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# Inequality by design: The politics behind forced migrants' access to healthcare

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## ABSTRACT

When a system comes under strain, the persons most likely to suffer from the repercussions are those at and beyond its margins, as the age-old rule 'Help yourself before helping others' typically guides crisis management within the system. Similar behavioural patterns on the side of policy-makers have left a distinct mark on the healthcare rights of forced migrants in the context and aftermath of the so-called 'migration crisis' of 2015–2016, as this article demonstrates. Following the crisis, this group of persons, who are traditionally situated at the margins of society already, have been pushed further outside social and healthcare systems through increasingly restrictive incorporation policies across Europe. By analysing recent legislative reforms in four countries (Germany, Italy, Sweden, and the UK) which stood out in various ways during the crisis, this article sheds light on the increasing politicisation and polarisation of the intersection of incorporation and healthcare. It shows that the crisis induced similar responses of legal adaptation in countries with fundamentally different healthcare and incorporation systems, and analyses the dynamics behind such processes of change. The article thereby contributes to a better understanding of healthcare legislation as a reflection of political opposition to or acceptance (if not fuelling) of societal inequalities.

**KEYWORDS:** Asylum seekers, Forced migrants, Healthcare policy, Incorporation, Inequality, refugees

## I. INTRODUCTION

Crises have the inherent potential to put to the test established systems and to put into question premises that have been unchallenged in less strained times. When a system thus comes under strain, the persons most likely to suffer from the repercussions are those at and beyond its margins, as the age-old rule 'Help yourself before helping others' typically guides crisis (re)actions within the system. Often, such detriments arising from phases of crisis management are not remedied once the crisis is over, as rules and measures adopted in times of strain are only slightly modified at best and consolidated at worst, rather than being replaced by solutions with a less emergency-driven, more long-term outlook.

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Such behavioural patterns have left a distinct mark on the healthcare rights of forced migrants[1] in the context and aftermath of the so-called 'migration (management) crisis' of 2015–2016, as I demonstrate in this article. Following the crisis, and in a period of strained systems and shifting discourses, this group of persons, who are traditionally situated at the margins of society already, have been pushed further outside social and healthcare systems through increasingly restrictive incorporation[2] policies across Europe. Making their position within the respective host societies even more vulnerable, such processes further increased the potential for this group's stigmatisation as 'outsiders' and non-contributing recipients of benefits payed through 'insiders' taxes/contributions. In this article I seek to explain the dynamics shaping these processes, thus shedding light on a deeply influential phase in European migration and health politics. Indeed, rather than providing short-term answers to crisis-induced needs, the adopted restrictive policies turned out to shape forced migrants' healthcare rights beyond the 2015–2016 crisis, and became even further consolidated as European states came under strain once more with the COVID-19 pandemic.[3]

The following analysis focuses on healthcare rights as an important aspect of forced migrants' mid- to long-term integration into host countries' societies, welfare systems and labour markets—or of political endeavours to keep them at the margins of society, based on different ideological and strategic considerations.[4] Varying political behaviour and resulting legislative acts demonstrate their authors' respective positions in this regard with particular clarity during times of sharply rising immigration numbers, which push to the fore 'the question of whether social solidarity is extended to members of other ethnic groups',[5] under which conditions, and based on what justification(s).

In this article I explore the repercussions of legislative reforms in this regard across Europe post-2015, with a specific focus on increasing inequalities regarding (and beyond) healthcare access in Germany, Italy, Sweden and the UK—four countries with very different healthcare and incorporation regimes and traditions, yet all of which stood out in the evolution of European political reactions to the 'migration crisis' and its repercussions, albeit in different ways. Germany and Sweden underwent similar processes of initial demonstrative openness to incoming asylum seekers, presenting themselves as 'moral superpowers' in comparison to other

[1] I use the term 'forced migrants' to include all persons seeking protection in a country other than that of their origin, both before and after a host country has assigned (or rejected) a legal status of protection and residence to them, with different concomitant sets of rights and claims. I consider these persons as belonging to one societal group in the context of this article, mainly because 'migrants' legal status is not always clear to them or to [health] care providers': H Bradby, 'Refugee and migrant health: A perspective from weden' in A Krämer and F Fischer (eds), *Refugee Migration and Health. Challenges for Germany and Europe* (Springer Nature 2019) 185–93, 187. I also adopt this approach because these persons are frequently subject to the same political as well as societal stigmatisation as 'outsiders', as I explain in this article.

[2] I use the term 'incorporation' (rather than the more broadly used term of 'integration') when referring to sets of rules and measures regulating and implementing migrants' entry and participation in a host country, its welfare system, economy and society. Following, for example, S Castles, 'How nation-states respond to immigration and ethnic diversity' (1995) 21 New Community 293–308; D Sainsbury, *Welfare States and Immigrant Rights. The Politics of Inclusion and Exclusion* (OUP 2012), incorporation is considered the overarching term for different types and forms of such regulation and implementation (such as more restrictive or more liberal measures, creating systems, for example, of inclusion, exclusion, assimilation or pluralism). By contrast to the concept of integration, which assumes a long-term/permanent and holistic approach to migrants' residence and concomitant rights in a host country, the concept of incorporation presupposes no specific duration of a migrant's stay and includes measures of a fragmented, vague and non-comprehensive nature, as well as formal and informal procedures shaping migrants' lives in a host country. See also B Nieswand and H Drotbohm, 'Einleitung: Die reflexive Wende in der Migrationsforschung' in B Nieswand and H Drotbohm (eds), *Kultur, Gesellschaft, Migration. Die reflexive Wende in der Migrationsforschung* (Springer 2014) 1–37.

[3] See, eg, L Dalingwater and others, 'Policies on marginalized migrant communities during Covid-19: migration management prioritized over population health' (2022) Critical Policy Studies, DOI: 10.1080/19460171.2022.2102046.

[4] M Cacace and J Pundt, 'Einleitung' in J Pundt and M Cacace (eds), *Diversität und gesundheitliche Chancengleichheit* (Apollon University Press 2019) 13–26, 13.

[5] P Marx and E Naumann, 'Do right-wing parties foster welfare chauvinistic attitudes? A longitudinal study of the 2015 "refugee crisis" in Germany' (2018) 52 Electoral Studies 111–16, 111.

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European countries, and taking in high numbers of people, but later changing their stance towards forced migrants under (perceived) pressure through a shift of public opinion. By contrast, Italy was among the Mediterranean countries with the highest numbers of arriving refugees, struggling to find political and administrative answers to the pressing challenges raised by the high numbers of arrivals, while simultaneously facing some remaining repercussions from the Eurozone crisis, as well as political instability manifested in a high turnover of governments. In the UK—equally a main target country for asylum seekers in Europe—migrants became the subjects of widespread political campaigns in the context of the Brexit referendum and national elections, leading policy-makers in government to adapt policies according to the public pressure they perceived, in their own pursuit of gaining voters' support. Moreover, as the British government had adopted an increasingly restrictive course in the area of incorporation already from the early 2010s—a course which was further intensified in the context of the crisis—it became something of a trendsetter in policies of deterrence among the countries examined here.

Despite these four countries' differing roles in Europe's response to the 'crisis', they are connected by surprisingly similar processes of political reaction to and instrumentalisation of the 'crisis' as regards forced migrants' healthcare access. This is particularly remarkable considering not only the different circumstances and main challenges each of the four countries faced post-2015, but also the fundamental systemic differences between the four countries' incorporation, welfare and healthcare regimes, concerning, for example, issues of centralisation, the relevance of citizenship, and individual preconditions for the utilisation of health and welfare services (discussed further below). In a comparative analysis of these 'most different cases', in this article I trace political, institutional and societal dynamics underlying the different selected countries' remarkably similar responses based on an extended review of recent literature, as well as in related primary and secondary national legislation and in policy documents that provide insight into the respective underlying policy-making processes. In so doing, I seek to answer the question 'how, why and with what effect were inequalities in healthcare access between forced migrants, on the one hand, and citizens/denizens of the host countries, on the other, politically regulated and instrumentalised?' To this end, following a conceptualisation section on the systemic embedding of health inequality, I discuss four dynamics which have shaped the politics behind forced migrants' healthcare access in the four countries under examination:

a) The increasing politicisation of the areas of incorporation/immigration and healthcare,
b) The policy change-triggering effects of the so-called 'migration crisis',
c) Current challenges putting healthcare systems under strain, and
d) Electoral threats by far-right and right-wing populist parties and the repercussions of fears of vote loss among centre parties.

By demonstrating how these different dynamics conditioned each other and governments' political behaviour in regulating forced migrants' access to healthcare, I shed light on the notable polarisation of this policy issue. In so doing, I demonstrate that the exacerbation of this marginalised group of persons' social and health rights was not only tolerated, in a sense of collateral damage, but in various cases actively sought by actors across the political left-right spectrum in the pursuit of other, larger political and strategic aims—despite a clear condemnation of such unequal treatment by international law.

