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ARTICLE

Navigating the Contradictory Politics of being a Marginalised Migrant during Covid-19

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This paper draws upon the theoretical literature on migration policy and health, and empirical data on three European states with differing welfare models – Sweden (social democrat), France (conservative), and the United Kingdom (liberal) – during Covid-19, to highlight the often hidden and contradictory politics through which refugees, asylum seekers, and undocumented migrants were forced to navigate during the most uncertain period of the pandemic. Although migrants' treatment during Covid-19 was generally better in Sweden with a social democrat welfare tradition, we see migration management priorities greatly undermining the extent to which welfare systems function overall for the benefit of population health. Furthermore, Sweden's recent political shift to the right exacerbates those negative tendencies. As the paper shows, there was considerable effort by civil society and local government to fill the gap where national governments failed to protect this group, stepping in to provide health information, and support.

Keywords: healthcare; migrants; Europe; marginalisation; pandemic

Introduction

This paper looks to the hidden politics of Covid-19 and its impact on marginalised migrants. The latter are some of the most vulnerable members of society, namely refugees, asylum seekers, and undocumented migrants. It explores the contradictory politics of migrant management during Covid-19 which served to undermine efforts to ensure health access for the entire population. In part, this reflects a continuation of a radical ideological shift against once fundamental principles like non-refoulement and the right to asylum, at the expense of humanitarian values and economic stability. Obstacles migrants face in maintaining their health pre-date the Covid-19 pandemic but intensified since the beginning of 2020.

In some countries, migrants were blamed for spreading the disease, despite evidence to the contrary. Border controls were reinforced, and human movement was increasingly surveilled. Yet, at the same time, from early 2020 onwards, there were significant interventions from several international organisations advocating that any strategy to manage Covid-19, as well as likely future pandemics, would be dependent upon ensuring universal health coverage that extends to all persons regardless of their citizenship status. There was considerable effort from civil society and local government to fill the gap where national government failed to protect this group, stepping in to provide health information and support.

The paper begins with a review of the contradictory and opaque politics of migrant health governance pre-dating the crisis. It will then highlight the issues of migrant management during

the initial stages of the pandemic. The first and second waves of the pandemic were an unprecedented period in many respects. With respect to marginalised migrants, it starkly highlighted the extent to which migration management policies were prioritised at the expense of more broadly accepted social and political principles. And, conversely, there was an ongoing countermove from various levels to try and cover the holes in public healthcare left by an increasingly and intentionally withdrawing state. In effect, the pandemic reveals important insights on the often otherwise hidden politics of the modern state with respect to human health and movement.

To illustrate the dynamics at play, the article draws upon the authors' earlier research comparing three European states with quite different welfare and migrant policy traditions: Sweden, France, and the United Kingdom (Dalingwater *et al.*, 2022). What we see is a situation in which public health is down prioritised compared to migration management policies, and civil society and other informal initiatives move to fill the gap and try to curtail the spread of the pandemic despite often deliberate state failure. Despite an overt focus on protecting population health, we see a largely hidden and contradictory dynamic in which migration management politics take priority to circumvent and potentially undermine pandemic resilience. Placing that contradiction in the context of the welfare state model is important for understanding wider shifts in migration politics and their impact on healthcare policies.

Variations in welfare regimes and contradictory politics of migrant integration

The contradictions in migrant integration in Europe stem from historical, political, and economic considerations which predate Covid-19. In particular, the three countries under study have contrasting welfare traditions and in addition have developed different migration policies. All EU members and the UK, as a former member, recognise the rights for all to 'the highest attainable standard of physical and mental health' having ratified the UN Refugee Convention of 1951. Article 23 of said Convention recognised the right of 'refugees lawfully staying in their territory the same treatment with respect to public relief and assistance as is accorded to their nationals' (United Nations, 1951). Migrants in Europe, even those without refugee status, can claim a lawful right to the protection of their health through the 1946 WHO convention, which grants the right to health for all people regardless of their status (WHO, 1946). The three countries under study have also adopted the 2008 World Health Assembly protocol for migrants which reinforces newly arrived migrants right to health protection (World Health Assembly, 2008). The WHO has reiterated that all states have an obligation to 'provide equal access to all, including asylum seekers and illegal immigrations, to preventive curative and palliative health services'. The Council of Europe Resolution (2006) also provides for minimum emergency care to undocumented migrants.

