clinicians do not consider to be immediately necessary, but which nevertheless cannot wait until the person can be reasonably expected to leave the UK. (DHSC 2021: 69 – 70).

Providing urgent and immediately necessary treatment is framed by the Charging Regulations as a human rights obligation regardless of a person's ability to pay upfront and in full for their healthcare (DHSC 2021: 69). It does not mean, however, that services provided on an immediately necessary or urgent basis are made free of charge. Migrant patients are still required to cover the costs of their healthcare, and charges must be recovered after their treatment has been provided if payment was not obtained in advance (DHSC 2021: 70). A range of issues arise in the provision of such services. For instance, critics of the charging regime have stressed that classing treatment as "urgent" is both complicated and highly subjective (Medact 2019: 18). It lies in the hands of clinicians to consider a plethora of factors in order to make an assessment as to whether a patient's need for healthcare is urgent, such as pain, disability the illness is causing or the risk of the delay exacerbating their condition (DHSC 2021: 70). Furthermore, for healthcare workers to properly ascertain the likely date of someone leaving the UK, they would need to carry out a detailed investigation of the patient's circumstances as well as having comprehensive understanding of the immigration system – something which most healthcare staff cannot (and should not) be expected to have (Medact 2019: 18). This is not to mention instances where clinicians have reported being pressured by Overseas Visitor Managers (OVM) or other non-clinical staff when making judgements regarding their patients' need for care (BMA 2019: 3)[16].

The complexity involved in making decisions about urgent treatment may lead to assessments being poorly made, which risks deteriorating the health and threatening the life of migrant patients in need of such services. The harm caused to "overseas visitors" under these circumstances can be illustrated by the story of Deidre, who was from the Caribbean, and lived in London with her daughter, Sally, a UK citizen. Deidre was diagnosed with cancer, with a clinician confirming that her need for chemotherapy was urgent. The hospital, however, demanded a five-figure sum prior to the beginning of the treatment. Deidre and Sally approached medical charity Doctors of the World (DotW) for help, but at that point her cancer was terminal. The charity advocated on Deidre's behalf to challenge the decision that her treatment was not urgent, unsuccessfully. On numerous occasions, the hospital provided care to stabilize Deidre and discharged her without ongoing care, which led to recurrent readmissions via A&E. DofW attempted to get Deidre admitted to a hospice for palliative care, but this was initially refused and delayed due to her

[16] The Overseas Visitor Manager is tasked with overseeing the implementation of the Charging Regulations in all departments of healthcare settings providing relevant services. They must thorough knowledge of charging rules, and be able to effectively communicate information about the charging regime to NHS staff and patients. Furthermore, they have the authority to identify, make and recover charges from chargeable 'overseas visitors' receiving medical care (DHSC 2021: 97).

immigration status. She passed away following an emergency admission to hospital with sepsis (DotW 2018: 4).

As explained above, intricacies relating to decisions about urgent and immediately necessary treatment allow for the exposure of migrant patients to death as well as increasing their risk of dying. Similarly, Charging Regulations provisions establishing the outright refusal of healthcare to migrants on the basis of their immigration status operate filtering and exclusions which allow for the manifestation of the function of death in an economy of biopower. There remains the question as to whether the provision of chargeable healthcare to those unable to cover its costs constitutes a simply benevolent of act of welcoming or if it allows for the operation of techniques of power which end up enacting different forms and degrees of hostility towards migrant patients. This is the analysis that I undertake in the following section of this chapter.

3. Surveillance and data-sharing policies between the Home Office and the NHS

As explained in the previous section, urgent or immediately necessary treatment cannot be withheld or withdrawn even if the patient receiving healthcare is unable to pay. This is framed by the DHSC (2021:68), as I have stressed, as an act of compliance of the UK with its obligations enshrined in human rights law. One could hardly argue that providing such services does not constitute a technology of care or even an act of welcoming in respect to migrant patients. After all, services will be provided with the aim of curing bodies and alleviating suffering. However, as my analysis of hospitality thus far has revealed, opening up the home and offering the gifts of a welcome allows for the enactment of hostility towards the guest. Would that be the case when it comes to the delivery of urgent and immediately necessary services to migrant patients who cannot cover the costs of their treatment? Do different forms and degrees of hostility come into play when such services are provided under the circumstances above? If so, what techniques of power enable the enactment of hostility towards chargeable migrant patients in this instance?

It is worth remembering that although inability to pay must not prevent or delay the provision of urgent and immediately necessary treatment, they are not made free of charge, and migrant patients must be billed after healthcare is provided. If the debt owed for NHS services is paid by the liable "overseas visitor", hostility is enacted through the operation of a "subtraction mechanism" which is enabled by the recovery of charges. That indeed alludes, from a Foucauldian perspective, to the sovereign "right of seizure" of things, time, wealth and even life, as pointed out by Foucault in his

analytics of power (Foucault 1984: 136). (Further) complications begin to arise, however, when the charges cannot be recovered due to the patient's inability to pay. What is the course of action to be adopted by NHS providers in this scenario? This is where the intersection of immigration enforcement and healthcare provision reveals itself through the operation of data-sharing policies between the Home Office and the NHS.

In the absence of prompt full settlement of the debt owed for NHS services or agreement to enter into a repayment plan, service providers must report to the Home Office outstanding debts of £500 or more which have remained unpaid for at least 2 months from the date of invoice (DHSC 2019c: 6). For purposes of this data-sharing policy, non-clinical data (e.g. name, address, telephone number) is not protected by privacy rights. In other words, personal information can be transferred via the DHSC to the Home Office without the patient's consent (DHSC 2019c: 7). The issue here is not exclusively that this data sharing amounts to pressures on migrant patients put by NHS bodies and debt recovery agencies. In addition to that, the Home Office has the authority to deploy the obtained data to identify individuals as they interact with immigration and border controls, e.g. through online applications, offices abroad or at border points in the UK (DHSC 2019c: 11). In the exercise of this prerogative, the department can make use of migrants' personal information to refuse further applications to enter or remain in the country (DHSC 2019c: 5). The implications of such data-sharing policy have been of particular concern for migrants with unlawful residence in the UK who have reportedly being deterred from seeking healthcare for fear of incurring charges and consequently coming to the adverse attention of immigration authorities (Medact, Migrants Organise and New Economics Foundation 2020: 10).

In light of the above, one could reasonably argue that the provision of urgent and immediately necessary treatment to "overseas visitors" who are unable to cover the costs of their healthcare *does* allow for the enactment of hostility towards migrant patients. More generally speaking, unpaid NHS debts owed for NHS services – be they provided on an urgent basis or not – have the potential to trigger practices of hostility through techniques of surveillance embedded in data-sharing policies which blur the boundaries between healthcare provision and immigration enforcement. It is important to note that my use of the term "surveillance" here draws on Foucault's (2007) conceptualisation of disciplinary power or discipline. As he explains,

> Discipline is the collection of techniques by virtue of which systems of power have as their objective and result the singularization of individuals. It is the

> power of individualization whose basic instrument rests in the examination. The examination is permanent, classificatory surveillance, which permits the distribution of individuals, judging them, measuring and evaluating them and placing them so they can be utilized to the maximum. Through the examination, the individual is converted into an element for the exercise of power (Foucault 2007: 147).

How do disciplinary techniques allow for the singularisation of individuals? To begin with, it is important to note that, for Foucault (1995: 27), "there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations." Viewed in this light, migrants' access to the NHS allows for the collection, storage and analysis of migrant patients' data in a way that knowledge of their bodies is produced and individuals singularised. Without such production of knowledge, surveillance techniques could not operate so that debts could be recovered and immigration enforced. This is illustrative of how the examination functions: It situates individuals in a field of surveillance while placing them in a "network of writing" that captures and fixes their individuality by drawing on methods of identification, signalling and description (Foucault 1995: 189). Surveillance here, as explained above, assumes a classificatory character which, in the case at hand, allows for determining what migrant patients are entitled to free healthcare, which ones must have their visa applications refused, and those who must be removed from the UK for residing unlawfully in the country.

It is important to note that surveillance techniques do not aim to simply subjugate bodies in the sense of subjecting them to disciplinary technologies focused on repression and punishment. As Foucault (1995: 194) reminds us, the effects of power cannot be exclusively described in negative terms because power is also a productive force with generative potential. Disciplinary power, in particular, directs itself to the performance of the body by attempting to optimise its forces and capabilities without at the same time making it more difficult for them to be governed (Foucault 1984: 141). For instance, healthcare provision requires the collection of migrant patients' medical and non-clinical data as a means of improving both the efficiency of the NHS and individual health. It enables healthcare staff to have accurate and up-to-date information for continuity of clinical treatment, inform the person of their test results or simply text the patient to remind them of a medical appointment. In this context, data-driven practices of surveillance which allows for the subjugation of migrant bodies also work to promote the parallel increase of their aptitudes.

It is worth remarking that data-sharing between the NHS and the Home Office does not occur only after chargeable healthcare has been provided to migrant patients who own debts for NHS

services. If a migrant's chargeable status is unknown by NHS staff, they are required to establish if the patient is liable for charges prior to healthcare provision (DHSC 2021: 96). In practice, the procedure usually consists of in-depth interviews with the aim of establishing whether patients are ordinarily resident in the UK or "overseas visitors" to whom charges apply, followed by the flagging of the patient's chargeable status in their records (DHSC 2021: 96). However, it might be the case that the chargeable status of the patient is unclear after these interviews are carried out, which requires a further step to be taken: NHS staff must share the migrant patients' non-clinical data with the Home Office which, in its turn, will respond to the request and confirm their entitlement to free healthcare. However, issues arise because – once the data has been passed on to the Home Office – the department can use the transferred data to update their records and potentially enforce immigration (Medact 2019: 11). The pre-attendance form which migrant patients are required to complete prior to receiving hospital treatment summarises the procedure, and is worth quoting:

> *This hospital may need to ask the Home Office to confirm your immigration status to help us decide if you are eligible for free NHS hospital treatment. In this case, your personal, non-clinical information will be sent to the Home Office. The information provided may be used and retained by the Home Office for its functions, which include enforcing immigration controls overseas, at the ports of entry and within the UK.* The Home Office may also share this information with other law enforcement and authorised debt recovery agencies for purposes including national security, investigation and prosecution of crime, and collection of fines and civil penalties. If you are chargeable but fail to pay for NHS treatment for which you have been billed, it may result in a future immigration application to enter or remain in the UK being denied. Necessary (non-clinical) personal information may be passed via the Department of Health to the Home Office for this purpose (DHSC 2014: 1, emphasis added).

Even registration with a GP surgery, which is free of charge in England, may put migrant patients at risk of having their non-clinical data shared with the Home Office. Patients wishing to register are required to fill out a form where they provide information such as name, telephone number, current and previous addresses and nationality. This form includes a patient declaration and optional supplementary questions where those who are not ordinarily resident in the UK can indicate if they are chargeable, exempt from charges or simply unaware of what their chargeable status is (DHSC 2022b: 1). Guidance on the implementation of the Charging Regulations states that practices should encourage patients to complete these questions while stressing that this is not mandatory for registration with a GP (DHSC 2021: 107).

The issue here is not the patient declaration or optional supplementary questions *per se* since migrant patients may choose not to complete them. The point of concern for an analysis of intersections between healthcare and immigration enforcement is that patients may require NHS

care outside of the GP practice, and be referred to specialised treatment which is not free of charge. If that is the case, the information provided on the form will be used to "assist in identifying [their] chargeable status, and may be shared, including with NHS secondary care organisations (e.g. hospitals) and NHS Digital, for the purposes of validation, invoicing and cost recovery" (DHSC 2022: 2). In light of the data-sharing policies explained above, migrant patients' non-clinical data can easily end up in the hands of Home Office officers for the fulfilment of their duties.

Another crucial impact of the data sharing between the NHS and the Home Office concerns the ways in which policies have affected migrants' healthcare-seeking behaviour. Critics of the system for charging migrants for health services have stressed that the "simple" threat of having their data shared with the Home Office for immigration enforcement deters migrants from seeking health services even if they are extremely unwell or if exemptions apply (BMA 2019: 3 – 4; Hiam, McKee and Steel 2018: 110; Morris and Nanda 2021: 17; Potter 2017: 219). The deterrent effect of the Charging Regulations echoes a dimension of disciplinary power that Foucault (1995: 202) describes as a mechanism of self-restraint which does not depend on the use of force or direct coercion to compel individuals to engrave in themselves the constraints of power in way that they perform self-discipline upon themselves. As he explains, "he [sic] who is subjected to a field of visibility, and who knows it, assumes responsibility for the constraints of power; he makes them play spontaneously upon himself; he inscribes in himself the power relation in which he simultaneously plays both roles; he becomes the principle of his own subjection" (Foucault 1995: 202-203).

Self-discipline as a manifestation of the deterrent effect of the Charging Regulations has been particularly illustrated by the experience of chargeable migrants in the context of the COVID-19 pandemic. It is true that COVID-19 diagnosis and treatment are free for all irrespective of immigration status. That means no immigration checks will be required in order for migrants to be tested and treated for the disease, including those with unlawful residence in the UK (DHSC 2021: 31). Issues begin to arise because – despite the introduction of the aforementioned exemption – charges do not apply *only* until the point where COVID-19 is negatively diagnosed. In other words, any treatment received for the suspected infection by coronavirus is exempt from charges until the moment that the patient tests negative. After being negatively diagnosed, any services provided to "overseas visitors" are subject to the provisions of the charging regime. To complicate matters further, the Government (Office for Health Improvement and Disparities 2022) establishes that the COVID-19 exemption does not comprise hospital treatment of any secondary or subsequent illness. In other words, any co-existent condition that a patient may have

lies outside the scope of the exemption even if its treatment is required to successfully treat COVID-19. Furthermore, conditions or complications which arise from the initial COVID-19 infection (including long COVID) remain chargeable[17].

The implication of the manner in which the UK Government frames the COVID-19 exemption is that fear and mistrust still prevail among migrants, especially those with unlawful or insecure immigration status, meaning that the deterrent effect remains despite the institution of the aforementioned exception (Medact, Migrants Organise and New Economics Foundation 2020: 2). In a study exploring the experiences of undocumented migrants over the COVID-19 pandemic, the Joint Council for the Welfare of Immigrants (JCWI) carried out interviews with migrants with unlawful residence in the UK as well as workers from third-sector organisations specialising in migrant support (Boswel 2022: 9). The findings of the research can be helpfully summarised in a statement by Francesca, who reflects on her experience of working with undocumented migrants during the pandemic in the following terms:

> A lot of people are just not seeking medical care when they get COVID, and I know of several undocumented Filipino migrants who died because they just didn't go to the hospital because they were too scared of being deported. It says so much about the Hostile Environment policy that people would rather die alone at home without access to medical care than face the possibility of being reported to Immigration Services (Boswel 2022: 23).

The testimony provided by Francesca seems to reflect the experience of a man known as Elvis, who died in April 2020 after suffering from COVID-19 symptoms for two weeks. Prior to falling ill, he had been living in the UK with his wife for over ten years as migrants with unlawful residence in the country. He used to work as cleaner, and sent money to his family back in the Philippines before becoming unfit to work. Despite experiencing a persistent fever and a cough, Elvis refused to go to a hospital and seek healthcare from the NHS. He was scared that he would incur medical expenses which he would not be able to afford, and feared that his unpaid NHS debts would be reported to the Home Office (Medact, Migrants Organise and New Economics Foundation 2020: 5). As the COVID-19 pandemic progressed, Elvis's story proved to be one among many: The charging regime has indeed the pervasive effect of deterring undocumented migrants from seeking healthcare despite being in urgent need of health services (Boswel 2022: 22 – 23).

[17] The same regulation applies to the diagnosis and treatment of a range of other infectious diseases specified in the Charging Regulations (DHSC 2021: 30).

The data-sharing policies between the NHS and the Home Office highlight the ways in which surveillance techniques enable the datafication of migrant patients so that health can be promoted while "overseas visitors" are subject to the enforcement of immigration. In this vein, healthcare settings do not simply constitute spaces of cure and alleviation of suffering. As disciplinary technologies operate through clinical practices, the NHS becomes a site of record and acquisition of knowledge which can be deployed to repress and punish individuals that transgress the rules of a data-driven government of migration. However, medical discipline is not limited to the production of knowledge for singularised interventions alone. Rather, it makes it possible for the integration of individual data into cumulative systems in a way that "an individual could be located in the general register, and that, conversely, each datum of the individual examination might affect overall calculations" (Foucault 1995: 190).

The disciplining of medicine renders the individual an object of power/knowledge while allowing for the observation and modification of phenomena common to the population (Foucault 2007: 151). In other words, knowledge of individual bodies overlaps with that of the population with surveillance consisting of a political technology of population management (Ceyhan 2012: 40). Viewed in this light, surveillance techniques aimed at regulating migration through healthcare provision constitute interventions that fall within the realm of the political technologies deployed to manage population processes. In other words, they are situated within the scope of what has been termed a biopolitics of the population (Foucault 1984: 139). In the next two sections of this chapters, I explore the role of biopolitics in hospitality for migrants in the NHS.

4. Free health services and the biopolitics of healthcare provision for migrants

Thus far I have emphasised provisions of the Charging Regulations which regulate the delivery of *chargeable* health services for those who are not ordinarily resident in the UK. In determining the circumstances in which migrants can be excluded from NHS care, they set out the services which can be withheld and withdrawn if payment is not secured upfront and in full. Furthermore, these provisions establish the services which cannot be refused or delayed even if charges are not recovered in advance of their delivery (i.e. urgent and immediately necessary treatment). However, it is worth remembering that the rules of the charging regime do not render these services free of charge: Inability to settle NHS debt or enter into (and adhere to) a repayment plan may constitute grounds for barring the indebted migrant from lawfully entering or staying in the UK.

The aforementioned provisions of the Charging Regulations are predominantly concerned with issues around the exclusion of migrants from NHS care as well as the surveillance of "overseas visitors" for purposes of debt recovery and immigration enforcement. From the perspective of hospitality, one could argue that such rules work to enact hostility towards those who (seek to) cross the borders of the NHS as the foreign guest in need of health enhancement. However, as laws of hospitality, the Charging Regulations are not entirely centred on techniques of surveillance and exclusion of migrants from the health service. As explained in Chapter One, the same laws which allow for hostility to be enacted are those which enable a welcome of the guest into the home. They instantiate the rules establishing what guests to be received and what "gifts" to be awarded as a manifestation of the welcoming dimension of practices of hospitality. In a similar vein, the Charging Regulations determine what guests must be excluded, which ones should be received and the extent to which they should be welcomed. Furthermore, they set out what health services fall within the scope of the charging regime, and which ones are free for all irrespective of immigration status or ability to pay.

I am not suggesting here that the health services exempt from charges are the manifestation of an unconditional welcome which breaks with the (risk of) enactment of hostility. On the contrary, those acts of welcoming might as well enable experiences of suffering and violence through the enforcement of immigration. This is the case, for instance, when migrants register with a GP – which is free of charge – and end up having their non-clinical data shared with the Home Office (e.g. if the migrant patient is referred to a hospital setting, and NHS staff need to establish their chargeable status). However, even though the risk of hostility remains, we are prompted to acknowledge that the provisions establishing free health services for migrants – including those with unlawful residence in the UK – operate a welcome of "overseas visitors" into the NHS by granting them healthcare as a gift of hospitality.

The question nevertheless remains as to what extent the provision of free health services for "overseas visitors" constitutes a politics of generosity and benevolence in the government of migration through the NHS. If by "generosity" we mean the willingness to render these services gratuitous in favour of migrant patients or the readiness to confer upon them a benefit without exchange, we can certainly argue that it is not a politics of generosity which is instantiated by the exemptions set out in the Charging Regulations. After all, migrants contribute to the operation of the NHS through general taxation, National Insurance (if working) and payment of the IHS (if applicable). Similarly, the argument that the provision of exempt services for migrants could be

conceived as a politics of benevolence can also be problematised. If by "benevolence" we mean the disposition to do "good" – that being the manifestation of a benign intent which is devoid of the capacity to cause harm – it is not of a politics of benevolence that we are speaking of.

For instance, Accident & Emergency (A&E) services comprise a type of secondary healthcare which falls outside the scope of the Charging Regulations. Since they are free of charge, migrants may end up resorting to this type of service multiple times before they are provided with specialised (chargeable) treatment, or they might wait until their illnesses progress into emergencies before they seek specialised healthcare (Shahvisi 2019: 208). In addition to leading to worse health outcomes for individual patients, the overuse of A&E contributes to increasing healthcare costs for the NHS as well as for migrants who may eventually need to treat their conditions at an advanced stage. Furthermore, it is important to note that emergency services provided after the "overseas visitor" is accepted as an inpatient (e.g. intensive care after their admission to the hospital) or at a follow-up appointment remain chargeable (DHSC 2021: 30). Because patients do not turn up with diagnosis – but with symptoms of an illness that may be exempt or not – there remains the risk of incurring charges which may lead to the sharing of their data with the Home Office.

Even if one considers the exemption of services such as palliative care or those provided for the treatment of a condition caused by torture or domestic violence, it is not entirely accurate to claim that migrant patients are protected from harm in their access to healthcare[18]. This is because the fact that a service is exempt from charges does not mean that migrants with insecure or irregular immigration status cannot be reported to the Home Office. In an explanation of the role of staff in the implementation of the Charging Regulations, the DHSC affirms that NHS hospitals may become aware that a migrant patient is residing unlawfully in the UK, and consider notifying the Home Office of that circumstance (DHSC 2021: 108). Even those lawfully residing in the UK for the time being cannot be entirely shielded from the potential risk of harm caused by the charging regime. For most migrants, immigration status is of a transient nature, and they can shift from legality to illegality by virtue of sudden change of the law, by being priced out of maintaining or regularising their lawful stay, or simply for filing a wrong visa application (Medact 2019: 15). Given that living illegally in the country constitutes a criminal offence, it remains unclear the extent to

[18] Palliative care per se does not constitute an exempt service. It will only be exempt if provided by a registered care charity or a community interest company (DHSC 2021: 14).

which ethical concerns may prevent NHS staff – especially those working in the OVM team – from reporting "illegal immigrants" to the Home Office.

As seems to be the case, exemptions do not prevent the causation of harm for "overseas visitors", and they do not impede the risk of immigration enforcement. In this vein, exempted services end up upsetting the very possibility of a politics of benevolence in the delivery of health services for migrants. Similarly, as previously explained, we cannot help but refuse to argue that free healthcare constitute a politics of generosity if we consider that a circle of exchange remains in place with migrants contributing financially to the funding of the NHS. In light of the above, my suggestion is that it is not of generosity or benevolence that we are speaking of but rather of a biopolitics of healthcare provision for "overseas visitors" which intervenes into migrants' bodies in order to regulate biological processes of the population (e.g. birth, death, morbidity, mortality, level of health, longevity), along with a whole set of related economic issues and associated political problems.

Foucault (2003: 245) explains that biopolitics centres its referent object of knowledge and intervention on the population. It is, of course, a technology of the body – but not at the level of their individuality as is the case with the operation of disciplines. Rather, it addresses the body to the extent that they constitute a global mass which is affected by biological processes and its correlated economic and political implications (Foucault 2003: 246). This biopolitics constitutes a regulatory technology of power by means of which the management of the population is assessed against criteria now to be found in "how well power regulate these domains of life, navigating between regulating too little and regulating too much, seeking to discover how much regulation [is] enough to successfully promote life in pursuit of making life live" (Dillon 2010: 64). This regulation draws on a range of mechanisms which revolve around the biological properties of the population in order to secure an optimised state of being (Foucault 2003: 246). The operation of such security mechanisms allows for the basic biological features of the human species to become the object of political strategy in a way that reveals security as biopolicitised and biopolitical interventions as constituting a biopolitics of security (Dillon & Lobo-Guerrero 2008: 266).

The rollout of the COVID-19 vaccination programme in the UK is a helpful example of how the delivery of exempt health services for "overseas visitors" can articulate a biopolitics of healthcare provision for migrants in the terms explained above. Vaccination against COVID-19 (including boosters) has been classed as an exempt health service, meaning that it is free of charge for all,

regardless of one's chargeable or immigration status. Similarly to the diagnosis and treatment of COVID-19, the Government has also made it clear that no immigration checks will be performed for 'overseas visitors' if they are only vaccinated against the COVID-19 infection (Office for Health Improvement and Disparities, 2022). There is no doubt that increasing migrants' immunity against COVID-19 implies the promotion of health at the individual level. However, the major concern here does not revolve around the protection of their health as singularised persons. Rather, emphasis is placed on the effects that vaccination against COVID-19 may ultimately have on the protection of the wider public health (DHSC 2021: 30). The same could be argued in relation to the vaccination, routine screening or treatment of other infectious diseases set out in the Charging Regulations (e.g. HIV, tuberculosis, yellow fever) which are also classed as a threat to the health of the population.

As a biopolitical intervention, the rollout of vaccines against COVID-19 for migrants tackles not only the biological processes of the UK population in respect to the disease (e.g. infection rate, morbidity, mortality). At the same time, the vaccination programme addresses related economic issues impacting the population as well as associated political problems arising for the UK Government. For instance, COVID-19 has been traced to sharp economic contraction, higher unemployment rates and increased living costs (Resolution Foundation 2020). On the other hand, increased vaccine administration in the UK has been associated to higher economic activity which turned out to mitigate the detrimental economic effects of the crisis (Inman 2021). Furthermore, it seems plausible to suggest that an effective vaccination programme can work to ease judgements about a government's response to COVID-19. Fewer new cases, reduced hospitalisation numbers, decreasing mortality rates and businesses reopening may have softened public views about the UK response to the pandemic – which was initially labelled as "too little, too late, too flawed" (Abbasi, Jacobson and Scally 2020: 1).