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## II. CONCEPTUALISING THE POLITICS BEHIND AND SYSTEMIC EMBEDDING OF HEALTH INEQUALITIES

Health is 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity', as outlined in the preamble of the World Health Organization's Constitution.[6] And it is even more than that: health is a prerequisite for membership, integration and active participation in a society, labour market, and (democratic) political system.[7] For persons on or beyond the fringes of society, persons marked and treated as 'outsiders' by society, health plays a particularly crucial role in gaining access to membership of and participation in society. After all, contrary to even the most disadvantaged 'insiders', they have to actively and lastingly demonstrate—by formal or informal obligation—their claim to be(-come) part of society, and to partake in its tax- or contribution-based welfare system.

Forced migrants belong to this group of 'outsiders' by various measures. First, their access to a host countries' healthcare system is typically restricted legally, especially prior to being granted some form of residence status, and, in many countries, (notably in case of a non-permanent residence status) even thereafter.[8] Secondly, their healthcare access is frequently restricted through a lack of knowledge, and of accessible information, on the functioning, structure and entry points of the healthcare system, as well as on the specific extents of rights to emergency, preventive, long-term care in the different concrete sub-areas of the respective healthcare system.[9] This lack of knowledge and accessible information exists not only on the side of forced migrants, but also of medical practitioners who (may fear to) face administrative or even legal trouble and the risk of having to cover costs themselves for care unlawfully provided, fears resulting in denied access to treatment which might have been legally covered.[10] Thirdly, practical aspects such as infrastructural constraints, lack of financial means to afford public or other transport, or language barriers may hamper forced migrants' access to healthcare.[11]

All these factors combined result in a situation of dependency and vulnerability for the concerned migrants.[12] This situation is further exacerbated by the fact that asylum seekers especially have typically very limited, if any, opportunity to proactively change their role as beneficiaries-only prior to being granted legal protection status, given that they are often not allowed to take up employment and thus become contributors to the system.[13] Not least through this imposed passivity, forced migrants form an especially disadvantaged group among migrants as they are particularly dependent, particularly vulnerable, and particularly exposed to questions regarding their deservingness of social and health services and benefits.

6 Constitution of the World Health Organization (<https://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf?ua=1> accessed 3 November 2022).

7 C Wolf and C Wendt, 'Perspektiven der Gesundheitssoziologie' in C Wendt and C Wolf (eds), *Soziologie der Gesundheit* (VS Verlag für Sozialwissenschaften 2006) 9–33, 20.

8 Indeed, hardly any country in Europe, and none of those examined here, offers the same healthcare access to its citizens/denizens as to asylum seekers. See, eg, A Krämer and F Fischer, 'Refugee Health: Public Health Theory and Disease Dynamics' 3–18; I Beauclercq and others, 'Overview of Migration and Health in Europe' 19–37, both in Krämer and Fischer (n 1).

9 J Butenop and others, 'Future challenges for the public and curative health sector' in Krämer and Fischer (n 1) 119–32; CA O'Donnell, 'Health care access for migrants in Europe' in DV McQueen (ed) *Oxford Research Encyclopedia of Global Public Health* (Oxford University Press 2018), DOI: 10.1093/acrefore/9780190632366.013.6.

10 Bradby (n 1) 189; J Wenner and others, 'Migrants, refugees, asylum seekers: Use and misuse of labels in public health research' in Krämer and Fischer (n 1) 49–62, 53–54.

11 S Parker, 'Inhibiting integration and strengthening inequality? The effects of UK policymaking on refugees and asylum seekers in Wales' (2021) 15 People, Place and Policy 72, 77–78; K Bozorgmehr and others, 'Health policy and systems responses to forced migration: An introduction' in K Bozorgmehr and others (eds), *Health Policy and Systems Responses to Forced Migration* (Springer 2020) 1-14, 3; Bradby (n 1) 190–91.

12 D Schmalz, 'Verantwortungsteilung im Flüchtlingsschutz: Zu den Problemen "globaler Lösungen"' 1 (1) (2017) Z'Flucht 9–40, 12.

13 F Boräng, *National Institutions—International Migration. Labour Markets, Welfare States and Immigration Policy* (ECPR Press/Rowman & Littlefield International 2018) 46.

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Regardless of questions of deservingness, forced migrants have a human right to health, as stipulated in general terms in Article 25 of the 1948 Universal Declaration of Human Rights. Article 12 of the 1966 International Covenant on Economic, Social and Cultural Rights, which has been ratified by all four countries examined here, emphasises the signatory states' duty to safeguard 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'. A similar paragraph is also included in part I, paragraph 11 of the 1961 European Social Charter, to which the governments of the four countries examined here are signatories as members of the Council of Europe.[14] However, even though 'international law regards inequalities based on residence status, ethnicity or country of origin as violation of the human right to health',[15] the possibilities of 'enforcement to meet human-rights obligations'[16] in this context are weak, not least due to the lack of enforcing institutions or bodies in the area. Beyond the issue of enforcement, the relatively generic formulation of rights in the international legal texts leaves states with significant room of leverage to stipulate themselves the conditions under which a person is to enjoy protection on their territory.

This holds true for the four countries examined here, even though EU law has imposed limits to Member States' political room of manoeuvre in the area through a number of directives. For example, the Qualification Directive 2011/95/EU obliges Member States to grant migrants with refugee or subsidiary protection status access to healthcare 'under the same eligibility conditions as nationals of the Member State' (Article 30). The Reception Conditions Directive 2013/33/EU stipulates that applicants for asylum must be guaranteed a standard of living which 'protects their physical and mental health' (Article 17), although it sets the bar notably lower than for migrants with recognised protection status, as it speaks of adequacy of healthcare access rather than equality with nationals. Both directives emphasise the particular need for the protection of especially vulnerable sub-groups, such as persons with disabilities or serious illnesses, elderly and pregnant persons, and victims of torture or other forms of violence.[17]

Yet, despite the relevant provisions included in these two directives, EU law and policy barely featured as a motivator or inhibitor in recent national policy-making on forced migrants' healthcare access in the four examined countries. Indeed, while evidently providing the legal, and to some extent moral, framework for national legislation in the area, the two directives and the Common European Asylum System seem to have had no major impact on the way governments in the four countries altered their legislation concerning healthcare for forced migrants as a response to the 'migration crisis', other than acting as general reference points for lowering incorporation standards based on the repeatedly decried lack of solidarity among Member

[14] Contrary to the European Social Charter, the European Convention on Human Rights (ECHR)—while setting the larger frame of asylum seekers' and refugees' fundamental rights in the signatory states—contains no express provision on healthcare. Nevertheless, there have been several attempts (some successful, some not, and many of them controversial) by forced migrants to invoke Articles of the ECHR to avoid refoulement with reference to (threats to) their health and wellbeing, notably Articles 2 (the right to life), 3 )the prohibition of torture and inhuman or degrading treatment), and 8 (the right to respect for private and family life). Examples are discussed in T Spijkerboer, 'Gender, sexuality, asylum and European human rights' (2018) 29 Law and Critique 221–39; V Stoyanova, 'How exceptional must "very exceptional" be? *Non-Refoulement*, socio-economic deprivation, and *Paposhvili v Belgium*' (2017) 29 International Journal of Refugee Law 580–616; contributions by J Ruiz Ramos, M Ineli-Ciger and C Díaz Morgado in D Moya and G Milios (eds), *Aliens before the European Court of Human Rights. Ensuring Minimum Standards of Human Rights Protection* (Brill Nijhoff 2021)). The analysis underlying this article could not, however, trace any impact of these instances of individual challenges to national asylum decisions with reference to health rights on legislation and policy-making concerning forced migrants' access to healthcare in the four countries under examination. Rather, they might constitute evidence for the fact that neither related EU Directives nor the ECHR system (and its case law) have born sufficient legal or normative weight with national governments to contain the politically driven lowering of standards towards forced migrants discussed in this article.

[16] SP Juárez and others, 'Effects of non-health-targeted policies on migrant health: A systematic review and meta-analysis' (2019) 7 The Lancet Global Health E420–E435, E433.

[17] See also TK Hervey and JV McHale, *European Union Health Law. Themes and Implications* (Cambridge University Press 2015) 178.

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States to share the 'burden' of incoming forced migrants, as discussed in Section III-B below. One reason for the limited impact of EU law on national policymaking in the area may be the fact thatthese directives provide Member States with discretion regarding the regulation and implementation of measures enabling forced migrants (especially those without refugee or subsidiary protection status) to access healthcare—or thwarting such access—within the stipulated remits.