However, individual welfare regimes and especially migrant management policies may well obstruct the right to the highest standard of physical and mental health provided for by international law. The provision of health and social care in the three countries under study is related to the historical construction of welfare state models. Esping-Andersen identified three welfare regime types: the liberal, the conservative, and the social democrat. The three examples under study in this paper are representative of Esping-Andersen's three welfare regimes: the UK (the liberal), France (the conservative), and Sweden (the social democrat). The liberal regime provides minimal welfare, benefits are low, entitlement strict, based on means-tested allocation, and recipients are often stigmatised. The Conservative regime works according to status differentiation, benefits are earnings-related, emphasis is on the family, and redistribution minimal. The Social Democratic regime provides universal and generous benefits; income protection, and the social security system is redistributive. In addition, access to healthcare for migrants is linked to several underlying points related to different welfare regimes. First the financial characteristics/financing systems of the healthcare system: public financing through tax

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and social securities, private health insurance, or out-of-pocket payments. Differences will also arise according to whether taxes are collected centrally, such as in the UK and France, or locally, such as in Sweden. Social insurance-based systems have complex registration processes which can represent barriers to healthcare access.

Entitlements to healthcare do depend to some extent on basic norms and institutions of welfare states but also in the case of undocumented migrants on migration policy at both national and local levels. While Esping-Andersen and similar typologies may go some way to explaining different approaches to health and social care access for migrants, they leave many questions unanswered in the case of newly arrived migrants' access to care. In particular, the Esping-Andersen typology suggests uniformity across each level of service supply, which is clearly not the case for newly arrived migrants. In the case of the UK, healthcare provision is universal for British citizens whereas other social service provision is restricted and means-tested. An extra complication is that the provision of healthcare is restricted for newly arrived migrants. The same is true for France and Sweden, where access to healthcare or accommodation is more problematic when dealing with marginalised populations.

Since such typologies can only go some way to explain the differences (or indeed the similarities) in terms of migrant health protection in the three countries under study, migrant scholars have provided complementary analysis. Firstly, they underline the necessity of specifying the immigration policy regime and its evolution over time to consider the inclusion and exclusion of immigrants in the reception country (Faist, 1995; Soysal, 1994). The immigration regime creates specific rules (legislation and rules to apply legislation), which relate to processes necessary for immigrants to access health, accommodation, and other services. Therefore, the different conceptualisations of citizenship will explain how immigrants receive health and social care in the three countries. In the UK, for example, the concept of citizenship changed with the introduction of the 2014 Immigration Act. Ordinary residence status is henceforth only granted after five years of residency. Non-residents are expected to pay for treatment administered by the public healthcare system, the NHS, with the exception of urgent care (Bendixsen and Näre, 2024). Empirical evidence from the Covid-19 period detailed in the following describes how the confusion over 'urgent care' prevented access to healthcare in the same way as it has done in normal times since this law was enacted.

Brücker et al.'s analysis of European welfare regimes and immigration reinforces the idea of inclusion and exclusion over time (Brücker *et al.*, 2002), illustrated through the key stages of immigration. The first stage was during the post-war period when European countries welcomed low-cost workers to make up for labour shortages. France and the UK were among the main countries of destination during this period. However, in the second phase from the 1970s and economic crises, the latter two countries along with other North European countries attempted to reduce the intake of immigrants, with a complete change in migration management in order to cut costs to public services, and notably health and social care services, which had been reported to be under financial strain in all three countries under study. The third phase also saw attempts to limit migration flows, particularly after 2015, with the refugee crisis in Europe. This crisis has led to major changes to migrant management in all three countries, none of which were well equipped politically or administratively to deal with an increased inflow of refugees and migrants (Geddes, 2018). Added to this is constant pressure from populist groups in all three countries to limit the intake of migrants.

Moreover, the complexity of multi-level governance issues in relation to the integration of migrants once they arrive in a territory adds further complexity to migration management. As Scholten and Penninx (2016) underline, while the EU has become more involved in immigration and integration policy, especially since the EU's political crisis of 2015, in practice migration management is decided and implemented almost exclusively at the national level in collaboration with municipalities. Local governments, particularly in large cities, have developed their own policies to deal with the migration situation (Scholten and Penninx, 2016). Complex and

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contradictory policies are thus applied at the various levels of policymaking creating challenges to intervene effectively to ensure sufficient healthcare to these vulnerable populations. In some cities, this has even led to a decoupling of policies at national and local levels (Sholten and Penninx, 2016). This is very much the case in London and certain French regions. The contradictory nature of politics emerges when there is divergence between these various levels in terms of their approach to migration policies and interventions. Such complexities played an important role in complicating the health response during Covid-19 as we can see from the following evidence.

