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# Civil society organisations and the healthcare of irregular migrants: the humanitarianism-equity dilemma

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## Abstract

Individuals who reside in a country without regular authorisation generally find it difficult to access public medical services beyond emergency treatment. Even in countries with universal healthcare, there is often a gap between rights on paper and their implementation. Civil society organisations (CSOs) fill this gap by providing medical services to vulnerable populations, including irregular migrants. What, if any, are the ethical dilemmas that arise for CSO staff when delivering such services in countries with universal healthcare? Under what conditions do these dilemmas arise? And what strategies do CSO staff use to mitigate them? We answer these questions using 40 semi-structured interviews with CSO staff working in two European countries with high levels of irregularity, universal healthcare provisions on paper, and significant differences in approaches and availability of public services for irregular migrants: Italy and Spain. We show that CSO staff providing medical services to irregular migrants in places with universal healthcare coverage face a fundamental dilemma between *humanitarianism* and *equity*. CSO staff respond to the humanitarian belief in the value of taking all possible steps to prevent or alleviate human suffering, thus promoting a decent quality of life that includes access to both emergency and non-emergency care. In doing so, however, they run the risk of substituting rather than complementing public provisions, thereby preventing governments from assuming responsibility for these services in the long term. Individuals who acknowledge the existence of this dilemma generally oppose the creation of parallel structures; that is, services specifically developed for irregular migrants outside the public system; while those who ignore it essentially subscribe to a tiered system, giving up on considerations of equity. We argue that CSOs involved in the provision of healthcare to irregular migrants do not simply provide services; they also play an inherently political role.

**Keywords:** Dilemmas, Ethics, CSOs, NGOs, Irregular migration, Humanitarianism

## Introduction

In many countries around the world, individuals who reside without regular authorisation find it difficult to access public medical services beyond emergency treatment (International Organization for Migration, 2016; Spencer & Hughes, 2015). Even in countries with universal healthcare, there is often a gap between entitlement on paper

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and implementation in practice. Civil society organisations (CSOs) fill this gap by providing healthcare to vulnerable populations, including irregular migrants (Castañeda, 2007, 2013; Gottlieb et al., 2012; Phillimore et al., 2019; Sandblom & Mangrio, 2017; Willen, 2011).[1] While contributing to building a system of support for vulnerable groups, the provision of services by CSOs has been found to have important unintended consequences. The activities of CSOs, for example, may lead to the creation of parallel structures of care, challenging principles such as the universality of care (Bommes & Sciortino, 2011), the accountability of service providers (Gottlieb et al., 2012; Padilla et al., 2022), and potentially undermining the quality of care (Tiedje & Plevak, 2014; Villadsen, 2019). Against this background, we ask: What, if any, are the ethical dilemmas that arise for CSO staff when providing healthcare services to irregular migrants in countries with universal healthcare? Under what conditions do these dilemmas arise? And what strategies do CSO staff use to mitigate them?

We answer these questions by conducting a phenomenological analysis based on 40 semi-structured, in-depth interviews with CSO staff in Italy and Spain, through which we identify and articulate ethical concerns experienced by CSO staff members. These two countries are characterised by high levels of irregularity among their immigrant populations (Serrano Sanguilinda et al., 2017) and universal healthcare provisions written in the law (Wendt et al., 2009). Although differences exist within these two countries in terms of availability of public services for irregular migrants due to their decentralised territorial systems of health governance (Piccoli, 2019, 2020; Perna, 2018a, 2018b), we are not interested in explaining variation in the services provided by CSOs. Rather, we identify the ethical dilemmas perceived by individual CSO staff involved in the provision of healthcare to irregular migrants in such contexts and we discuss the strategies to deal with them, cutting across organisational characteristics and territorial settings.