In consequence, the entire area of asylum and incorporation policy provides fertile ground for normatively charged debates of deservingness, entitlement, and questions regarding the extent to which the task of protecting forced migrants should have the same weight of responsibility for a state as taking care of its citizens. The answers to these questions, which circle around the fluid and frequently re-determined boundaries of inclusion and exclusion, are shaped by various factors such as 'economic interests, human rights considerations, xenophobia, societal norms and values, history, culture and tradition, institutional capacity and international obligations'.[18]

Since the middle of the previous century, and the emergence of national incorporation and asylum policies, the four European countries considered here have taken different fundamental positions on the inclusion–exclusion scale of incorporation systems. Whereas the UK's incorporation system is typically referred to as an example of a restrictive incorporation regime,[19] Sweden, with its traditionally liberal system, has usually been placed on the other end of the inclusiveness–exclusiveness scale, especially with regard to its exceptional openness vis-à-vis forced migrants.[20] Germany, while traditionally also being seen as one of the more restrictive regimes, has since the early 2000s moved gradually towards a more open system through a major legal reform of its incorporation system and asylum policy.[21] Italy, however, cannot be placed as easily on the liberal–restrictive/inclusive–exclusive scale as the other three countries, because not only did it develop a genuine legal system on the incorporation of forced migrants relatively late (during the 1980s),[22] but its incorporation system remains fragmentary. Much of Italy's asylum policy has been reactive rather than proactive over the past decades, and its 'asylum system has been traditionally characterized by a scarcity of reception measures and resources, as well as by a generalized lack of institutional coordination, fuelled by a sense of permanent emergency'.[23] In consequence, regulation and implementation competences lie to a significant extent with the regions and communes (and often also non-governmental actors), producing a large variance of local/regional standards, so that it is difficult to speak of a uniform national incorporation system.[24]

When studying the political regulation (and construction) of insiders' and outsiders' rights and access to health at the intersection of incorporation and healthcare systems, it is important to note that disparities have their roots not only in restrictive legal provisions. Indeed, equal access to healthcare:

[18] Boräng (n 12) 9.

[19] See, eg, Parker (n 10); Boräng (n 12); Sainsbury (n 2).

[21] G Baldi and S Wallace Goodman, 'Migrants into members: Social rights, civic requirements, and citizenship in western Europe' (2015) 38 West European Politics 1152–73; Sainsbury (n 2).

[23] D Giudici, 'The list. On discretion and refusal in the Italian asylum system' (2020) 23 European Journal of Social Work 437–48, 440.

[24] V Federico and P Pannia, 'The ever-changing picture of the legal framework of migration: A comparative analysis of common trends in Europe and beyond' in S Barthoma and ÖA Çetrez (eds), *Responding to Migration. A Holistic Perspective on Migration Governance* (Acta Universitatis Upsaliensis 2021) 15–43, 25.

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> *is determined . . . also by the availability of information for all about health and the healthcare system; by making health services easily reachable and by minimising language and cultural barriers.*[25]

However, as I discuss, reaching the highest possible level of equality in healthcare access has not been the target of recent national policy measures at the intersection of health and incorporation policies in the four countries examined here. Indeed, states have significant leverage in deliberately disadvantaging some groups of persons over others, by only providing information, reachability and the reducing barriers for some, or by disregarding the particular needs of persons with restricted mobility, insufficient language skills, or a lack of knowledge about the respective healthcare system.

Such unequal treatment is deeply rooted in the fundamental tasks and functions of the welfare state and healthcare system. The intervening welfare state was built, not least, to secure and foster loyalty among the state's citizens through social compensation. In consequence, the welfare state traditionally acts inwards, focusing exclusively on its members, and has a clear delineation towards the 'outside'.[26] In so doing, the welfare state has played a crucial role in 'both presuppose[ing] and perpetuat[ing] an ideology of nationhood', in which citizens have 'special obligations' to their co-nationals, but not (or at least not to the same extent) to non-members of the state.[27] After all, 'the welfare state is tied to an image of social membership, not universal humanitarianism'.[28] What is more, European welfare states and their political regulation have come under the influence of a shift in political and public discourses 'from thinking of social solidarity as a redistributive welfare state, to a socially cohesive workfare state based on obligations and responsibilities, rather than rights'.[29]

## III. COMPARATIVE ANALYSIS OF DYNAMICS SHAPING THE POLITICS BEHIND FORCED MIGRANTS' ACCESS TO HEALTHCARE IN GERMANY, ITALY, SWEDEN, AND THE UK

The inherent connection of welfare system, state, social membership, and members' obligations outlined above, makes questions of access and 'outsiders' admittance to healthcare particularly prone to political instrumentalisation. This has led a number of national governments across Europe to adopt restrictive policies regarding, amongst other issues, asylum seekers' healthcare access, starting in the 1980s and 1990s.[30] In the wake of the 'migration crisis' in the mid-2010s, political endeavours of delimiting this group's social and healthcare rights have once more intensified. Similar to the 1980s and 1990s, a dense network of intertwined dynamics has shaped and conditioned this reappearing trend of increasing restrictions, which widen health-related inequalities. In Sections III-A–D, I discuss a range of such dynamics which were particularly impactful in the four countries examined here. Before doing so, it is necessary to provide a brief overview of legal changes in the four countries' incorporation policies since 2015 to help better

[26] J Oltmer, 'Einführung: Steuerung und Verwaltung von Migration in Deutschland seit dem späten 19. Jahrhundert' in J Oltmer (ed), *Migration steuern und verwalten* (VR unipress 2003) 9–56, 11–12.

[27] W Kymlicka, 'The multicultural welfare state' in PA Hall and M Lamont (eds), *Successful Societies: How Institutions and Culture Affect Health* (CUP 2009) 226–53, 229.

[28] K Banting and W Kymlicka, 'Introduction. The political sources of solidarity in diverse societies' in K Banting and W Kymlicka (eds), *The Strains of Commitment. The Political Sources of Solidarity in Diverse Societies* (Oxford University Press 2017) 1–58, 8.

[29] J Phillimore, 'Approaches to health provisions in the age of super-diversity: Accessing the NHS in Britain's most diverse city' (2010) 31 Critical Social Policy 5–29, 11.

[30] Parker (n 10); Boräng (n 12); D Sainsbury (n 2); G Kuhn-Zuber, *Sozialleistungsansprüche für Flüchtlinge und Unionsbürger* (Nomos 2018).

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understand and contextualise forced migrants' healthcare access, and the dynamics which shape(d) it.

In Germany and Sweden, the adaptation of policies regulating this access was shaped by the (justified)[31] perception of having taken in more asylum seekers than most other EU Member States, creating needs for adjustment in the respective reception systems and triggering political reactions to shifts in public opinion and discourses. In this vein, the Swedish governmental discourse was strongly marked by references to the country's traditional role as 'moral superpower' in the reception and incorporation of asylum seekers,[32] and to the 'general feeling ... that the country was in a position to say it had done more than its fair share, and that it had the right to say "enough" without being morally wrong', so as to protect an overburdening of its welfare, healthcare and incorporation systems.[33] One of the government's most impactful steps to safeguard the functioning of these systems, and to reduce overall numbers of asylum seekers, was the adoption of the (initially) temporary Law 2016:752 in June 2016, providing for the primary issuance of temporary rather than permanent residence permits, which had been the 'general rule in asylum policy' in Sweden until then.[34] Given that a range of social and healthcare rights depend on residence status, this law significantly restricted asylum seekers' access to the welfare and healthcare system, leaving them entitled to no more than essential 'care that cannot wait' and maternity care.[35]

While also invoking its country's role-model position during the first months of the 'migration crisis',[36] the German government did not pursue a similar course of collectively lowering incorporation standards, but rather introduced selective restrictions targeting specific groups of asylum seekers. Among other legal changes, the government introduced, with the Asylum Procedure Acceleration Act of 20 October 2015 and several subsequent legal amendments, a series of measures transforming a range of social and healthcare benefits for asylum seekers from 'safe countries of origin' (from cash to absolutely necessary in-kind benefits), and restricting healthcare access of asylum seekers whose asylum application had been rejected to mere emergency care, regardless of the amount of time passing between the administrative decision on their legal status and their actual departure.[37]

In Italy, the political, as well as public, discourse post-2015 was shaped by the role of the country as a gateway for asylum seekers from African and Middle-East origins, leading to, in EU comparison, unproportionally higher numbers of arrivals entering an already strained reception and incorporation system, with little if any support and solidarity from other EU Member States.[38] Seeking to alleviate the incorporation system, and with it the welfare and healthcare system, the most impactful legal act adopted by the government was the so-called Security or Salvini Decree (Decree Law 113/2018, implemented by Law 132/2018).[39] This decree 'introduced a "procedure for manifestly unfounded asylum claims" and a list of "safe countries

[31] See, eg, Eurostat, newsrelease 44/2016 (4 March 2016 <https://ec.europa.eu/eurostat/documents/2995521/7203832/3-04032016-AP-EN.pdf/790eba01-381c-4163-bcd2-a54959b99ed6> accessed 28 July 2022).

[32] See, eg, Bradby (n 1) 185; P Nedergaard, 'Borders and the EU legitimacy problem: The 2015–16 European refugee crisis' (2018) 40 Policy Studies 80–91, 86.

[33] C de Freitas and others, *Asylum Challenges, Debates and Reforms. How Germany, Poland, Portugal and Sweden have Developed their Asylum Systems since 2015* (Bertelsmann Stiftung 2021) 165.

[36] F Trauner and J Turton, '"Welcome culture": The emergence and transformation of a public debate on migration' (2017) 46 OZP—Austrian Journal of Political Science 33–42, 36.

[37] See, eg, *Asylverfahrensbeschleunigungsgesetz*, Bundesgesetzblatt, Part I No 40 (2015), 23 October 2015, 1722–35. For a detailed overview of provisions added to the German Asylum Seekers' Benefit Act (*Asylbewerberleistungsgesetz*, <https://www.gesetze-im-internet.de/asylblg/BJNR107410993.html> accessed 1 August 2022), see Federal Government Commissioner for Migration, Refugees and Integration: 11. Bericht der Beauftragten der Bundesregierung für Migration, Flüchtlinge und Integration—Teilhabe, Chancengleichheit und Rechtsentwicklung in der Einwanderungsgesellschaft Deutschland (December 2016), especially 587–91.