The restrictive immigration policies have become increasingly dominant in Europe, notably by limiting the rights of newly arrived migrants, including restrictions on welfare provision in the name of immigration control and restricting migration not formally authorised by the state (Bomems and Geddes, 2000). At the supra-national level, important to the discussion is thus extra-territorial expressions of sovereignty. The EU has tightened its external frontiers with stricter visa regimes and agreements such as the 2001 Carrier Agreement, putting pressure on naval and air carriers to ensure only passengers with valid travel documents and residence permits are allowed entry (Frelick *et al.*, 2018; Geddes, 2018; Oliveira Martins and Strange, 2019; Palm, 2020). The same forms of territorial control are also present in the UK and France, which have continued to cooperate to reinforce immigration control over their shared borders with bilateral agreements such as the Sangatte Protocol (1991), the Treaty of Le Touquet (2003), and the Sandhurst Treaty (2018), reinforcing security in and around the Channel Tunnel and ferry terminals. Since 2019, preventing small boat crossings has been the focus of cooperation between these two countries with a three-year border control deal introduced in 2023 (Gower, 2025). Such forms of action in the name of reinforcing borders and sovereignty can be challenged to the extent that they undermine international human rights standards and notably international rights to public health. Police violence towards immigrants stranded in Calais hoping to cross the border to the UK has been described as having worsened since the dismantlement of 'The Jungle' in 2016, and appears to be encouraged under such border control systems as part of the deterrence regime (Keen, 2021). Police removal of material goods has the effect of worsening health and social conditions for those in Calais. The following empirical evidence is testimonial to the continued reinforcement of supranational migration control laws during the health crisis.

Other barriers to healthcare add to the multi-level infringements on migrants' right to health in many European countries irrespective of the welfare regime in place. The undocumented are often reluctant to seek care for fear of being reported to the police or immigration authorities by health workers or administrative staff (Asgary and Segar, 2011). Denunciation has been an explicit part of national policy in some countries, the intention being to cut off undocumented migrants from public services (Thomas *et al.*, 2010). In very complex systems, refusal to provide care may be because staff do not know the rules or rights to access (Breanne *et al.*, 2018) Other barriers include linguistic obstacles because of a low level of skill in the host country's language. The mobility of asylum seekers and dispersal can result in disruption in access to care for these vulnerable populations. Finally, xenophobia against migrants can lead to discrimination in access to healthcare or essential services, which impact public health (housing, employment etc.). In the specific context of Covid-19, the literature and empirical evidence have shown that the same kind of barriers emerged and were intensified.

Research has already shown that there is significant inequality of health experiences during epidemics (Chu *et al.*, 2020). For marginalised migrants, epidemics are times of cumulative hardship. The accumulation of structural constraints weakens the already difficult daily situation experienced by migrant populations. They live with higher levels of health insecurity linked to the risk of exposure to the virus in collective structures, difficulties in accessing healthcare, and increased levels of economic insecurity due to the likelihood that their livelihoods will be interrupted due to lack of activity during confinement.

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Contradictions and conflicts in healthcare provision during Covid-19: a three-country survey

The following section looks more closely at such issues by drawing on empirical research conducted from the period March to November 2020, which covers both the first and the second wave of the pandemic in three European states that had significantly high per capita infection rates in Europe but quite different welfare state regimes and migration policies in place: Sweden, France, and the UK (Dalingwater *et al.*, 2022). The following draws on interviews with prominent civil society organisations in all three countries (three France, four Sweden, two UK), which work with migrant health and welfare. All interviews were semi-structured and conducted over the period October-November 2020. The civil society interviews provided us with information about healthcare interventions for marginalised migrants at both national and local levels in all three countries. The sample size is small but we argue the subsequent findings are generalisable due to the prominence of the interviewed organisations working with healthcare access for marginalised migrants during the pandemic. The empirical evidence is also supplemented by extra material including other empirical studies, reports, and secondary literature to complete the analysis of the contradictory migration politics identified during Covid-19.

Already in March 2020 at the supra-national level guidance was issued on how to ensure health interventions to marginalised populations by some of the most authoritative public health and migrant health organisations: World Health Organisation (WHO), International Organisation for Migration (IOM), the United Nations Refugee Agency (UNHCR), and the International Federation of Red Cross and Red Crescent Organisations (IFRC). Such information essentially included guidance on ensuring access to health services for migrant populations; providing adequate support to migrant populations to prevent the spread of Covid-19; non-discrimination, that is avoiding scapegoating and stigmatisation towards migrants; and devising strategies towards community engagement including declaration of temporary amnesties from deportation to encourage full participation. Our findings supplemented by other general literature underlines the mixed results in terms of the application of international guidance in all three sites of study. Some of the international guidance seems to have been applied at national and local levels to a certain extent but policy implementation was well below the international guidance and in some cases contradicted the international guidance and policy recommendations. The reasons for such failures to provide the essential health and social care to these marginalised populations are related to issues of insufficient administrative and political structures in place as mentioned in the previous section. This is evident in the three countries under study.