We show that, in places where there is a universal right to healthcare that exists on paper but is not enforced by public authorities, staff members of CSOs are invariably faced with a fundamental dilemma between humanitarianism and equity. One the one hand, CSO staff respond to the humanitarian belief in the value of taking all possible steps to prevent or alleviate human suffering (Flynn, 2020; Ticktin, 2006).[2] In the health domain, this belief can be applied to the provision of emergency care that saves lives, which is frequently provided by governments to irregular migrants, at least in most European countries (International Organization for Migration, 2016; Spencer & Hughes, 2015), but also to non-emergency medical services to preserve individuals' physical, mental, and emotional well-being. On the other hand, by engaging in the provision of voluntary services in countries where healthcare is recognised as a universal right, the activities of CSOs may be distorted by the state. Governments may use this work as a

[1] We refer to irregular immigrants as those individuals who live in a country without having the legal permit to do so; in the literature, this group of the population is also referred to as undocumented, irregularised, illegalised, unauthorised. Regarding CSOs, we treat them as "self-organised, self-governing, nonstate, non-profit, nonprivate institutions that employ nonviolent means to achieve a public interest or good through collective action" (Alagappa, 2004: 34). Alternative ways to refer to them include third sector, charitable, grassroots, and voluntary organisations. These terms include different types of organisations, such as unions, religious institutions, philanthropic organisations, formal and informal associations. These organisations are established outside of the state and outside of the market on the basis of shared ideas and voluntary membership.

[2] Humanitarianism is a contested concept at the heart of intense normative debates (among others, see: Flynn, 2020; Bradley, 2022). In this paper, we rely on its broadly agreed understanding as being about alleviating others' avoidable suffering by addressing its symptoms (see, for instance: Ticktin, 2006).

pretext to alleviate public responsibility to achieve health equity; that is, the possibility for everyone to have a fair and just opportunity to be as healthy as possible by eliminating obstacles to healthcare for groups relegated to the lower levels of the social hierarchy in terms of race/ethnicity, migration status, wealth, power, etc. (Braveman et al., 2018; Marmot et al., 2012, p. 1012). The conflict between these two morally worthy values, humanitarianism and equity, may thus be understood as a 'hard ethical dilemma' (Bauböck et al., 2022) for CSO staff involved in the provision of medical services for irregular migrants in countries with universal health provisions.

There is no definitive solution to this dilemma. However, individuals who acknowledge its existence generally oppose the creation of parallel structures; that is, services specifically developed for irregular migrants outside the public system. By contrast, those who ignore the dilemma essentially subscribe to a tiered system of healthcare, giving up on considerations of equity. Our argument is that CSO staff involved in the provision of healthcare to irregular migrants do not simply give services: they also play a political role. The presumed neutrality and impartiality of humanitarianism is—at least in this case—an illusion.

## Background: CSOs as mediators and providers of rights for irregular migrants

Access to essential medical treatments—services aimed to prevent, diagnose, or treat an illness, injury, or disease, as opposed to 'luxury' treatments such as cosmetic or aesthetic surgeries—is defined as a fundamental human right (Pace, 2013) and has been recognised by various international instruments ratified by European countries (International Organization for Migration, 2016). This definition should protect socio-economically disadvantaged and vulnerable groups regardless of their legal status or financial resources (ECHR, 1950).

Concerning irregular migrants, the UN Committee on Economic, Social and Cultural Rights (2000) has issued an authoritative 'Comment 14', which specifies that states are "under the obligation" to refrain "from denying or limiting equal access for all persons, including […] illegal immigrants, to preventive, curative and palliative health services" and to refrain "from enforcing discriminatory practices as a state policy". Likewise, the European Committee of Social Rights, which supervises the application of the European Social Charter, holds that "legislation or practice which denies entitlement to medical assistance to foreign nationals, within the territory of a State Party, even if they are there illegally, is contrary to the Charter" (European Committee of Social Rights, 2004).

Despite these provisions, national regulations in many countries severely restrict access to healthcare for those who do not have regular documents (Cuadra, 2012; International Organization for Migration, 2016; Spencer & Hughes, 2015).[3] Even where states do not formally restrict access to medical care, administrative, organisational and cultural barriers, as well as mistrust of public service providers, represent serious obstacles (Fox-Ruhs & Ruhs, 2022; Mladovsky, 2023; Mladovsky et al., 2012; Rechel et al., 2013; Spahl, 2022). These barriers discourage irregular migrants from seeking care in public structures despite formal entitlements, with detrimental implications for both the health

[3] Although "firewalls" and "sanctuary cities" may exist in favour of irregular migrants (Permoser and Bauböck, 2023), their effectiveness is often disputed (Fox-Ruhs & Ruhs, 2022).

of irregular migrants themselves (Biswas et al., 2011; Lebano et al., 2020; Piccoli, 2022; De Vito et al., 2015; Woodward et al., 2014) and public health systems more generally (Boso & Vancea, 2016; European Union Fundamental Rights Agency, 2015; Kerani & Kwakwa, 2018).