As the discussion above reveals, rather than a politics of generosity and benevolence, delivery of exempt health services to "overseas visitors" constitutes a biopolitics of healthcare provision for migrants. The techniques of care which operate in this biopolitics work to enhance health at the individual level, but with the aim of regulating population phenomena so as to promote the security of the whole. One should not be misled, however, by the biopolitical impetus of "making live" through the management of bio-social processes of the population. As the techniques of exclusion and surveillance analysed in the previous sections point to, the "business" of making life live is firmly rooted in that of disallowing life to the point of death. The rationality underlying the

operation of biopolitics furthers the understanding that promoting security for some relies on the failure to defend security for others. Biopolitics therefore is a question of (in) security because, from this perspective, "security can only be thought by incorporating the trace of insecurity […] in the very articulation of security itself" (Dillon 2003: 127). But how can one trace the boundaries between those who must live and those who must die? And how does this logic operate in healthcare provision for migrants in the NHS? These are the questions which will be addressed in the following section of this chapter.

5. Migrants, racism and the function of death in healthcare provision by the NHS

Biopolitics incorporates the duality which the formulation of (in) security bears within itself. To put it differently, biopoliticised practices of security imply securing security for some at the expense of rendering others insecure. This logic of (in) securitisation rests entangled with the biopolitical imperative of making live alongside the operation of the function of death in an economy of biopower. Taking this argument further, this power of death could be conceived as a form of "necropolitics" (Mbembe 2003: 12) so as to stress that making life live constitutes a "lethal business" which enacts a "making die" for the sake of life (Dillon 2008: 167). The question remains as to how the power to kill differentiates between those who must live and those who must die. In other words, what remains to be explained is the way in which power sets the boundary between life that should be fostered, and life that can be disallowed to the point of death in the name of life itself. From a Foucauldian point of view, the exercise of the function of death in a regime of biopower can only be explicated through the operation of racism as a technique of government that constitutes the precondition to render killing acceptable for biopolitics (Foucault 2003: 256). As Foucault explains,

> We are dealing with a mechanism that allows biopower to work. So racism is bound up with the workings of a State that is obliged to use race, the elimination of races and the purification of the race, to exercise its sovereign power. The juxtaposition of – or the way biopower functions through – the old sovereign power of life and death implies the workings, the introduction and activation of racism (Foucault 2003: 258).

Foucault identifies two main mechanisms operating through racism in a system centred on biopower. First, racism is concerned with establishing a hierarchical fragmentation of the population as the biological continuum that power controls – one that sets apart life that must live from life that must die. In doing so, it separates groups within the population that is conceived as a mixture of races, which happen to be ranked and unequally valued (Foucault 2003: 254 – 255). Because it is associated with superiority or inferiority, belonging in a particular "race" determines

one's eligibilities for particular goods, and ultimately specifies whether or not "life" is to be deemed eligible for life as such (Dillon 2008: 168). From this perspective, "race" contributes to the "triangulation of biopolitics with its necropolitics" (Dillon 2008: 168), i.e. the letting die required by the biopolitical impetus to make live or simply the "subjugation of life to the power of death" (Mbembe 2003: 39). This triangulation articulated by "race" helps strip biopolitics of any assumed innocence in relation to its project of securing life (Dillon 2008: 170).

The second function or mechanism of racism described by Foucault specifies a positive type of correlation between the life of the self and the death of the other. Putting it simply, racism enacts a relationship whereby the killing of the "bad race" consists of an indispensable requirement to secure life that is valued more highly on a biopolitical scale. Those comprising the "bad race" must be "killed" – not because they are adversaries in some sort of military relationship of confrontation – but because they constitute a biological threat to the population and for the population (Foucault 2003: 255 – 256). As previously explained, killing does not only entail murder itself, but also different forms of indirect murder, such as exposing someone to death or increasing the risk of death for some people (Foucault 2003: 256). The power of death echoes the old sovereign right to "take life" but not in the sense of a prerogative of the ruler. Rather, the function of murder constitutes the right to kill those who represent a kind of biological danger to a population that must be secured. The power of death is therefore exercised in the name of protecting life from life that is biopolitically unfit or "dangerous" (Dillon 2008: 168).

As explained above, racism constitutes the technique of government which renders killing acceptable in the economy of biopower. Its role therefore consists of regulating the "distribution of death and to make possible the murderous functions of the state" (Mbembe 2003: 17). If we assume that healthcare provision constitutes a biopolitical intervention, could we argue that it carries within itself the mechanisms of racism identified by Foucault in his analytic of biopolitics? It is worth reiterating that racism justifies the "death-function" in the regime of biopower by appealing to the principle that "the death of others makes one biologically stronger insofar as one is a member of a race or a population, insofar as one is an element in a unitary living plurality" (Foucault 2003: 258). Is that the logic underpinning the system for charging migrants for their healthcare? Does the charging regime allow for the operation of racism as explained above? My answer to this question is affirmative, as I will explain in the following lines.

To begin with, it is important to recapitulate the way in which the system for charging migrants has been justified by the UK Government. The official narrative advances the argument that in order for the NHS to be financially sustainable, it is vital that "overseas visitors" cover the costs of their healthcare (Department of Health 2017a). One can observe here a clear relationship between charging migrants for health services and ensuring the sustainability of the NHS. In a similar vein, the Department of Health (2015b: 5) makes the claim that "[t]o continue to improve the NHS we need to recognise that it can only be sustained as a National, not an international health service." Again, the correlation between charging migrants and the sustainability of the NHS is notorious, but it appears be more complex than it initially seems: It implies a positive relationship between "letting die", on the one hand, and "making live" on the other. I will not turn to the impacts of the exclusions engendered by the Charging Regulations because they have been previously discussed in this chapter. It suffices to reiterate that banning migrants from the NHS and deterring them from seeking healthcare through the charging regime have amounted to the deterioration of their health and increased death rates, especially among those in most vulnerable conditions (Morris and Nanda 2021).

However controversial the argument is, the UK Government contends that the exclusions and restrictions articulated by the Charging Regulations consist of an indispensable instrument to maintain the sustainability of the NHS. Given that the service is designed to deliver improvements in the health and wellbeing of the population, the correlation between the power to kill and the power to make live comes to the fore. Putting it differently, we are confronted here with the argument that to secure security as an optimised state of health and wellbeing for ordinary residents in the UK, we need to accept the sacrifice of security (conceptualised in these same terms) for "overseas visitors" in the country. Exposing these migrants to death or increasing their risk of dying through the refusal or restriction of healthcare is justified as a means to make life live. In this sense, "overseas visitors" constitute a disenfranchised race whose life can be disallowed to the point of death since that is what is required to ensure the security of forms of life valued more highly on the biopolitical scale.

The argument made above can be helpfully illustrated by the refusal of chargeable healthcare provision for "illegal immigrants". Migrants with unlawful residence in the UK are framed in terms of threat and harm to the sustainability of the NHS and to the welfare state as a whole. The argument is that immigration offenders harm the economic wellbeing of country by contributing to unnecessary financial and resource pressures on public services, such as the NHS (DHSC and

Home Office 2018: 3). In this vein, they constitute a group in the population – or, in Foucauldian terms, a race – that puts at risk the capacity of the service to maintain its aim of delivering improvements in health and wellbeing for its legitimate users. Withholding healthcare for these migrants – along with a range of other restrictions and refusals comprising the hostile environment – does not simply consist of an instrument to restore the sovereign power of the UK to control its borders. Rather, it is framed an indispensable means of securing health and wellbeing through the operation of the NHS. Racism therefore rests justified because it is necessary to protect the security of the whole from its internal dangers (Foucault 2003: 249).

The above explanation of how racist mechanisms operate to legitimise the function of death in an economy of biopower provides a helpful starting point to understand the racialisation of immigration enforcement through the NHS. It remarks the role of racism as a technique of government which allows for killing in a regime of power primarily concerned with making live. It demonstrates how racial distinction constitutes "the drawing of a line between populations, some of which are to be fostered and managed and others rendered subject to the sovereign right of death" (Allinson 2011: 114). However, such explanation does not specifically address the ways in which controlling borders through the NHS has been entrenched in racist practices centred on "tangible identifiers of difference", such as skin colour and foreign-sounding accents or names (Potter 2018: 420). Putting it differently, it does not attend to the ways in which migrants – by virtue of their (mis) perceived markers of "non-Britishness" – can be faced with difficulties in access, lower quality experience and poorer health outcomes arising from immigration enforcement through the NHS.

It is important to note that the Foucauldian framework advances that racism "is not merely an irrational prejudice, a form of political discrimination, or an ideological motive in a political doctrine; rather, it is a form of government that is designed to manage a population" (Su Rasmussen 2011: 34). In this vein, Foucault deploys the term in a sense which is not identical – albeit not irreconcilable – with that utilised in the broad field of Critical Racial Theory (CRT) where scholars are concerned with demonstrating "the socially constructed, rather than biological nature of 'race', and its fundamental emergence from structures of oppression and privilege, conceived of as unearned benefits accruing to the dominant" (Allinson 2015: 117). Notwithstanding its compatibility with a socially construed conceptualisation of race which confers dominance and privilege on the basis of "whiteness", Foucault does not unpack the ways in which "tanglible identifiers of difference" (Potter 2018: 420) can work to constitute a particular group as a race

subjected to the sovereign power to kill in an economy of biopower. In this regard, Foucault does not ignore racism in his exploration of biopolitics, but ends up corroborating the whitewashing of raciality in modern forms of power and violence (Howell and Richter-Montpetit 2019: 2).

However, an analysis of immigration enforcement through the NHS cannot neglect the ways in which border control through healthcare draws on (mis) perceived markers of "non-Britishness" (commonly conflated with non-whiteness) to enact hostility towards migrant patients. Racial profiling and discrimination have been denounced as intrinsic to the design and implementation of the charging regime (Medact 2019: 23; Potter 2018: 420). Checking eligibility for free NHS care allows for selective identification mechanisms based on patients' appearance, and a growing body of evidence suggests that OVMs scan patient lists for names that "sound" foreign in order to verify chargeability (Morris and Nanda 2021: 18). In a study carried out by charity Maternity Action, midwives stressed how OVMs have failed to identify white British women who are not ordinarily resident in the UK while pressing minority ethnic women on their eligibility even if they had been born in the country (Maternity Action 2019: 19). What such episodes suggests is that the system for charging migrants has been framed as a "recipe for racism" which subjects some races to stricter forms of border control while turning a blind eye to those with perceived traits of Britishness (Salisbury 2019: 1).

In all, the analysis of the system for charging migrants for health services point to the understanding that healthcare provision – under the Charging Regulations – constitutes an issue of "deservingness" according to which some groups can be "killed" and exposed to higher risks of dying if that implies securing the health and wellbeing of those valued more highly on a biopolitical scale. This distinction, however, cannot be simply whitewashed as the experiences of migrants accessing the NHS have pointed out. As Robbie Shilliam (2018: 171) contends, "[t]he distinction that renders some deserving of social security and welfare and others not is racialised so as to classify collectives in order to judge individuals." In other words, the racialisation of the deserving/undeserving distinction reveals how tangible markers of non-whiteness (generally conflated with non-Britishness) can engender discriminatory judgements which risks migrants' individual health by identifying the foreigner as constitutive of an inferior and less worthy race. From this perspective, one can argue that healthcare provision is not racially "blind", and that the system for charging migrants for health services exposes hospitality in the NHS as racialised.

6. Conclusion: Power and micro-practices of resistance against the charging regime

In this chapter, I investigated how the power of hospitality in healthcare provision for migrants is exercised as a form of governmentality in the NHS. I demonstrated how techniques of care, surveillance and exclusion are articulated in the system for charging migrants for healthcare in order to secure security – as an optimised state of health and wellbeing – for ordinary residents in the UK. In this process, the impetus to deliver improvements in health for those deemed to be legitimate users of the service rests upon the necessity to refuse and restrict migrants' access to healthcare as a means to ensure the sustainability of the NHS as a national – and not an international – health service. However, exclusions and restrictions are not equally experienced by "overseas visitors" in their access to healthcare. (Mis)perceived tangible identifiers of non-Britishness expose some migrants to a higher risk of perishing and dying by virtue of incorporating "markers of foreignness" that trigger practices of racial-profiling in the delivery of health services. The charging regime therefore reveals hospitality as racialised.

Some final considerations are worthy of note. By investigating the power of hospitality as healthcare provided for migrants in the NHS, I explored a range of ways in which technologies of exclusion, surveillance and care of migrant bodies blur the boundaries between health enhancement and border control. In drawing on a Foucauldian framework to carry out my analysis, I implied that my discussion is based on a non-essentialist – but relational – understanding of power as a productive force which does not limit itself to repressive effects. To put it differently, power engenders relations between individuals – singularly or collectively considered – in a way that one can only speak of the existence of power when it is put into action (Foucault 1982: 788). As power relations play out, those over whom power is exercised do not constitute mere "recipients of power", but rather the place where power is enacted and the site where it is resisted (Mills 2003: 35). Power relations are not therefore simple relations of violence or domination which annihilate struggles and confrontations while paving the way for the entire subjugation of the "oppressed". Power, in fact, implies resistance – "and in order to understand what power relations are about, perhaps we should investigate the forms of resistance and attempts made to dissociate these relations" (Foucault 1982: 780).

Bearing in mind the significance of analysing resistance as means of assessing the operation of technologies of power, I conclude this chapter by shifting attention to the ways in which resistance has manifested itself in respect to immigration enforcement through the NHS. By no means do I

attempt to offer an exhaustive discussion of how hostile environment policies operating through the service have been contested by the wide range of healthcare workers, professional bodies, academics, politicians and non-governmental organisations, taking issue with the charging regime and data-sharing policies between the Home Office and the NHS. Notwithstanding its relevance in interrogating border control through healthcare, resistance, from this perspective, has been widely debated and described in charities' reports, professional bodies' briefings and academic works, to name just a few (Medact 2019; BMA 2019, Potter 2018). These constitute what I would define as "macro-practices of contestation" which challenge immigration enforcement in the NHS through public manifestation of disagreement and confrontation. What I emphasise here is what I term "micro-practices of resistance", i.e. the acts of everyday clinical practice which seek to disrupt the aim of subjecting migrants to immigration enforcement through their access to the NHS.

A few examples might be helpful in clarifying the micro-practices of resistance to which I alluded above. The use of the Safe Surgeries Toolkit designed by charity DotW (2022) to help healthcare workers address difficulties faced by vulnerable migrants describes one of these practices. As previously explained, patients are not legally required to provide proof of address when registering with a GP, and (technically) cannot be refused registration due to inability to present documents[19]. However, this data can still be obtained when patients provide their address to establish that they live within the practice boundary (patients may be refused if they live outside the practice area), or even when requested by GP surgeries over NHS workers' lack of knowledge of the relevant rules for patient registration. Whatever the case, the Safe Surgeries Toolkit explains that members of staff can still work to protect patients' data, and avoid risks of their information being shared with the Home Office. Rather than requiring migrant patients to inform their actual place of residence (if they do have one), staff members could "register them with an alternative address; this could be the practice address, or the address of a mosque, church or community centre where post might reach them" (DotW 2022: 5). In doing so, they are not acting in violation of the law, but are reducing the risk of subjecting migrants to border control and, more broadly speaking, resisting immigration enforcement through healthcare.

[19] I use the term "technically" to reinforce that most surgeries refuse to register undocumented migrants in spite of NHS England guidance mandating otherwise (Bureau of Investigative Journalism 2021). Either for lack of knowledge of the relevant rules for patients' registration or for the intended purpose of controlling borders, collecting migrant patients' personal information facilitates immigration enforcement through the NHS.

In a similar vein, a report published by charity Maternity Action (2019) describes micro-practices of resistance in the everyday clinical practice of midwives attending to women with unlawful or insecure immigration status. While collecting information to deliver improvements in maternal care and pregnancy outcomes, midwives turn out to acquire data which may be used for purposes of subjecting migrant patients to border control (e.g. nationality, immigration status, length of time in the UK). However, some midwives have attempted to circumvent official procedures in order to avoid migrants' information reaching OVMs and their team. For instance, one midwife reported that "if she learns that someone she is caring for is undocumented, and therefore chargeable, she will purposely not contact the OVM in order to prevent the family from being charged" (Maternity Action 2019: 26). I will not debate whether this procedure is legal or illegal, ethical or unethical. What I wish to highlight here is how the refusal to inform the OVM of an "illegal" patient under her care reveals this midwife's confrontation of the charging regime and data-sharing policies. In other words, her micro-practice of resistance. More broadly, her refusal to submit highlights what Foucault (1982: 790) describes as the "recalcitrance of the will and the intransigence of freedom" which constantly provokes and upsets the exercise of power.

Last – but definitely not least – what is left to say about micro-practices of resistance on the part of migrants themselves? Do they constitute mere objects of technologies of power operating through healthcare provision in the NHS? If looking from the perspective of macro-practices of confrontation (e.g. campaigning alongside charities against hostile environment policies in the healthcare sector), it becomes evident that migrants can certainly have a prominent role in challenging immigration enforcement through the NHS. This is the case of Simba, the failed asylum seeker who was charged nearly £100,000 after having a stroke, and became the protagonist of the "Justice for Simba" movement, which sought to press the NHS to cancel his debt while contesting the overall structure of the charging regime (Medact 2021). Simba's story was detailed in the introduction to this thesis, and illuminates how migrants can play an important part in macro-practices of resistance against border control in the delivery of health services. But what can be said about those migrants who have perished and died? Or those who privately experienced suffering but managed to live, without engaging with macro-practices of confrontation?

My claim is that their death and suffering cannot be simply dismissed as an instance of ultimate subjugation of migrants to techniques of power. Their bodies are marked by the "performative capacity to spark creative and eruptive moments of political resistance and transformation" (Shinko 2012: 364). If not for their death and suffering, what could possibly substantiate any claims

against immigration enforcement through the NHS? Where inspiration could ever be drawn from to argue for (and eventually achieve) change? Furthermore, by resisting to seek healthcare despite clinical need, migrants are not simply being affected by the deterrent effect of the charging regime. They are also exercising power over themselves and subverting the cruelty of a logic which assumes that health needs will lead migrants to the NHS, where healthcare provision will allow for the enforcement of immigration. In this vein, migrant bodies do not only constitute the "inscriptive surface" through which – and on which – power operates, but also the "counter-inscriptive surface" of struggle and contestation of border control through the provision of healthcare (Shinko 2012: 361). Death and suffering therefore do not wither away the embodied resistance of those "killed" or left to die by virtue of the system for charging migrants for health services.

CHAPTER THREE:

ETHICAL DILEMMAS IN HEALTHCARE PROVISION FOR MIGRANT PATIENTS IN THE NHS: THE (IM) POSSIBILITY OF RESPONSIBILITY IN THE WELCOME OF THE OTHER

1. Introduction

Broadly speaking, ethics is concerned with what we should do. In traditional terms, it seeks to uncover and present principles that tell us "the right thing to do" when were are confronted with moral issues of real life (Fieser and Pojman 2011: 2). These principles serve as guidelines to orient our conduct in the world, but they also put forth the criteria against which we (and others) can evaluate our actions, and determine whether they were "right" or "wrong", "good" or "bad". In subscribing to this view, we can appeal to principles devised in the abstract and apply them to concrete moral situations, in an attempt to put to rest dilemmas where we are compelled to make tormenting decisions. As John D. Caputo (1993: 4) explains, "[e]thics lays the foundations for principles that force people to be good; it clarifies concepts, secures judgments, provides firm guardrails along the slippery slopes of factical life." In doing so, ethics plays a significant part in securing the responsibility and righteousness of moral agents, as well as in justifying their actions in light of moral dilemmas.

When it comes to healthcare provision by the NHS, as I explained in Chapter One, the ethics governing the operation of the service – which implies guiding the professional practice of those who work for it – has its foundations in the NHS Constitution for England. The set of moral norms enshrined in the Constitution establishes ethical duties, responsibilities, rights and pledges of the service and its staff, while pointing to the rights of individual patients and those of the communities that the NHS serves through a range of bodies comprising the healthcare system. Alongside the codes of conduct setting standards of professional practice for healthcare workers in the UK, the NHS Constitution provides the ethical framework establishing what it means to provide health services in a responsible manner, and how to attend to patients' needs in the "right" way. As previously explained, this ethics of healthcare is framed as an ethics of hospitality – but not just *any* type of hospitality: Being hospitable here implies a welcoming reception of migrants, one that cures and alleviates suffering in a cordial and benevolent manner. Offering hospitality as

healthcare enacts a normative commitment to humanity in the provision of health services, and a sense of universal care on the basis of equal human worth.

The ethical guidance provided to clinicians by the British Medical Association (BMA) helpfully illustrates the universalism and pledge to equity advanced by the ethics of hospitality governing the operation of the NHS. For instance, when orienting doctors on how to attend to migrant patients seeking healthcare, the BMA advises that "[i]mmigration status makes no difference, any person in the UK is able to register with a GP practice and receive NHS primary medical services free of charge. Practice staff do not have to make any assessment of immigration status or eligibility for non-primary NHS care. You are not expected to act as immigration officials" (BMA 2021a). Irrespective of the best of intentions the BMA may have or its genuine interest in promoting better health outcomes for migrant patients, the analysis of the Charging Regulations, carried out in Chapter Two, demonstrates that immigration status *does* make a difference in the provision of healthcare for migrant patients. Those who are not entitled to free health services and are unable to afford them can be subjected to severe consequences if provided with chargeable NHS care, ranging from refusal of visa applications to deportation from the UK.

Resemblances born to the data-sharing policy set out by the MoU are not a mere coincidence: Once again, the offer of hospitality as healthcare to migrant patients enacts the opposite of welcoming itself. It enables a regime of hostility whereby those who are welcomed into the NHS experience pain and suffering by virtue of the healthcare they have been provided with. Hospitality here accommodates both a welcome and hostility in the provision of health services, and the ethics enshrined in the NHS Constitution and in the ethical codes of professional practice for healthcare workers cannot efface the harm inhabiting attempts to be hospitable. Indeed, this ethics points to the "right thing to do" in an effort to provide advice for those working for the NHS while looking to secure their responsibility. However, these ethical guidelines are not able to indicate a course of action which can protect migrant patients from the hostility of the charging regime, in the various degrees and forms that it can affect them. This ethics does not offer a "way forward" in which its integrity can be preserved because it succeeds in preventing pain and suffering for migrant patients.

We are then left with some troubling questions: If the ethical framework governing the operation of the NHS does not ensure a hospitable reception of migrant patients into the service, if it does not secure that their welcome into the NHS equates to the cure of bodies and alleviation of suffering, could we therefore argue that it is simply impossible to be responsible in healthcare

provision for migrants? Assuming that is the case, could we contend that hospitality simply "fails" as an ethics? In this chapter, I contend that hospitality as healthcare entails the enactment of hostility against migrant patients, even when the NHS is seeking to be responsible towards them. Nevertheless, it does not imply that hospitality simply "fails" as an ethics. It is because our actions in the welcome of the other are always already marked by the irresponsibility underlying our attempts to be hospitable that we can situate them in an unstable site of perfectibility by engaging ourselves in a relentless negotiation between conflicting moral obligations.

This chapter is organised as follows. In the next section, I explain how the "ethical" is disrupted by the system for charging migrants for healthcare. By exploring the story of Saloum, an "illegal immigrant" accessing the NHS in the last months of his life, I show how this ethics of healthcare as hospitality – constructed by reference to the moral norms enshrined in the NHS Constitution and in the codes of conduct for healthcare workers in the UK – is upset by the charging of migrants who are not entitled to free health services, and are unable to pay for them. In the following section, I interrogate the limits of this ethics in preventing the causation of harm to migrant patients by analysing the ethical guidance provided by BMA. While the ethical guidelines proposed by the organisation seek to secure doctors' moral responsibility, they cannot avoid that these clinicians risk patients' health and wellbeing through the professional practice of medicine.

I then explicate how healthcare workers' efforts to fulfil their duty of care towards migrant patients do not efface the irresponsibility underlying their attempts to be responsible. I look at the case of maternity treatment provided for migrant women to explore how midwives are confronted with ethical dilemmas in which, whatever course of action is adopted, pregnant migrant women who are unable to cover the costs of their care will experience pain and suffering. In other words, it is not simply that healthcare provision implies hospitality and its refusal enacts hostility: In their endeavours to be responsible, midwives cannot help but somehow undermine the fulfilment of their ethical duties and moral obligations. Finally, in the conclusion of this chapter, I further explore why the impossibility of resolving moral dilemmas arising from healthcare provision for migrants does not suggest that hospitality simply "fails" as an ethics by drawing attention to the idea of "negotiation" as proposed by Derrida (2002b).

Some clarification in respect to Chapter Three is required before going further. While offering a critique of traditional medical ethics in its claim that healthcare provision enacts (ethical) professional responsibility, I run the risk of implying that medical ethics does not attend to the

fact that the resolution of moral dilemmas may cause harm to patients. This is not the point that I attempt to make. In fact, in their "Principles of Biomedical Ethics", a seminal work in the study of modern medical ethics, Tom L. Beauchamp & James L. Childress (2013: 16) explain that "[a]n agent who determines that an act is the best act to perform under circumstances of a conflict of obligations may still not be able to discharge all aspects of moral obligation by performing that act. Even the morally best action in the circumstances may still be regrettable and may leave a moral residue, also referred to as a moral trace."

To a certain extent, the above perspective on ethics is aligned with my view of ethical decision-making. It acknowledges that, by making a decision which seeks to be ethical, we may end up causing harm to those towards whom we are looking to be responsible. If that is the case, what does a Derridean approach to ethics bring to light that "traditional" medical ethics does not? In what ways do they stand in contrast? To begin with, we should remember that, for Derrida (1999a), questions of ethics arise when we are confronted with the undecidable. Therefore, medical scenarios where healthcare workers simply apply established rules to put a conflict to rest do not constitute a matter of ethics. Secondly, it is important to note that while traditional medical ethics assumes that an agent can determine that an act is the best action to be performed under circumstances of conflicting moral imperatives, a Derridean approach contends that we cannot establish that we are pursuing the "best" or even the least harmful course of action because we simply cannot govern the outcome of our decisions (Zehfuss 2018: 49). In fact, we cannot even establish if there is such a thing. At any rate, it can never be known. Given that we cannot determine the "morally best action" (Beauchamp and Childress 2013: 16) there is not a possibility of remaining in "good conscience" as a state of "subjective certainty" (Derrida 1993, 19). It does not equate to guilt or remorse but it does trigger the "perpetual uneasiness" (Derrida 1984: 110) which keeps us in the constant pursuit of the "least bad" decision.