In Sweden, healthcare was originally provided through voluntary service but at the beginning of the 1700s the regional and national level took over the responsibility of the healthcare and at the beginning of the 1900s private actors entered into the healthcare. Currently in Sweden, healthcare access and its options for the citizens are decided at a national level but carried out on a regional level (Region Skåne, 2018) with a social democrat tradition of welfare provision. Sweden has historically been seen as a welcoming country for migrants with around 20 per cent of the population were born outside of the country (Parusel 2023). However, in 2015 Sweden's political discourse altered in the context of the wider EU political failure to manage Syrian refugee arrivals. This included an electoral shift and subsequent policy paradigm move towards increased restrictions on asylum applications (Parusel, 2023). Prior to the pandemic, Sweden had established broad access to emergency healthcare for all migrants no matter their legal status (Region Skåne, 2018). However, in practice there are many more barriers limiting that access than the formal regulations suggest (Mangrio *et al.*, 2018). All migrants have, despite legal status, the right to healthcare that could not be deferred, which practically means all healthcare that could not be waited for. Even if Sweden formally provides such a right for healthcare, not all healthcare staff know practically how this law works and therefore it happens that refugees do not get their rights

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met (Mangrio *et al.*, 2022). Because of this, there is still a great need in Sweden for civil society to support healthcare agencies in reaching migrants (Lundåsen, 2023).

At the onset of Covid-19 during the beginning of 2020, international organisations and non-governmental organisations stated the necessity to target actions that could protect refugees and undocumented migrants (Bhopal, 2020). Despite these efforts Sweden and especially the Stockholm area was disproportionally affected by Covid-19 due to socioeconomic differences amongst the population exacerbated by inequalities connected to citizenship status (Valeriani *et al.*, 2020). There were more deaths and more incidents among migrants compared to the rest of the population (Valeriani *et al.*, 2020).

An interview with a society and health communicator, working at the county government of Scania, provided insight into an assignment they received from the Public Health Agency of Sweden, to translate information about Covid-19 into different languages and to create films that could be shown during the society and health communication classes that the newly arrived refugees get in Sweden. According to the society and health communicator, this translation of information worked well, but Doctors of the World mentioned that several relevant migrant languages (e.g. Romanian) were missing. And, despite this information being translated, not all migrants were able to receive information and were having difficulties to access care when needed. The Red Cross in Stockholm mentioned that the access to healthcare for migrants has worsened during the pandemic through ignoring barriers impacting migrants with uncertain residency status, stating:

> Due to the healthcare being more digital, it excluded migrants without bank ID to be able to access healthcare during the pandemic.

According to the Swedish Red Cross, there was also a lack of knowledge among the healthcare staff as to what rights migrants have and without this knowledge some were denied care. This was also confirmed by the Doctors of the World, that mentioned that some EU migrants had been denied care and that the rights for healthcare had differed across the country.

One society and health communicator interviewed said that he wished that they could have been able to sit down with key people within the communities that are in contact with migrants living there and together go through the information about Covid-19 and make sure that these people understand and are able to spread the right information around. They could also have worked with the associations that are in close contact with migrants in Sweden. This information could have been relevant since the public health agency of Sweden led by Anders Tegnell famously took a much less restrictive approach than other European countries (Tegnell *et al.*, 2023).

Regarding the social situation for the migrants in Sweden during the pandemic, a healthcare clinic for undocumented migrants, Rosengrenska, told that the undocumented migrants they encountered survive through informal working contracts and through food service by the civic society. During the pandemic this support was challenged since many of the volunteers are older people that due to the pandemic had to isolate themselves from social contacts. And this is a challenge for the Rosengrenska, since their work and service are built on elderly volunteers, they had to close much of their service during this period. The Swedish Red Cross reported that already prior to the pandemic, migrants were living in vulnerable areas but have been more prone to vulnerability during the pandemic period. The ones that suffer from no support from the social welfare system have been more dependent on civil society for support. And this is a support that already before the pandemic was difficult to give due to the challenge of connecting particularly undocumented migrants with such organisations. Further on, the Swedish Red Cross explained that:

> Meeting places have been closed down due to restrictions on social contacts, which means a decline in the support and protection for these people.