In many countries, CSOs fill some of these gaps. They act as "rights intermediaries" (Bruzelius, 2020, pp. 603–604), providing guidance and practical assistance in accessing medical services. Sometimes, they provide medical services themselves (Ambrosini, 2015; Ambrosini & van der Leun, 2015; Spencer & Delvino, 2018).

CSOs have become key actors in the direct provision of welfare services since the 1980s, with the gradual introduction of New Public Management's principles of privatisation, outsourcing and marketisation in European welfare states and increasing trends towards public welfare retrenchment (Gottlieb et al., 2012; Martinelli, 2012). This expanding presence is particularly visible in migration governance processes: over 85% of the cities consulted for a recent OECD report on local integration of migrants and refugees collaborate with CSOs, and more than half of the cities delegate integration services to CSOs (OECD, 2018). Through their personal interactions with migrant communities, CSOs possess unique expertise that can be used to propose pragmatic solutions to the authorities and contribute to building a system of support for migrants at the local and regional levels of government (Mallet-Garcia & Delvino, 2020; Piccoli, 2019; Schilliger, 2020; Spahl, 2022).

Although CSOs have always been part of welfare systems, in contemporary debates their engagement as service providers is often portrayed as a panacea for all social problems (Busso & De Luigi, 2019). Regardless of whether this optimism is ideologically driven or based on financial austerity goals, it might obfuscate the problems that arise with CSOs' involvement in welfare provision, specifically when it comes to essential, costly, and specialised medical services. In 2011, Heide Castañeda wrote about the nascent "two-tiered medical systems in many host countries as well as a proliferation of work performed by non-governmental organisations" (2011, p. 1). In addition to the risk of creating parallel and potentially unjust structures of care (Dwyer, 2004; Larchanché, 2012), the provision of services by CSOs may pose challenges to the universality of services (Bommes & Sciortino, 2011), obfuscate the accountability of service providers (Gottlieb et al., 2012; Padilla et al., 2022), and undermine the quality of care (Tiedje & Plevak, 2014; Villadsen, 2019). Important unintended effects may arise when CSOs become welfare-service providers alongside the state.

We contribute to this debate on the relationship between CSOs and the state by discussing the moral dilemmas experienced by CSO staff at the everyday level of practice. Previous research has contributed to understanding such dilemmas by focusing specifically on frontline workers, often in countries where access to medical services for irregular migrants is legally restricted (among others, see: Perna, 2018a, 2018b; Portes et al., 2012; Ruiz-Casares et al., 2013; van der Leun, 2006). These studies show that workers and health professionals are frequently confronted by situations of "dual loyalty", as they are caught between deontological norms that favour inclusiveness and institutional constraints that push towards restrictiveness in access. Studies based on Foucault's concept of "biopolitics" demonstrate how healthcare workers' humanitarian practices towards excluded migrant groups are inevitably entangled with power operations for purposes of

surveillance and migration control (Fassin, 2001; Ticktin, 2006) and illustrate how practices of the self that are put in place by individual medical staff can be used as subtle forms of resistance against processes of categorisation and exclusion of migrants from the provision of services (Lafaut, 2021).

We join these debates by focusing on the specific situation of CSO staff—as opposed to frontline workers employed by the public—in places where there is a universal right to healthcare that is not enforced by public authorities. In principle, in these settings, CSO staff are not confronted with competing obligations towards both the patients and the state. Rather than situations of dual loyalty, CSO staff may face ethical dilemmas due to the ambiguity of their role within a larger system, with questions about the quality, duration, and consequences of the services provided. In this sense, although the dilemma that we discuss is specific to the provision of healthcare for irregular migrants, it illustrates a much broader problem that emerges when states indirectly withdraw from their responsibility by opening provision gaps at the everyday level of practice. This question is relevant for migration and welfare studies at times of greater reliance on CSOs for the provision of welfare services to different groups of the population.

## Case selection, data, and methods

### Cases

We conducted research in Italy and Spain, two Southern European countries with high levels of irregularity among their immigrant populations, universal healthcare provisions on paper, and significant intra-national differences in the approaches and availability of public services for irregular migrants due to the decentralised territorial systems of health governance and the accelerated deterioration of welfare services caused by the Great Recession of 2007–2009.