2. The system for charging migrants for NHS care and the disruption of the "ethical"

Why is it unethical to charge migrants for healthcare provided by the NHS? And on which grounds rests the argument that the charging regime prevents healthcare staff from meeting their moral obligations? Apart from controversies around the economic benefits of enforcing immigration through healthcare and the juridical consistency of the argument in light of national and international human rights law (DotW and JCWI 2018), a strong case has been made that controlling borders through the NHS breaks with the "ethical" (Abubakar et al. 2019; Mitchell and Reynolds 2019; Zaklaki 2019). It is true that the "ethical" can assume a range of connotations in

regard to healthcare provision, which may vary according to the theory of ethics taken into account (Summers 2019). However, when it comes to the delivery of health services by the NHS, most contenders of the system for charging migrants seem to secure the "ethical" by appealing to the norms enshrined in the NHS Constitution as well as the rules contained in the codes of conduct setting professional standards of practice and behaviour for healthcare workers in the UK. The analysis of Saloum's journey through the NHS, an "illegal immigrant" accessing the service in the last months of his life, can be particularly useful to illustrate how the "ethical" is constructed by reference to the aforementioned documents, and how this ethics is troubled by the charging regime:

> Saloum (Sal) came to Derby from The Gambia about 10 years ago, having fled in fear of political persecution for his activism against female genital mutilation (FGM). Sal never claimed asylum but worked odd jobs to make ends meet. His friends reported that this work was often exploitative. He had never had any health issues, so had never seen a doctor during his time in the UK. In December 2018, Sal had been homeless for about two months, staying on friends' sofas, when he collapsed suddenly on the street. He fell unconscious and woke up days later in Royal Derby Hospital, where he was diagnosed with two brain tumours and lung cancer. He was given days to live but after being treated for several days, he was told that as an undocumented migrant he was not eligible for further NHS treatment unless he could pay for it. Being destitute and homeless, Sal would no longer receive the palliative chemotherapy that had been planned. He said: "Somebody came and told [me] they couldn't care for me anymore because of my status... They told me I'd have to pay, and it would be very expensive" (DotW 2020: 13).

How does Saloum's journey through the NHS in the last months of his life corroborate the argument that the charging regime disrupts the "ethical"? To begin with, it is important to stress that the NHS Constitution establishes that the NHS exists to improve people's wellbeing, supporting them to be physically and mentally well, to recover when they are ill, *and to stay as well as they can to the end of their lives* (Department of Health 2015a: 2, emphasis added). This is aligned with a range of ethical guidelines established by the General Medical Council (GMC), such as that prescribing that clinicians must "take all possible steps to alleviate pain and distress whether or not a cure may be possible" (GMC 2013: 7). The ethical commandment is also enshrined in the code regulating the professional practice of nurses, midwives and nursing assistants in the UK, which reiterates the importance of "meeting the changing health and care needs of people during all life stages", while recognising and responding "compassionately to the needs of those who are in the last few days and hours of life" (NMC 2018: 7). What the case of Saloum reveals is that – irrespective of the individual morals and intentions of the doctors responsible for his care – healthcare provided by the NHS (or the lack thereof) did not attend to the ethics governing the operation of the service or the ethical guidance applicable to healthcare workers in the UK: Saloum

could have received the palliative chemotherapy that had been planned, but he did not due to his inability to pay for it.

Furthermore, the issue raised above has implications for one of the core principles of biomedical ethics in modern medicine, which comprises the so-called four principles approach to healthcare: respect for autonomy, i.e. a norm of respecting and supporting patients' autonomous decisions regarding to the medical interventions which they can be subject to (Beauchamp and Childress 2013: 27). In other words, the principle implies that the patient has autonomy to decide the course of medical action to be adopted in the face of deterioration of their health. "Respect for autonomy" – similarly to the others comprising the principlist approach – consists of a cluster of rules, obligations, rights and virtues under the rubric of a same heading (Sommerville 2003: 285), e.g. obtaining informed consent, medical confidentiality and transparent communication (Gillon 1994: 185). As previously mentioned, at the core of this principle lies the "obligation to respect the decision making capacities of autonomous persons" (Beauchamp 2003: 269). The charging regime, however, breaks with this ethical commandment, and Saloum's case is illustrative of this argument: He was allowed to deliberate on his treatment until issues around his immigration status disabled his autonomy. His inability to cover the costs of palliative chemotherapy left him with no options in regard to his medical treatment but to not receive healthcare. As a patient, his autonomy was violated since the medical intervention which he opted for could not be enacted by virtue of his immigration status.

In respect to Saloum's ineligibility for free health services, it is worth recapitulating that the first NHS principle states that the service has a "wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population" (Department of Health 2015a: 3). This ethical commitment is aligned with another principle constituting the principlist approach, i.e. the principle of justice, which instantiates "obligations of fairness in the distribution of benefits and risks" in the provision of healthcare (Beauchamp 2003: 269). Illegal immigration status is deemed to be a factor that amounts to migrants' socioeconomic and health vulnerability, and renders the charging regime "morally questionable" (Zaklaki 2019: 57). Migrants with unlawful residence in the UK face more barriers accessing healthcare, and tend to experience poorer health outcomes, with the Charging Regulations widening inequalities (Hiam and McKee 2017). That was the case of Saloum, an "illegal immigrant" who experienced

exploitation and destitution during his stay in the UK, and ended up undergoing significant suffering prior to his death because he was unable to cover the costs of his healthcare.

The narrative of Saloum's navigation of the NHS continues as follows:

> Sal was discharged without any referrals to community care or efforts to ensure he had an appropriate place to stay. He was left without any advice about ongoing care and only with a prescription for anti-seizure medication. He later received a bill for £8,397 for the treatment received before his care was terminated. Sal would have been discharged onto the streets if it hadn't been for his friends who raised money to rent a bedsit for him. His friend said: "He was homeless leaving the hospital. He had to stay on my sofa... Can you imagine someone as sick as him staying on a sofa? Honestly, it's just ridiculous... He's sick and they want him to stay on the street." After raising some money, Sal's friends found a small bedsit for him to stay in and looked after him in shifts. He was extremely weak, coughing frequently, and drifting in and out of consciousness. Understandably, they were at a loss as to how to properly care for him and felt abandoned by his doctors. DotW dedicated over 20 hours of case work time to support Sal to register with a GP, to persuade the NHS trust to start the treatment he was entitled to, and to arrange visits from community nurses (DotW 2020: 13).

Of particular relevance in the quote above is how Saloum's journey through the NHS points to the breach of the "principle of beneficence" (Beauchamp and Childress 2013: 27), a component of the principlist approach and a crucial ethical guideline underpinning the moral norms governing healthcare provision in the NHS. The principle sets out the obligation for healthcare workers to provide benefits for patients in their professional practice, and to balance benefits against risks when attending to their patients' health needs (Beauchamp 2003: 269). As Gillon (1994: 185) explains, the principle reiterates that "the traditional Hippocratic moral obligation of medicine is to provide net medical benefit to patients with minimal harm." Putting it simply, the most basic obligation of healthcare workers in their professional practice consists of delivering the best possible health services in order to meet their patients' needs. This can be inferred by the ethical guidance set out by the GMC, establishing that when clinicians assess, diagnose and treat patients under their care, they must "promptly provide or arrange suitable advice, investigations or treatment where necessary" (GMC 2013: 7) or by the ethical guideline issued by the NMC, stating that nurses, midwives and nursing assistants must "make sure that any treatment, assistance or care for which [they] are responsible is delivered without undue delay" (NMC 2018: 6).

In light of the above, we could argue that a breach of beneficence occurs when NHS staff are not framing their actions in order to benefit those in their care, or positioning patients' wellbeing as the decisive factor determining the adopted course of medical action. As the story of Saloum

reveals, clinicians may find themselves in a position where they must deny or interrupt the best possible treatment to cure their patients simply because of their inability to cover the costs of health services. In doing so, as asserted by Caroline Mitchell and Josephine Mary Katharine Reynolds (2019: 497), "the medical profession is betraying its core ethical principles" given that clinical practice consists of promoting healing, care and comfort to the sick, and cannot constitute a strategy to enforce border control without compromising doctors' moral obligations (Mitchell and Reynolds 2019: 502). In other words, medical practice must be committed to providing healthcare: "If a doctor's actions are divorced from the fundamental goal of medicine, then that practice cannot be called 'doctoring' any more" (Zaklaki 2019: 56).

Finally, the description of Saloum's journey through the NHS concludes by explaining that

> During the course of his illness, the NHS trust continually pressured Sal to pay for his treatment and withheld care because of outstanding charges, despite knowing he was homeless and had no income. This was a great source of stress for Sal right up until his death. His friend said: "Last night, just before he died, he became panicked and anxious and I could see he was scared he might be discharged again because he could not pay for his treatment. I knew him for a long time. He was a very brave soul the way he challenged FGM in Gambia. He had a very tough time in the UK because of the labour exploitation and never really had any time to enjoy his life" (DotW 2020: 13).

One issue is of particular note here. The segment above sheds light on the pain, suffering and deterioration of Saloum's physical and mental health caused by the operation of a health system that furthers an ethics centred on patients' right to be treated with dignity and respect, in accordance with their human rights, and healthcare workers' responsibility to protect them from abuse, neglect, care or treatment deemed to be degrading (Department of Health 2015a: 8). Such rights and responsibilities set out in the NHS Constitution are rooted in the first principle guiding healthcare provision by the service, which establishes that the NHS "has a duty to each and every individual that it serves and must respect their human rights" (Department of Health 2015a: 3). The principle reiterates the service's commitment to responding "with humanity and kindness to each person's pain, distress, anxiety or need" (Department of Health 2015a: 3), and the promise that the NHS seeks, through the things it can do, however small, to provide comfort and relieve suffering (Department of Health 2015a: 3).

What comes to the fore at this point is that not only are healthcare staff under the duty to respond to patients' clinical needs while acting with respect, compassion and dignity, but also that they *mustn't* inflict suffering and pain upon patients through their professional practice. This idea

constitutes the foundation of the "principle of non-maleficence" which instantiates the obligation to avoid causing harm in the provision of healthcare (Beauchamp 2003: 269). In fact, this principle overlaps with the medical obligation of providing "net benefit for patients" (Gillon 1994; 185) or, in other words, with the principle of beneficence. There is some acknowledgement here that the traditional imperative *primum non nocere* takes into account that "much of healthcare involves pain, discomfort, inconvenience, expense, and perhaps disfigurement and disability" (Summers 2019: 42). However, it is still mandatory that risks be assessed against benefits, and that the advantages of the adopted course of action trumps the detrimental effects of acting otherwise.

The issue raised by the account of Saloum's navigation of the NHS in light of the principle of non-maleficence is that the refusal and withdrawal of healthcare did not amount to *any* benefit to his health and wellbeing. On the contrary, as the story reveals, it is because healthcare was withheld and treatment interrupted that his physical and mental health came to a breaking point, culminating in his death. Despite being homeless and destitute, Saloum was discharged with two brain tumours and lung cancer, without any referrals to community care or advice about ongoing treatment. Furthermore, by making and seeking to recover charges, the NHS rendered Saloum, a migrant patient in need of health services, into a "debtor", which constituted grounds to withhold necessary medical treatment due to outstanding debts. As explained in the account of his experience, he was confronted with a bill for £8,397 for the care received while agonising in the very last moments of his life. This is not to mention the great amount of stress, panic and anxiety that he was subjected to by attempts of the NHS to recover his debts, and for fear of being discharged and left without care, as was the case on the night prior to his death.

As demonstrated above, the system for charging migrants for healthcare disrupts the "ethical" conceived as the prescriptions established by the NHS Constitution, as well as the rules contained in the codes of professional conduct for healthcare workers in the UK. Decision-makers in healthcare – notably those responsible for the assessment, diagnosis and treatment of patients – are urged to secure the "ethical" by protecting the aforementioned norms, and to take them into account when providing the moral justification for their course of action. Given that this ethical framework reflects the moral guidelines advanced by the four principles approach, charging migrants for NHS care implies a violation of respect for autonomy, non-maleficence, beneficence and justice, conceptualised as the foundations and moral imperatives of an ethical provision of healthcare (Beauchamp and Childress 2013: 27). Putting it differently, the Charging Regulations instantiate a regime which troubles the provision of health services for migrants as an "ethical"

practice of curing bodies and alleviating suffering which promotes feelings of inclusion, comfort and security for migrant patients in the NHS.

As discussed in Chapter One, the above conceptualisation of healthcare provision implies a view of the "ethical" as the hospitable reception of migrants into the NHS. In other words, by aiming to provide healthcare to migrant patients "ethically" – i.e. in line with the prescriptions of the NHS Constitution and their professional codes of conduct – healthcare staff seek to secure an ethics of hospitality in the delivery of health services. As previously explained, the notion of hospitality furthered by this ethics is centred on a notion of healthcare as intrinsically good and beneficial to patients, and of medicine as the instrument for delivering it (Zaklaki 2019). For instance, as the story of Saloum suggests, the main issues he was confronted with revolve around the hostility that he was subjected to for having crucial healthcare refused and palliative treatment withdrawn. The underlying argument here is that if healthcare had been provided, the "right thing" would have been done and the "ethical" decision would have been made. The following dichotomy is then set up: Healthcare provision implies hospitality and its refusal or withdrawal enacts hostility.

The issue with such a perspective is that hospitality may "fail" to prove itself as an entirely benevolent practice or a "sufficiently" ethical principle to set guidelines for action. The analysis of the MoU, in Chapter One, underlined that such a view of hospitality can be problematised: While offering hospitality as healthcare to "illegal immigrants", NHS staff were subjecting them to immigration enforcement. Even though hospitality as healthcare is framed in terms of curing illnesses and relieving pain while amounting to patients' feeling of "being-at-home", it cannot help but generate hostility towards those that it seeks to welcome. The issue that I raise here is the following: Under the Charging Regulations, could one possibly claim that providing chargeable NHS care to migrant patients, irrespective of their immigration status or ability to pay, constitutes an entirely or sufficiently ethical decision? For instance, could clinicians remain in good conscience that they did the "right thing" by providing health services to an "illegal immigrant" because they were carrying out their duty of care? These questions will be explored in the next section of this chapter.

3. Healthcare provision for chargeable migrant patients: The responsible course of medical action?

At the end of the previous section, I posed the question as to whether healthcare provision for migrants, irrespective of their immigration status or ability to pay, can be deemed to enact the ethical course of action for healthcare staff attending to migrant patients. One potential implication of responding affirmatively to this question is the fact that healthcare workers can assume that they did the "right thing" for their patients by providing them with health services. In other words, they can rest assured that they acted ethically: Their course of action was "sufficiently" ethical or hospitable. This seems to be the case in light of the story of Saloum's journey through the NHS in the last moments of his life, as remarked in section two: The refusal and withdrawal of healthcare for the patient were the core issues accounting for the deterioration of his physical and mental health, and culminating in his death. As I explained, a dichotomy is thus put into place: Healthcare provision implies hospitality and its refusal or withdrawal enacts hostility.

The way of reasoning outlined above seems to inform the view of the BMA that providing healthcare for migrants, irrespective of their immigration status or ability to pay, consists of the ethical decision to be made by doctors in their professional practice. Two examples are particularly illustrative of this point: The provision of immediately necessary and urgent treatment to migrants who are not entitled to free NHS care; and referrals of migrant patients to chargeable non-primary care made by GPs. When it comes to chargeable non-urgent treatment, the approach to healthcare for migrant patients is rather straightforward: Payment must be made in full and upfront unless it is deemed to be exempt, or if the patient is exempt from charges in their own right. However, immediately necessary or urgent treatment cannot be withheld or delayed even if the migrant patient is unable to cover the costs of health services or if they have not agreed to do so. Clinician's failure to attend to patients' needs in these circumstances can be deemed unlawful under domestic (and international) human rights law, as set out by the Charging Regulations (DHSC 2021: 67).

The exception made by the charging regime in respect to making and recovering charges in full and prior to healthcare provision instantiates a right for migrant patients, but also a duty for clinicians that suggests a commitment to humanity beyond an individual's ability to pay for immediately necessary treatment or urgent care. It does not simply point to the concern expressed by the DHSC (2021: 9) that NHS relevant bodies must observe their human rights obligations, but it also stresses that doctors are bound by the law to attend to their patients' health needs in the

above context. This imperative, however, is not exclusively framed as a matter of medico-legal commitment; it is also considered to enact a moral command that attends to justice and ethics in the practice of medicine (Mitchell and Reynolds 2019: 500). This is reflected in the BMA's ethical guidance to doctors providing healthcare for migrants under the Charging Regulations:

> Doctors' ethical training is based on a duty to respond to need. Doctors in the NHS may not be used to making decisions that may lead to clinically indicated, but otherwise non-urgent, treatment being withheld in lieu of payment. However, clinicians play a vital role in protecting patients by ensuring that chargeable patients receive appropriate and timely treatment for urgent and immediately necessary health needs, irrespective of their entitlement status or ability to pay (BMA 2021b).

The point being made here is that providing immediately necessary or urgent treatment to chargeable migrants is not simply the "right thing to do" because doctors need to ensure that their conduct is lawful. Healthcare provision for migrants also enacts the "ethical" course of action, and consubstantiates doctors' "ultimate responsibility" towards their patients (BMA 2021b). In fact, it is the BMA's understanding that clinicians can make an "ethical" decision by identifying and applying legal or professional guidance to medical dilemmas they are confronted with in their professional practice (BMA 2013: 13). In this vein, the organisation contends that, if legal rules and/or good practice protocols issued by regulatory or professional bodies clearly dictate what must be done, "it would be pointless to look beyond them when the aim is to provide practical advice" (BMA 2013: 10). In other words, the "ethical" can be found in the law and guidance for practice that doctors are expected to follow. And when it comes to immediately necessary and urgent treatment for chargeable migrants, the law (i.e. the Charging Regulations) determines that doctors must provide them. In its turn, the BMA frames this legal duty as the "ethical" and responsible course of action.

As mentioned above, the second argument illustrating the BMA's view that providing healthcare to chargeable migrants, irrespective of immigration status or ability to pay, constitutes the ethical course of action to be adopted by doctors, relates to referrals of migrant patients to chargeable non-primary care made by GPs. Of particular note, as explained in Chapter Two, is that primary care in the NHS is free for all, irrespective of nationality, place of residence or immigration status. It is usually the first point of contact in the healthcare system, and it entails a broad range of services such as registration and consultations with a GP. Putting it simply, GPs are "general doctors' providing health services in primary care settings, and they are in charge of determining whether a patient needs to be seen by a clinician who has a particular expertise to treat certain

conditions" (e.g. clinicians working in secondary care) (NHS England 2022). If that is the case, GPs must make an appointment on behalf on this patient – a process which is termed a "referral". At this point, it is worth remembering that non-primary NHS care is usually chargeable unless an exemption applies. With regard to referrals, the ethical guidance set out by the BMA establishes that:

> It is not the role of GPs to determine whether a patient is eligible for non-primary care without charge. GPs should treat the patient in the same way as they would any other when making a referral to secondary care or elsewhere and refer whenever clinically appropriate - irrespective of the patient's potential chargeable status (BMA 2021c).

What the ethical guideline above highlights is the argument that making referrals on behalf of a migrant patient, regardless of their immigration status or ability to pay for NHS care, constitutes the "ethical" course of action if such is required in light of the patient's clinical needs. The BMA's ethical guidance speaks to what Mitchell and Reynolds (2019: 497) deems to be the "fundamental tension" between the "border-bound duties of the State and borderless duties of the clinician", and "resolves" this tension by implying that doctors seeking to be ethical must attend to their borderless duty and provide healthcare to their migrant patients – even if this care is chargeable and their patients are not entitled to free health services. As clearly stated, an individual's potential chargeable status should not constitute grounds for a doctor's refusal to make a referral on their patient's behalf. On the contrary, the moral imperative is that patients be treated equally in regard to their access to the NHS, and that they be referred to chargeable non-primary care whenever it is clinically appropriate.

The BMA's ethical guidelines further the moral stance that healthcare provision for migrants in need of immediately necessary or urgent treatment, as well as referrals to chargeable NHS care, constitutes the "ethical" and responsible course of action to be pursued by doctors in their professional practice, irrespective of migrant patients' immigration status or ability to pay. This is framed as a moral obligation which echoes views of healthcare as intrinsically good and beneficial to patients, and of medicine as the instrument for delivering it to those under clinical care. To put it in terms of hospitality, providing healthcare implies being hospitable towards migrant patients. There are, however, points of concern that open up avenues for challenging the certainty of this claim. To begin with, we must remember that, under the Charging Regulations, "treatment is not made free of charge by virtue of being provided on an immediately necessary or urgent basis. Charges found to apply cannot be waived and if payment is not obtained before treatment then every effort must be made to recover it after treatment has been provided" (DHSC 2021: 68).

Even initial assessments and investigations conducted to determine if immediately necessary or urgent treatment is required must be included in any charges (DHSC 2021: 67).

In addition to that, although consultations and registrations with a GP are free for all, secondary care provided by virtue of a referral made by a GP on behalf of a patient is chargeable, with charges being made and recovered upfront and prior to the provision of healthcare if the clinically indicated treatment is deemed to be non-urgent. The issue here is that by receiving chargeable NHS care – and not being able to cover the costs of the care received – migrant patients are subjected to a range of immigration enforcement interventions that break with medicine's commitment to promoting patients' health, ensuring their physical and mental wellbeing while amounting to feelings of comfort and protection that enable their healing.

The case of Saloum, explored in the previous section, exemplifies how providing chargeable NHS care to migrants who are not entitled to free health services enables experiences of pain and suffering. As a migrant with irregular immigration status in the UK, he was not eligible for free treatment of his two brain tumours and lung cancer. However, after collapsing on the street and being taken to an NHS trust where he received medical care, he was discharged and billed for more than £8,000 despite being homeless and destitute. Following the provisions of the Charging Regulations, the NHS trust shifted their focus from providing healthcare to making every effort to recover charges after Saloum's treatment was provided. As his story tells us, the NHS trust continued to pressure him during the course of his illness to pay for the care he had received, which constituted a great source of stress until the moment of his death. After being hospitalised one more time the night before his passing, friends accompanying his navigation of the NHS reported how Saloum experienced feelings of fear, panic and anxiety because he was scared that he could be discharged again and left without care.

The point being made here is that "just" because doctors are seeking to promote patients' health by providing them with healthcare – even if doing so in a welcoming manner – it does not mean that healthcare as hospitality can secure patients' wellbeing and relieve their suffering. Indeed, as Saloum's journey through the NHS reveals, healthcare provision worked to enable the very opposite of what clinicians (and medicine, broadly speaking) set themselves to achieve – at least in terms of the moral obligations established in the ethical framework governing their professional practice. Providing health services ended up generating pain and causing harm to an extremely vulnerable patient, both in terms of his clinical condition and socioeconomic status. On this note,

it is worth noting that 'harm' is that which worsens a patient's condition, despite the definitions of "harm" and "worsen" being the object of disagreement and contestation (Summers 2019: 42). Even though this is the case, as Summers (2019: 42) explains, "most healthcare professionals consider harm to mean physical harm because the long history of healing has focused primarily on overcoming bodily disorders. However, harm can occur in other ways. […] The ways in which harm can occur are infinite."

I follow the understanding indicated above, and suggest that subjecting individuals to immigration enforcement through healthcare provision constitutes a considerable form of harm, which inflicts pain and suffering on migrant patients. As explained in Chapter Two, the NHS shares migrants' data with the Home Office to verify their eligibility for free health services, which may allow immigration authorities to identify migrants seeking healthcare, and determine their location. The aforementioned data-sharing policy can implicate migrants' arrest, detention or deportation if their residence is not lawful in the UK. To claim that this is an uncomfortable position for those deemed to be "immigration offenders" is certainly an understatement – and the same applies for those who anticipate a shift from "legality" to "illegality" in their immigration status. Furthermore, NHS debts of £500 or more outstanding for over two months must be reported to the Home Office, if no agreement for repayment is reached between the patient and the healthcare provider. Unpaid debts constitute grounds to refuse visa applications to enter or remain in the UK, putting migrant debtors, again, in a rather precarious position.

The violence of expulsion, the threat of freedom deprivation, undesired (but inescapable) surveillance, (the risk of) indebtedness – all with their clinical and non-clinical implications – are perceived and experienced by migrant patients as a form of harm, which generates pain and causes suffering. For instance, a survey of BMA members' experiences of the Charging Regulations has reported that a migrant patient refused to seek antenatal care due to the costs of the health services involved. According to attending clinician, "[s]he was complicated, had a heart and haematological condition and therefore needed secondary care, but could not pay for that. She was insisting that her whole care and delivery should be GP" (BMA 2019: 4). By following the BMA's ethical guidance that referrals should be made in light of clinical need, irrespective of a patients' potential chargeable status, the GP attending to the migrant patient was required to refer her to a specialised doctor who could better treat her medical conditions. The problem with this course of action is that it troubles medicine's commitment to its ethics in at least two significant ways.

First, by making the referral on behalf of the migrant patient, the GP would be subjecting her to immigration enforcement, with all the harmful implications that I have outlined above. That implies a breach of the principle of non-maleficence as elaborated in the previous section. Secondly, the BMA (2012: 2) is of the view that "an action is only harmful if the person experiencing it believes it to be so. Patients choose for themselves what is a harm or benefit in their own circumstances." Obviously, the organisation explains that such an imperative is not absolute in that "[t]here is a moral obligation to respect people's self-determination as long as that does not impinge on the rights or welfare of someone else" (BMA 2012: 2). The issue here is that the patient did not agree to be referred to secondary care despite her clinical needs requiring otherwise. What does it mean to be "ethical" in this context? To respect the patient's autonomy and risk their life and that of the baby? Or to refer her to secondary care and risk subjecting her to immigration enforcement while fulling the moral obligation to provide the most appropriate clinical treatment?