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Further on, Doctors of the World Sweden mentioned that many of the undocumented and the EU migrants were not reached by the employment service and its information during the pandemic. And even if they were included in the employment service care, they were not sure that they did get the information about temporary laws that could affect their living conditions. They were also concerned that if migrants should be able to self-isolate, they had to do so in overcrowded living conditions that are insecure as well. Doctors of the World told that they often meet homeless people who are not able to take care of their own personal hygiene, and that it differs between different regions in Sweden to what extent homeless migrants are able to get a hostel to stay in when needed. They also talked about that there are within the Stockholm area, very few places that host homeless migrants and migrant women especially suffer regarding this. Many of the migrants that are homeless have difficulties finding a public bathroom when needed and were therefore more susceptible for catching the virus.

Burström and Tao (2020) conclude that governments should take early actions to mitigate the negative effects of Covid-19 and protect vulnerable groups, and that increased collaboration is needed across multiple levels and stakeholders, including health and social care, between different administrative levels and between public and non-governmental organisations. Specific preventive measures should be targeted towards where the need is greatest and focused on lower socioeconomic areas where there are high rates of infections and severe diseases (Burström and Tao, 2020).

In France, where welfare services are tied to a conservative model based on wage-related contributions, policies and procedures to deal with migratory pressures are very much devolved to the local level. Civil society organisations are the main actors providing support to newly arrived migrants at that level. Some of these organisations are financed by the *Fonds d'Action Social (FAS)*, which is a national agency with regional offices and through the municipalities. Policies do not directly target migrants but rather neighbourhoods and vulnerable persons. However, there are marked differences between localities in terms of the health and social care provided to migrants.

During the Covid-19 pandemic, it was difficult to identify clear and specific community engagement and coordination from the national level to the field level any more than the basic emergency care that was provided through civil society. The Town and Accommodation Ministry was commissioned to work with associations, communities, and businesses to identify additional accommodation solutions, in public facilities, hotels, or buildings that have become vacant because of the health crisis, or to support food distribution during the Covid-19 pandemic. However, on the ground and in large agglomerations like the Paris region or Marseille, it was ad hoc and uncoordinated.

According to Mrs Gary from the association Aurore, in Paris, the pandemic made the situation worse in terms of providing accommodation for marginalised migrants who come to their day centre for assistance and for the possibility of being transferred to suitable accommodation:

> The vast majority of them don't have any accommodation. What they are looking for really when they come here is to leave for a transfer to a centre where they are provided accommodation[1] and the problem is that since the beginning of lockdown, the places have been drastically reduced (. . .)

The housing crisis thus exacerbated the situation for migrants and their exposure to Covid-19 and marginalised migrants experienced a deterioration in living conditions during Covid- 19 in France. According to *Médécins sans Frontières* (MSF), one in two marginalised persons (90 per cent marginalised migrants) tested positive for Covid-19. Conducted between 23 June and 2 July 2020, the MSF study revealed large disparities according to the types of sites where people were tested. In the ten accommodation centres where it provides healthcare, the positivity rate reached 50.5 per cent, compared with 27.8 per cent in the food distribution sites and 88.7 per cent in the two migrant worker hostels. MSF explained that the main reason for such disparities is owing to unsuitable shelter which creates clusters (Roederer *et al.*, 2020).

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Aurélie Denoual from Doctors of the World underlined those conditions deteriorated for the migrants after the outbreak of Covid-19 in the Calais and Grande Synthe regions, too.

> Living conditions are extremely difficult in the camps and it's true that during lockdown everything was that bit worse. (. . .). During lockdown, the State put in place access to water, access to showers and so on in the Grande Synthe area, and at the end of lockdown everything was removed, so it was a fairly short period. However, the situation is still as complex as ever before in the Grande Synthe area, there is one water point, 6 toilets for 400 people and no access to showers.

The larger camps such as the notorious 'Jungle' were dismantled by the local authorities in Calais and Grande-Synthe in 2016 and since then, public authorities have applied intransigent policies to prevent attempts to cross the channel at specific anchor points along the Channel coast, that is the points where immigrants attempt to cross from France to the UK. The result has been that the police constantly destroy makeshift shelters, blankets, sleeping bags, and other material. The exiles are thus obliged to constantly wander and erect new shelter often in dangerous areas (CNCDH, 2021). All non-governmental organisations interviewed in the region confirmed that conditions for exiles were worse after the outbreak of Covid-19 than they had ever been and no sustainable solution was found:

> Because the government's objective is to discourage migrants from staying close to the border and they consider, obviously wrongly, but they consider that the fact that we help them on a material level allows them to stay here. We can see this, moreover, with the hardening of the government's policy over the last two months, which has increased the number of evacuations, which has reduced the services that the state should provide to the exiles so as to discourage them from staying in Calais (. . .) it's a policy that is inhumane, that puts people in difficult conditions for survival, but it's also a policy that is very costly, that is ineffective and that is contrary to human rights on so many levels and in any case contrary to the values of our country.