In both countries, irregular migrants are formally included among the beneficiaries of public and free-of-charge healthcare provisions (Spanish Immigration Law No. 4/2000 and Royal Decree-Law No. 7/2018; Italian Immigration Act No. 286/1998). Nevertheless, cases of healthcare exclusion and heterogeneous implementation across regions have frequently been reported (Piccoli, 2019, 2020; Perna, 2018a, 2020; Yo Sí Sanidad Universal, 2022). The existence of irregular migrants' healthcare rights on paper and their neglect in practice poses specific dilemmas for CSO staff, which are possibly even more acute than in contexts where the state deliberately excludes irregular migrants from public healthcare coverage beyond emergency care (e.g., in the United States, and in fourteen EU countries; IOM, 2016; Fox-Ruhs and Ruhs, 2022). In these places, CSOs provide such services because of the absence of the state. In Italy and Spain, owing to the gap between entitlements on paper and implementation on the ground, the operations of CSOs occur within a framework in which the state should, in theory, be responsible for those services (Petmesidou et al., 2014).

### Data

We conducted 40 semi-structured, in-depth interviews between 2015 and 2023. We interviewed doctors, nurses, and other professionals, including social workers, support staff, and cultural mediators belonging to different CSOs, either paid staff or volunteers. All respondents answered to our questions in an individual capacity.

We interviewed staff working for CSOs that differ in size, source and basis of funding, relations to the government, setting where they operate, and motivations. Our goal was not to explain variation across different CSOs or across different political contexts and professional profiles, but rather to understand the transversal dilemmas faced by CSO staff, discuss the conditions under which these dilemmas arise, and propose a typology of how individuals may mitigate these dilemmas through their actions. For a full list of the interviews carried out and the main characteristics of the organisations involved, see Appendix A1 "Characteristics of the CSOs included in the sample" in the Additional file 1.

In addition to these interviews, we consulted the websites of CSOs and collected their reports, briefs, statutes, and news. We used quotations with our own English translation from both the interviews and these documents to highlight the dilemmas that CSOs face and provide examples of how they deal with them.

### Methods

We take a phenomenological approach that is sensitive to the ways in which CSO staff perceive, interpret, and experience moral dilemmas in their work (for similar approaches see: Little & Macdonald, 2015; Mann & Mourão Permoser, 2022). This perspective is useful for explaining how a specific phenomenon is experienced and rendered meaningful by research participants, particularly in the field of social research on public health institutions (van Wijngaarden et al., 2017). In contrast to other such approaches, the emphasis is on the meaning of a lived experience (van Manen, 2017) and on how people interpret those experiences rather than on the description of what they do (as would be in the case of, for example, content analysis). Consequently, our approach presents 'an essence' (van Wijngaarden et al., 2017, p. 5), that is, a common thread of how our interviewees construct meaning in relation to their experiences and activities.

## The humanitarianism-equity dilemma

> *On the one hand, you must guarantee the right to life, the right to care. This is a right of the individual, which is protected by our Constitution. On the other hand, you realise that the institutions are taking advantage of your presence, of your ethics, of your duty to provide an answer. They can sit quietly for years and they say: "Why should we take responsibility for the situation of irregular immigrants in, for example, Casterlvolturno? There is already a CSO that works there so it is not our problem" … Sometimes I wonder whether it wouldn't be more useful, or more disruptive, to take a bus and bring fifty migrants who need healthcare to the public hospital. (I-21)*

This quote, by one of the coordinators of the mobile clinics created by a large international CSO for the provision of healthcare services to irregular migrants in Southern Italy, plastically represents the core dilemma that we identify: the tension between the commitment to protect human life, on the one hand, and the promotion of a system where public authorities take full responsibility to provide everyone with healthcare, on the other hand. This is a hard choice between the promotion of two competing values: *humanitarianism* versus *equity*.

When CSO staff provide medical services to irregular migrants in these contexts, they risk playing "a convenient role" for states (Romero-Ortuno, 2004; Ticktin, 2006), which can offload their responsibilities to guarantee adequate healthcare to the population and eliminate health inequalities affecting the most disadvantaged groups. Ultimately, the dilemma between humanitarianism and equity consists of recognising that by providing health services, CSO staff may make it more difficult or even impossible to advocate for the equitable inclusion of irregular migrants in existing healthcare provision structures.[4]

Worse even, they risk becoming complicit in the exclusion of irregular migrants, by creating or perpetuating separate structures of care. Below, we include a quote from the coordinator of a local health agency in Piedmont, who explains how the activities of CSOs can unwillingly provide an excuse for governments to free ride:

> *In 2009, the region of Piedmont said a peremptory 'no' to [the president of a famous Italian CSO] who came to a meeting and wanted to open a clinic for irregular migrants … here in Turin ... It was decided to say 'no thanks, absolutely no, thank you' … We thought it was redundant, because healthcare for foreigners, even if they are not regularly present, is recognised by the law … One councillor who thought otherwise said: "Oh well, let's close the Health Centres [note: public centres where irregular migrants can already receive healthcare] because there can be this CSO that does it now". (I-1)*

This quote shows how the humanitarian work of CSOs can make it difficult to address the root causes of the problems they want to solve. This is sometimes referred to as 'the fig leaf' problem (Castañeda, 2013; Gottlieb et al., 2012). It is a dilemma that CSO staff concerned with the protection of migrants' rights often face, also outside of the specific realm of medical care: conflicting priorities between principles of human rights and professional ethics on the one hand, and state demands on the other (Mann & Mourão Permoser, 2022).

Why do CSO staff members consider it against health equity to take up medical services for irregular migrants? Below we show how our interviewees articulate two key dimensions of this dilemma, or two ways in which immediate humanitarian action to improve the health status of irregular migrants may jeopardise the promotion of health equity in the long term.

#### Sustainability: makeshift versus structural

Many CSOs have a precarious financial base, mainly relying on donations and temporary contracts stipulated with public institutions. Where the activities of CSOs are dependent on the benevolence of other private actors, there is a risk that their services are short-term and not sustainable over time. Lacking appropriate resources and capacities, it may be impossible for CSO staff to offer a comprehensive response to the health needs of the population that CSOs care for and to monitor health outcomes over time (see, e.g.: Listorti et al., 2022, p. 7). When they are not embedded into public structures, CSO staff

[4] To make sure, public institutions may well be complacent even when CSOs do not provide their services. We do not want to suggest that CSOs' operations are causally responsible for the unequal provision of basic medical services, but many CSOs recognise this "humanitarian trap" (Gottlieb et al., 2012, p. 844).

often feel that their actions may be patchwork and have concerns about the standard of care (I-7, I-19, I-22, S-7, S-13). Indeed, individuals volunteering or working for CSOs cannot provide the same level of comprehensive and high-quality healthcare as a public healthcare system (Castañeda, 2013; Eick et al., 2022; Gottlieb et al., 2012). Hence, they can never provide equitable care, that is, they just patch up a much larger challenge.

Related problems include health monitoring, health surveillance, and health planning. When irregular immigrants receive services that are not fed into a database managed by public health institutions, they remain "invisible" to the public eye, as the services they receive cannot be tracked in public records[5] (I-19). If no information on needs, issues, and inequalities is collected, irregular migrants are not considered by health policies.[6]

#### Entitlement: charity versus rights

Having to operate in a context of scarce and volatile resources inevitably opens the question of 'who deserves what' (van Oorschot, 2006; Willen, 2012). Resource limitations (material resources, staff, time, etc.) may force CSO staff to make choices and be selective about who to assist first (Kuehne et al., 2015). Again, there is a risk that dependence on external funding drives the priorities of CSOs, creating hierarchies of deservingness (Fassin, 2005; Bruzelius, 2020, p. 605). What happens if there is a dramatic increase in patient numbers and needs? How can equal access be ensured? During the interviews, CSO staff repeatedly reported that they feel they are constantly working under pressure.[7] This was clearly put by the Europe Region Medical Referent of a relatively large CSO operating in Italy and other countries in Africa and Europe, InterSOS:

> *The risk of contradictions is very high for us because we work in an emergency context. Sometimes you have to make instant calls and take a leap in the dark. (I-18)*

This situation can force CSO staff to select deserving patients based on considerations other than universal criteria of entitlement or medical criteria of health needs. There is a risk that, in this context, CSO staff prioritise certain individuals who are considered in special need of protection, or "especially vulnerable". Unlike governments in universal healthcare systems, CSOs are not morally required to provide equal access to services for the entire population. As voluntary associations, they can specialise on target populations. For example, if a CSO is set up to provide healthcare only to irregular children on the grounds that this group is more likely to lack access to public services, this is legitimate, just as it is legitimate if a CSO specialises in health care for some rare diseases, or hospices for terminally ill. An excessively heavy reliance of governments on the activities of CSOs may thus create a patchwork of healthcare services with unjustifiable inequalities between territories and population groups.