The uneasiness generated by the issues above prompts a range of questions: Can one argue that doctors are pursing the "responsible" course of action by ensuring that healthcare is provided? Is it possible to claim that the decision to provide healthcare is entirely or sufficiently "ethical" because it aims to cure an illness? Do attempts to cure migrant bodies assume a more morally privileged status compared to endeavours to secure their mental health and emotional wellbeing? Last but not least, could one contend that providing migrant patients with healthcare efface the moral (ir) responsibility of subjecting them to the violence of immigration enforcement? Under the circumstances described above, one could certainly argue that doctors cannot escape but *fulfil* and *breach* their duty of care and moral obligations at the one and same time. In other words, by providing healthcare to migrant patients who are not eligible for free health services and unable to pay, clinicians risk not only being "unethical", but also causing them harm through their professional practice.

The issue that I am taking with the BMA's ethical guidance – and its suggestion that healthcare provision enacts responsibility regardless of a patient's immigration status or ability to pay – does not consist in the refusal of the view that healthcare can do *some* good for migrants who are provided with health services despite being ineligible for free NHS care. My point is to draw attention to the precariousness of this ethics in that it cannot ensure that no harm is caused to migrant patients. Or more precisely, as Madeleine Fagan (2013: 3) explains, "the issue here is not so much with the precariousness of ethical claims *per se*, but with the way in which, rather than

acknowledging this precariousness, an attempt may be made to cover it over and instead employ the category of ethics to shift an issue outside the realm of contestation and debate." In this vein, my argument is that problems with this ethics arise from the certitude that healthcare provision is the "ethical" course of action to be pursued by doctors, and from the underlying conviction that their actions are fully or sufficiently "responsible" because they are attending to patients' clinical needs. That begs the question as to whether it is simply impossible to be responsible, and if hospitality as healthcare simply "fails" as an ethics. This will be my point of investigation in the next section.

4. The (ir) responsible decision to offer hospitality as healthcare to chargeable migrants in the NHS

Thus far, I have demonstrated how hospitality does not offer a principle or a set of rules which can secure an entirely or sufficiently "ethical" welcome of the other. When it attempts to do so, its endeavours are simply not successful: Practices of hospitality enact hostility towards those who (aim to) cross the threshold of the home. In fact, offering hospitality does entail delivering something of value to the guest – but one cannot tell for sure whether the welcome which inhabits this offer outweighs the hostility that it enacts or vice-versa. In this chapter, I have reiterated the argument that offering hospitality as healthcare does not equate to the cure of migrant bodies and the alleviation of their suffering. Rather, providing chargeable NHS care for migrants who are not entitled to free health services can cause them harm, the deterioration of their wellbeing, and generate the opposite of the security and comfort commonly associated with the feeling of "being-at-home". That prompts us to interrogate ourselves: Is it simply impossible to be responsible in the welcome of the other? Does hospitality "fail" as an ethics?

If we are coming from a view of ethics as a "theory of right and wrong" (Fagan 2013: 21), we cannot help but be puzzled by the fact that hospitality does not provide us with commands that can guarantee we are doing the "right" thing or even that our actions were the most "ethical" or responsible in the welcome of the other. The principles devised in the abstract to be applied in concrete situations of the "real" world do not put dilemmas to rest nor do they overcome impasses we are confronted with when we face two or more equally compelling imperatives that cannot be entirely fulfilled at the same time. As I argued in the previous section, to claim otherwise risks effacing the hostility that the chosen course of action in a given ethical dilemma inevitably entails. Therefore, can hospitality as an ethics invest us with anything of value to help us in the welcome

of the other? If so, how can it possibly be experienced in the context of healthcare provision for migrants in the NHS? In order to approach these questions, my suggestion is that we look at ethics from a Derridean point of view, as I will explain below.

For Derrida, ethics is at issue when we are confronted with the question of undecidability, i.e. when we are faced with a problem, and we know that "the two determined solutions are as justifiable as one another" (Derrida 1999a: 66). With undecidability, enacting either of the competing commands does not get us out of the bind of moral dilemmas because each one is equally imperative and, whichever course of action is taken, there remains a lack of guarantee warning us that "there is no way of securing against the worst, of identifying and guarding against evil, whatever that might be" (Fagan 2013: 89). In other words, undecidability implies that we can simply not know whether we are doing the "right" thing when moral obligations collide, or even if the chosen path will cause the least possible harm to those towards whom we are seeking to be responsible. The question of undecidability is therefore tied to the experience of the aporia as the very condition of ethics itself (Bulley, 2007: 135).

From this perspective, principles devised in the abstract cannot put to rest concrete dilemmas we are confronted with because "there is no way – word, discourse, genre, or technique – which can resolve the crisis of ethical and political judgement anterior to our engagement in the circumstances in which the demand for such judgement arises" (Dillon 2003: 118). The implications of this assertion are quite significant: There is no ethical decision which can be made a priori and separated from the singularity of the circumstances that claim it. This is not to argue that knowledge of principles has no usefulness in approaching ethical dilemmas. Ethics and responsibility require knowledge but they always go beyond it and leads to a leap of faith: We may assume that we are doing the "right" thing, but there is not a way of assuring that "right" thing was actually done. In this vein, the ethical is not encapsulated in the domain of stability – but rather in the transient nature of changing situations and uncertainty. It is in this vein that we could argue that ethical practices of hospitality are always invented for the singularity of the new arrival (Derrida and Dufourmatelle, 2000: 83), and forever remain outside the realm of moral certitude.

Undecidability, as the condition of ethics and of responsibility, may sound rather abstract, but it can be helpfully illustrated by reference to the ethical dilemmas encountered by midwives when providing maternity care to migrant women who are not eligible for free health services (Maternity Action 2019). Under the Charging Regulations, maternity care must always be treated as

immediately necessary, meaning that it cannot be refused or delayed irrespective of one's ability to cover upfront the costs of any antenatal, intrapartum and postnatal services provided. As the DHSC (2021: 67) explains, "[n]o one must ever be denied, or have delayed, maternity services due to charging issues", with the exception being justified in light of the importance of protecting the lives of both the mother and the baby. The suggestion here is that welcoming pregnant migrant women into the NHS, irrespective of their immigration status or ability to pay, is the "right" thing to do. Not only does it enact the "ethical", but also the responsible decision to avoid pregnancy-related risks and the causation of harm to migrant women and their babies.

Fundamental to offering hospitality to migrant women in need of maternity services is the procedure known as the "booking appointment" (Maternity Action 2019: 25). Conducted by midwives, it entails history taking and collection of information which is paramount to promoting good maternity treatment. It seeks to inform women on issues around self-care, preparation for child birth, future parenting, as well as explaining the risks and benefits of medical interventions occurring throughout pregnancy and after birth. Furthermore, it allows midwives to shape the best possible course of maternity treatment by taking into account both clinical and non-clinical information, such as that relating to "complex social factors", i.e. the socioeconomic situation of pregnant women that might impact adversely on maternal health (Maternity Action 2019: 46). Given the holistic nature of the procedure, details of pregnant migrant women included in the booking form varies from medical history to questions relating to the aforementioned social factors, such as "Are you a refugee or asylum seeker?" and "Are you a recent migrant (within last 12 months)?" (NHS, 2016: 4). Answers to these questions are considered to be important for clinical decision-making by helping midwives to identify particular risk factors or to indicate appropriate support (Maternity Action 2019: 27).

On the face of it, the booking appointment has nothing to do with determining migrant women's eligibility for maternity services (Maternity Action 2019: 26). As explained above, midwives collect clinical and non-clinical data in order to promote maternal care and shape maternity treatment. The issue is that once the information in on the NHS system, there can be serious implications for migrant women in terms of immigration enforcement, especially for those with unlawful residence in the UK: Personal non-clinical data becomes available to the OVM, who is tasked with overseeing the application of the Charging Regulations; information can also be shared with the Home Office in order to determine eligibility for free NHS care, which places migrant women on the radar of border control; and inability to cover the costs of maternity services can result in debts

that may affect (present or future) visa applications to enter and remain in the UK (Feldman 2021). The following account provided by Maternity Care (2018: 9 – 10) is particularly illustrative of the impacts of data-sharing policies on the provision of maternity services for chargeable migrant women:

> How they were charged or approached about charges affected women as much as did the size of the bills. They often received letters requesting payment together with invoices demanding payment on receipt of the invoice, never having been informed before that they were going to be charged. Letters frequently contained threats that they would be reported to the Home Office, to debt collection agencies, or to fraud investigators. Many letters came directly from debt collection services. Women described being besieged by telephone calls demanding payment as well as by letters. The callers often threatened that if the woman did not pay she would be reported to the Home Office. One woman, billed the day after she gave birth, was told she could make a repayment plan of £100 per month. It was clear that the caller, almost certainly a debt collection agency, had no notion that she had no right to work or benefits.

Furthermore, evidence has shown that charging migrant women for maternity care adversely impacts on maternal health and pregnancy outcomes by inducing high levels of anxiety and fear, which affects their physical and mental health (Maternity Action 2018: 10). This is not to mention how the charging regime undermines migrant women's trust on midwives, and how the blur of boundaries between midwives' duty of care and immigration enforcement interrogates the ethicality of their practice, given that "they know that their information and history taking from the woman is not simply benign" as the data acquired through the booking appointment may be deployed for charging purposes (Maternity Action 2019: 28). This process confronts midwives with a profound ethical dilemma: They can fulfil their duty of care, but at the same time subject pregnant migrant women to immigration enforcement and all its non-clinical *and* clinical consequences. Or they can overlook questions relating to immigration status in the booking form, but risk negatively affecting maternal health and pregnancy outcomes.

To complicate matters further, if midwives opt for collecting immigration-related data but not to inform the OVM, they will be attending to their moral obligation of putting the interest of migrant women first, as established by the code of conduct setting the standards for their professional practice (NMC 2018: 6). However, they will be in breach of the legal prohibition set out by the Charging Regulations which determines that NHS employees must not attempt "by fraud and deception to facilitate a chargeable patient receiving free care without identification or correct charge" (DHSC 2021: 104). As one can see, undecidability leaves midwives in a rather precarious position in light of the above ethical dilemma: To paraphrase Fagan (2013: 84), it is not only that they are always acting irresponsibly in any attempt to be responsible, but more broadly that they

cannot even mitigate such irresponsibility. They stress that they do not wish to have any active part in the charging process, but at the same time they recognise that they do collect details and cannot prevent them from being passed on the OVM (Maternity Action 2019: 32).

The ethical dilemma faced by midwives when providing maternity care to chargeable migrant women who are not entitled to free health services brings back the main questions guiding my analysis in this chapter: Is it simply impossible to act ethically when responding to those towards whom we are seeking to be responsible? Putting it differently, does hospitality simply "fail" as an ethics? From a Derridean point of view, the answer to these questions are negative. As Maja Zehfuss (2018: 46) explains,

> For Derrida, questions of ethics arise when we encounter an aporia, that is, when there is no right way forward. There is no right action that would enable us to satisfy all rules, principles, and obligations at the same time. In this type of situation, we are caught in a genuine dilemma, for example because all possible courses of action are likely to result in people getting hurt. […] These predicaments cannot be resolved or transcended. The question of ethics arises precisely when we do not (and indeed cannot) know what to do, when we feel drawn into competing obligations that we are not able to fulfil all at the same time.

If it is the experience of the aporia that invites the "ethical" to come, if it is the undecidable that allows for the chance of the responsible decision being made, then the argument that hospitality simply "fails" as an ethics is thus dismissed. In other words, it is because hospitality is an aporetic experience, because undecidability is what comes to the fore when we speak of and offer hospitality, that we can call it an ethics in the first place. It is important to note, as Derrida reminds us, that there is no ethics, justice or responsibility without the experience of the undecidable (Derrida 1999a: 66; Derrida 1992: 24) – and what hospitality for migrants in the NHS reveals is that undecidability is at the core of the medical dilemmas encountered by healthcare workers attending to migrant patients. Drawing inspiration from Derrida, I contend that we cannot move *against* or *outside* of the undecidables posed by these ethical dilemmas in a way that they can simply be resolved through the fulfilment of equally compelling but conflicting moral obligations. Rather, my suggestion is to move forward *with* and *through* "a sort of non-passive endurance of the aporia" as the condition of any ethico-political responsibility[20] (Derrida 1993: 16).

[20] I choose to use the term "ethico-political" (rather than simply "ethical") in order to emphasise how our conceptualisation of the political always already retain a reference to the ethical, and vice-versa (Bulley 2007 138 – 139). The words of Zehfuss (2009 98) provide a useful explanation in this regard: "It is impossible to understand ethics – what we should do or what is right – as separate from questions of politics, not least the question of how we come to believe that particular responses to these questions are more valid than

The allusion to a "movement" with and through a non-passive experience of the aporia highlights that undecidability does not equate to "paralysis in face of the power to decide" (Derrida 1999a: 66). It is true that undecidability leaves us in a precarious position: "We do not know what to do, we have no guarantees and whatever we might do will be necessarily insufficient. But this does not leave us free of the demand to be responsible" (Fagan 2013: 88). The point here is not simply that a decision should happen if it is ethics and responsibility that we are speaking of; in fact we *must* make a decision even though we are confronted with equally imperative but contrasting moral obligations. If we do not decide, the gifts of hospitality (e.g. the cure of bodies and alleviation of suffering) will forever remain a promise, and we risk not delivering them through concrete practices that offer something of value to the guest.

We might think that passivity and paralysis will prevent us from causing harm, or minimise the risks of that happening. However, as the ethical dilemmas faced by midwives reveal, that does not appear to be the case: How can "not deciding" do anything but cause harm to migrant women seeking NHS care despite not being able to pay for services they need? First, would passivity and paralysis (i.e. not providing maternity services) do any good to chargeable migrant women in terms of pregnancy outcomes and maternal health? Secondly, how would passivity and paralysis shield midwives from breaching their duty of care established by the law and the ethical guidance set out by their code of professional conduct? Not that making a decision will offer any guarantees that harm will be avoided – even if midwives, in the best of their efforts, work to promote migrant women's health and wellbeing:

> Whether or not they want to, midwives find themselves involved in the charging process. Both the practice of good record keeping in health care, and midwives' need to enquire and know about a woman's personal and social situation mean that information collected for the purpose of providing good care can easily be used for the purpose of charging. Midwives are uncomfortable about this, because even if they would like to have nothing to do with the charging process, their professional responsibility forces them to (Maternity Action 2019: 33).

We can't not even contend that the least harmful course of action has been adopted when midwives opt to offer migrant women hospitality by providing them with maternity services. One might argue that ensuring maternal health, from a clinical standpoint, is the "right" thing to do,

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others. What we understand ethics to be is already political and therefore what might be called the politics of ethics must be considered."

but all the detrimental consequences of healthcare provision for migrants arising from its intersection with immigration enforcement reveal that such an argument is disputable and contested. As we can see, there is both chance and threat in responsibility (Fagan 2013: 89), but there must be a decision if it is ethics that we are speaking of. It is important to note that even though there is no way of telling what the "right" or least harmful course of action is, it does not mean that medical decision-making under circumstances of conflicting moral obligations is "a matter of spontaneous, unreflective intuition without reasons" (Beauchamp and Childress, 2013: 36). As Derrida (1999a: 66) explains,

> Not knowing what to do does not mean that we have to rely on ignorance and to give up knowledge and consciousness. A decision, of course, must be prepared as far as possible by knowledge, by information, by infinite analysis. At some point, however, for a decision to be made you have to go beyond knowledge, to do something that you don't know, something which does not belong to, or is beyond, the sphere of knowledge.

Therefore, knowledge has a significant role to play in ethical decision-making and responsible action. Reference to maternity care provided by midwives to chargeable migrant women can again be a useful illustration here. According to a report by Maternity Action (2019), which analysed the impacts of the charging regime on the professional practice of midwives, knowledge of the Charging Regulations has been deemed instrumental to encourage women to challenge the charges they have allegedly incurred, to point women to local services that might be able to help them with the consequences of the charging system, as well as assisting midwives in identifying cases where exemptions apply – so that maternity care can be provided free of charge. Knowledge is framed as a crucial factor for midwives to be able to support and advocate on behalf of migrant women (Maternity Action 2019: 35). However, knowledge of the Charging Regulations cannot efface the ever-present hostility inhabiting midwives' attempts to be hospitable towards those in their care. It cannot mitigate the irresponsibility underlying their efforts to act responsibly.

Furthermore, when we make a decision, there are no assurances that our intended results will be achieved, or that the harm we seek to avoid will not occur. When it comes to responsibility, attempts to be "ethical" are a chance as much as they are a threat, and which of these will prevail after a decision has been made is undecidable. As Derrida (1992: 24) explains, the undecidable remains "caught, lodged, at least as a ghost – but an essential ghost – in every decision, in every event of the decision." It is within this framework that principles and rules tasked with providing the roadmap to the "ethical" are not successful in their mission to tame the risks of a future that remains unknown when a decision is made. Indeed, if someone is appealing to a moral norm to

put a dilemma to rest because this command claims that it secures an entirely or sufficiently "ethical" course of action, it is not ethics or responsibility that they are speaking of. It would only consist of an application of a program or the unfolding of a calculable process (Derrida 1992: 24).

The understanding of ethics and responsibility explained above interrogates the ethicality of the argument furthered by the BMA that healthcare provision for migrants, irrespective of their immigration status or ability to pay, secures the "ethical" in the professional practice of medicine. In this vein, a Derridean perspective challenges the view that medical dilemmas can be easily and quickly resolved by reference to the general duties of a doctor or to the relevant law or professional guidance (BMA 2012: 13). The issue here is that following the BMA's ethical guidance fails to fulfil doctors' moral obligation of protecting migrant patients from harm if one considers the multiple forms and degrees of hostility embedded in the provision of healthcare for migrants who are not entitled to free health services. In other words, attending to a rule that is arguably invested with the "ethical" fails to ensure that clinicians fulfil their duty of non-maleficence, given that healthcare provision can end up subjecting migrants to pain and suffering stemming from immigration enforcement.

Even if we agree with the BMA's argument that the organisation seeks to facilitate ethical decision-making – not by telling doctors what to do, but by helping them reach a morally justified decision (BMA 2013: 10) –, we still cannot help but acknowledge that it ends up undermining ethics and responsibility. To paraphrase Dan Bulley (2010: 454 – 455), while the ethical guidance is not making the decision for clinicians, it clearly aims to make the decision decidable. Indeed, the imperative to provide healthcare for migrants, irrespective of their immigration status or ability to pay, assumes a certain knowledge of the situation (i.e. what is best for migrants in need of NHS care, being eligible or not for free health services), points to the "responsible" decision, and therefore depoliticises and "resolves" the ethical dilemma. One thing is for sure: By following a rule that invests itself with the "ethical", clinicians cannot wither away the irresponsibility underlying their professional practice when medicine intersects with immigration enforcement.

To complicate matters further, this way of reasoning about ethics turns out to disable the endurance of the aporia which constitutes the possibility of any ethico-political responsibility in the first place. The guarantee that a decision has been entirely or sufficiently ethical suggests that that we can rest assured that we made the most responsible decision in a given space, at a given time. It implies that, under certain circumstances, we know what the "right" thing to do is and –

in order to act responsibly – we simply have to "go ahead" and do it. The issue with this way of "ethical" decision-making, founded on the assurance of principles and rules, is that it takes our minds off the "perpetual uneasiness" that must surround our decisions (Bulley 2007: 134); it suggests that undecidability can be erased, and leave us to remain in "good conscience" because we arguably acted with ethics and responsibility. However, as Derrida (1993: 19) warns,

> good conscience as subjective certainty is incompatible with the absolute risk that every promise, every engagement, and every responsible decision if there are such – must run. To protect the decision or the responsibility by knowledge, by some theoretical assurance, or by the certainty of being right, of being on the side of science, of consciousness or of reason, is to transform this experience into the deployment of a program, into a technical application of a rule or a norm, or into the subsumption of a determined "case."

The warning that Derrida provides us with carries in itself a powerful reminder: We cannot relax and remain in "good conscience" if our actions are subjecting people to the hostility that we are looking to protect them from. We cannot take our minds off the "perpetual uneasiness" of the decision if those towards whom we are seeking to be responsible are experiencing pain and suffering because of our arguably responsible actions. In this vein, it is worth noting that midwives providing maternity care to migrant women report experiencing "an awful, awful feeling" for taking part in the charging process (Maternity Action 2019: 28). Or how "uncomfortable" and "conflicted" they feel to know that their well-intended actions are amounting to the implementation of the charging system (Maternity Action 2019: 29; 33). The harm which we are causing to the other in our efforts to welcome them must forever "haunt" any certitude or assurance that we are being entirely or sufficiently ethical, and motivate a relentless negotiation between our conflicting moral obligations, so that we can venture maintaining our attempts to be hospitable in a constant movement of progress and perfectibility (Derrida 2005b: 6).

5. Conclusion: Negotiation and responsibility in the welcome of migrants into the NHS

In this chapter, I have explained that ethics and responsibility require the undecidable to be vivid within themselves, which implies the impossibility of being in "good conscience" in our attempts to be hospitable towards the other. Because we can never fully satisfy the equally imperative and conflicting moral obligations that we are faced with in an ethical dilemma, we cannot simply efface the "perpetual uneasiness" surrounding our decisions, given that our endeavours to offer hospitality can cause pain and suffering to those towards whom we are seeking to be responsible.

Putting it differently, there is no site in the realm of ethics that we can simply relax and "feel at ease" because the hostility we enact in our attempts to be ethical always already remains. This is what my analysis of healthcare provision for migrants who are ineligible for free health services sought to illuminate. Nevertheless, this realisation does imply that hospitality simply "fails" as an ethics: It is because we cannot take our minds off the "perpetual uneasiness" surrounding our decisions that we are able to maintain our efforts to be hospitable in a site of progress and perfectibility by negotiating between our conflicting moral obligations.

Prior to concluding this chapter, it is worth exploring why "negotiation" is a relevant element for a responsible welcome of the other and for an ethics of hospitality. Derrida associates negotiation with a permanent state of "un-leisure", i.e. "the impossibility of stopping, of settling in a position" (Derrida 2002b: 12). That speaks to the impossibility of "good conscience" that prevent us from stopping or establishing ourselves anywhere in ethical decision-making. However, the fact that we cannot "stop" or settle in one position does not suggest the mere oscillation between competing ethical duties, but rather a process of negotiation between our moral obligations. As Derrida (2002b: 13) notes, "[t]here is negotiation when there are two incompatible imperatives that appear to be incompatible but are equally imperative. One does not negotiate between exchangeable and negotiable things. Rather, one negotiates by engaging the non-negotiable in negotiation." The examples that I addressed in this chapter constitute a helpful illustration of Derrida's claims. For instance, midwives providing chargeable maternity services for migrant women can be fulfilling their duty of care by attending to pregnancy outcomes and maternal health. However, by offering them hospitality as healthcare, midwives are also subjecting these migrants to the rules of the charging regime and to border control. The enactment of hostility in their endeavours to be hospitable undermines their moral obligation to avoid pain and suffering for those patients in their care.

Whichever decision midwives make will forever be marked by the irresponsibility corrupting the ethicality of the adopted course of action. Nevertheless, if there is at least an attempt to be ethical or any consideration for responsibility in such decision-making, it is because the moral obligations in conflict were engaged in negotiation. It is true that we can never escape risk and doing "wrong" when it comes to negotiation, and even a negotiated decision "will always be unethical as well as ethical, irresponsible as well as responsible" (Bulley 2007: 139). For instance, a specialist midwife reported that if she finds out that a migrant woman in her care has overstayed her visa, but the information has not been updated on the system, she will not tell anyone about it (Maternity Action

2019: 26). Another midwife explained that she would informally record migrant women's immigration status, so that it could be taken into account if they stop attending appointments, but she would not share her records with anyone else (Maternity Action 2019: 27). The "irresponsibility" of these midwives, however, does not efface the possibility of ethics: After all, attempts to make an "ethical" decision must "both *refer to* and *suspend* moral norms and laws" (Bulley 2007: 133, emphasis added).

One could possibly claim that such actions do not reflect a view of ethics as the enactment of an immaculate "good" or "right". Some might even claim that these actions are simply immoral or "wrong". However, it is the "negotiative ethos" (Bulley 2007: 140) that – if nothing – opens up the door for the chance of an ethical decision while inviting responsibility to come. Hospitality as an ethics therefore requires that we keep an interminable negotiation between our conflicting moral obligations, between "right" and "wrong", welcome and hostility, the conditional and the unconditional in order to find the least bad hospitality (Bulley 2006: 655). This seems to be case, for instance, when midwives explain that working out repayment plans for migrant pregnant women is far from the ultimate enactment of their ethical duty, but since they believe the termination of the charging regime is unlikely to happen in the foreseeable future, this can the 'best of the bad situation' (Maternity Action 2019: 32).

Ethics and responsibility in the welcome of the other enacts what Derrida terms the "double law of hospitality: to calculate the risks, yes, but without closing the door on the incalculable, that is, on the future and the foreigner" (Derrida 2005b: 6). In other words, attempts to be ethical towards those who (aim to) cross the threshold of the home demands that we attend to the hostility enacted in our welcome of the other, to the harm that we are causing them in our endeavours to be hospitable. We must negotiate these two figures of hospitality, but never seek to efface the inevitable irresponsibility inhabiting our pursuit of the ethical. In doing so, we must make a decision, which will always entail a certain level of closure without which hospitality will offer nothing but a promise of welcoming. However, these are closures with the "character of an opening" (Bulley 2007: 131) in that they are mere "stopgaps" that must not prevent us from continuing an infinite search for the least bad conditions of hospitality (Bulley 2006: 655).

Unconditional hospitality will always be an inevitable – and necessary – "ghost" reminding us that we might have been hospitable, but not hospitable enough. That which we deem to enact a "better" form of hospitality – let us say, free maternity services to all, irrespective of immigration

status – "haunts" our welcome of the other and warn us that we cannot simply "feel at ease" with the decisions that we make. Putting it differently, we cannot take our minds off the "perpetual uneasiness" surrounding our decisions because those towards whom we are seeking to be responsible are experiencing pain and suffering by virtue of our actions. By evading the misleading comfort of a "good conscience", we keep at work the "un-leisure" that prevents us from settling for the "least bad" just because it is not the worst – even though we never know if the "best is yet to come" since we cannot govern the outcome of our decisions. However, it is this unstable site of ethical decision-making that constitutes the possibility of perfectibility of the decisions we make in our efforts to be hospitable.