The intervention of NGOs on the ground is very complex, and this was even more difficult with the outbreak of Covid-19. The only coordination that really took place to take care of the exiles in the region across local authorities was at the very beginning of the pandemic. François Guennec explained:

> The sub-prefect of Calais regularly calls us to meetings and the frequency of these meetings, which was about every two months before the epidemic, increased. We had meetings practically every fortnight at the sub-prefecture, with civil society organisations and hospital services. So civil society has been consulted, but the support system for migrants has been late and insufficient (. . .)

According to Aurélie Denoual from Doctors of the World, a coordinated approach was absent in the Calais and Grande Synthe regions to take care of exiles during Covid-19. Moreover, she notes that not all the actors involved in managing migrant health attended and most of the consultations were bottom up and conducted thanks to initiatives at the grassroots levels.

Our research found that intervention of civil society organisations was essential to provide information in a timely manner (translation of government information, keeping migrants up to date with new information about Covid-19, communication in a language and medium accessible to migrants, and providing day care for migrants or initiate proceedings to find adequate shelter and provide food). However, the interviews with civil society working in France underlined the limits of their action. It was impossible on a large scale to provide shelter that respected social

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distancing and the necessary health interventions in a timely manner, this required more government intervention from the housing ministry and local accommodation action. The analysis bears witness to how complex multi-level governance of migration management, as described in the previous section, at both the supra-national and local levels resulted in the inability to attend to the health of vulnerable populations during the Covid-19 pandemic and thus contributed to the deterioration of their wellbeing.

In the UK, within what is otherwise a liberal welfare model, nationwide provision of healthcare free at point of use is available to UK citizens via the National Health Service (NHS). However, the NHS has become structured across an increasingly complex network of regulatory bodies including regional hospital trusts and different agencies along a market-oriented system. The complex structure of healthcare provision in the UK has been driven by a series of policy initiatives focused around new public management and a market-based model such that there are often several decision-making actors overlapping and competing within the same domain, creating significant coordination problems during the pandemic (Jones and Hameiri, 2022).

With respect to healthcare for migrants, and marginalised migrants in particular, the situation is particularly complex and confusing for both patients and providers because healthcare professionals are legally required to enforce migration management. The UK's Home Office requires that healthcare professionals assess a patient's migration status before providing treatment, as well as levy fees for some. Imposing migration policies within the hospital or surgery context has created significant challenges and uncertainty resulting in refugees and asylum seekers being refused or not seeking healthcare despite their need and their legal entitlement (Tomkow *et al.*, 2020).

Whilst the UK formally provides 'urgent' care to refugees and asylum seekers who have a residency application or appeal under review, this creates ambiguity for both those individuals and healthcare practitioners where many treatments might also be said to overlap with non-urgent conditions; a situation which exists because of the evolution of migration management over time as described in the previous section. Such ambiguity becomes a problem where treatments classed as 'non-urgent' require billing patients, risking that those individuals can unwittingly fall into debt to the NHS. Fearing that such debt may undermine their legal rights to stay, migrants living in an already marginalised situation must then balance their needs for healthcare against longer-term goals to avoid deportation. The uncertainty marginalised migrants experience when accessing healthcare is mirrored within the overall hostility they are subject to in employment and housing policy which, in turn, undermines their living conditions and, subsequently, their health (Institute for Public Research, 2020).

During the first two waves of the pandemic, the UK's response to marginalised migrants reflected the poor coordination seen within its overall approach but was particularly detrimental to migrant populations. For example, the UK government was extremely slow in targeting health communication on the pandemic so that it would reach migrant populations. According to interviews with UK civil society working on migrant rights, there was a total absence of information for migrants until the NGO Doctors of the World translated NHS guidance on its website. The effort of translating health guidance for migrants was also joined by local governments – primarily the London Mayor's office. When the national level began putting these materials online, only in July 2020, they linked to the efforts already conducted by these other actors such that rather than provide a well-resourced and coherent source of information, migrants were required to know of these websites and then navigate across multiple sources of guidance. The decentralised provision of pandemic health guidance to migrants ran contrary to the increasingly centralised efforts to exclude migrants from services and other aspects of UK society. It meant that migrants were both expected to access websites despite often lacking their own internet-capable devices, and that the information online was not sufficiently maintained such that it fell behind the changing developments in government health advice.