[5] To make sure, this is not always the case. CSOs can stipulate conventions with public authorities so that medical services can be tracked.

[6] The 'dark side' of health monitoring and surveillance relates to the potential use of these tools as technologies of border enforcement and migration control (Ataç & Rosenberger, 2019) while increasing the reach of the state to govern (migrant) bodies (French & Smith, 2013).

[7] The problem of being overwhelmed with demand and scarce resources is not specific to CSOs: witness the near collapse of some public healthcare systems in the pandemic or the notorious problems to maintain entitlement standards in the British National Health System.

Finally, some interviewees explain that it is important for individuals to be included in public services as a matter of recognition:

> *For some of them, having the right to receive healthcare from the hospital and being able to have a relationship with public doctors is a sign of recognition. It means that these people, too, are depositories of rights and can enforce them. By contrast, when the responsibility to provide healthcare falls entirely on CSOs, it feels like a ghettoization whereby you are not treated equally. (I-20)*

Being cared for in a public hospital is a sign of belonging. Not getting access to a hospital and having to resort to a CSO creates social stratification. In this situation, beneficiaries may feel that they are treated as victims rather than carriers of rights.

## A dilemma for whom?

The humanitarianism-equity dilemma is not felt by all individuals who work or volunteer for CSOs. Its manifestation depends on the ways in which CSO staff interpret their role in relation to the state, as actors that complement, substitute, or supplement public health provision for irregular migrants. These differences in state-civil society relations have been effectively summarised by one of our interviewees.

> *On the one hand, there are CSOs that manage to transfer their services to the public or stipulate agreements with public hospitals, so that they cooperate effectively. On the other hand, there are CSOs that supplement the public and engage with it at the same time, shedding light on its shortcomings. And then there are CSOs that are, by nature, disconnected from the public service and do not want to engage with it in any way. (I-17).*

We now explain how each of these ways of understanding the relationship between CSOs and the state affects whether the humanitarianism-equity dilemma is felt. We distinguish between three possible understandings: complementarity, substitution, and supplementarity.

First, CSOs may be understood by their staff as actors complementing the state in the provision of services. For example, CSOs may be integrated into public programmes through dedicated agreements and formal collaborations. These agreements are not without problems: they risk undermining public healthcare and inclusionary claims (Gottlieb et al., 2020). Indeed, one of our interviewees discussed the dangers of becoming "agents of the state" (e.g., I-22). Yet, many of our interviewees reported an effective collaboration with public bodies, whereby the services offered by CSOs were funded by and designed together with public institutions (e.g., I-19, I-18, S-17). Where the work of CSOs is complementary to that of public institutions, humanitarianism can be compatible with equity. The quote below shows how in these situations CSO staff create a bridge to access public services.

> *If a CSO does not reach an agreement with the public system, there will inevitably be a separation of care, its activities will always be a quick fix, and this will create two channels: on the one hand, public, universal healthcare; on the other hand, what you as CSO can build, with one doctor and some volunteers. And listen, my CSO has doctors, of course! But we use them for preventive campaigns and health*

> *education. We are not at all substituting the public system. Our goal is to get the public service closer to irregular migrants, not to do public charity. (S-17)*

On the other hand, there are CSOs that operate separately from public institutions. These CSOs substitute the state, performing a 'safety net' function regardless of public provision. While doing so, these organisations neither act to promote the inclusion of irregular migrants into the public system, nor consider dismantling inequity in public service provision as their task. Although this position is often framed as 'being apolitical' or 'neutral', these CSOs still make political decision, effectively subscribing to a tiered system of healthcare provision. In these cases, the humanitarianism-equity dilemma simply does not arise.

Between these opposite stances, there are those CSOs that engage in the direct provision of healthcare to irregular migrants as a 'provisional fix' against state's de-responsabilisation. This approach is best explained by the words of two of our research participants who coordinate the provision of services for irregular migrants in Italy and Spain, respectively:

> *Irregular migrants are people who should have the right to healthcare but this right is, I do not want to say negated, but we can say boycotted … And when the public doesn't take responsibility for this right, volunteers fill this gap to stimulate a reaction. (I-21)*
>
> *Our clinic exists because the Spanish state, like many other European states, does not comply with the universal principles of the U.N. declarations on human rights signed and with its own constitution, which provides for a right to health, regardless of legal status, race, or other discriminating factors. (S-13)*

These actors recognise and problematise their role as 'supplementary' to public provision: they deliver healthcare to irregular migrants but claim that the state should bear such responsibility. As declared in the mission statement of a CSO working in Milan, Italy: "The Naga intends to die out when the public bodies in charge assume concrete and direct responsibility over the handling of immigration" (Naga, 2022a).