[38] A Stocchiero, 'Italy. The public debate on the Italian isolation in the European Union migration crisis' in M Barlai and others (eds), *The Migrant Crisis: European Perspectives and National Discourses* (LIT Verlag 2017) 169–91.

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of origin"',[40] and abolished the 'humanitarian protection' status, which until then was the most common permit that 'granted sanctuary to vulnerable groups of migrants that could not meet the criteria for refugee status or subsidiary protection',[41] and had provided access to the Italian labour market and healthcare system. This status was replaced by a range of different, mostly short-term, permits coming with a significantly restricted scope of claims and rights already during their validity, but even more so after their virtually inevitable expiry.[42]

The main thrust of the UK's current approach to regulating asylum seekers' rights was already determined prior to the 2015–2016 migration crisis, in the government's 'hostile environment policy' which took legal shape first in the Immigration Act 2014, and was expanded further in the Immigration Act 2016 (as well as secondary legislation).[43] These Acts significantly restricted undocumented migrants' and certain groups of asylum seekers' access to healthcare, social security, housing and the labour market, amongst other things. While initially directed first and foremost at 'illegal immigrants' and rejected asylum seekers, this legislation was explicitly intended to signify an approach of exclusion and deterrence and has since affected forced migrants beyond the original target group. Indeed, it has increased insecurity and disinformation about rights and claims on the side of administrations, service providers, and migrants alike, and hampered, or resulted in (falsely) denied, access to services and benefits.[44] What is more, through the adopted policy measures and their underlying, and repeatedly and explicitly emphasised, aim to keep anyone but 'those in genuine need of asylum'[45] at the margins of society and outside of the welfare and healthcare system, the UK government has contributed significantly to forced migrants' stigmatisation as illegal and/or undeserving residents with no claim to participation in or support from 'one of the most successful multiracial democracies in the world'.[46]

### A. Politicisation processes in the areas of incorporation and healthcare

Across Europe, the policy area of incorporation/migration and that of health have experienced increasing levels of politicisation, and a rising level both of political and public contestation and saliency.[47] The concomitance of such increased politicisation in both areas has led, not least, to an intensification and polarisation of debates on membership, rights, claims, and deservingness in welfare and healthcare systems.

An intensification of politicisation can have a major impact on policies by strengthening their normative dimension, and enhancing their instrumentalisation in the pursuit of political aims, the real target group of which are not necessarily those who are affected first and foremost by the respective political measures. What is more, intensified politicisation can 'make it more difficult to understand policy-making against the background of an institutional

[39] In Italy, the government may adopt a decree law— a regulatory act with provisional legal force—in case of urgently required action. This decree law, however, needs to be implemented through adoption of a respective legislative act by parliament, potentially including amendments, in order to have definite legal force.

[40] Geddes and Pettrarchin (n 63) 237.

[41] ibid 236.

[43] See Y Namer and others, 'Discrimination as a health systems response to forced migration' in K Bozorgmehr and others (n 10) 195–211, 203.

[44] See i.a. A Kaya and A-K Nagel, 'Reception policies, practices and responses' in S Barthoma and ÖA Çetrez (n 23) 227–56, 233; F Webber, 'On the creation of the UK's "hostile environment"' (2019) 60 Race & Class 76–87.

[45] See the description of the Consultation outcome: New Plan for Immigration, 24 March 2021 (<https://www.gov.uk/government/consultations/new-plan-for-immigration> accessed 20 January 2022), including this quote as well as a reference to 'those [migrants] with no right to be here'.

[46] Quote from the UK government's 'Guidance' on the 2016 Immigration Act, 12 July 2016 (see <https://www.gov.uk/government/publications/immigration-bill-2015-overarching-documents/immigration-bill-201516-overview-factsheet> accessed 20 January 2022).

[47] On the conceptualisation and definition of politicisation, see W van der Brug and others, 'A Framework for Studying the Politicisation of Immigration' in W van der Brug and others (eds), *The Politicisation of Migration* (Routledge 2015) 1–18, 4–8.

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framework'.[48] When political actors perceive the necessity to react to discourse–defining events, (resulting/unrelated) shifts in public opinion or newly arising party pressure (especially from the political fringes) may shape these actors' behaviour temporarily to a larger extent than established institutional, or even normative, structures and traditions. Even a temporary deviation from such established frameworks, however, may contribute to lasting shifts in a country's health and incorporation regimes.

In the area of incorporation and, more generally, migration policy, dynamics of politicisation are not new phenomenon. Over the past decades, '[t]hroughout Europe, the issue of migrant integration has become an issue of high politics' and 'one of the most challenging social issues in the context of a globalizing world where nation states are still struggling to come to terms with immigration and diversity'.[49] Among the four countries studied here, the UK experienced the earliest politicisation dynamics in the area of immigration, starting in the 1950s, whereas Germany, Italy and Sweden underwent similar processes only from the 1990s.[50]

Generally, short-term significant increases in the numbers of arriving asylum seekers have traditionally come with boosts of increased politicisation in countries across Europe. Events with a high impact on public and political perception of migrants, internal security and aspects of cultural homogeneity/heterogeneity, such as riots and terrorist attacks, have been shown to produce a similar effect.[51] Such events and their repercussions in politics and society, have contributed to larger dynamics of rising 'Islamophobia, populist anti-immigration movements, a growing preoccupation with "terrorism", and the accelerated securitization of migration and asylum policies'.[52] These dynamics, in turn, have had an increasing impact on welfare state reforms and social (including health) policies, leading not least to an amplified distinction in the access to social rights and claims for different groups of 'entry categories': asylum seekers, refugees, and undocumented migrants have seen a deterioration of their social rights, whereas labour migrants' rights—especially of highly skilled workers—have overall improved.[53] Such shifts in public and political discourses, and subsequently in legal frameworks, have contributed to a growing 'moral categorization' of migrant groups, fuelling already existing patterns of unequal treatment and of underlying perceptions of certain groups of persons' (un)deservingness.[54]

Forced migrants' social and health rights have further been exacerbated by recent trends of intensified politicisation in the area of healthcare. This development has its roots in multiple intertwined factors, with the universal importance of the area to all of a state's subjects as a basis, combined with shifting priorities under the impression not least of demographic change, rising healthcare costs through technological progress, and unsatisfied public demand for healthcare. In combination, these have a strong potential to 'lead the public to blame politicians—especially those in government—for not managing the healthcare system well'.[55] Increased public attention, in turn, has led political parties to attribute more importance to healthcare policy, resulting in an overall increase of political saliency.[56]

48 Boräng (n 12) 156.

49 P Scholten and S Verbeek, 'Politicization and expertise: Changing research–policy dialogues on migrant integration in Europe' (2015) 42 Science and Public Policy 188–200, 192.

50 ibid, 193–34; Boräng (n 12) 133–34; Sainsbury (n 2) 223.

52 S Castles and C-U Schierup, 'Migration and ethnic minorities' in FG Castles and others (eds), *The Welfare State* (Oxford University Press 2010) 278-91, 288.

54 Ruedin, 'Citizenship regimes and the politicization of immigrant groups' (2017) 46 OZP—Austrian Journal of Political Science 7–19, 8.

55 C Green-Pedersen, *The Reshaping of West European Party Politics. Agenda-Setting and Party Competition in Comparative Perspective* (Oxford University Press 2019) 152–53.

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While all of these factors play a role, albeit to different extents, in healthcare systems across Europe, the resulting degree of politicisation of health policy varies among different systems. This degree depends on the respective level of centralisation of healthcare governance as regards 'organization, funding, and actual service provision'.[57] In national healthcare systems and those organised by central state actors, as in the UK and (to a less centralised extent) Sweden, responsibility is perceived to lie more strongly with political actors such as national (governing) parties—implying potentially higher levels of political saliency situated at that level—than in more de-centralised systems and those in which local, corporate, and private actors play a stronger role, as, for instance, in Germany and Italy.[58] Boräng suggests thatother factors impacting the level of politicisation are the degree of the respective welfare state's comprehensiveness, and whether welfare institutions are characterised by universalism or by individual means-testing.[59] These aspects influence social solidarity, generalised trust in the (welfare) state, as well as the 'citizens' view of state capability, or, in other words, the kinds of tasks that the state can and should be entrusted with',[60] including decision-making on who is entitled to, or 'deserves', welfare and healthcare benefits. In this context, Boräng reports 'that citizens in social-democratic welfare states display less welfare chauvinist attitudes than citizens in liberal or conservative welfare states, who are more reluctant to distributing welfare services to immigrants'.[61]

Yet, post-2015, developments in public and political discourses with regard to 'outsiders' access to welfare and healthcare systems call this distinction between different welfare regimes into question. The more themes such as 'welfare fraud', cheating and questioned deservingness have become ingrained in the public discourse, which can be traced in all four countries examined here with regard to forced migrants in the aftermath of the 'migration crisis'[62] the higher the potential for politicisation of related policy issues, regardless of regime types.