CHAPTER FOUR:

THE WELCOME OF FOREIGN NHS STAFF INTO THE UK: RECONFIGURING SUBJECT POSITIONS AND DISRUPTING POWER RELATIONS AMIDST THE COVID-19 PANDEMIC

1. Introduction

In June 2019, then-Secretary of State for Health and Social Care, Matt Hancock, delivered a speech at the East London NHS Foundation Trust announcing the launch of the NHS People Plan. In short, the plan sets out the vision of the UK Government for how people working in the NHS will be supported to provide the healthcare that patients need (DHSC 2019b). One of the key themes addressed in the speech related to the international recruitment of migrant workers. Rather than drawing on statistics or technical arguments to explain the necessity of staff from overseas for the operation of the service, Health and Social Care Secretary Hancock relied on a hypothetical example of a foreign nurse wishing to work for the NHS. His choice of words is especially telling and merits quotation:

> She, or he, doesn't live in this country – yet. They're in the Philippines, or India, or Poland, or any other number of countries around the world. They look to the NHS as a beacon of excellence, and of opportunity. Somewhere they can come to, to be the best nurse they can possibly be. Somewhere they can learn new skills, earn money, and return home as a world-class nurse, or stay and build a new home and a better life here in Britain. To that nurse I say: we welcome you, we need you, we want you to come and help us build an NHS that's fit for the future (DHSC 2019b).

What is of particular note in the above quote is not simply the reiteration that migrant workers constitute a necessity for the efficient operation of the NHS. In addition to that, the point is made that these workers are *welcome* to come to the UK to build a better life and a new home. The stated message is clear: The Government welcomes them, needs them, and wants them to come to work for the service, while making the offer of financial prosperity and high-standard professional training for those who "have the talent, the skills, and the determination to pack up [their] hopes and dreams in a suitcase and travel to the other side of the world" (DHSC 2019b). What the narrative scripted by the Government reveals is that the reception of migrant workers into the NHS – and the UK itself – is not simply a matter of bureaucratic arrangements, but notably a question of hospitality. One that allows for a welcome of foreigners into the service (and the

country) while somehow asserting the superiority of the new home: A place where the guest can prosper, flourish and become an improved version of themselves.

In the spirit of "clap for carers", the official weekly applause honouring NHS workers for their engagement in the fight against the COVID-19 pandemic, then UK Prime Minister, Boris Johnson, made sure to thank two foreign nurses who looked after him when he battled the disease. As he praised Jenny McGee and Luis Pitarma for helping "save his live", he stressed that they had come from overseas to join the NHS (Merrick 2020*)*. His "gratitude" echoes the COVID-19-related measures adopted – *and framed* – by the Government as an effort to facilitate migrant workers' visa application and acknowledge their fundamental contribution to the NHS in the fight against the pandemic. In spite of his words, he also made it clear on the occasion that migrant health workers needed to continue to bear the cost of the Immigration Health Surcharge (IHS) - the fee to be paid during the visa application which allows migrants to access the NHS on a similar basis to those ordinarily resident in the UK. In other words, even for those indispensable guests, on the frontline of COVID-19, hospitality was, too, inserted in a circle of exchange where the guest is expected to give back to the host for the welcome that they have been granted.

In this chapter, I interrogate the extent to which COVID-19-related measures equate to a more hospitable welcome – or at least a less hostile reception – of foreign workers into the UK. I analyse the ways in which the COVID-19 pandemic reveals the hostility encountered by foreign NHS workers by virtue of their immigration status in their reception into the country. I highlight that they are hosts who carry out the material acts of welcoming patients into the NHS, but also guests in the UK who are subject to experiences of hostility in their reception into the country. In other words, even though they carry out acts of hosting in the welcome of nationals and foreigners into the NHS, they are subject to different forms and degrees of hostility – similar to those experienced by migrants who occupy the sole position of guests when accessing healthcare provided by the service. I argue that their experience of guesting/hosting prompts us to reconceptualise traditional understandings of the role of guests and hosts in practices of international hospitality by demonstrating the disruption of the conventional power relations that operate through the dynamics between these two subject positions.

The chapter begins by explaining how foreign NHS staff trouble common understandings that associate nationals with hosts and migrants with guests. In doing so, I remark that while performing acts of hosting overseas NHS workers allow for the enactment of "hostipitality"

(Derrida 2003: 3): They welcome migrant patients into the service, but also subject them to hostility by operating data-sharing policies between the NHS and the Home Office. In the next section, I shift attention to the fact that, despite being hosts, foreign NHS staff also experience different forms and degrees of hostility in their reception into the UK. By analysing the figure of hôte (Derrida 1999b), I highlight that they carry out the material acts of an "indispensable host", but they also constitute the embodiment of the "acceptable guest" who remains undecidably caught between these two subject positions. In the following section, I interrogate whether the Health and Care Worker Visa (HCWV) enables a more hospitable welcome of foreign health and care workers into the UK, and point to the ways in which it regulates a less hostile reception of these migrants – but one that produces exclusions and filtering all the same.

In the next section, I make the argument that hospitality for overseas NHS staff instantiates a "hierarchy of deservingness" that favours those deemed to be highly skilled. By focusing on the notion of the (g)host (Bulley 2013; 2016), I explain how low-paid NHS workers experience a more hostile reception into the country compared to their counterparts who are valued more highly on a scale of (mis) perceived merit. Finally, in the conclusion, I draw inspiration from Bulley's works (2013; 2017) to explain one more manner in which migrant workforce enables hospitality in the NHS, i.e. by helping the UK Government constitute a narrative of gratitude and acknowledgement which portrays the service as a genuinely open and hospitable space for foreigners from across the globe. In doing so, I remark how this narrative risks effacing arguments which interrogate hospitality for overseas workers as an entirely hospitable reception.

2. Foreign hosts and the enactment of "hostipitality" towards migrant patients

In its most elementary conceptualisation, hospitality brings to light three fundamental components inevitably embedded in its enactment: The home, the host and the guest. In International Politics, the home is commonly conceived as the sovereign state, the space of hospitality *par excellence* in the global arena. State agents operating immigration policies and tasked with the reception of non-citizens traditionally take on the role of the hosts. In this framework, migrants are usually thought of as the guests, who (seek to) cross the territorial boundaries of a state of which they are not citizens (Baker 2011; Benhabib 2004; Brown 2006; 2010; McFadyen 2016). This classical imaginary of the key figures of hospitality, however, has not remained unchallenged in the field of International Politics. Literature on "post-sovereign" spaces of hospitality (e.g. the refugee camp and global cities) has unveiled these sites as locations where the dichotomy defining migrants as

guests and nationals as hosts is profoundly troubled (Bulley 2013; Bulley 2017; Bulley and Lisle 2012).

When it comes to hospitality for migrants in the NHS, the aforementioned dichotomy also requires further scrutiny: A restrictive understanding of foreigners as guests who receive – but do not offer – a welcome appears to be insufficient for the analysis of how hospitality operates in the service in respect to the constitution of its two subject positions. To begin with, it is worth stressing the acknowledgement that "most NHS staff in England are British – but a *substantial* minority are not" (Baker 2022: 6, emphasis added)[21]. This understanding is not without reason. In the face of concerning workforce shortage in the NHS (King's Fund 2021), the point has been made that "international staff are the only realistic short-term lever for dealing with current widespread vacancies" (Health Foundation, King's Fund and Nuffield Trust 2019: 84). From this perspective, migrant NHS workers are portrayed as indispensable hosts, whose acts of hospitality are fundamental to maintaining the operation of the home. They are doctors, nurses, paramedics, managers, cleaners and porters – to name just a few – who are in charge of offering hospitality to patients experiencing the deterioration of their health and the risk of dying. COVID-19 has been particularly illustrative of the importance of foreign NHS staff for the operation of the service: The measures put in place by the UK Government to facilitate international recruitment stress the reliance of the NHS on overseas workforce. Viewed in this light, "the NHS is not drained by migrants, but sustained by them" (Malik 2020).

Recognising that foreign-born workers enable a welcome of patients into the NHS through their acts of hosting should not be confused with an attempt to romanticise their role in the offer of hospitality for migrants in the service. The scenario characterised by COVID-19 and the charging regime is a useful illustration here. The Charging Regulations remained in place throughout the most severe moments of the pandemic, and so did the data-sharing policies between the NHS and the Home Office (Morris and Nanda 2021). That means that despite widespread opposition remarking that the system for charging migrants for healthcare undermined the UK response to COVID-19, hostility arising from the charging regime continued to be enacted throughout the pandemic, affecting migrant patients' healthcare-seeking behaviour (DotW et. al 2021; Medact et. al 2020). As explained in Chapter One, hostility operates through practices of welcome offered by

[21] According to Baker (2022: 6), "as of June 2022, 222,107 NHS staff reported a non-British nationality, accounting for 16.5% of all staff for whom a nationality is known (one in six). Between them, these staff reported around 200 different nationalities."

the same hosts tasked with opening the NHS as a space of hospitality – and that inevitably entails foreign NHS staff carrying out the material acts of hosting in the service. While they offer a welcome to migrant patients experiencing the deterioration of their health, they also enact hostility towards foreigners accessing the NHS. In doing so, they enable what has been termed by Derrida (2000: 3) 'hostipitality'.

The following example is illustrative of the "hostipitality" to which I referred. As explained by the Charging Regulations, the success of the system for charging migrants depend on all staff, including clinicians, being supportive of the work of the OVM and their team. In this vein, if it is the clinician providing healthcare to a migrant who first becomes aware that their patient may be chargeable, the guidance provided by the Regulations is that they should notify the OVM, and they can inform their patient that charges may apply (DHSC 2021: 100). These acts of "notifying" and "informing", embedded in the offer of hospitality as healthcare, ignite the cycle of hostility that the charging regime puts into motion. "Hostipitality" therefore is part of the clinical practice of NHS staff members, both UK and foreign-born. Even though migrant workers upset the stability of the guest and the host as separate and incommunicable entities, the ambivalence of this position does not prevent them from causing suffering and pain to migrant patients crossing the threshold of the home. Foreign NHS staff cannot help but risk enacting hostility towards those to whom they seek to be hospitable.

3. Hostility against the *hôte* in their experience of guesting

Migrant workforce taking on the role of hosts in the provision of healthcare by the NHS demonstrates the precariousness of the dichotomy that entrenches migrants as guests and nationals as hosts in practices of international hospitality. This is indeed an important aspect to be stressed as it remarks a rupture with conventional understandings of migrants' agency in International Politics, which tend to encapsulate their role in acts of hospitality as that of guests. However, there is more to be said about migrant workers becoming members of NHS staff: It is not simply that a shifting of subject positions occurs, which removes foreigners from the realm of guesting to that of hosting. Migrants, in fact, find themselves in the undecidable position of the *hôte*, a French word that designates both "guest" and "host": They offer hospitality to those seeking health services provided by the NHS, but they are also subject to different forms and degrees of hostility – similar to those experienced by migrants who occupy the sole position of guests in the service. The undecidability of this position is well-captured by the definition proposed by Derrida (1999b: 41):

> the *hôte* who receives (the host) , the one who welcomes the invited or received *hôte* (the guest), the welcoming *hôte* who considers himself the owner of the place, is in truth a *hôte* received in his own home. He receives the hospitality that he offers in his own home; he receives it from his own home – which, in the end, does not belong to him. The *hôte* as host is a guest (Derrida 1999b: 41).

The host is conventionally conceived as the one who welcomes and offers hospitality in the home. As the master in the house, their role is to affirm the law of the place that opens itself to welcome the foreigner (Derrida 2000: 4). In enacting this law, the host guarantees that the conditions of hospitality be met so that they can offer the guest passage across the threshold of the home (Derrida 2000: 13). Furthermore, to recapitulate the explanation of Derrida (2005a: 17), being the host "supposes a reception or inclusion of the other which one seeks to appropriate, control, and master according to different modalities of violence […]". In other words, the power of hospitality as traditionally exercised by the host takes the form of the choosing, electing and filtering – not only of those who are to be welcome – but also of the gifts of hospitality to be given after the threshold of the home is crossed. In a nutshell, the host constitutes the sovereign master who is tasked with the management of the home by excluding and doing violence (Derrida and Dufourmatelle 2000: 55).

By calling out the limitations of the above logic, the "foreign NHS worker", as the incorporation of the *hôte,* reconfigures the traditional roles of the host and the guest. They are guests who carry out material acts of hosting, but at the same time they are foreign hosts who experience the hostility inhabiting acts of welcoming. By straddling the realms of hosting and guesting, they disrupt the conventional configuration of the power relations operating through the dynamic between these two subject positions: On one hand, they enact the hostility underlying the acts of welcome of migrant patients into the NHS; on the other, they themselves experience different forms and degrees of hostility – similar to those experienced by migrants who occupy the sole position of guests in the service. In other words, they perform the material acts of the "indispensable host", but they are also the embodiment of the "acceptable guest" who *remains undecidably caught between these two positions*. The story of Egyptian doctor Basem Enany, who became critically ill after contracting COVID-19, constitutes an emblematic instance of how pain and suffering could be experienced by foreign NHS staff by virtue of their immigration status – echoing the hostility to which migrants can be subject when receiving healthcare provided by the service.

Dr Basem Enany, a consultant cardiologist from Egypt, worked for the NHS on a temporary visa due to expire in December 2020. He lived in the UK with his wife and four daughters, all residing legally in the country. Since the beginning of the COVID-19 crisis, the doctor worked on the frontline fighting the pandemic, being described by colleagues as a restless professional spending day and night shifts treating very sick COVID-stricken patients (Taylor 2020a). In mid-September, the cardiologist tested positive himself. Initially experiencing average symptoms, the disease progressed, and the cardiologist started suffering from a rare complication of COVID-19, the Guillain-Barré syndrome, which left him partially paralysed and unable to breathe unassisted. The severity of his disease had him placed on a ventilator, although his brain was functional and he was able to communicate. Prior to falling ill, he had been working on job applications, since his contract with the NHS was set to end in late November, with the aim of renewing his work visa to remain with his family in the UK (Taylor 2020a).

While he lay in his bed on a ventilator, his critically ill condition was exacerbated by the prospect of facing deportation from the UK with his family. Given that he was in the country on a temporary work visa due to expire in late December 2020, with no expectation of full recovery by then, he feared that he and his family would be forced to leave the country. Grant of a work visa requires applicants to hold at least a job offer and a certificate of sponsorship from a UK-based employer, which is put at risk if their ability to work is compromised[22]. By the time Dr Enany was hospitalised, the distress experienced by the cardiologist and his family over his immigration status was precisely captured by the statement issued by Dr Terry John, the BMA international committee chair, who remarked that "the last thing that his wife should be worrying about at this difficult time is uncertainty around her family's future in this country, a country where they have laid roots and they call home […]" (Taylor 2020a). As a foreign-born NHS worker, Dr Enany was confronted with the hostility many migrants experience when navigating the UK immigration system: What if he remained unable to work, and denied the renewal of his visa? Would he and his dependants be forced to leave the UK because his ability to work was compromised due to COVID-19? Fortunately for him and his family, the Home Office decided to extend his visa for another 12 months in early December, which temporarily mitigated his concerns over his stay in the country (Taylor 2020b)[23].

[22] These were requirements established by the Tier 2 visa route for international doctors. From 1 December 2020, the Tier 2 pathway was replaced the "Skilled Worker route", under which healthcare workers can apply for the Health and Care Worker Visa (BMA 2021). The new visa route still requires a job offer and a certificate of sponsorship as criteria to be met for a work permit to be granted (BMA 2021d).

[23] The terms on which the visa extension was granted to Dr Enany are unclear. As explained, the cardiologist lived in the UK on a temporary work visa, which presupposes migrants' ability to work and a job offer made by a UK-based

It is true that while Dr Basem Enany went through his process of recovery from COVID-19, the Government had in place the free one-year visa extension scheme for most health workers (e.g. doctors, nurses, paramedics) which waived the visa fee and immigration health surcharge (IHS) for these applicants as well as their dependants, meaning that they were eligible for a free visa extension from the day their visa was due to expire (Macdonald 2020: 13)[24]. However, it did not suffice to put an end to his concerns about his immigration status, and how it would affect his right to remain in the UK. Even though the scheme covered NHS workers with visas expiring on or before March 31st 2021 – which implies covering Dr Enany as his visa was set to expire in December 2020 – an extension of his stay in the country still presupposed his ability to practice medicine, and he would need to apply for the extension in the normal way (UK Government 2021a). Given that he was on a work permit, if Dr Basem Enany remained unfit for work, the success of his application to remain in the UK with his family – on the basis of him being a healthcare worker – would be uncertain – not to say, highly unlikely.

The predicament experienced by Dr Enany represents a personal ordeal and a wider issue. The hardship that he was confronted with as he grappled with the uncertainty about his future remarks that being a host in the NHS does not protect migrants from the hostile effects of a precarious immigration status. The pain and suffering that he experienced constitute a dimension of the hostility that foreign NHS staff may encounter when navigating the UK immigration system despite being hosts who welcome nationals and foreigners into the NHS. As the COVID-19 pandemic highlighted, overseas NHS workers incorporate the "indispensable hosts" who are fundamental to maintaining the integrity and the operation of the home. However, at the same time, they are made into the "acceptable guests" who undergo different forms and degrees of hostility. By straddling the realms of hosting and guesting, their experience suggests a reconfiguration of these subject positions by articulating a disruption of the conventional power relations operating in the dynamics between hosts and guests: the *hôte* becomes a hostile subject in the exercise of power over the guest, but they experience hostility as they navigate the realm of guesting.

employer. Dr Enany's contract with the NHS ended in November, and he was unfit to work by the time his extension was granted. Under the immigration law, the Home Office has the power to grant applicants discretionary leave on medical grounds, without any prohibition on work (Home Office 2021: 9). Given that Dr Enany's situation gained considerable traction and publicity, discretionary leave might have been applied to his case.

[24] Details of the free one-year visa extension scheme will be provided in the fifth section of this chapter.

4. The Health and Care Worker Visa: A more hospitable welcome of foreign NHS staff into the UK?

Against the backdrop of COVID-19, hospitality for foreign NHS staff has gained particular traction. For one thing, the pandemic has shed light on the longstanding reliance of the NHS on overseas workforce. Moreover, the death of foreign healthcare workers has not gone unnoticed: As of April 2020, eight doctors on the frontline of the pandemic had lost their lives after contracting coronavirus, all of whom were immigrants coming from India, Egypt, Nigeria, Pakistan, Sri Lanka and Sudan to practice medicine in the UK (Mueller 2020*).* Among others, these are circumstances that put the contribution of migrant workers to the UK's response to the pandemic under the spotlight. In this context, the UK Government has put in place a range of measures which aim to respond to workforce shortages in the health and care sector – but which have also been framed as the honouring of overseas staff on the frontline of COVID-19. One exemplary of such measures consists of the scheme inaugurated by the Health and Care Worker Visa (HCWV) (UK Government 2021b).

Under the scheme launched on 4th August 2020, professionals covered by the HCWV rules are entitled to reduced visa fees, prioritisation in the assessment of their application (the fast-track entry) and, as has been particularly singled out by the Government, exemption from paying the IHS (UKVI 2021: 4). For instance, under the general rules applying to most visa applicants, a nurse coming to the UK on a three-year-visa along with a partner and two children would be charged £464 each for their visa fees, and their application would take from eight to twenty weeks to be reviewed (UK Government 2021c). Under the HCWV scheme, the visa fee would fall to £232 for each applicant, with applications aimed to be processed within three weeks (UKVI 2021: 7- 8).[25] Even more notorious are the figures relating to the IHS: Outside the scheme, the aforementioned nurse and their family would be required to pay £6,564 (£624 x two adults plus £470 x two children x three years) upfront and in full for the surcharge, on top of their visa expenditures. Under the HCWV rules, no payment for the IHS is required, meaning they are exempt from the costs of the referred fee in order to access NHS care on a similar basis to those ordinarily resident in the UK[26].

[25] 'Nurses' is a job on the healthcare and education shortage list in all four nations of the UK. Occupations on this list entitle applicants (and their dependants) to a reduced visa fee of £464 for a stay of up to three years (UK Government 2021d). As for occupations not included on the list, the visa fee stands at £610 if the application is made from outside the UK (UK Government 2021c).

[26] The Health and Care Visa Guidance states that another benefit granted to applicants under the scheme is "dedicated support to come to the UK with their families" (UKVI 2021: 4). However, the phrasing of this "benefit" seems to be misleading. The Guidance itself explains that such advantage consists of "enabling Health and Care Visa sponsors to contact UKVI's specialist team if they have any issues with the application process or eligibility for the Health and

Award of benefits through the HCWV begs the question: Does the new visa route imply a more hospitable welcome – or at least a less hostile reception – of overseas NHS workers into the country? Exemption from paying the IHS, a substantial reduction in visa fees and priority in the processing of applications can all be conceived as "gifts" of a hospitality that affirms itself through the "conditional" but which ensures a more hospitable welcome of the guest. To argue that we are looking at a *more* hospitable welcome does not seek to efface the fact that hospitality here inscribes itself in a cycle of exchange, reciprocity and economy; after all, the master of the house offers something concrete and of value, but the "scene of gratitude among hosts and guests' demands that the latter give back to the former" (Derrida 1999a: 69). The emphasis on a *more hospitable* welcome – as opposed to a *hospitable* welcome – aims to remark that it is of forms and degrees of hostility that we are speaking. Putting it differently, the laws of hospitality that *allow for a more hospitable welcome* are the same laws that simply *regulate a less hostile reception* of guests into the home – one that all the same produces filtering and exclusions. This is the case for all forms of conditional hospitality, and that applies to the rules relating to the HCWV as I will explain below.

The first aspect worthy of note is the precariousness of the immigration status of migrant workers covered by the HCWV. The issue here is not simply one of temporality, given that the validity of the visa – as is usually the case – is circumscribed by a timeframe (maximum of five years). Uncertainty, insecurity and instability stemming from the immigration status of HCWV holders are most notorious if one attends to the fact that the HCWV forms part of the Skilled Worker route, meaning that applicants must meet all the criteria of this visa category so that their application can be successful (UKVI 2021: 7). One important requirement to be met consists of having a "certificate of sponsorship" issued by a UK employer that has been approved by the Home Office where details of the job offer are provided (e.g. salary, job description, start and end dates). The first point to be raised is: What if this certificate of sponsorship is withdrawn by the employer? By highlighting the issue of a certificate of sponsorship being withdrawn, I am not addressing a problem of hypothetical significance only. Concerns have been raised by medical professionals who have expressed fears of deportation in the event of their certificate being cancelled, as well as outrage for finding themselves in an insecure immigration status despite the contributions they have made to the NHS (Taylor 2021).

Care Visa" (UKVI 2021: 4). The service therefore seems to constitute more of a support network to assist sponsors (employers) rather than "dedicated support" offered to applicants and their families to come to the UK.

Another issue of concern is: What if the sponsor licence granted to the employer by the Home Office is revoked? Employers wishing to recruit overseas workers must meet a range of criteria in order to be granted a sponsor licence by the Home Office. One of the requirements to be met consists of appointing people within their business to manage the sponsorship process. For instance, if these individuals (or the employers themselves) have incurred a violation of the law, have been reported to UK Visas & Immigration (UKVI), or even failed to pay VAT (value added tax applied to the purchase price of most goods and services), the employer's sponsor license may be suspended or withdrawn (UK Government 2021f). Let us assume that two years into their contract with a private organisation providing services for the NHS, a staff member tasked with the management sponsorship process is found to have "broken the law" and have been reported to UKVI. An immediate result of such predicaments may be the cancellation of the employer's sponsor licence, meaning that they are unable to employ workers from overseas (UK Government 2021f). In this context, healthcare professionals are left in a rather precarious position in respect to their stay in the UK on the basis of their HCWV.

The insecurity of the immigration status conferred on HCWV holders has given rise to claims that the UK Government should offer permanent residency to overseas health and care workers and their close family members – i.e. grant them the immigration status of 'Indefinite Leave to Remain' (ILR) – or British citizenship (Macdonald 2020: 19; UK Parliament 2021). In regard to the former, the reading of a parliamentary bill that would grant health and care workers as well as their family members the right to permanent residence in the UK (the Health and Social Care Staff Bill) has been indefinitely postponed (Taylor 2021; UK Parliament 2021). As for the latter, the Government has made the argument that British citizenship cannot be granted on a discretionary basis, and that all those wishing to become citizens should meet the same core criteria (Macdonald 2020: 20). The issue with the temporary nature of the HCWV is not simply a lack of full acknowledgement of migrant workers' contribution to the UK response to COVID-19, but also a matter of entitlement to rights conferred on British citizens and foreign nationals with ILR. Of particular relevance is the "no recourse to public funds" (NRPF) condition attached to temporary migrants' leave to enter or remain in the UK, which prevents them from accessing most social security and welfare benefits and services (e.g. income support, housing benefit) (Home Office 2021b: 11).

In short, the UK Government argues that migrants from all over the world play a vital role in health and social care, and that it is grateful for the work which they provide. However, would the hostility enacted by the HCWV not undermine the more hospitable welcome that the Government

argues to be offering to such foreigners through the new visa route? Its reluctance to adopt measures to secure migrant workers' permanent stay in the UK has called into question the extent to which the welcome of overseas health and care staff into the country points to a trend towards a more hospitable reception of foreign workers or simply to a temporary tolerance of migrant workforce (Dagdelen 2020) – especially in the case of those deemed to be "low-skilled" and therefore less worthy of the "benefits" awarded by the UK points-based immigration system that prides itself on attracting to the country "the brightest and the best" while underestimating the contributions made by those in lower-paid jobs (Desira 2020)[27]. Perceptions of "less deserving" migrants are also embedded in the COVID-19-related measures in respect to health and care staff, with the HCWV being no exception. It is to this "hierarchy of deservingness" that I shift attention in the next section.