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As the pandemic worsened, many local health authorities took up the task of translating and disseminating guidance to migrant populations. There were also many local ad hoc initiatives, such as doctors from minority backgrounds choosing to drive around migrant neighbourhoods and spread health guidance in the appropriate language and sometimes even via public address speakers. The disjointed and reactive approach towards health communication for migrants was out of keeping with the extent to which the UK forcibly keeps persons in asylum accommodation. The pandemic positioned the UK's long-established hostility towards refugees and asylum seekers against the needs to protect population health. Although immigration checks were suspended for overseas visitors seeking Covid-19 testing and treatment, the exception was poorly communicated to migrants and healthcare practitioners. Furthermore, it did not extend to other health conditions, which was a particular problem where individuals worst affected by Covid-19 typically suffered other negative health conditions that on their own were not classed as 'urgent' and so were potentially subject to both charging and deportation. An activist from the civil society group Doctors of the World UK stated:

> It's impossible for a patient to make a decision about whether to go forward to services or what the risks for them are so it just means that they postpone it . . . until they become really desperate. Which is obviously a disaster for public health.

The lack of coherence between migration and health policies was repeated in policies governing how asylum seekers are housed, with activists reporting that many migrants were forcibly moved out of accommodation with access to sanitation, and into larger units that private contractors found easier to handle but where it was often impossible to wash let alone maintain social distancing. An activist from the Institute of Race Relations noted the problem as follows:

> What is the point in offering them a test when you have created conditions for them to get Covid? And contained them in these circumstances.

In such cases, individuals were forcibly placed in a dangerously contradictory situation in which they both received guidance to socially distance and maintain good personal hygiene, whilst being forced to live in mass accommodation and share beds with strangers, whilst also experiencing limited access to hand sanitiser.

Discussion

Sweden, France, and the United Kingdom sit along the spectrum of welfare models – respectively ranging from social democrat, to conservative, and liberal. Moving along that spectrum the state takes an increasingly small coordinating role with the market becoming more dominant. This fits with the 'varieties of capitalism' approach developed by Soskice and Hall (2001), but which has been frequently criticised for its oversimplification of political-economies that treats the state as a black box (Blyth, 2003). Esping-Andersen's model of welfare states likewise provides a partial cultural-institutional explanation for the variation in how these three states treated migrants during the most uncertain period of the pandemic. We see that in the UK there was more reliance on the private sector, in France it was almost fully dependent on civil society to fill the gap in welfare provision specific to marginalised migrants, and in Sweden the state – in the form of the regional government – took a slightly bigger role. Yet, notably, in all cases the state grossly underperformed. In the Swedish case, it could also be said that part of the problem for migrants was that the social democrat model assumed everyone required the same welfare benefits and therefore was blind to the changes they faced with uncertain or inferior citizenship status. Other research has firmly established that the pandemic disproportionately impacted individuals living

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with uncertain legal status as either undocumented or otherwise marginalised migrants (Hu, 2020; Shen and Bartram, 2021; Islamoska *et al.*, 2022; Fu *et al.,* 2022; Bastick and Mallet-Garcia, 2022; Solheim *et al.*, 2022; Juárez *et al.*, 2024; Krannich and Massey, 2024). Despite that research and the lessons learnt during the height of the pandemic, we see a worsening in the political and policy climate for migrants in all three countries. Although existing studies corroborate our findings, scholars have tended to provide only country-specific studies and usually on only either the UK or US. Of that literature, several points should be highlighted alongside our comparative research. First, whilst civil society often used digital technologies to try and enhance access for vulnerable migrants (e.g. Fu *et al.*, 2022: 36-37), vulnerable migrants find it harder than more privileged groups to access and use such technologies (Spencer *et al.*, 2024). Also, whilst civil society was seen as important in our study, the wellbeing of vulnerable migrants was more dependent on community support (Aftab *et al.*, 2025). That matches similar experiences for the broader society where, whilst civil society matters, access to social ties plays a bigger role (Höltmann *et al.*, 2023:824). Social ties therefore indicate a significant mechanism by which anti-immigrant sentiment harmed the health of individuals marked by that stigma. Second, it is notable immigrant's economic vulnerability led to their overrepresentation in essential jobs (healthcare, transportation, food) in which they were both key to the functioning of the host country but also disproportionately exposed to the pandemic (Fasani and Mazza, 2024:6). Ironically, vulnerable migrants were also more likely to work longer hours but also face a higher risk of redundancy (Fasani and Mazza, 2024:18-19).