### B. Political effects of the migration crisis'

Both public and political party attention for immigration and asylum issues peaked in the course and aftermath of the so-called migration crisis. At the time, politics across European party systems were increasingly shaped by conflicts between 'openness and closure, diversity and cohesion, cosmopolitanism and nationalism',[63] rather than previously dominant capital-labour or state-market cleavages. Like several of the other dynamics and developments discussed here, this process had started to unfold across Europe long before the migration crisis, but this crisis added a new momentum, pushing parties to situate themselves even more strongly along these newly determinant cleavages.

In connection to rising anti-immigration sentiments in society, this process contributed to the strengthening of right-wing/far-right populist parties and their growing political influence

[57] ibid 153.

[58] Federico and Pannia (n 23) 36.

[61] ibid 45; see also PA Hall, 'The political sources of social solidarity' in Banting and Kymlicka (n 27) 201–32, 219; F Roosma and others, 'The achilles' heel of welfare state legitimacy: perceptions of overuse and underuse of social benefits in Europe' (2016) 23 Journal of European Public Policy 177–96, 182–83, 186, who trace high perceptions of welfare overuse and underuse in the Mediterranean countries.

[62] See eg Marx and Naumann (n 5) for Germany; A Pellegata and F Visconti, 'Transnationalism and welfare chauvinism in Italy: Evidence from the 2018 election campaign' (2020) 26 South European Society and Politics 55–82 for Italy; M Goossen and others, 'Suspicion of welfare overuse in Sweden: The role of left-right ideology, anti-immigrant attitudes and gender' (2021) 44 Scandinavian Political Studies 115–39 for Sweden; B Leruth and P Taylor-Gooby, 'Does political discourse matter? comparing party positions and public attitudes on immigration in England' (2019) 39 Politics 154–169 for the UK.

[63] C Fernández, 'Cosmopolitanism at the crossroads. Swedish immigration policy after the 2015 refugee crisis' in EM Gozdziak and others (eds), *Europe and the Refugee Response. A Crisis of Values?* (Routledge 2020) 220–35, 230.

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across Europe, such as the Alternative for Germany, the Lega Nord in Italy, the Sweden Democrats, and the UK Independence Party, as discussed in Section D below.[64]

In the same vein, governing parties adopted a variety of measures intended to deter asylum seekers, typically with an explicit focus on those with limited prospects (or 'deservingness') of being granted protection, but often enough implicitly directed at all potential asylum seekers so as to reduce overall numbers of incoming migrants. This approach implies an inherent mark of inequality in that it seeks to principally bar 'outsiders' from entering the system so as to protect (and/or please) the 'insiders'. Healthcare rights and access have assumed an important role in that regard; in the increasingly politicised areas of migration and incorporation:

> *[p]oliticians and the media portray access to welfare as a major pull factor, attracting migrants for generous benefits and free healthcare . . ., and use this argument to justify a move away from welfare provision for all, to a model of provision for the legitimate and the deserving.*[65]

While this conception of welfare as pull factor and the resulting political reaction to restrict migrants' social and healthcare rights and claims are not phenomenon of the 2010s,[66] they have gained new prominence in the aftermath of the 2015–2016 crisis in all four examined countries. Among them, two addressed their policies of deterrence at all persons potentially considering to seek protection in their country, whereas two directed the respective policy measures explicitly at asylum seekers deemed to have no claim to such protection.

As one of the former countries, Sweden's government sought ways to reduce total numbers of incoming asylum seekers so as to prevent an overburdening of the state's welfare and healthcare system. Indeed, the government argued that, in order to safeguard the functionality of its welfare and healthcare system for 'insiders' and 'outsiders' alike, there was no other way but to 'temporarily adjust the asylum regulations to the minimum level in the EU so that more people choose to seek asylum in other EU countries'.[67] It did so by making the standard protection status more precarious—being no longer permanent but only temporary—and by consequently restricting social and healthcare rights of those holding this status, as described above.

Italy's government acted under similar premises. Whereas the pull factor narrative of favourable welfare and healthcare conditions for asylum seekers was not as prominent in the Italian political response to the crisis as in the other three countries, the perception of overwhelmed systems was acute, leading the government to try and convince asylum seekers either not to come to Italy in the first place, or not to stay in the country but to move on towards other EU Member States. The former was attempted through legislation, such as the above-mentioned Security/Salvini Decree (Decree Law 113/2018). In pursuit of the latter aim—channelling asylum seekers to other EU Member States—the Italian reception system purposefully did not register large numbers of asylum seekers, intending instead to let them migrate further north so that the first country in which they officially entered the EU, and so taking on responsibility for them, according to the Dublin Regulation, would not be Italy.[68]

[64] M Neureiter, 'The effect of immigrant integration policies on public immigration attitudes: Evidence from a survey experiment in the United Kingdom' (2021) International Migration Review (first online, DOI: 10.1177/01979183211063499), 1–29, 2; A Geddes and A Pettrachin, 'Italian migration policy and politics: exacerbating paradoxes' (2020) 12 Contemporary Italian Politics 227–42; de Freitas and others, (n 32) 165.

[66] See, eg, Sainsbury (n 2); F Römer, 'Generous to all or "insiders only"? The relationship between welfare state generosity and immigrant welfare rights' (2017) 27 Journal of European Social Policy 173–96.

[67] Press release by the Swedish Prime Minister's Office: 'Government proposes measures to create respite for Swedish refugee reception', 24 November 2015 (<https://www.government.se/articles/2015/11/government-proposes-measures-to-create-respite-for-swedish-refugee-reception/> accessed 20 January 2022).

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As a result, however, numerous asylum seekers ended up in a month-long legal limbo on Italian territory, as I discuss further below.

By contrast to the approaches in Italy and Sweden, the governments of Germany and the UK pursued a course of selective rather than collective deterrence. In Germany, the government further extended the emphasis on deservingness in according social and healthcare rights, especially to asylum seekers with a low probability of being entitled to refugee or subsidiary protection status because of, for example, their national background from a so-called 'safe country of origin'.[69] It also targeted asylum seekers whose application for protection had been rejected with new restrictive measures, including in the area of healthcare, which was to be limited to mere emergency care. Beyond such targeted measures, German policies and laws generally tend to manifest asylum seekers' 'outsider' position through the application of the fundamental principle that their social security and healthcare coverage should be significantly below the level provided for citizens/denizens by the German *Sozialgesetzbuch* (Social Security Code).[70]

While the 'deservingness' dimension can be traced in UK legislation restricting forced migrants' welfare and healthcare access since the 1980s, the initial main purpose of such restrictions 'was to eliminate alleged misuse of the welfare system—not to curb immigration'.[71] This had changed by the early 2010s, most clearly signified by the 'hostile environment' approach which the British government adopted in 2012 and introduced by then Home Secretary Theresa May.[72] Thus, in the UK, the migration crisis did not have the same effect of inducing the government to pursue a course of deterrence, because this momentum can be traced to pre-crisis times. Nevertheless, the migration crisis triggered an intensification of policies, political and governmental discourses of deterrence in the UK. In the presentation of its 2016 Immigration Act, the UK government emphasised its aim of 'deterring illegal migrants from coming and making it harder for those already here to live and work in the UK'.[73] Further target groups of the Act's restrictive–deterrent approach were asylum seekers whose claims for asylum had been rejected and, more generally, 'people who shouldn't be in the UK'.[74] This 'focus on deterrence rather than integration'[75] can also be found in the Nationality and Borders Act 2022, through which asylum seekers' access to care provided by the National Health Service (NHS) is restricted and the pre-treatment charging system extended.[76]

Beyond the immediate impact on discourses and policies, the crisis and its aftermath accentuated various unresolved, insufficiently or inefficiently regulated issues across European incorporation systems. Through the sudden intensification of the administrations' sheer workload, and under the impression of the demand to do justice both to each individual asylum seekers' case and to political and societal interests and expectations from the host

[68] Terlizzi (n 8) 107.

[69] For a discussion of the 'safe country of origin' concept, see M. Hunt, 'The Safe Country of Origin Concept in European Asylum Law: Past, Present and Future' (2014) 26 (4) International Journal of Refugee Law 500–35.

[70] See eg W Kluth, 'Die besonderen Bedürfnisse von schutzbedürftigen Personen im System des europäischen und deutschen Migrationsrechts' 4 (2020) Zeitschrift für Ausländerrecht und Ausländerpolitik 119–26, 123; Kuhn-Zuber (n 29) 53, 101–02.

[72] See, eg, speech by Theresa May on 'An immigration system that works in the national interest', 12 December 2012 (<https://www.gov.uk/government/speeches/home-secretary-speech-on-an-immigration-system-that-works-in-the-national-interest> accessed 4 August 2022).

[73] Quote by Immigration Minister James Brokenshire, included in the UK government's 'Guidance' on the 2016 Immigration Act, 12 July 2016 (see <https://www.gov.uk/government/publications/immigration-bill-2015-overarching-documents/immigration-bill-201516-overview-factsheet> accessed 20 January 2022).