5. Low-paid workers and hospitality in the NHS: (G)hosting patients into the service

At the end of the previous section, I described what I termed a "hierarchy of deservingness" in respect to health and care staff in the UK, which consubstantiates perceptions of "less deserving" migrants in terms of access to public services, benefits and entitlement of rights. Most importantly, I highlighted that COVID-19-related measures in respect to foreign NHS staff also translate into practice such "ranking of merit", with the HCWV consisting of an exemplar of this predicament. But why is it the case? As previously explained, the new visa route does allow for a more hospitable welcome of overseas workers into the UK compared to the general rules applying to migrants who do not work in the health and care sector. From this perspective, they could be deemed to embody the figure of the "favoured guest" who are granted the gifts of hospitality that the scheme provides: Reduced visa fees, no payment of the IHS and faster processing of visa applications. The issue is that despite its contention that it is "immensely grateful for the work all NHS employees and social workers are making to tackle coronavirus" (Home Office 2020b emphasis added), the UK Government provides a hierarchical welcome of migrant workers into the countries – not all foreigners are equally received.

In regard to the HCWV, the aforementioned hierarchical welcome is particularly evident. The scheme is aimed at doctors, nurses and "allied health professionals" as well as those working in the social care sector (UKVI 2021: 4). It is worth noting that by "allied health professionals" the UK Government refers to a range of occupations consisting of jobs involved in direct patient care

[27] The points-based immigration system will be further explored in Chapter Five.

(e.g. midwives, paramedics and psychologists) but also those of a more administrative character (e.g. health services and public health managers and directors, as well as residential, day and domiciliary care proprietors) (UKVI 2021: 4). However, one category of health and care workers has been obliterated on the list of occupations eligible for the HCWV: NHS support staff. To be more precise, by "support staff" I refer to porters, cleaners, caterers, hospital receptionists, to name just a few, who work to facilitate and enable the provision of healthcare by the NHS, but do not qualify for the "benefits" of a scheme that claims to acknowledge the contribution of overseas staff amidst the COVID-19 pandemic. On the one hand, they perform the everyday acts of hosting in low-paid jobs. On the other, their contribution to the operation of hospitality in the NHS is obliterated through their exclusion from the HCWV scheme.

This "absent presence" of these guests/hosts is helpfully captured by what Bulley (2013: 236; 2017: 70) terms the (g)host: On one level, these are subjects who perform the everyday acts of hosting in low-paid occupations, carrying out the mundane – but indispensable – tasks of hosting which enable the operation of hospitality (e.g. servicing, feeding, sheltering and cleaning). On another level, these subjects are ostensibly produced and governed as less valued guests who provide traditional hosting services. The HCWV consists of a useful example of the production and government of these (g)hosts in the context of healthcare provision by the NHS. However, the new visa route constitutes but one instance of the ways in which (g)hosts come to "haunt" the narrative of a hospitable welcome of foreign NHS staff into the UK while illuminating the "hierarchy of deservingness" to which I alluded above. The previously mentioned one-year visa extension scheme also consists of a helpful illustration in this regard.

On 31 March 2020, the Home Office announced that doctors, nurses and paramedics working for the NHS (or an independent healthcare provider) with visas due to expire before 1 October 2020 would be entitled to an automatic one-year visa extension free of charge. The scheme would be extensible to their family members, effective immediately and retrospectively, with the option of a refund of any fees relating to pending visa applications. It is also relevant to note that those benefitting from the scheme would not be required to pay the IHS. Similarly to the visa fee relating to outstanding applications, the surcharge could be refunded to overseas healthcare staff covered by the free extension. One month later, the Government broadened the scope of the new scheme to comprise other healthcare workers as well as persons working in social care (Home Office 2020c). The timeframe of the scheme would undergo two more alterations in the months to come: In November 2020, it began to cover those with visas expiring on or prior to 31 March 2021.

Finally, as of April 2021, a second extension pushed back the visa expiration deadline to 30 September of the same year. Unlike the first phase of the scheme, extensions were not set to be automatic – they remained free, but an application would be required *(*UK Government 2021a).

Once again, we cannot help but acknowledge that the one-year visa extension consists of a policy that allows for a more hospitable welcome of *some* migrants into the UK. Be it automatic or dependent on an application, the extension granted to a range of overseas NHS workers allowed them to experience a less hostile reception into the country compared to that they would have received if the general rules for visa applications were to be enforced: Applications would not be free of charge and the requirement to pay the IHS would still be in place. However, despite its argument of immense gratitude to all foreign NHS staff helping to tackle COVID-19 (Home Office 2020b), the UK Government reinforced the idea of a "hierarchy of deservingness" by excluding from the scheme low-paid workers who would in principle benefit the most from an arrangement that alleviates the financial burden of a visa application. As the scheme reveals, a hierarchical welcome is put in place, the recipients of "gifts" of hospitality turn out to be filtered, and migrant workers' contributions are not equally valued. Foreign low-paid staff carry out the everyday acts of hosting which enable hospitality to operate, but at the same time are obliterated from the one-year extension scheme. Putting it differently, they consubstantiate the embodiment of the (g)host.

(G)hosts also come to "haunt" the hospitable character of the welcome of migrant workers into the UK in at least two other ways. The first of these refers to the bereavement scheme, which grants ILR to the family members of overseas health and care staff who have died as a result of contracting COVID-19. The offer of ILR is set to be free of charge and effective immediately and retrospectively from May 2020. In its announcement, the Home Office framed the initiative as an act of acknowledgement on the part of the UK Government of the "ultimate sacrifice" made by foreign NHS staff in the pursuit of saving the lives of others (Home Office 2020a). What is particularly worthy of note is that – as of April 2020, when the scheme was initially put in place – overseas NHS support staff and social care workers were not covered by the arrangement. Putting it differently, in the first instance, only the death of health professionals working in the NHS or in the independent sector would not imply the return of their family members to their country of origin. In the event of the passing of an NHS cleaner, porter or caterer – to name just a few – those who came to the UK depending on their visa would be removed from the country unless they were entitled to remain in their own right. Bereavement has therefore a two-fold implication:

It interrogates responsibility towards the living while stressing the necessity "[t]o answer for the dead, to respond to the dead" (Derrida 2006: 136).

Finally, NHS low-paid workers also undermine the hospitable character of the reception of migrant workers into the UK if one looks at issues surrounding the IHS. This constitutes an aspect of peculiar relevance given that the Government, as of May 2020, made a promise to waive the fee for all overseas health and care staff working in the NHS and in the independent sector. The benefit would be extended to their dependants, and would cover any periods after 31 March 2020 for which the surcharge might have been paid. Furthermore, if a visa application was outstanding and the IHS had already been paid, eligible migrants would be entitled to its automatic reimbursement by the Home Office, directly to the bank account or card used to pay the fee (UK Government 2021g). The argument was that the IHS aims to help the NHS achieve its goal of treating the ill and saving lives, and that is what migrant workers have been doing through the "fantastic contribution" that they are making to the service (Home Office 2020b). Issues arise when one notes that the delivery on this promise has not been as straightforward as the Government's announcement suggests, and constitutes one more instance of what I referred to as a "hierarchy of deservingness" which values certain foreign NHS workers more highly than others.

Indeed, *some* overseas health and care workers are exempt from paying the IHS in order to access health services in the NHS on a similar basis to those ordinarily resident in the country. For these migrant workers, the promise of hospitality made by the UK Government has in fact been delivered: The success of their visa application does not depend on the payment of the surcharge anymore. That begs the question: Who are those that get to enjoy this "gift" of hospitality? The response to this question is: "Favoured" hosts/guests who are placed hierarchically above those performing hosting activities qualified as low-skilled. These comprise a list of occupations consisting of doctors, nurses, paramedics, and social workers, to name just a few, overlapping with the list of eligible jobs for the HCWV scheme (UK Government 2021g; UKVI 2021). NHS support staff in their turn are not exempt from paying the IHS. Rather, they are eligible for reimbursement following payment of the charge. Furthermore, payments cannot be claimed in just one go, but instead in six-month blocks to be returned by the Home Office to the claimant in monthly instalments (Macdonalds 2020: 17 – 18). The detrimental treatment of NHS support staff has been met with criticism that contends that the policy is unfair and "will leave some of the lowest paid health and social care under a terrible financial burden" (UNISON 2020: 1).

The predicaments faced by low-paid workers in NHS support occupations illuminate the "hierarchy of deservingness" to which I have drawn attention, and highlights the hierarchical character of the welcome of migrant health and care workers into the UK. These (g)hosts carry out the mundane – but indispensable – acts of hosting which enable the operation of hospitality in the NHS, and yet are deprived of a range of "gifts" provided by COVID-19-related schemes which favour those deemed to be highly skilled. From this perspective, the welcome offered to these less valued, "undeserving" guests/hosts remarks that – when it comes to the reception of migrant workers into the UK – "hospitality turns into a question of who deserves and who does not. To whom will we extend our pity, our acknowledgement – or, for that matter, our contempt?" (Dufourmantelle 2013: 16). It is not simply that hostility becomes embedded in acts of welcome since it has always already been. Forms and degrees of hostility are determined by understandings of the deservingness of the guest to be welcomed, which are then translated into acts of exclusion and deprivation.

6. Conclusion: Scripting the NHS as a space of hospitality for foreign workers

In this chapter, I have drawn on the COVID-19 pandemic to demonstrate how the welcome of migrant workers into the NHS allows for a reconfiguration of the traditional roles of guests and hosts in the management of the home. Furthermore, I explained how the blurring of boundaries separating these figures disrupts conventional power relations stemming from the dynamics between these two subject positions. Foreign NHS workers are hosts that enable the offer of hospitality in the NHS. However, in doing so, they enact the hostility underlying the welcome of migrant patients into the service by taking part in the data-sharing policies between the NHS and the Home Office. In other words, their acts of hosting allow for the enactment of 'hostipitality' because they cannot help but risk being hostile towards those to whom they seek to be hospitable. In addition to that, foreign NHS staff are themselves subject to hostility in their experience of guesting as revealed by the COVID-19-related measures adopted by the UK Government in respect to overseas health and care workers. It is noteworthy that this hostility is not experienced by migrants in the same manner because some foreign workers are less welcome than others. This is the case of NHS support staff who helpfully illustrate the operation of a "hierarchy of deservingness" in the hospitality offered to overseas workers who wish to enter or remain in the UK.

There is one more way in which foreign NHS workers enable hospitality in the health service. To be more precise, I am referring to a second manner in which overseas NHS staff strengthen the sense that hospitality lies at the core of the operation of the health system: They help the UK Government constitute a narrative of gratitude and acknowledgement that portrays the NHS as a genuinely open and hospitable space for migrant workers from across the globe. A few examples are illustrative of this point. In a letter to the Home Affairs Committee regarding the one-year visa extension, former Home Secretary Priti Patel stated that "[w]e recognise that *every* individual working in and to support the health and care sector is playing a crucial role in the UK's efforts to tackle coronavirus and save lives" (Home Office 2020d: 2, emphasis added). In another instance, the point was made that the Government is "incredibly grateful to *all* overseas health and care workers fighting this invisible enemy" (Home Office 2020c, emphasis added). This is not, however, a simple exchange of statements between governmental bodies and departments. Rather, this narrative of gratitude and acknowledgement is vastly promoted by public announcements (Home Office 2020a; 2020c), and receives widespread publicity through the media coverage of the UK's response to COVID-19 (Woodcock 2020).

In regard to low-paid workers, the extension of the bereavement scheme to NHS support staff consists of an example of particular relevance. The measure was framed by the Home Office as one of the unprecedented initiatives to proactively support these "heroes" by offering their families and dependants ILR in the event of their death due to contracting coronavirus. Once again, the policy makes a stated attempt to demonstrate that the Government recognizes "the tireless dedication and selflessness of those on the frontline", and that it owes foreign workers "a great deal of gratitude" (Home Office 2020e: 1). As previously mentioned, this is an illustration of peculiar significance given that the UK Government more often than not obliterates NHS support staff's contributions by excluding them from a range of benefits provided by COVID-19-related schemes for overseas workers. This is the case for the arrangements that put in place the one-year visa extension and the HCWV. However, in announcing that the bereavement scheme was being extended to NHS support staff, the UK Government stepped up efforts to make them visible so that it reiterates the narrative that all migrants are equally valued, and that foreigners from across the globe are welcome to join the health system.

On one level, the narrative of gratitude and acknowledgement advanced by the UK Government allows for the portrayal of the NHS as a hospitable space for migrant workers from across the world. On another level, this same narrative enables the fulfilment of a different purpose: By

remarking the welcoming of foreign staff into the service, it shifts attention from the hierarchical character of the welcome offered to overseas workers by the UK. The inauguration of the aforementioned points-based immigration system helpfully captures this argument as it promises to "open up the UK to the brightest and the best from around the world" while offering no specific route for those deemed to be low-skilled workers (Home Office 2020f). Such a discrepancy in the treatment of foreign workers paints a puzzling picture: (G)hosts are celebrated in the narrative of gratitude and acknowledgement advanced by the UK Government for enabling the operation of hospitality in the NHS and for risking their lives to ensure healthcare provision. However, these same (g)hosts, under the points-based immigration system, are portrayed as "parasites", guests who are wrong, illegitimate, unwanted and uninvited (Derrida and Duffourmatelle 2000: 61).

The narrative of gratitude and acknowledgement of the role of foreign staff in the operation of the NHS also works to obfuscate ethical issues arising from the recruitment of healthcare workers from overseas. The global crisis triggered by COVID-19 shed light on the problem as the UK Government created the aforementioned set of measures to boost international recruitment for the NHS, such as the HCVW scheme explained in this chapter. However the ethical implications of recruiting staff from overseas amidst the pandemic – especially if they are coming from low and middle-income countries significantly impacted by COVID-19 – remains under significant contestation (Macdonalds 2020: 30). The situation alludes to what some have framed as an instance of a "postcolonial continuation of the colonial extraction of resources" (Shahvisi 2018: 341) where countries in the Global South which were colonies of the past British Empire continue under exploitation of their resources through practices of international recruitment. These criticisms, however, risk being overshadowed by the narrative of gratitude and acknowledgement of the role of overseas workers in the operation of the NHS, which help portray the service as a space of hospitality for migrants from across the globe.

CHAPTER FIVE: TOWARDS AN ANALYSIS OF HOSPITALITY THROUGH THE LENS OF THE DISPOSITIF

1. Introduction

My analysis of immigration enforcement through the NHS has been centred on the notion of hospitality. In other words, my examination is concerned with the ways in which border control through the provision of healthcare interferes with more or less welcoming forms of receiving migrant patients into the service. To explain my understanding of hospitality, I draw inspiration from the work by – and the literature based on the thought of – Derrida. As I explained in Chapter One, decisions and responsibilities regarding the welcome of the other must be taken between the two heterogeneous – but indissociable – figures of hospitality: Unconditional and conditional, the law and the laws (Derrida 2005b). Conditional hospitality translates the unconditional into something concrete and determinate while the unconditional works as reference and inspiration for the perfectibility of the laws (Derrida 2003: 129). It is worth remembering that the aforementioned decisions are always the outcome of interminable negotiations between these two poles. Because our negotiation does not establish the "best" hospitality, there is simply not a moment when we can stop or settle in one position without being "haunted" by the shadow of hostility. The ever-lasting task of negotiating between the conditional and unconditional allows for the pursuit of the "least bad" conditions to be placed on the welcome of the foreigner; the "least bad" hospitality is not the "best", but the important thing is that, at the same time, it does not offer the guest the worst reception (Bulley 2006: 655).

Derrida proposes another way in which we can conceive unconditional and conditional hospitality. His suggestion is that we look at those figures from the perspective of the visitation and invitation of the other (Derrida 2002a). For Derrida, in order to be hospitable, one must "let oneself be swept by the coming of the wholly other, the absolutely unforeseeable stranger, the uninvited visitor, the unexpected visitation beyond welcoming apparatuses" (Derrida 2002a: 361-362). In other words, hospitality requires an openness to welcome when we are not ready or prepared to receive the foreigner who comes without notice. However, this is just half the story when it comes to the hospitable reception of the other. Hospitality "must be ready to welcome, to host and shelter, to give shelter and cover; it must prepare itself and adorn itself for the coming of the *hôte*; it must even develop itself into a culture of hospitality, multiply the signs of anticipation, construct

and institute what one calls structures of welcoming, a welcoming apparatus" (Derrida 2002a: 360 – 361).

Taking my cue from Derrida, I suggest that the workings of the welcoming apparatus define the form of hospitality to which the guest is subject in their interplay with the host in the space of the home. I ague that they do so by shaping the constitution of the subject positions of the host and the guest while framing their experience of hosting and guesting. This chapter approaches the question as to how to map out and understand the factors and contingencies shaping the reception of the foreigner into the homely space. In my view, in order to do so, we need to explore the apparatus that – while being established for the welcome of the other – "shapes behaviours, conditions the possibility of different outcomes, and is performative of different types of subjectivities" (Lundborg and Vaughan-Williams 2011: 381). In other words, we need to pay regard to the constitution and operation of the welcoming apparatus or dispositif of hospitality.

In order to carry out this analysis, I articulate the notion of the welcoming apparatus with the concept of the dispositif (Foucault 1980). In simple terms, the dispositif can be conceived as the system of relations which can be established between the heterogeneous elements making up an apparatus. In their interconnections, they constitute an ensemble that is formed to respond to an "urgent need" relating to the government of distinct dimensions of life. Drawing inspiration from Foucault, I argue that the welcoming apparatus consists of a heterogeneous assemblage of discursive and material elements which are linked together to construct a system for responding to the arrival of the foreigner. While doing so, I explicate the significance of the dispositif as a methodological device for comprehending practices of hospitality against the backdrop of immigration enforcement through the NHS.

This chapter is organised around the three "methodological prescriptives of the dispositif": heterogeneity, relationality and function (Thomas 2014: 168). In this vein, in the next section, I address the heterogeneous elements constituting the welcoming apparatus by proposing that we understand them as rationalities and technologies of government (Aradau and Rens van Munster 2007). In the following section, I explore the mobile relations between the discursive and material elements constituting the dispositif. I draw especial attention to the way in which the shifting interplay of discourse and institutions can frame the decisions regarding the welcome of the foreigner while impacting on their experience of guesting. In the next section, I suggest an analysis of the welcoming apparatus from the perspective of its functionality. By highlighting how it

operates strategies to respond to an "urgent need", I explain why the welcoming apparatus can be conceived as a dispositif of security in an economy of biopower. Finally, in the conclusion, I explain how the dispositif performs a re-signification of its "negative" outcomes in order to convert them as means of achieving distinct ends and reinforcing its own operation. In the different parts of the chapter, I refer to my analysis of hospitality for migrants in the NHS in order to build my argument.

Before going any further, it is important to highlight – what thus far has been implied – that my suggestion of investigating hospitality through the lens of the dispositif is concerned with its conditional form – i.e. hospitality of invitation in the terms explained above. Not that my analysis downplays the significance of the unconditional for the offer of hospitality. While being aware that absolute hospitality cannot be translated into policies and laws without the risk of disallowing the very possibility of hospitality itself, my examination takes into account that the reference to the unconditional is paramount for the progress of the conditions imposed on the welcome of the other. Putting it more beautifully, Derrida (1999: 70) goes on to argue that "it is not for speculative or ethical reasons that [he is] interested in unconditional hospitality, but in order to understand and transform what is going on today in our world." That being said, it is worth remembering that it is conditional hospitality that is commonly practiced by individuals, communities and states – i.e. the type of hospitality that generates, with certain conditions, laws, regulated practices, and conventions on the national and international levels (Derrida 1993: 128). In other words, "the expected arrival is a far more common way in which the everyday ethics of hospitality is practised" (Bulley 2017: 5). It is in reference to this understanding that I draw on the concept of the dispositif to focus attention on conditional offers of hospitality.

2. The heterogeneity of the welcoming apparatus

An initial endeavour to utilise the dispositif as a methodological framework to investigate the factors and contingencies shaping the reception of the foreigner into the homely space raises the question as to what the dispositif consists of. More precisely, the issue at hand is that of determining what elements can be constitutive of the apparatus, even without the aim of providing an exhaustive list of its components. In his most straightforward explanation of the concept, Foucault offers a helpful illustration in this regard:

> What I'm trying to pick out with this term is, firstly, a thoroughly heterogeneous ensemble consisting of discourses, institutions, architectural forms, regulatory

> decisions, laws, administrative measures, scientific statements, philosophical, moral and philanthropic propositions - in short, the said as much as the unsaid. Such are the elements of the apparatus. The apparatus itself is the system of relations that can be established between these elements (Foucault 1980: 194).

In International Politics, scholarly works have drawn attention to the constituents of the dispositif. Claudia Aradau, Martin Coward, Eva Herschinger, Owen D. Thomas and Nadine Voelkner (2014) argue that "the dispositif can be operationalized as a methodological device that attends to the heterogeneous articulation of discourse and materiality" (Aradau et. al 2014: 63). In their view, "materiality" alludes to "the matter out of which the world is composed: the nonhuman things that make up our everyday existence as well as the corporeality of our embodiments". Discourse, in its turn, refers to what Aradau et. al (2014: 58) describe as meaning-making activity which constitutes the social and natural worlds by providing us with the conceptual tools that define them. In his turn, Mark B. Salter (2008: 248) contends that the dispositif "constitutes a constellation of institutions, practices, and beliefs that create the conditions of possibility within a particular field. It is a capability for governance, or the disposition of a field towards a mode of governance." In another vein, Eva Herschinger (2015: 184) highlights that the dispositif "encompasses a wide range of practices, institutions, and convictions" while Alexander D. Barder and François Debris (2009) stress that the elements of the dispositif constitute "machines *for* government (but not *of* government) whose regularities of conduct nonetheless owe very little to the possible existence of a centralized power or to the traditional model of sovereignty" (Barder and Debris 2009: 408, emphasis in the original).

The way in which I conceive the elements making up the dispositif is to a great extent indebted to the aforementioned theorisations of the concept. Such approaches, in their turn, do not constitute conflicting views of what the apparatus consists of. Rather, they shed light on specific dimensions of this methodological device while emphasising particular features which the dispositif holds. Generally speaking, we could argue that they interpret the apparatus in different manners, but these interpretations do not necessarily conflict with one another. In what follows, I add one more theorisation on the elements making up the dispositif which – as previously explained – do not contradict the approaches that I referred to above. However, it does orient our attention to certain aspects which are paramount for the purposes of characterising the structures of welcoming put in place for the reception of the foreigner into the homely space. In this vein, my view is aligned with that of Claudia Aradau and Rens van Munster (2007) for whom "the heterogeneous elements that make up a dispositif can be understood more systematically as rationalities and technologies of government" (Aradau and Rens van Munster 2007: 97).

Putting it simply, the argument is that "rationalities are ways of thinking about a social problem that will make its management practicable" while technologies are the means of realisation of such rationalities (Aradau and van Munster 2007: 97). As the explanation suggests, these two distinct categories are not rigidly separated from each other. According to Dillon (2008: 178), there is a "continual interplay" between them in a way that "an understanding of the real lurks in every technology", and every political rationality "desires" to be appropriately technologised. Here, further consideration of these elements is required. If political rationalities are ways of thinking about a social problem, what factors can possibly frame such modes of thought? To name just a few, we could follow Peter Milles and Nikolas Rose (1990) and consider "assemblages of philosophical doctrines, notions of social and human realities, theories of power, conceptions of policy and versions of justice" which are elaborated for governing domains of existence while seeking "to specify appropriate bases for the organization and mobilization of social life" (Milles and Rose 1990: 6).

In another vein, an emphasis on technologies of government suggests "a particular approach to the analysis of the activity of ruling, one which pays great attention to the actual mechanisms through which authorities of various sorts have sought to shape, normalize and instrumentalize the conduct, thought, decisions and aspirations of others in order to achieve the objectives they consider desirable" (Milles and Rose 1990: 8). These technologies, however, are not restricted to grand political interventions but also comprise the "apparently humble and mundane mechanisms which appear to make it possible to govern", such as the invention of devices and the building of architectural forms (Milles and Rose 1990: 8). This perspective echoes the view of Aradau et. al (2014) in relation to the relevance of materiality to an analysis of the dispositif (e.g. objects, infrastructures, databases and architectures). The "nonhuman things" which permeate our existence and participate in everyday life constitute (and are constituted by) technologies of government that – along with political rationalities – are co-constitutive of the social order where they find themselves embedded.

Understanding the rationalities embedded in the structures put in place for the welcome of the foreigner is paramount for an analysis of their reception into the homely space. In the case of hospitality for migrants, conceptions of the role of the state, views of the moral status of the foreigner and notions of social justice held by the host – to name just a few – are decisive elements for determining the conditions of the welcome of the guest. In this vein, they constitute modes of

thinking which are fundamental to shaping the degrees and forms of hostility to which migrants are subjected once they cross the threshold of the home. This is helpfully revealed by my analysis of hospitality for migrants in the NHS. For instance, we could take the political rationalities underlying the claim that the NHS can only be sustained as a national – not an international – health service (DH 2015b: 5). The argument implies that healthcare as provided by the NHS (comprehensive and free at the point of delivery) is not an entitlement of everyone in need of health services. British citizenship is valued more highly than foreignness in this regard, despite the official description of the NHS as a residence-based healthcare system. Viewed in this light, this way of thinking can be traced back to the ethos orienting the hostile environment in the UK, which is prominently characterised by an anti-immigration sentiment.

Political rationalities shaping hospitality for migrants are operationalised through technologies consisting of mechanisms deployed to render the control of borders governable. These mechanisms, in their turn, work to inform (and transform) the rationalities with which they are in constant dialogue. A useful example in this regard are the laws and administrative arrangements regulating the reception of the foreigner into the homely space – i.e. their functioning as power technologies deployed to regulate the movement across borders. For instance, against the backdrop of the Charging Regulations, as much as healthcare workers attempted to be as hospitable as they could, the charging regime set boundaries for their conduct or – in Foucauldian terms – it governed their conduct in the sense of structuring their possible field of action (Foucault 1982: 790). Of course, these boundaries could be more or less challenged as the case of the midwives circumventing official procedures to protect migrant women revealed. However, the practice of hospitality was always framed with reference to the rules set out by the charging regime.