Migration management relies extensively upon creating uncertainty and legal grey zones, leaving the individual in a precarious and mentally stressful situation. In all three countries, regardless of welfare type, there is a pre-Covid-19 history of reduced health access despite actual legal rights for access to healthcare due to uncertainty amongst both migrants and healthcare personnel over their rights. Covid-19 worsened that uncertainty, even where migrants were temporarily granted increased legal rights to healthcare, but also the rapidly changing situation highlighted longer-term structural failings within health communication that excluded migrants. Migration management has effectively created a series of parallel societies in which much welfare provision has shifted over to voluntary civil society organisations. That undermines the rights of migrants, but the pandemic also demonstrated how such a withdrawal of the state undermines the overall wellbeing of society by declining population health.

To be a migrant today increasingly means that one must navigate a hidden society in which the paths towards accessing welfare are opaque and ever-changing. There is no basis by which to know if decisions are fair or correct. The result in Europe is that there is a rupture between the state and significant parts of the population, with the latter largely focused on being unseen by the former to avoid deportation. For those looking to reduce migration such a scenario might seem desirable. The pandemic demonstrated, however, both the extent to which the capitalist models in all these three states depend on migrants and the deadly consequences of their inferior citizenship status. By allowing migration management to take precedence over the principles of population health and overall wellbeing, all three states have moved to a position in which illness within parts of the population has become socially acceptable and even apparently desired. Whereas migration control has often been argued as necessary to protect welfare – whether liberal, conservative, or social democrat – the pandemic revealed the extent to which it has been eroding at the core foundations of human welfare. Necropolitics – the spectre of death as a controlling device – has been noted in numerous cases of migration management (Lopes Heimer, 2022: 1382; Mbembe, 2003).

As the paper shows, and is well established in the literature, vulnerable migrants' lower access to healthcare made them more vulnerable to the pandemic. Yet we did not need a pandemic to realise that healthcare exclusions harm human health. Critical research from organisations working with vulnerable migrants has argued that, by ignoring their needs, the pandemic evidences a point at which migration management policies have been prioritised over public

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health and wellbeing (Boswell, 2022:7). Whether that leads to any policy readjustment might well seem unlikely given continuing anti-migrant sentiment in all three of the countries considered here, but equally it remains a point of reflection exposing how we presently prioritise different policy goals as well as the subsequent cost.

Conclusion

The paper has compared how marginalised migrants – refugees, asylum seekers, and undocumented migrants – were treated by the state in France, Sweden, and the United Kingdom. In a time of uncertainty – as we saw with the first and second waves of the pandemic – assumptions and values otherwise hidden become visible. As the analysis highlights, much of 2020 revealed significant tensions between migration management and population health. Being in the position of a marginalised migrant meant that many individuals were not only denied basic protection of their health, but also faced heightened risks that, in turn, ran counter to the state's supposed focus on controlling the pandemic.

Where the pandemic revealed that those states once seen as 'strong' were in fact weak, the analysis presented here underlines the extent to which Covid-19 showed how the state has effectively dehumanised individuals based on their migration status such that they are living in countries where the state has no remaining function beyond policing and basic infrastructure. In the space vacated by the state, the task of population health falls upon a disparate cluster of lower state (i.e., regional) actors and civil society. Lacking sufficient resources, these actors inevitably prove to be inadequate. Yet, to survive, it has become necessary for that part of the population lacking permanent residency or citizenship to somehow navigate amongst that cluster of actors.

The dehumanising politics of migration management are made possible through a paradoxical shift in which the governance of health and migration are both connected but also politically disassociated such that society ignores the detrimental effects of hostility towards marginalised migrants on population health. Deportation to a third country is an extreme form of hidden politics, taking the issue out of sight and out of mind. Yet, as the analysis here shows, such a disassociation is only ideological and not does negate the material consequences of inhumane treatment of persons on the grounds of their migration status.

Note

1 These centres provide accommodation for migrants occupying the illegal camps in north-east Paris, who have been directed via the regular roundups or referred to by one of the two-day centres run by the regional prefecture. During their stay, which lasts on average ten days, migrants can benefit from health, social, and administrative support before registering their asylum application with the *Guichet Unique pour Demande d'Asile (GUDA*), located close to the CAES. Depending on their administrative situation, migrants are then redirected to structures adapted to their situation in Ile-de-France (Paris region), while their asylum application is being processed. On 1 January 2020, the national reception system had around 43,600 authorised places in reception centres for asylum seekers (CADA). The accommodation is mainly located in Ile-de-France, Auvergne-Rhône, and Grand Est. However, the largest number of new centres have been created in the Pays de la Loire, Brittany, New Aquitaine, and Occitania regions. The main operator is ADOMA and then COALLIA, FTDA, Forum réfugiés-Cosi. In recent years, the SOS group and France Horizon have developed an important network.

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