[76] C Kang and others, 'Access to primary healthcare for asylum seekers and refugees: A qualitative study of service user experiences in the UK' (2019) 60 British Journal of General Practice e537-45, e537 (DOI: https://doi.org/10.3399/bjgp19X701309).

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country's perspective, weak spots in the provision of social rights (among them access to healthcare) became apparent. In the introduction to their recent volume, Soner Barthoma and Önver Çetrez summarise a range of dynamics and developments brought forth and exacerbated by the crisis (or 'Refugee Emergency' as they—perhaps more aptly—refer to it)[77] in European countries' migration governance. Amongst others, they point out[78]

- 'Governance failure'; that is, governance responses which proved to be insufficient to answer arising needs, and the increasingly impactful construction of migration as political scapegoat;
- 'Two contrasting trends in migration governance: "renationalization" and "externalization"'. These are relevant here with regard to a rising degree of fragmentation and ad hocism in legal and political frameworks and practices, processes which can also be traced in the area of healthcare provision for forced migrants;
- 'Protracted transitionality and extended EU waiting rooms', especially but not only in 'frontline states' of arrival where asylum seekers were (and are still) often left for significant periods of time 'in *legal limbo* (emphasis in original) under precarious conditions of uncertainty';
- 'Lack of understanding' of policy makers for those persons targeted by their incorporation policy making, leading to the objectification of forced migrants during the asylum procedure, followed by the expectation that once legal residence is granted, the concerned persons would 'abruptly transform into ordinary members of society and integrate rapidly and seamlessly into the system'.

Veronica Federico and Paola Pannia add to this a sharply increased need for entities such as non-governmental organisations (NGOs), courts, subnational and international actors to fill the '[l]egal and political voids left by national governments'[79] in regulating and implementing forced migrants' claims and rights under the impression of a state of crisis. The, most often unintentionally, strengthened role of these actors in determining and fulfilling claims and rights came with a variety of problems, such as lacking coordination, control and monitoring mechanisms, and widely varying standards between regions or even communes in the effective regulation and implementation of (for example, social and healthcare) rights. The arising new dimension of subsidiarity, even in incorporation systems which are normally characterised by a high degree of centralisation but in which these centralised structures came under unprecedented strain during the crisis, created not only increased fragmentation but new dimensions of discrimination among the persons seeking protection.[80]

The combination of governance failure, legal and political voids, and asylum seekers being left in 'legal limbo' waiting for the issuance of a legal status—or even just their registration—over longer periods of time (a dynamic reaching most severe extents in Italy, among the countries examined here),[81] has resulted in limited (if any) access to healthcare structures beyond emergency care. After all, even if asylum or health legislation provides for forced migrants' access to healthcare systems, they typically need *some* kind of a status to gain such access, and (maybe more importantly) they need access to knowledge on provided services and their own claims and rights in order to be able to make use of them. Such knowledge,

77 S Barthoma and ÖA Çetrez, 'Introduction' in Barthoma and Çetrez (n 23) 1–12, 1.
78 ibid 6–7.

81 See, eg, Geddes and Pettrarchin (n 63) 231; T Caponio and TM Cappiali, 'Italian migration policies in times of crisis: The policy gap reconsidered' (2018) 23 South European Society and Politics 115–32, 125.

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however, is difficult to come by for concerned persons who are left waiting for administration's responses in extended admission procedures within overwhelmed incorporation systems and overcrowded reception facilities, such as the Italian hotspot system or the German Ankerzentren. Initial contacts and the introduction to procedures and institutions in this first crucial phase after asylum seekers' arrival, however, may set in motion path dependencies in what they know and expect from the incorporation and healthcare systems of the host country, particularly if this first phase is stretched over months or even years. Moreover, overburdened administrations and reception facilities have led, at times, to the assignment or rejection of a legal status—with all ensuing rights, duties and restrictions (health-related and other)—based on 'an approximate and superficial assessment'.[82] Even if such administrative mistakes may be corrected at a later stage, this requires an (often lengthy) appeal procedure, which prolongs the concerned persons' time in 'legal limbo'.[83]

Restricted healthcare access due to uncertainty about a person's legal status may similarly apply to those whose applications for asylum have been rejected or whose residence permits have expired but they have not been repatriated/expelled because of overwhelmed administrative and police systems, and/or because they have gone into hiding. This leaves such people without any legal status and in permanent danger of expulsion. They not only lack social rights, but will also be afraid to make use of those they still hold for fear of being identified as illegal residents and deported. In Italy, the number of people left in this legal limbo was particularly significant, partly as a result of the effects of Decree Law 113/2018, which introduced a range of new short-term permits which could not be converted into residence permits.[84]

### C. Current challenges to national healthcare systems

Following the 2015–2016 migration crisis and the COVID-19 pandemic,[85] new emphasis has emerged in political and societal discourse on the supposed interconnectedness of sharply increasing numbers of asylum seekers and already and increasingly strained national healthcare systems. As Kayvan Bozorgmehr and others point out,

> *'[p]re-existing and generic weaknesses of national and regional health systems, such as poor health information systems, fragmented healthcare delivery, health workforce shortages, and an underdeveloped organizational infrastructure, are amplified in the context of forced migration'.*[86]

Further challenges to healthcare systems consist in the combination of higher costs and demands through a combination of an ageing society and increased expenses through advanced technologisation, digitisation, and increasing treatment options, alongside a rising degree of economisation and (resulting) privatisation in the provision of healthcare.

Such amplified challenges stimulate the perception of need for policy change among political actors, so as to react to related worries in the native (voting) population[87] for instance, by further restricting access to healthcare for those who have not yet contributed to the

[82] A Terlizzi, 'The Italian migration governance regime and the role of narratives in the policy-making process (2011-2018)' in Barthoma and Çetrez (n 23) 101–19, 113.

[83] In the UK, for instance, 70% of persons who applied for asylum between 2016 and 2018 appealed against the initial decision on their legal status (see The Migration Observatory, 'Asylum and refugee resettlement in the UK' (11 May 2021, <https://migrationobservatory.ox.ac.uk/resources/briefings/migration-to-the-uk-asylum/> accessed 28 July 2022).

[85] See eg BN Kumar and others, 'Reducing the impact of the coronavirus on disadvantaged migrants and ethnic minorities' (2021) 31 European Journal of Public Health iv9–iv13.

[87] See eg Fernández (n 62) 228; S Masocha and MK Simpson, 'Xenoracism: Towards a critical understanding of the construction of asylum seekers and its implications for social work practice' (2011) 23 Practice 5–18, 13.

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system. This political reaction, in turn, exacerbates the position of persons considered as 'outsiders', because aggrandising inequalities within the native population's healthcare access (including between assumed better access in the past, a perceived 'now'/near future, and the ideal state of such access) seems to weigh heavier politically than inequalities between 'insiders' and 'outsiders'. Regardless of moral considerations or actual healthcare needs, this makes forced migrants a group particularly vulnerable to unequal treatment, together with other marginalised groups such as homeless and stateless persons, and irregular migrants.

Aggravating their position even further, 'asylum seekers in Western host societies are more likely to be viewed as a fiscal burden than other immigrant categories, regardless of their sociodemographic characteristics'.[88] Michael Neureiter states that this perception is particularly prevalent among host-society members with low socioeconomic status from countries 'with a relatively large immigrant population and generous social benefits for immigrants',[89] as they feel that they are competing for the same welfare resources. The 2015–2016 migration crisis induced such concerns in the German and Swedish population, because both countries took in, and had to provide care for, an exceptionally high number of asylum seekers compared to other European countries. In times of already palpable strains on, and following cuts in, the national healthcare systems, the perception of an additional and disproportionate burden increased the potential of host-society members being more prone to embrace narratives of asylum seekers as a threat to the already struggling healthcare system. Similarly, in the UK, the increase of numbers of incoming asylum seekers added to existing deeply rooted fears that the host population might suffer under the impact of increased 'outside' demand on the already struggling NHS.[90] One tool in policy makers' hands to alleviate such fears was, again, to restrict asylum seekers' access to the national healthcare systems, and to emphasise through primary or secondary legislation that the native population would principally receive more favourable access to benefits and services than those newly entering—or rather, being kept at the fringes of—the system.

Yet, such political considerations, driven not least by the above-mentioned rise in anti-immigrant sentiments across European societies, bear a certain degree of economic and administrative contradiction. This is because a large and growing corpus of research has shown that restricting migrants' access to healthcare does not, in fact, lead to a reduction in healthcare costs for the host country in the mid- to long term. Thus, varying restrictions in healthcare access based on immigration status require additional and more complex bureaucratic structures and procedures, imposing additional financial and administrative burdens on the healthcare and incorporation system.[91] A recent example for such practical 'failure of migration policies'[92] was the exclusion of asylum seekers from registration with municipal administrative offices in Italy—a consequence of Decree Law 113/2018, noted above—through which asylum seekers were denied a range of services and benefits, not least regarding their access to healthcare. In a judgment against this practice, the Italian Constitutional Court 'objected to the intrinsic irrationality of the provision', alongside references to the principle of non-discrimination, and that by complicating the process of asylum seekers' identification, 'the regulation contradicts the very purpose of the decree, which is to enhance security and territorial control'.[93]

[88] Neureiter (n 63) 6.