It is worth noting that the issue of pushing the boundaries set by the Charging Regulations highlights the role of moral propositions in the offer of hospitality. As my discussion throughout the thesis revealed, confrontation and resistance against the charging of migrants for their healthcare commonly invoked moral and philosophical claims reflecting concerns with human rights, social justice, equal human worth and healthcare workers' ethical responsibility (Hiam et. al 2018; Potter 2017; Shahvisi 2019). These concerns were generally traced to the safeguarding of the values and principles enshrined in the NHS Constitutions and to the observation of the rules establishing professional standards of practice and behaviour for healthcare workers in the UK (Abubakar et. al 2019; Mitchell and Reynolds 2019). As explained in Chapter One, these constitute the ethical framework orienting healthcare provision in the NHS while establishing the moral

grounds on which most resistance against the charging regime finds its justification. Hospitality therefore was produced through the attempts to abide by the norms enshrined in this ethical framework with an attendant eye to the rules set out in the Charging Regulations.

It is worth here recapitulating that the technologies of government constituting the dispositif are not exclusively the grand political interventions aimed at administering social problems, but also the micro-practices of management which make government possible. This is the case for the apparatuses established for the reception of the foreigner into the homely space. Returning to the case of midwives providing maternity care for migrant women in the NHS, we can conceive the booking appointment as one those micro-practices shaping hospitality in the service. As explained in Chapter Three, it constitutes the gateway for the planning of care during pregnancy. Among other procedures, it entails filling out the booking form by means of which patients' personal information is collected with the aim of fostering maternal care and pregnancy outcomes. However, this same procedure allows for the identification of migrant women's chargeability and their subjection to immigration enforcement (Maternity Action 2019: 26). In other words, the booking appointment consists of a technology forming the welcoming apparatus which enables the welcome of pregnant migrant women into the NHS while enacting hostility towards them.

Finally, the technologies of government constituting the welcoming apparatus can also be seen from the perspective of their materiality, i.e. "the matter out of which the world is composed" (Aradau et. al 2014: 63). Among other things, that refers to nonhuman things such as objects in general, infrastructures and architectures (Aradau et. al 2014; Miller and Rose 1990). It seems important to give prominence to infrastructures and architectural forms in an analysis of hospitality given the centrality of the home for the practice. It is true that the home is more than the matter from which it is built, with affective components being relevant for the constitution of the homely space (Bulley 2015; 2017). However, its materiality cannot be simply disregarded. From the perspective of healthcare provision, this is particularly captured by the argument that "poor NHS buildings mean poor NHS care", implying that the precarious condition of some NHS buildings and equipment has affected patients' experience and the ability of the service to fulfil its purposes (King's Fund 2022). In other words, it has affected the ability of the NHS to offer a hospitable reception of patients as well as their experience of guesting when accessing the health system.

Furthermore, the disposition of things inside the home has a crucial role to play in framing the guest's experience of hospitality and in illuminating the host's attitude towards the guest.

Differences in the approach to the reception of migrants into healthcare settings by NHS providers are helpful to illustrate this point. As I mentioned in the introduction to this thesis, humanitarian organisation Doctors of the World (DotW) created a safe surgeries toolkit in order to encourage general practices to become a more hospitable place for migrants. Part of this toolkit was formed by posters informing migrants that they were welcome to be patients of those surgeries, and that they would not be subjected to unnecessary protocols potentially leading to immigration enforcement (e.g. providing proof of identity, residence or regular immigration status).

As of October 2022, more than 1,000 practices across the UK had embraced DotW's initiative and chosen to become safe surgeries (DotW 2022). However, that is not the case for every NHS provider. Some hospitals in England display in their receptions posters informing migrants that treatment is not free for all, and that visitors, temporary residents and those with unlawful residence in the country can be liable for charges (Open Democracy 2018). The aforementioned practices constitute technologies forming the structures of welcoming for migrants in the NHS. They suggest distinct attitudes towards the reception of foreigners into the service, and can result in different perceptions of hospitality on the part of migrant patients. In doing so, they reiterate the view that more attention needs to be paid to the materiality of the welcoming apparatus if one seeks to investigate the practice of hospitality.

3. Relationality and the operation of the welcoming apparatus

Foucault (1980: 194) asserts that the dispositif consists of the system of relations which can be established between the heterogeneous elements constituting the apparatus. Such relationality, as Aradau et. al (2014: 63) explain, "conveys an articulation of heterogeneous elements – the discursive and the material – bound to each other in a particular arrangement constitutive of meaning." In other words, shifts in the relation between the constituents of the apparatus imply different ways of governing the realm of social life which is addressed by the dispositif in question. For instance, in regard to the welcoming apparatus, an anti-immigration policy articulated by the executive branch of government can be countered by a more welcoming law created by the legislature or by a less hostile ruling made by the judiciary – all addressing the same socio-political problem. In a different vein, further pieces of legislation and legal decisions can reiterate the anti-immigration rationality underlying the given policy. Hospitality can therefore constitute a more or less welcoming experience for migrants, according to the elements making up the dispositif in a given time and space, and the connections established between them under particular

circumstances. The issue of the mobile relations between the elements of the apparatus is well-described by Foucault in his explanation of relationality in the dispositif:

> Secondly, what I am trying to identify in this apparatus is precisely the nature of the connection that can exist between these heterogeneous elements. Thus, a particular discourse can figure at one time as the programme of an institution, and at another it can function as a means of justifying or masking a practice which itself remains silent, or as a secondary re-interpretation of this practice, opening out for it a new field of rationality. In short, between these elements, whether discursive or non-discursive, there is a sort of interplay of shifts of position and modifications of function which can also vary very widely (Foucault 1980: 194 - 195).

Hospitality for migrants in the NHS provides a useful illustration of the mobile relations between the elements of the dispositif, and how the shift in these relations can constitute a more or less welcoming reception of migrant patients into the service. In order to address this question, I propose an examination of relationality by focussing on the Department of Health and Social Care (DHSC) and discourses on healthcare provision by the NHS. Some notes on the deployment of the term "discourses" can be of use at this point. To begin with, it is worth stressing that discourse does not equate to language nor does it merely describe reality. As Sara Mills (2003: 55) explains, "[d]iscourse does not simply translate reality into language; rather discourse should be seen as a system which structures the way that we perceive reality." What are the constitutive elements of discursive formations? Even though the reduction of discourse to language is inaccurate from a Foucauldian perspective, the latter has an important role to play in the constitution of the former. In this vein, language can be conceived of as an "intellectual technology" which "provides a mechanism for rendering reality amenable to certain kinds of action" (Miller and Rose 1990: 7). However, understood as a meaning-making activity that allows us to make sense of the social and natural worlds, discourse assumes a rather broad character making room for knowledge and practices (Aradau et. al 2014, 58). Not that there does not exist a realm of the non-discursive (e.g. technical devices, infrastructures or architectural forms), but materiality can only be apprehended through discursive mediation (Mills 2003: 56).

The second point to raise in respect to the use of the term discourse concerns the fact that it goes beyond a mere description of reality, but rather works to frame the ways in which we make sense of it. In doing so, it opens up avenues for a range of manners in which action can be taken to conform to, transform or resist the effects of power relations. This is helpfully captured by Foucault (1981: 100 – 101) when he explains that "we must make allowances for the complex and unstable process whereby discourse can be both an instrument and an effect of power, but also a

hindrance, a stumbling block, a point of resistance and a starting point for an opposing strategy. Discourse transmits and produces power; it reinforces it, but also undermines it and exposes it, renders it fragile and makes it possible to thwart it." For instance, the discourse advanced by the MoU portrayed "illegal immigrants" as "dangerous" foreigners that threatened the sustainability of the NHS. It produced a certain type of subjectivity (i.e. that of the dangerous immigrant), corroborated the rationality of the hostile environment, and legitimised the technologies of power that subjected "immigration offenders"/migrant patients to border control. At the same time, this discourse amounted to the emergence of knowledges and practices which worked to resist and undermine the data-sharing policy set out by the MoU (e.g. the design of the Safe Surgeries Toolkit by DoTW and its use by general practices across England).

Having explained my use of the term "discourse", I now begin my analysis of relationality within welcoming apparatuses by drawing attention to the DHSC and discourses on healthcare provision by the NHS. Following Foucault's definition of the dispositif, I start by addressing the particular discourse which figures as the programme of the aforementioned institution: Delivering improvements in the health and wellbeing of the population in England. As the DHSC puts it, the department "helps people to live more independent, healthier lives for longer. It leads, shapes and funds health and social care in England, making sure people have the support, care and treatment they need, with the compassion, respect and dignity they deserve" (DH 2013: 7). Framing the mission of the department as a biopolitics of care constitutes a useful way to portray its operation as an instrument to secure security as an optimised stated of health and wellbeing. However, when the DHSC advocates for the implementation of the charging regime, this discourse assumes a different function and works to justify practices which are effaced from the self-proclaimed aim of health enhancement: The restriction and exclusion of migrants from the NHS, resulting in worse health outcomes and their increased risk of death. This is nonetheless half the story. The discourse of delivering improvements in health and wellbeing allows for a re-interpretation of such restrictive and exclusionary practices: In principle, they are enacted not because immigration is managed as a threat, but because they constitute an indispensable means of ensuring the sustainability of the NHS.

On a final note, it is worth highlighting that the mobile relations of the elements making up a welcoming apparatus results in arrangements of continual variation which establish distinct outcomes for those caught within them. In other words, the dispositif produces "political practices differently depending on what elements are present and how they are related in a particular

moment" (Thomas 2014: 169). One of the most significant implications of the instability of the elements of the apparatus – and the variable nature of their connections – lies in the fact that the effects of particular technologies of government can be constrained (or maximised) by the specific arrangement in which they find themselves. That is why it makes sense to argue that "a given technology of governance can operate one way when embedded within one particular arrangement, and in an entirely different way when embedded in another" (Thomas 2014: 169). And, when it comes to the welcoming apparatus, shifts in how governmental technologies perform result in different experiences of hospitality. One can take the example of primary healthcare provision for "illegal immigrants" under the MoU and after the memorandum was withdrawn. In the first scenario, delivery of health services implied a more hostile reception of migrants into the NHS, given that their data could be transferred to the Home Office for immigration enforcement. After the agreement was terminated, the data-sharing policy came to a halt, which allowed for less hostility to be enacted towards migrant patients.

4. The functioning of the welcoming apparatus

The third angle from which I suggest an analysis of the welcoming apparatus is that concerned with the set of functions and capabilities associated with it. The definition which I propose tells us much in this regard. In my view, a welcoming apparatus is a heterogeneous assemblage of discursive and material elements which are linked together to construct a system *for responding to the arrival of the foreigner*. My conceptualisation implies that such an apparatus sets up the structures of welcoming put in place for the reception of the foreigner into the homely space. The point that I wish to make here is that – by definition – the establishment of the welcoming apparatus works to provide the guest with an offer of hospitality – however hostile that might possibly be. Nonetheless, Foucault draws our attention to an important peculiarity of the dispositif in regard to its functionality. This is helpfully captured at the end of the definition of the apparatus which he provides us with:

> Thirdly, I understand by the term "apparatus" a sort of – shall we say – formation which has as its major function at a given historical moment that of responding to an *urgent need*. The apparatus thus has a dominant strategic function. (Foucault 1980: 195, emphasis in the original).

Following Foucault, an analysis of the dispositif requires an examination of its dominant function at a certain time and space, and under particular circumstances. Furthermore, it demands an investigation of how the dispositif is operated as a strategy aimed at responding to what is deemed

an "urgent need". In our times, the so-called "migration crisis" – or rather "the non-welcoming crisis" (Dadour 2021:29) – illuminates how the dispositif of hospitality has been deployed to be manage the "urgent need" to regulate international migration – be it by closing borders, filtering migrants to be welcomed or outsourcing asylum seekers to third countries. However it is deployed, the operation of the welcoming apparatus is primarily centred on the security of the receiving state and its citizens. At this point, it is useful to recapitulate that, in an economy of biopower, the government of life is exercised through – and in reference to – security (Foucault 2003). In this process, life is fostered for some but disallowed to the point of death for others. From this perspective, we could argue that the welcoming apparatus constitutes a dispositif of security which tackles the "urgent need" to protect the home and the host against the "threats" and "dangers" arising from the reception of the foreigner. Against the backdrop of the governmentalised state, the welcoming apparatus functions as a means to secure security for the state and its citizens against the "dangerousness" of opening up the home to the "risky" other. It does enable the welcome of the foreigner, but that reception is conditioned by the imperative to protect the host and the home against the "dangers" coming from the "outside".

An incursion into the UK points-based immigration system is a helpful illustration of how the welcoming apparatus can be conceived of as a dispositif of security. In a nutshell, the scheme operating from January 2021 assigns points for specific skills, qualifications, jobs and salaries, with visas being awarded only to those obtaining the required number of points. From the outset, the Home Office contends that the system constitutes a means of putting an end to free movement, reasserting the control of national borders, and restoring public trust in the UK Government (Home Office 2020f). In other words, the new way of regulating migration establishes a specific relation between interventions in the present and potential outcomes in the future. However (un) realistic the delivery of these promises may be, their realisation remains situated within the realm of uncertainty and probability – which constitutes a fundamental mechanism through which the dispositif of security operates (Foucault 2007: 6). One could argue here that the welcoming apparatus set up by the scheme characterises an instrument for accomplishing goals whose achievement makes it more difficult to welcome the foreigner. In this scenario, hospitality risks being undermined by the operation of rationalities and technologies of security.

It is also important to note how the UK Government frames the immigration system as a way of maximising benefits for the nation and its citizens by "giving top priority to those with the highest skills and the greatest talents" to the detriment of "cheap, low-skilled labour coming into the

country" (Home Office 2020f). As the Home Office puts it, this restrictive focus on "the brightest and the best from around the world" would boost the national economy and unleash the UK's full potential, as well as bringing down overall migration numbers (Home Office 2020f). This approach to immigration is intrinsically related the operation of the dispositif of security. To begin with, it renders the welcome of the foreigner into a matter of calculating costs and benefits for the host. For Foucault, that is one of the most prominent features of the dispositif: Prompting "power" to insert phenomena into a calculation of cost (Foucault 2007: 6). Hospitality therefore is conceived as a form of transaction in which the host expects to make most gains, and profit as much as possible from the reception of the guest.

On the basis of the analysis above, the welcoming apparatus is designed to ensure the most efficient management of the home – even if that implies a more hostile reception of migrants or their outright exclusion. In doing so, it does not instantiate a mechanism for sealing off the UK's borders so that overall migration can be reduced. Rather, the dispositif renders the management of migration into "a matter of organizing circulation, eliminating its dangerous elements, making a division between good and bad circulation, and maximizing the good circulation by diminishing the bad" (Foucault 2007: 18) – another fundamental feature of the operation of the dispositif of security. Such an administration of the movement across borders constitutes hospitality as a regulatory instrument devised to maintain overall migration figures within "an average considered as optimal on the one hand, and, on the other, a bandwidth of the acceptable that must not be exceeded" (Foucault 2007: 6).

Hospitality for migrants in the NHS also illuminates the ways in which the welcoming apparatus can be conceived as a dispositif of security. To begin with, it is worth recapitulating that the apparatus set up for migrants to access healthcare is framed by the UK Government as a means to secure security as an optimised state of health and wellbeing for those ordinarily resident in the country. The dispositif is designed to respond to the "urgent need" to protect the NHS against the alleged pressures arising from the use of the service by migrant patients. In pursuing this aim, the UK Government situates hospitality for migrants in the NHS in the arena of uncertainty and probability: A more welcoming reception of foreigners into the service risks its sustainability, and might compromise its ability to provide healthcare to those deemed to be its legitimate users. Furthermore, hospitality in this scenario finds itself embedded in a process of calculation of costs where the making and recovering of charges from migrants is central for the management of their welcome. Last, despite concerns with the sustainability of the NHS and the "threats" posed by

migrants, hospitality for migrants in the service does not aim to simply close the "doors" of the health system on the foreigner: Mechanisms are put in place so that certain migrants are granted access to healthcare while others are left to perish and die.

5. Conclusion: The strategic completion of the dispositif and the possibility of a less hostile reception of the foreigner

In this chapter, I contended that a welcoming apparatus consists of a heterogeneous assemble of discursive and material elements which are linked together to construct a system for responding to the arrival of the foreigner. I began by explaining how we can conceive of the different elements making up the dispositif as rationalities and technologies of government – i.e. ways of thinking that shape the reception of foreigners into the homely space, and the means through which such rationalities are operationalised. Then, I emphasised that the relations between the elements of the dispositif are in constant variation and, therefore, shifting its character and operation. In this regard, the changing relations between the components of a welcoming apparatus give rise to the emergence of differentiated arrangements which allow for a more or less welcoming of the other into the home. I finally suggested an analysis of the dispositif from the perspective of its functioning. In doing so, I explained that the apparatus has a dominant strategic function that works to respond a time/space-bound "urgent need". In an economy of biopower, my argument is that the welcoming apparatus constitutes a dispositif of security which responds to the "urgent need" to protect the home and the host against the "threats" stemming from the reception of the guest. Through the operation of the governmentalised state, the welcoming apparatus enables the welcome of the foreigner, but such a reception is conditioned by the imperative to secure the state and its citizens against the "dangers" of opening up its borders to the "risky" other.

As revealed in this chapter, the proposal of exploring hospitality through the lens of the dispositif is illustrated by my analysis of immigration enforcement through the NHS. At this point, it is worth noting that hospitality for migrants in the service orients our attention to another significant feature of the apparatus, i.e. its "strategic completion" (Foucault 1980: 196). Foucault deploys this expression to refer to what he terms a reutilisation of the unintended, unforeseen or "negative" effects of the dispositif within a new strategy which re-signifies the "failures" of the apparatus by deploying them for the achievement of diverse economic and political ends (Foucault 1980: 195 – 196). From this perspective, the side-effects of the dispositif do not destroy it but are instead deployed to reinforce it (Thomas 2014: 170). As previously explained, the Charging Regulations

(as laws shaping the welcome of migrant patients into the NHS) are one of the elements making up the welcoming apparatus set up for the reception of foreigners into the health service. The main justification of the charging regime, as has been explicated, consists of making and recovering charges from "overseas visitors" in order to ensure the sustainability of the service. However, charging destitute migrants for their healthcare – or even those who are not destitute but unable to cover the costs of the delivered health services – fails to accomplish the strategic goal of the dispositif because these migrants are simply unable to pay for the healthcare that they have received.

What is important to note about the aforementioned "failure" of the dispositif is that this negative outcome is re-utilised by the UK Government to reinforce the welcoming apparatus regulating the entry and stay of migrants into the country. As explained in Chapter Two, inability to pay NHS debts of £500 or more for at least two months can result in a visa application being refused. In this scenario, it is true that the aim of ensuring the sustainability of the NHS through the recovery of charges may not be achieved. Nevertheless, the "negative" outcome of the workings of the dispositif constitutes – less of a threat to its operation – and more of a "successful failure" in the sense that it is employed for the achievement of political ends whose accomplishment reinforces the overall aim of the welcoming apparatus set up by the UK Government: Providing an offer of hospitality for migrants conditioned by the imperative to secure security for the state and its citizens. That is the process of strategic completion of the dispositif which renders its frailties into strengths, its negatives into positives.

In light of the above, what could be said about the possibility of transformation of the welcoming apparatus in order to enable a less hostile reception of the foreigner? Does its strategic completion imply an inevitable reinforcement of the hostility experienced by the guest? My response to this question is negative for two main reasons. First, it is crucial to remember that "the relations between elements in a dispositif are under continual variation" which undermines deterministic approaches that stabilise the effects of the apparatus for those caught within it (Thomas 2014: 169). Because discourses and materiality making up the dispositif are not stagnant, there remains the possibility of identifying what Gilles Deleuze (1992: 162) terms the "lines of splitting, breakage and fracture" composing the apparatus, which can always emerge in the process of re-arrangement of its elements. In doing so, we can pursue opportunities to render the reception of the foreigner into a less hostile experience. Secondly, the structures of welcoming put in place for the reception of the other are always the result of the negotiation between the law and the laws of hospitality.

And this negotiation, as Derrida (2002b) reminds us, is interminable and always susceptible to change. It is true that this implies the chance of a more hostile reception taking place. However, it also opens up avenues for a more welcoming reception to be offered.

CONCLUSION

By focusing attention on the system for charging migrants for NHS services, my thesis argued that practices of hospitality which deliver improvements in migrants' health and wellbeing also subject them to hostility by means of technologies of power which control borders through the provision of healthcare. My investigation was motivated by the quest to identify and analyse power technologies operating through acts of hospitality in the NHS which allow for a welcome of migrants into the service but also subject them to immigration enforcement in their access to healthcare. In carrying out my examination, I demonstrated that techniques of care, surveillance and exclusion are embedded in practices of hospitality in the NHS in a way that interrogates healthcare as an intrinsic good and medical practice as the instrument for delivering it. In this vein, hospitality does not constitute *per se* a benevolent act of welcoming migrants into the NHS which works to improve their health and wellbeing alone. Once health services are provided as hospitality, migrants are also subject to different forms and degrees of hostility enabled by immigration enforcement in the healthcare system.

In analysing what happens when migrants are welcomed into the NHS, my thesis demonstrated how hospitality allows for the enactment of hostility towards migrant patients in a way that hospitality itself turns out to operate the opposite of welcoming (Derrida 2002a: 359). In doing so, my discussion remarked how hospitality is incommensurate with a stable representation in the sense that it remains forever torn between the law and the laws of hospitality. Attempts to encapsulate the concept in any fixed conceptual determination simply fail because decisions about the welcome of the foreigner are always taken between these two figures of hospitality. This "double law of hospitality" requires an interminable process of negotiation between the unconditional (as a reference point for the perfectibility of the laws) and the conditional (as the enactment of the law so that it offers something determinate) while defining the "unstable site of strategy and decision" (Derrida 2005b: 6). Because the decisions and responsibilities which enact the concept of hospitality remain in the precarious terrain of instability, there is always a promise of progress and improvement of the conditions stipulated for the welcome of the other. At the same time, there is no way of making assurances that the "best is yet to come" or that the renegotiated decision will provide a less hostile reception of the foreigner.

The operation of hospitality marked by its ever-present hostility – therefore, of "hostipitality" (Derrida 2003: 3) – was especially captured in Chapter One, where I analysed the data-sharing

policy set out by the MoU establishing the protocol under which the NHS should transfer migrant patients' non-clinical information to the Home Office for purposes of immigration enforcement. My discussion focused particular attention on the circumstances of migrants with unlawful residence in the UK as the agreement was especially centred on the reduction of immigration offenders in the country as well as minimising the alleged detrimental impacts of illegal immigration on the welfare state (e.g. alleviating pressures on the NHS). As "illegal migrants" were provided with healthcare as a means of health enhancement, NHS staff collected personal data which – after being transferred to the Home Office – allowed for the subjection of "immigration offenders" to practices of border control. Hospitality as healthcare carried hostility within itself, and effaced the possibility of being conceptualised as entirely benign and benevolent.

The issue of hostility underlying practices of hospitality has also been captured in my discussion of technologies of power operating through healthcare provision in the NHS. Hospitality requires sovereignty over the home – but the host can only exercise their sovereign power through a system of filtering and exclusions which determines what guests are allowed to be welcomed (Derrida and Dufourmatelle 2002: 55). From this perspective, hospitality is primarily concerned with issues surrounding the inclusion of the foreigner and the sovereign control of borders. However, immigration enforcement through the NHS pushes us to go beyond a conceptualisation of the power of hospitality as the mere policing of thresholds. Controlling borders through healthcare reveals that the power of hospitality operates in the NHS as a form of governmentality (Foucault 2001). Techniques of care, surveillance and exclusion of migrants operate through the provision of healthcare as a means to secure security for those deemed to be the legitimate users of the service. The analysis of the system for charging migrants for healthcare offered a useful lens for the explication of this process.

The charging regime establishes that "overseas visitors" are excluded from free healthcare provided by the NHS unless they are an exempt person (e.g. refugees) or if the specific health service is exempt in its own right. To be more precise, healthcare must be paid upfront and in full by migrant patients who are not ordinarily resident in the UK – and therefore not entitled to free health services. However, the issue here is not simply one of funding the NHS, but rather one of exposing migrants to death or increasing their risk of dying by denying or restricting their access to healthcare. To put it in Foucauldian terms, the question here is one of killing and letting die. This is particularly illustrated by the stories of Zimbabwean national Simba Mujakachi and Eritrean asylum seeker Esayas Welday, explored in the introduction and in the second chapter of this thesis,

respectively. It is important to note that the charging regime is not entirely concerned with the establishment of exclusions on the basis of immigration status. The Charging Regulations set out that urgent and immediately necessary services cannot be withheld or withdrawn even if payment has not been secured in advance of their delivery. However, services remain chargeable and inability to cover their costs may result in migrants' data been transferred to the Home Office for purposes of debt collection and refusing entry or stay in the UK for those with outstanding NHS debts.

The aforementioned data-sharing policy reveals the operation of techniques of surveillance which allow for the subjugation of migrant bodies and the simultaneous maximisation of their aptitudes. On the one hand, they enable the enforcement of immigration enforcement, but at the same time work to improve migrants' health. However, these surveillance techniques do not operate on the level of singularised individuals only. They constitute the migrant body as an analysable informational flow in order to maintain it under the gaze of a corpus of power/knowledge, but also allow for the constitution of a system that makes possible the management of population phenomena (Foucault 1995: 190). In this respect, they enable the operation of biopolitical interventions which are centred on "making live" through the administration and promotion of life. This is of particular note in the provision of exempt health services for migrants which – rather than instantiating a politics of benevolence and generosity – constitutes a form of biopolitics that relies on the provision of free healthcare as a means to secure security as an optimised state of health and wellbeing. Biopolitics, however, reveals its lethal dimension when it draws upon the killing of the "inferior" race in order to make life live for those who rank higher on a biopolitical scale. Racism is that which justifies the power of death in an economy of biopower, and immigration enforcement through the NHS illustrates how racist mechanisms operate in the control of borders by relying on the identification of (mis) perceived markers of non-Britishness.