[90] A Shahvisi, 'Austerity or xenophobia? The causes and costs of the "hostile environment" in the NHS"' (2019) 27 Health Care Analysis 202–19.

[91] I McManus, 'The case of the United Kingdom Independence Party (UKIP)' in M Falkenbach and SL Greer (eds), *The Populist Radical Right and Health. National Policies and Global Trends* (Springer 2021) 139–55, 148.

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Moreover, forced migrants' limited access to preventive care and routine checkups may lead to the aggravation of ailments which could have been treated relatively easily and inexpensively, or at least in a shorter timeframe, if detected early on, but which require more cost- and time-intensive care once they have become acute.[94] This applies to physical as well as mental health issues, for which forced migrants often get neither diagnosis nor treatment, both because of restricted healthcare rights (including the rejection of treatment where therapies need to be applied for through justification of individual need) and of limited actual access to medical specialists (even where legally covered), due to various reasons such as language barriers, shortages of available/reachable specialists or long waiting times.[95] Restrictive entry and incorporation policies thus have negative effects on migrant health and host healthcare systems alike, and further deepen the divides between the 'newcomers' and the host country's population.[96]

### D. Growing influence of far-right and right-wing populist parties in national party systems

Considerations on the part of political actors of how to please and appease voters have been noted above, but warrant more in-depth examination in the pursuit of a better understanding of persisting and increasing healthcare inequalities in the four countries under consideration. The fact that policymakers behave in ways that are likely to maximise voters' support is not a new phenomenon but a fundamental principle of party politics in democratic systems. However, its ramifications may change in connection with shifts in national party landscapes, such as the emergence of new parties, and (consequently or unconnectedly) shifting balances in the distribution of public support, votes, and resulting influence among the ensemble of parties on the political left–right scale. The likeliness and also the impact of such shifts have increased in consequence of the 'electoral turn' in capitalist societies:

> *[P]olitical parties no longer define their policies by reference to stable alliances with specific economic interests (e.g., social democratic party alliances with labour unions), but rather define their policies so as to build more fluid and complex coalitions of groups in the electorate. As a consequence, policy is driven less by interest-group bargaining, and more by electoral outcomes.*[97]

Even the mere expectation (or fear) of certain electoral outcomes has the potential to induce policy change, to which the area of asylum policy has borne witness in all four countries studied here. Specifically, one of the above-mentioned shifts in national party landscapes with major implications for the political regulation of forced migrants' access to healthcare is the rise of right-wing populist and far-right parties, and resulting fears of vote loss among centre parties. Indeed, there is one party in each of the four examined countries that can be named as the main right-wing populist/far-right challenger within the respective party systems: the Alternative für Deutschland (AfD) in Germany, the Lega Nord (Lega) in Italy, the Sverigedemokraterna (SD) in Sweden, and the UK Independence Party (UKIP)[98] in the UK. Driven by these parties' growing support in the voting population, as well as their dominant position in the political discourse on immigration and incorporation, established parties

[94] See, eg, Juárez and others (n 15); K Bozorgmehr and O Razum, 'Effect of restricting access to health care on health expenditures among asylum-seekers and refugees: A quasi-experimental study in Germany, 1994–2013' (2015) 10 PLoS One e0131483.

[95] H Zeeb and others, 'Migration und Gesundheitliche Ungleichheit' in Pundt and Cacace (n 4) 117–36, 126–7.

[98] While UKIP has lost significantly in votes and influence in the aftermath of the 2016 Brexit referendum, it did leave a noteworthy mark—in and beyond the referendum—on the public and political discourse, with regard to the areas of immigration and asylum policies and healthcare (see, eg, McManus (n 89)).

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across the political spectrum felt inclined to address propagated scenarios of 'outsiders' over-burdening the system and threatening the host society's security, wealth and welfare.

Some of the centre parties' reactions consisted in explicit distancing by embracing, amongst other things, distinctly open and liberal positions vis-à-vis forced migrants. Among these parties were the German Green Party, as well as—initially (in autumn 2015)—the German Social Democrats, whereas other parties reacted by converging to challenger parties' narratives and demands, such as the German Christian Democrats.[99] In Italy, the Movimento 5 Stelle (M5S) allowed the Lega to take full ownership of the area of immigration policy during the time of their coalition government (June 2018 to September 2019), resulting in a sharp turn towards a more restrictive, nativist line.[100] In the UK, UKIP's welfare-chauvinist and anti-immigration positions, concerning not least 'healthcare benefit restrictions for migrants, have made it into the centre-right Conservative Party's platform',[101] from whom UKIP largely took ownership of the immigration issue in British party politics under the leadership of Nigel Farage (party leader of UKIP during the periods 2006–2009 and then 2010–2016).

These examples of centre parties' reactions to right-wing challengers' positioning and power gains may come as no surprise. Parties on the right half of the political spectrum moved closer to the challenger party, whereas those on the left half sought to distance themselves by explicitly opposing the challenger's positions and narratives. Yet, in the aftermath of the 2015–2016 crisis, we can also trace the less intuitive dynamic of centre-left parties seeking to meet the perceived populist right-wing/far-right threat by adopting similar narratives and policy suggestions. For instance, already prior to Matteo Salvini's takeover of the Italian Ministry of the Interior, and the Lega's ensuing dominance over migration policy, the area underwent a sharp shift towards a more restrictive course under Salvini's predecessor as Minister of the Interior, Marco Minniti from the centre-left Partito Democratico.[102] Danilo Di Mauro and Luca Verzichelli also find 'a sort of contagion effect'[103] of right-wing positions on the centre-left governments led by Prime Ministers Matteo Renzi (2014–2016) and Paolo Gentiloni (2016–2018).

Another case in point for centre-left parties' approximation to right-wing/far-right challengers' positions post-2015, is the Swedish party landscape. The political shifts are even more distinctive here than in the Italian case, considering that the Italian centre-left had, to some extent, endorsed ideological positions similar to the centre-right in some migration-related areas already prior to 2015; for example, with regard to security concerns vis-à-vis migrants.[104] In Sweden, all other parties had made a point of establishing and upholding a cordon sanitaire between them and the SD ever since the latter entered the Riksdag—the Swedish parliament—in 2010.[105] Indeed, even the centre-right parties pursued a distinctly liberal line on immigration in the years prior to the 'crisis', seeking to distinguish themselves from the SD.[106] The results of the 2014 general elections, however, taught parties across the political spectrum that pleas for solidarity with forced migrants did not translate into vote gains, as the centre parties suffered a significant shift of votes to the immigration-hostile

99 PD König, 'Intra-party dissent as a constraint in policy competition: Mapping and analysing the positioning of political parties in the German refugee debate from August to November 2015' (2018) 26 German Politics 337–59; Marx and Naumann (n 5).

100 J Dennison and A Geddes, 'The centre no longer holds: The Lega, Matteo Salvini and the remaking of Italian immigration politics' (2022) 48 Journal of Ethnic and Migration Studies 441-60 (DOI: 10.1080/1369183X.2020.1853907); Geddes and Pettrachrin (n 63).

101 McManus (n 89) 139, 147–48.

103 D Di Mauro and L Verzichelli, 'Political elites and immigration in Italy: Party competition, polarization and new cleavages' (2019) 11 Contemporary Italian Politics 401–14, 410.

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SD.[107] This message was seemingly taken to heart by the Socialdemokraterna, who formed a centre-left minority coalition government with the Green Party under Prime Minister Stefan Löfven. Triggered by a rise of increasingly outspoken anti-immigrant attitudes in the aftermath of the summer and autumn of 2015, the Social Democrats 'moved from affirmative and "generous" approaches to receiving people in need of protection to more restrictive attitudes and policies that focus on keeping refugee inflows at lower levels than before 2015'.[108] This implied the adoption (against the opposition of their coalition partner) of policy measures further restricting forced migrants' rights, including their access to the Swedish healthcare system.

Acutely aware of the ideological U-turn in its immigration policy towards positions which had previously 'been reserved for the SD',[109] the Swedish government was at pains to justify its introduction of 'drastic restrictions . . . as a necessary but morally painful action to salvage the administrative functionality of the Swedish welfare state, not a prioritization of national interests over those of the refugees'.[110] A similar internal ideological struggle can be traced in the case of the German Social Democratic Party (SPD), junior partner in a coalition government with the Christian Democrats from 2013 until 2021. As mentioned above, the party's initial reaction to the 2015 sharp increase in numbers of asylum seekers consisted in embracing a policy line of openness and Willkommenskultur (welcome culture) vis-à-vis those seeking protection in Germany and Europe.[111] This changed, however, when public opinion began to turn on forced migrants—even among 'supporters of immigration friendly parties such as the SPD or the Greens'.[112] The pressure of shifting public opinion became acute for the German Social Democrats as general elections approached in 2017, and statistics showed record-low voter support for the SPD. In the light of these developments, the SPD's positioning on asylum policy changed, and it moved closer to the political right, not least by backing various legislative packages further restricting forced migrants' social and health rights. Albeit rejecting the argumentative logic of right-wing demands for policy change—similar to their Swedish counterpart—the German Social Democrats justified their adapted course of action as a required answer to current challenges, and as a necessary element of their governing responsibility.[113]

These examples of centre parties' reactions to rising right-wing/far-right challengers demonstrate that vote and power gains by the latter, or even the mere fear of such gains, bear a significant potential for political repercussions throughout entire party systems. This is particularly true in times of crisis and in the run-up to elections, and even more so when both coincide. Such pressure grows further when fringe parties succeed in securing ownership of issues which have assumed a dominant position in public discourse, turning developments such as the rise of welfare chauvinism, the polarisation of public debates on forced migrants, and the sharp increase of anti-immigration rhetorics in the aftermath of the migration crisis, into potential political game changers.[114] As parties' focus on voters intensifies, groups at the margins of society who cannot vote face being pushed even further aside, and becoming mere (side/secondary) objects of policy proposals and political narratives. The rise of right-wing populist and far-right challenger parties thus comes with a tangible potential to extend already existing societal, political and legal inequalities to the detriment of forced migrants.