The ways in which hospitality ends up enacting hostility were also illustrated in my discussion, in Chapter Three, of maternity services for migrant women who are not entitled to free healthcare by virtue of their immigration status. My primary concern was centred on the ethical dilemmas encountered by midwives when confronted with the need to fulfil their duty of care to the patient and follow the rules of the system for charging migrants for health services. On the one hand, best clinical practice required that medical and demographic information was collected in order to improve maternity care and pregnancy outcomes. However, in doing so, non-clinical data acquired in the best interest of migrant women and their babies could be transferred to the Home Office

via the OVM team for purposes of debt collection and refusing entry or stay in the UK for those with outstanding NHS debts. The dilemma at hand demonstrates how the offer of hospitality as healthcare undermined the fulfilment of ethical responsibility. Not only were midwives acting irresponsibly in their attempts to be responsible, but they could not even prevent the enactment of hostility in their efforts to be hospitable towards migrant women under their care. Ethics and responsibility here emerge through the experience of the aporia, and the "right thing to do" under those circumstances remains undecidable.

The undecidability that midwives are faced with requires them to negotiate between the two equally compelling – but at the same time conflicting – moral imperatives arising through the entanglement of healthcare provision and immigration enforcement. Knowledge of the Charging Regulations is required to establish the "least bad" conditions of hospitality for migrant women (e.g. identifying cases of exemption), but midwives cannot simply remain in "good conscience" when making a decision because attempts to be responsible do not prevent the causation of suffering. The "perpetual uneasiness" surrounding ethical decision-making must remain for there to be any chance of progress and perfectibility of the conditions stipulated for the welcome of migrant pregnant women into the NHS. The case at hand reveals that the application of principles devised in the abstract does not put to rest the dilemmas which midwives are confronted with, nor can any ethical judgement be made separate from the singularity of the circumstances which bring the dilemma to the light. That is why attempts to encapsulate the ethical in a certain course of action (e.g. providing healthcare) simply obscures the different forms and degrees of hostility that hospitality can enable. The same can be said of claims that following a specific rule can ensure that the "less harmful" thing was done (e.g. provide healthcare irrespective of migrants' chargeable status) as suggested by the BMA ethical guidance for doctors in the UK.

The ways in which hospitality blurs the border between health enhance and immigration enforcement were also explored in my analysis of the reception of foreign NHS staff into the UK against the backdrop of the COVID-19 pandemic. However, the issue that I was concerned with in Chapter Four did not restrict itself to the ways in which migrant workers operated as foreign hosts in the implementation of the Charging Regulations and their associated data-sharing policies. My discussion was not exclusively focused on how they enacted hostility towards migrant patients while carrying out activities of hosting. I also drew attention to the ways in which their experience of guesting subjected them to different forms and degrees of hostility – similar to those experienced by migrants accessing the NHS in the sole position of guests. In this vein, they find

themselves caught in the undecidable role of guests/hosts or – in Derridean terms, of *the hôte* – which disrupts the conventional configuration of power relations operating through the dynamics between these two subject positions. This is helpfully illustrated by the scheme inaugurated by the Health and Care Worker Visa (HCWV), which instantiates a more welcoming reception of foreign staff into the NHS without effacing the trace of hostility.

Furthermore, what the case of the recruitment of foreign NHS staff during the COVID-19 pandemic reveals is that lower-paid overseas workers (e.g. NHS cleaners and porters) experienced a greater level of hostility compared to their better paid counterparts (e.g. doctors and nurses). For instance, they were not granted the advantages of the HCWV scheme, such as reduced visa fees, no payment of the health surcharge and faster processing of visa applications. This "hierarchy of deservingness" instantiates a stratified welcome of foreign workers into the UK despite the Government's frequently invoked rhetoric of gratitude for the work of all NHS employees in the fight against COVID-19 (Home Office 2020b). As they figure as absent/present in the COVID-related measures in respect to overseas workforce recruitment, these low-paid workers constitute the embodiment of the '(g)host' (Bulley 2013; 2017) in the sense that they perform indispensable acts of hosting while being produced and governed as less valued guests. This is particularly problematic if one considers that these (g)hosts play a fundamental role in scripting the NHS as a hospitable space for migrant workers from across the world, a narrative that at the same time obfuscates the hierarchical character of the welcome offered to overseas workers by the UK.

Having provided an analysis of the technologies of power operating through practices of hospitality for migrants in the NHS, I carried out, in Chapter Five, an exploration of the constitution and operation of the welcoming apparatus through the lens of the dispositif. In doing so, I advanced the argument that the welcoming apparatus/dispositif of hospitality consists of a heterogeneous assemblage of discursive and material elements which are linked together to construct a system for responding to the arrival of the foreigner. My analysis focused particular attention on three methodological prescriptives of the dispositif – or simply put – the three main dimensions of the apparatus: the heterogeneity of its elements, the relationality between them and the strategic function which the apparatus displays (Aradau et. al 2014 and Thomas 2014). By drawing on the dispositif as a methodological device, I emphasised the contingencies and factors shaping the reception of the foreigner into the homely space while illuminating how the practice of hospitality is framed by discursive formations and materiality. Healthcare provision for migrants, in this regard, constituted a helpful illustration of the ways in which the concept of the

dispositif can helps arrive at a more comprehensive understanding of the constitution and operation of the welcoming apparatus.

1. Research limitations and areas for further investigation

My analysis of hospitality for migrants in the NHS led me to a wide range of issues that while falling outside the scope of this thesis remain connected to the core concerns I grappled with in my work. They are not minor questions that did not merit my attention. Rather they are problems that – however implicit – provoked my ideas and to a certain extent framed and informed the writing of this thesis. In doing so, they opened up avenues for thought while outlining areas for further investigation. Most of them cut across different chapters of this work even when they were not explored in an explicit manner. Some of them remained in the background – albeit not forgotten – haunting my writing which, as every act of writing itself, at least from a Derridean perspective, pushes to the margins that which is echoed in the text and informs its production. After all, as Johnson (1995: 46) reminds us, "[w]hen one writes, one writes more than (or less than, or other than) one thinks." It is with this reflection in mind that I introduce the first of the aforementioned issues: gender.

Why does "gender" constitute a fruitful area for further investigation in a study about hospitality for migrants in the NHS? The general reference to "overseas visitors" as set out in the Charging Regulations might initially suggest that the charging regime constitutes a system which does not differentiate between men and women. It might imply that both sexes are equally treated under such rules. After all, there are no provisions specifying that NHS care is to be charged at a higher rate if the service user identifies themselves as a woman or as a man. The gender-blindness of the charging regime is simply apparent. We can take the case of migrant pregnant women, for instance. Even though maternity care cannot be refused or delayed if not paid upfront and in full, it is still chargeable. Migrant pregnant women are liable for this debt, and inability to pay can interfere with future visa renewals, preventing them from legally entering or staying in the UK. There are not immigration-related implications for male progenitors arising from this process.

In addition to that, matters become further complicated for migrant women with unlawful residence in the country: They are deterred from seeking healthcare by virtue of their immigration status, which may lead to greater health risks and poorer pregnancy outcomes (Feldman 2021: 448). These will impact the health of pregnant women and their babies – not those of the male

parent. A feminist approach to hospitality for migrants in the NHS casts light on these gender-related discrepancies in that it highlights the links between gender, disadvantage and health, as well as the power relations embedded in public health policy-making and programme delivery (Rogers 2006: 351)[28].

Another area for further investigation lies at intersection of race and migration. In this thesis, I drew attention to the ways in which immigration enforcement through the NHS reproduces racial hierarchies in the UK. In other words, how racism risks being perpetuated through the operation of practices of border control in the health service. I made an explicit reference to the compatibility of my approach to those advanced in the broad field of Critical Race Theory (CRT) while pointing towards the need to avoid the white-washing of raciality in analyses of the enforcement of immigration through healthcare. For the purposes of this work, it sufficed to make the case for the use of "race" as a fundamental analytical category to understand border control in the NHS. However, further links with CRT can be explored. For instance, Delgado and Stefancic (2012: 8) explain that the process named "interest convergence" constitutes one of the tenets of CRT. It refers to the ways in which benefits and advantages can be granted to members of an under-privileged race – in the case of their analysis, blacks – due to a concern with securing the interests of members of the more advantaged race – in their work, whites. In other words, procedures adopted to favour the latter does not imply the undermining of racism. Instead, these concessions are made more because granting benefits advances the interests of the privileged race.

The process above identified as one of the tenets of CRT speaks to one of the arguments that I made in Chapter Two, i.e. that the provision of free health services for migrants does not constitute a politics of generosity and benevolence in the government of migration through the NHS. I argued that rather it consists of a biopolitics of healthcare provision which intervenes into migrant bodies in order to regulate processes of the population. This regulation is in itself racialised. Take the case of COVID-19. Vaccination, diagnosis and treatment of the disease were free of charge irrespective of one's immigration status. However, treatment of any underlying or subsequent illness remained chargeable even if related to the coronavirus infection. What this restriction suggests is that the aforementioned health services were provided more as a means to curb the

[28] I am aware that I am making this argument within a binary framework, and that no all persons who are pregnant identify themselves as women. This is not to erase the nuances and complexities involving the right of self-identification when it comes to questions of gender. Rather, I am attempting to draw attention to ways in which those who identify as women – including those assigned male at birth – are more likely to experience health inequities by virtue of their gender.

pandemic – and therefore secure security for the "superior" race – and less as an instrument for protecting the individual health of members of the "inferior" race (e.g. migrants with unlawful residence in the UK). The health policy implemented to respond to COVID-19 revealed itself as racist. This example illustrates the potential of CRT as an analytical framework to explore issues of hospitality for migrants in the NHS, and points to an area for future work.

The third area for further inquiry which this thesis points to consists of the intersection between postcolonialism and migration. In my final thoughts in Chapter Four, I hinted at the significance of exploring the links between postcolonial theory and migration studies as I referred to the criticism levelled against the detrimental consequences of international recruitment of migrants to work for the NHS (Shahvisi 2018: 341). Exploring the intersection of the aforementioned fields of study can provide us with a more complex and comprehensive understanding of processes of international hospitality in the contemporary world. As Declan Cullen et al. (2013: 134) explain, postcolonial theory has impacted on the analysis of migration at least in two main ways: "First, it has extended the temporality of the discussion by recognizing the extent to which today's migrations draw on colonial histories. Second, it has highlighted some ways in which distant places have refigured the near because 'here' has been formed and performed only through long interactions with 'there'."

It is true that I suggest that the reliance of the NHS on foreign staff allows for the constitution of the health service as international, which speaks to the second point raised by Cullen et al. (2013). However, I did not approach the situation of postcolonial migrants as patients in an explicit manner. The issue illuminates an area for future work centred on how the colonial legacy of the UK impacts healthcare access for those who came to the country from former colonies and their descendants. Within this framework, exploration of postcolonial theory allows for the investigation of "empirical cases" which were not addressed in this thesis. Of particular relevance in this regard is the Windrush scandal. At the core of the crisis is the so-called "Windrush Generation" that refers to a group of migrants who came to the UK from Commonwealth countries – mostly Britain's former colonies in the Caribbean – in the aftermath of the Second World War in order to enable the implementation of the welfare state after the devastation engendered by the international conflict, e.g. by staffing the recently inaugurated NHS (Gentleman 2020: 13 – 14). Against the backdrop of the hostile environment policies, these migrants (the majority of whom being black) their spouses and children who joined them in their journey to the UK – sometimes even those who were born in the British territory – were required to prove that they were legally

residing in the country in order access public benefits and services (e.g. healthcare). This is not to mention the imminent risk of arrest, detention and deportation for being erroneously identified as "illegal immigrants".

It is important to note that the Windrush Scandal has clear connections with issues of migration and hospitality in the NHS. A helpful example is the predicament experienced by Albert Thompson (not his true name), who came from Jamaica in 1973 to join his mother in the UK. Despite living in the UK for more than 44 years, Thompson was refused cancer treatment and handed a £54,000 bill for not being able to provide proof of legal residency in the country (Gentleman and Walker 2018). Even though the case illustrates links between immigration enforcement and healthcare provision, those affected by the hostile environment policies operating through the NHS by virtue of belonging to the Windrush Generation (or being their descendants) cannot be categorised as migrants in the sense that I am employing in this thesis for purposes of research delimitation: They are not overseas visitors to whom the Charging Regulations apply – i.e. migrants with unlawful residence or temporary leave to remain in the UK. They were granted by the Government the legal right to enter and stay in the country, and had never been required to provide proof of their immigration status to access healthcare until the implementation of the hostile environment policies. Because this thesis is concerned with those labelled by the UK Government as "overseas visitors", the Windrush scandal sits outside of its remit. However, it points to a field for future inquiry where issues of migration and postcolonialism intersect and can be fruitfully explored.

Reflections on areas for further investigation have also prompted me to revisit the potential and limitations of my research methods – in particular, the issue of whether or not to carry out interviews with healthcare workers and migrant patients accessing the NHS. The analysis of the grey literature provided me with robust empirical material to offer a critical analysis of hospitality for migrants in the health service: Not only did it introduced me to the overall views of NHS staff on immigration enforcement through healthcare provision, but it also allowed me to "listen to" migrants' stories by exploring their oral testimonies transcribed into reports, news articles, blogposts – to name just a few of the materials published by professional bodies, charities, journalists and humanitarian movements, which served as the principal empirical source of my inquiry. The question remains as to what conducting interviews with migrants and healthcare workers might have added to the empirics of my analysis and the overall design of my research. To begin with, it is important to note "that conducting an interview not only helps to acquire

information or opinion, but also opens up neglected areas and directions in the research design, and points to directions and issues overlooked by the researcher" (Fedyuk and Zentai 2018: 175). Therefore, while it is not possible to anticipate specific findings that I could have come across in this process, a few points are worthy of attention.

The points that I wish to raise here are concerned with the potential opportunities and challenges which the conduction of interviews might have given rise to. In regard to healthcare workers, while interviews could have allowed me to capture clinical staff's immediate expressions of emotions, experiences and opinions on issues surrounding immigration enforcement through the NHS, they might have also amounted to the sensitivity and vulnerability of these professionals in light of emerging ethical dilemmas, tragedies and health crises (Anthierens et al. 2022) – specifically, the COVID-19 pandemic, in the course of which most of my research was carried out. In relation to migrants, interviews could have offered them the space to provide an account of their own lives by telling stories through a guided conversation (Gu 2013: 509), with interviewing being used "as a platform for interviewees' more direct claim-making" (Fedyuk and Zentai 2018: 177). However, storytelling could have also implied dwelling on pre-migration traumatic events and post-migration stressors, such as the experience of having healthcare refused by virtue of their immigration status (Field et al. 1997: 351). Engaging with new avenues opened up by carrying out interviews, and moving through the challenges arising from this process constitute a field which merits further exploration for purposes of broadening – and deepening – the scope of my methods in the future.

As demonstrated above, drawing on stories to approach hospitality for migrants in the NHS is no simple matter. As I mentioned in the introduction of this thesis, stories can be useful in focusing attention on particular issues, they can work as illustrations to corroborate – or counter – certain views of socio-political problems, and they play a fundamental role in avoiding the effacement of the peculiarities of singular experiences which can be easily erased from the grand narratives of public policies and their contestation. These ideas have informed the use of stories in my work: They have allowed me to raise awareness of issues surrounding hospitality for migrants in the NHS, challenge delivery of health services as a form of border control, and pay regard to the singularity of the adversities experienced by migrants in their access to healthcare. In this vein, my attitude towards migrants' stories reflects, to a great extent, that of critics of immigration enforcement through the health system. As demonstrated in this thesis, criticism levelled against border control through healthcare provision advocates for bringing those stories to light and giving visibility to the suffering experienced by migrant patients.

However, one cannot help but wonder the extent to which migrants' stories have been instrumentalised by those who explore these accounts to critically assess the control of borders through the NHS. Even unintended or non-anticipated, the effects of the utilisation of such narratives by NGOs, journalists, academics and activists entail the risk of commodifying migrants' stories and turning them into an "asset" which may allow those actors to empower themselves as "truth-holders" about hospitality in the NHS, undermine the confrontation of their views, and promote their own agendas by framing their practices as "right" and "good". While it is true that one should keep an attendant eye to the dangers of "the instrumentalisation and commodification of stories of personal experience" (Mäkelä and Meretoja 2022: 191), it is also paramount to ponder its opposite alternative: Erasing migrants' (biographical or autobiographical) account of their experiences of accessing healthcare. In doing so, one might miss the opportunity to draw on storytelling to mobilise movements of contestation against immigration enforcement through the NHS, to frame it as a "weapon" to undermine arguments in favour of controlling borders through healthcare provision, and, most importantly, to employ it as a means of fostering the transformation of a system where migrants can be left to die due to their inability to cover the costs of health services. In my view, these are important reflections to bear in mind in my future works involving storytelling – either through primary or secondary data collection.

2. Main research contributions

My thesis is primarily concerned with practices of hospitality which deliver improvements in migrants' health and wellbeing while subjecting them to hostility enacted as immigration enforcement through the NHS. My discussion consisted of an exploration of the technologies of power which not only allow for the enhancement of migrants' health, but also expose them to practices of border control in their access to the health service. In this process, a few contributions were made to the existing literature. First, my analysis drew attention to a healthcare system as a space of international hospitality. International studies have pushed the boundaries of state-centred analyses of hospitality but – to the best of my knowledge – none of them have investigated how migrants come to experience their reception into healthcare systems as an act of welcome. This constitutes an important point of inquiry for International Politics, given that continuous attention has been paid to acts of hospitality carried out in spaces other the borders separating sovereign states (Bulley 2013, 2015, 2017) – and yet health systems as such have remained unexplored. Furthermore, empirical evidence highlights how the inclusion and exclusion from

health systems have a significant impact on migrant's experience of being received into countries of destination, which corroborates the relevance of looking into healthcare provision for foreigners in studies of international hospitality (WHO 202).

Another contribution made by this thesis concerns the question as to how we can map out and comprehend the factors and contingencies shaping the reception of the foreigner into the homely space. In this regard, I drew on the concept of the dispositif as a methodological device in order to understand the constitution and operation of the welcoming apparatus/dispositif of hospitality: The heterogeneous assemblage of discursive and material elements which are linked together to construct a system for responding to the arrival of the foreigner. My thesis explained how the workings of the welcoming apparatus define the form of hospitality to which the guest is subject in their interplay with the host in the space of the home. As I contended, they do so by shaping the constitution of the subject positions of the host and the guest while framing their experience of hosting and guesting. Viewed in this light, my contribution can be deployed as a methodological tool to explore practices of hospitality in a range of sites in addition to healthcare settings, as well as acts of welcoming in a variety of empirical contexts. It is important to note that my suggestion does not constitute an attempt to define what hospitality "is" but rather an effort to explore how the practice of hospitality is framed in specific scenarios of everyday life while analysing the performative power of welcoming apparatuses over the conduct of hosts and guests, and on the constitution of their subjectivities.

Finally, this thesis makes a contribution to the sub-field of security studies in International Politics by amounting to the literature on the ways in which health has become an issue of security concern, and how the provision of security can be conceived as somatic (Elbe 2012). In other words, my analysis speaks to works that highlight the functioning of security through medical interventions into the inner workings of the human body (Elbe 2012: 321). It is within this framework that I explained how free healthcare provision for migrants who are not ordinarily resident in the UK constitutes a biopolitics of care which seeks to secure security as an optimised stated of health and wellbeing. Putting it differently, health security requires that medical interventions are made into migrants' bodies so that the security of the population can be achieved. Furthermore, my research illuminated how migrants' health needs are securitised in the enforcement of immigration through the NHS. Viewed in this light, attending to migrants' needs for healthcare – through the diagnosis and treatment of their diseases as well as interventions to foster their wellbeing – becomes a security problem in that free healthcare provision for "overseas visitors" is framed as a threat to

the sustainability of the service. In this vein, my thesis demonstrated how the analysis of hospitality for migrants in the NHS illuminates ways in which the inner biological processes of migrant bodies have been turned into the "battlefield" of security policies (Elbe 2012: 321). COVID-19 has demonstrated the contemporary usefulness of analyses which explore the securitisation of the biological processes of the human body. Therefore, my contribution demonstrates potential to engage with – and open up avenues for – a research field of particular significance for our times.

3. Final remarks

Before this thesis comes to an end, there are a few remarks yet to be made. These will not be the development of an argument against practices of border control in the NHS, nor will they offer a critique of any particular policies in respect to immigration enforcement through healthcare. In fact, these are some reflections upon the ways in which my PhD research allowed me to see my own experience as a migrant living in the UK through a different lens. In other words, the following are a few thoughts on how – through the unfolding of my research over the past four years – I came to reframe my own position against the backdrop of the hostile environment entrenched in the UK immigration system. These final remarks also present some reflections on how my own experience helped me better understand the hostility which I was attempting to analyse through my studies.

As I mentioned in the introduction, my initial concern when beginning my PhD studies was to understand how the data-sharing policy set out by the MoU made it possible for healthcare provision to enact both a welcome and hostility towards migrants with unlawful residence in the UK – or the so-called "immigration offenders", to use the language deployed in the arrangement. On the one hand, in terms of research organisation, focusing on the MoU was a helpful methodological tool to centre attention on and deepen my knowledge of a specific policy-relevant issue. On the other, it prompted me to think (perhaps for longer than I should) that those in my position – i.e. entering the UK lawfully and sponsored by a Higher Education Institution (HEI) – would somehow be shielded from the most aggressive aspects of the hostile environment. Putting differently, those aspects that mostly deepens inequalities among individuals on the basis of their place of birth and immigration status.

Of course, different migrants experience the hostile environment on different terms – and those most vulnerable are indeed the most detrimentally affected by its operation. However, it certainly

does not mean that those with a less precarious position (e.g. legally residing in the country and complying with their visa conditions) are free from the hostility cutting across the UK immigration system. That was one of my first realisations as I went further into the questions that I was exploring in my research. One situation was of particular note for me. I came to understand that – even though I would be spending at least three years of my life in the UK (i.e. the average length of my PhD) – I would still be considered a temporary resident in the country or, as the Charging Regulations state, an "overseas visitor". But this is not simply a matter of ascertaining legal labels without further implications for life in the UK as a foreigner. As a student with temporary leave to remain in Britain, I am subject to the condition of "no recourse to public funds", which prevents me from accessing a range of social benefits such as housing and homeless assistance or income-based jobseeker's allowance. The relative safety stemming from my immigration status did not impede me from being in the same position as those with unlawful residence in the UK in this particular regard.

In addition to rethinking my position in the UK immigration system in light of the hostile environment, I also drew on my experience of complying with a range of immigration-related obligations to help me better comprehend the hostility on which I was shedding light in my PhD studies. A few situations springs to mind. First, the police registration requirement which demanded foreign nationals from certain nationalities (e.g. Brazilians, like myself) to register with the local police authority within seven days of their arrival in the UK. The obligation entailed the payment of a £34-fee (on top of visa costs) as well as informing the police of any changes in respect to addresses and other personal details. The reasons why my nationality (and therefore myself) was marked by a higher degree of "dangerousness" was never stated by the visa documents establishing the mandatory fulfilment of this requirement. But critics of the hostile environment agree that the scheme constituted a racist process which attached risk and danger to particular foreign nationals on the basis of their country of origin (JCWI 2022)[29].

The second situation that drew my attention to the hostility affecting my own experience of being a foreigner in the UK relates to the international student census carried out by HEIs in the country. The requirement makes it mandatory for universities to keep track of international students' attendance, and share this information with the Home Office through the Department for

[29] Since August 2022, the Police Registration Scheme has been scrapped. However, as the JCWI (2022) explains, the end of the scheme does not imply a retreat of the hostile environment. The police have been granted access to the Home Office data, which allows the institution to work with the department in the monitoring of foreign nationals.

Education (Institute of Race Relations 2018). In doing so, HEIs are embedded in the hostile environment, and allow for the Home Office to monitor students' compliance with their visa requirements. In practice, the situation, as I perceived, was the following: On one hand, I was an international student, welcomed into the UK to pursue a degree from of one its most renowned universities. On the other, I was deemed a potential immigration offender, whose compliance with visa conditions had to be monitored through a scheme that attached hostility to a space of welcome for international students.

And finally comes the issue of whether the hostile environment in the NHS somehow affected me as an international migrant living in the UK. This is a particular significant situation. I remember being asked if, in my view, I considered that the hostile environment policies had a detrimental impact on my access to healthcare in the UK. Still in the initial months of my PhD research, I was primarily focused on the situation of "immigration offenders" affected by the data-sharing policy set out by the MoU. I recall that my immediate response to this question was simply "no". Perhaps my interlocutor, who was a medical practitioner in the NHS, knew better than I did back then. After all, as a pre-requisite to have my visa application assessed by the Home Office, I had to pay the costly Immigration Health Surcharge, which I later came to identify as an instrument of border control as it prices out some migrants from coming to the UK and impedes others from regularising their immigration status for not being able to afford the fee.

In light of the above – and considering all the analysis carried out in this thesis – I arrive at two particular conclusions here. First, there is little alternative but to acknowledge that there is still a long way to go if one conceives of a more welcoming UK to migrants. In an interview for British online newspaper The Telegraph, Home Secretary Suella Braverman was quoted as saying that it is her "dream" and "obsession" to see a flight take asylum seekers to Rwanda (Dearden 2022), in a scheme which has been classed as an outsource of the UK's refugee responsibilities to the African country (Yeo 2022). The ideal expressed by the top Home Office representative tells us much about the scenario that migrants have been faced with, especially – but certainly not only –, the most vulnerable. However, and this is the second conclusion at which I arrive, much has also been done by critics of the hostile environment, who have continuously denounced the harsh conditions which migrants have been subjected to by the intertwinement of border control with acts of everyday life. Without resistance and confrontation from journalists, NGOs and migrants themselves, change perhaps would have never gone beyond the status of hope. It is my intention

that this thesis amount to those critical voices somehow – especially to those who have tirelessly endeavoured to make the NHS a more hospitable space for migrants living the UK.

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