107 ibid.
108 de Freitas and others (n 32) 165.
109 Fernández (n 62) 229.

111 DS Atzpodien, 'Die SPD im Spagat zwischen Regierungsverantwortung und Überzeugung—Migration im parlamentarischen Parteienwettbewerb' 14 (2020) Zeitschrift für Vergleichende Politikwissenschaft 123–48, 140–41.

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## IV. THE POLARISATION OF POLITICS BEHIND THE REGULATION OF FORCED MIGRANTS' ACCESS TO HEALTHCARE

In their combination, the different dynamics outlined above have contributed to an increasingly polarised political discourse on forced migrants' rights and claims, as compared to those of citizens/denizens.[115] The comparative analysis of dynamics shaping the respective policy outcomes across four major European immigration countries has demonstrated that the increased (physical as well as discursive) presence of forced migrants 'has helped legitimate the restructuring' of healthcare and incorporation systems, and 'has played an important role in strategies to divide the "deserving" from the "undeserving" poor',[116] and thus, once more, 'insiders' from 'outsiders'.

The policy changes successively adopted in the four examined countries during and after the so-calledmigration crisis have been shown to have followed an overall trend towards more restrictions. They have thus further manifested the increasing inequality between forced migrants and citizens/denizens. Even those restrictive measures which were introduced as temporary crisis management, or which were officially opposed by later governments (formed partly of parties which were in opposition to those who adopted the respective measures), remain largely in force:

- In Sweden, Law 2016:752 which had introduced the primary issuance of temporary rather than permanent residence permits for asylum seekers and which had an initial applicability of three years, was first extended to apply until 20 July 2021, and was then succeeded by a larger overhaul of Swedish immigration law making the primary issuance of temporary residence permits the general, indefinite rule in Sweden's incorporation system.[117]
- In the UK, the newly adopted restrictive measures discussed above have not been subject to change, as there has been no change of government since their adoption, and they were not introduced as temporary crisis response. Having said that, it is important to note that research has traced 'a significant decline in focus on immigration among the [British] population as a whole'[118] in the years after the Brexit referendum.
- In Germany, the change of government in December 2021 may lead to major changes in asylum and incorporation legislation, not least in the area of healthcare access. The coalition agreement between Social Democrats, Greens, and Liberals aims to reduce bureaucratic hurdles in asylum seekers' access to healthcare and to eliminate all restrictions which minors face in the area.[119] This is the first time that forced migrants' healthcare access explicitly figures in a German government's coalition agreement. However, at the time of writing, no draft legislation to that end had been submitted by the new government.
- The most significant adaptation of previously introduced restrictive policy measures has taken place in Italy, alongside a trend towards less negative public attitudes towards migrants in the country.[120] The coalition government formed of the M5S, the

[115] Barthoma and Çetrez (n 23) 1.

[117] See Ändrade regler i utlänningslagen. Socialförsäkringsutskottets betänkande 2020/21: SfU28, adopted by the Swedish Parliament on 22 June 2021 (<https://www.riksdagen.se/sv/dokument-lagar/arende/betankande/andrade-regler-i-utlanningslagen_H801SfU28> accessed 24 January 2022).

[118] See B Duffy and others, *Divided Britain? Polarisation and Fragmentation Trends in the UK* (<https://www.kcl.ac.uk/policy-institute/assets/divided-britain.pdf> 2019, accessed 25 January 2022) 67.

[119] See Koalitionsvertrag 2021–2025 zwischen FDP, Bündnis 90/Die Grünen und FDP: Mehr Fortschritt wagen. Bündnis für Freiheit, Gerechtigkeit und Nachhaltigkeit, adopted on 24 November 2021 (<https://www.bundesregierung.de/resource/blob/974430/1990812/04221173eef9a67200S9cc353d759a2b/2021-12-10-koav2021-data.pdf?download=1> accessed 24 January 2022) p 140.

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Democratic Party and the Liberi e Uguali parliamentary group, which replaced the M5S-Lega coalition government in September 2019, undertook a detailed revision of the Salvini/Security Decree. This resulted in Decree Law 130/2020, which provided for broader possibilities to renew 'special protection' permits and to transfer them into work permits. However, despite introducing more inclusive and liberal incorporation measures in some respects, the new law does not roll back all of the restrictive provisions introduced by Decree Law 113/2018. It does not, for example, reintroduce the overall more favourable 'humanitarian protection' status, and it upholds reference to 'safe countries of origin', which reduces asylum seekers' chances to receive a protection/residence status.[121]

The persistence of measures which were introduced either as temporary crisis response or as prestige projects by parties with evolving or established anti-immigrant, immigration-sceptical or welfare-chauvinist positions, and the swift and demonstrative adoption or announcement of counter-measures by political opponents, points, again, to the polarisation of politics behind the regulation of forced migrants' access to healthcare. The findings of this comparative analysis fits into the larger corpus of literature on the development of asylum and incorporation policies under the impression and in the aftermath of the migration crisis. Being part of these intense polarisation processes, forced migrants' healthcare access, which may on first sight seem a rather marginal aspect of the larger field of migration and incorporation politics, has gradually turned into a highly salient and politically potent issue. Rather than serving first and foremost a country's abidance to international laws and conventions, or the most effective incorporation of this group of immigrants into the host country's welfare system, labour market and society, the regulation of this 'outsider' groups healthcare access has become charged with a broad bandwidth of political and societal meaning brought forth by a variety of recent dynamics, including (but not limited to) those I have discussed in the above.

## V. CONCLUSION

The regulation of forced migrants' access to healthcare constitutes a crucial element in the larger framework of circumstances determining their incorporation into a host country's social system, economy, and society. This issue has evolved into a central aspect in different political actors'—and thus, more generally, states'—fundamental positioning vis-à-vis this group of vulnerable persons. By gaining political salience, their healthcare access has also become, from a research perspective, a lens allowing for the focused analysis of shifting political discourses and the strategic use/instrumentalisation of specific related items and instances in the pursuit of different political aims. In a comparative analysis, in this article I have traced instances of such shifts and cases of instrumentalisation in recent political reforms regarding forced migrants' healthcare access in four main European host countries: Germany, Italy, Sweden, and the UK. While these four countries each have very distinct incorporation and healthcare traditions, I have demonstrated that policy reforms in the area under examination were significantly shaped in all of them by a number of intertwined dynamics.

First, the impact of increasing politicisation processes in the areas of healthcare and incorporation/migration, moving the issue of forced migrants' healthcare access more into the

[121] C Bove/Association for Legal Studies on Immigration (ASGI), *Country Report: Italy. 2020 Update* (Asylum Information Database/European Council of Refugees and Exiles, <https://asylumineurope.org/wp-content/uploads/2021/06/AIDA-IT_2020update.pdf> accessed 24 January 2022), 48–50.

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focus of political and public discourses. This serves to make it an increasingly popular policy item to address larger political questions and express fundamental positions, on issues such as immigration, membership, solidarity, deservingness, and 'insider' versus 'outsider' rights and claims. Secondly, the concrete consequences of the so-called migration crisis in asylum policymaking and implementation, such as shifts in institutional responsibilities, involved actors' roles and party positions, which resulted in an exacerbation of existing inequalities between citizens/denizens and forced migrants. This further increased the latter's vulnerability. Thirdly, the effects of recent challenges faced by national healthcare systems, including risingcosts and increasing demands, as well as attempts to address them via restructuring and privatisation. Such responses have raised further concerns within populations and thus the political saliency of healthcare. Finally, the emergence of far-right and right-wing populist parties as electoral threats to other parties and as challengers in the four examined countries national party systems, has left a mark on political discourses and, thus, on policiees.

These different dynamics have resulted in the polarisation of the politics underlying the regulation of forced migrants' access to healthcare. This polarisation has increased the inequality between citizens/denizens and forced migrants as regards healthcare rights and claims, and thus their respective positions and opportunities within the host countries more generally. To address these inequalities requires political willingness, as '[p]ublic health is an inherently political question, turning as it does on the distribution and availability of resources and services across society',[122] as well as political and societal perceptions of such distribution and availability. It is this complex combination of actual circumstances and their perceptions which shape the legal regulation of forced migrants' healthcare access, and thus their position and possibilities in host societies, in and beyond times of crisis.

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