The humanitarianism-equity dilemma is experienced most acutely in these cases, when CSO staff see the risk of supplementing public healthcare provision. This is because CSO staff understand their activities as necessary to deal with the health needs of irregular migrants; but at the same time they see the risk of perpetuating separate structures of care that ultimately contradict the principle of health equity. In the words of a social worker who organises medical services for irregular migrants in Andalusia:

> *It often happens to me to wonder whether we are substituting the government in solving a problem by putting a provisional fix; or whether we are shedding light on a problem and helping the community to find a solution. (S-8)*

## Carving out a dilemma-free space of action

Those CSO staff members who perceive the humanitarianism-equity dilemma in their work identify three strategies to mitigate it through lobbying, advocacy, and litigation. These strategies are not mutually exclusive and have a common goal: to convince public institutions to take over the tasks that are currently fulfilled by CSOs.

### Lobbying

Lobbying involves reporting, intermediation, and soft pressure on policy-makers. Through this strategy, CSOs identify existing problems and push local, regional, and national administrations to provide solutions, sometimes suggesting and experimenting with innovative paths of action.

> *We must not replace the missing pieces. Volunteering must find new recipes, cover grey areas, experiment, practice and shed light on hidden phenomena. (I-8)*

CSOs lobby policy-makers using the expertise and information they possess to highlight weaknesses and gaps in rules or in the way they are enforced, demonstrating the need for policy. In this sense, effective lobbying entails data collection, reporting, and mobilisation of such resources through personal contacts developed over time. Through this process, CSOs can assume a complementary role in public healthcare provision.

Lobbying is difficult, however, because it is expensive and time consuming. Not all CSOs have the resources to produce statistics, write reports, and build personal connections with policy-makers and politicians. In the words of our interviewees:

> *You should talk to everyone, have systematic engagement with the institutions, and build a relationship that has an impact over time. It is not enough to go there and say 'You have to change this directive or regulation.' You must provide data, suggest solutions, and create a context that is not belligerent. (I-18)*
>
> *We are talking about 'surgery' policies, that is, proposing minimum but necessary changes. You don't go to politicians speaking in general terms. If you do that, if you don't bring concrete proposals, you will lose credibility and you will fail. You need in-depth knowledge of the system, concrete and feasible proposals, and reputation. It takes time and resources to develop all these. (S-17)*

Beyond considerations about resources, there are also some dangers in political engagement: the more CSOs engage with local political structures, the less they may be able to criticise them (Spencer & Delvino, 2018). This is a risk of cooptation. However, there may be agreement on policy design and objectives when authorities outsource tasks to CSOs or support them financially. Cooperation with CSOs brings expertise and new solutions to challenges related to migration and diversifies the provision of integration services by trusting different actors who are experts in their respective areas.

### Advocacy

Advocacy works through campaigns, petitions, and reporting on the media. The objective is to raise awareness by telling stories of migrants and explaining the rationale behind the existence and activities of different CSOs.

> *We find it unacceptable that the municipal administration does not find structural solutions ... We find it unacceptable that a city that prides itself on its modernity and the possibilities it offers continues to perpetrate logics of exclusion and privilege ... We organised a flash mob in the Gallery and a subsequent press conference in front of the Town Hall together with other associations to shed light on the conditions of these people and call the institutions to their responsibilities. (Naga, 2022b)*

Advocacy takes many forms, from writing articles in newspapers to publishing videos on social media channels and organising protests in public spaces. It is generally used when public authorities are not receptive to lobbying. When CSO staff provide substitutive healthcare, they can advertise what they are doing not only to collect donations, but also to push the government to take responsibility. "Doing good and speaking about it" could serve both purposes. Through advocacy, CSO staff have opportunities to develop networks, raise funds, provide visibility for a given issue, and push governments to change or enforce existing rules.

However, advocacy is both a consequence and a cause of more confrontational relationship between CSOs and public authorities. Advocacy can also be used as a threat, or as a way of getting the attention of policy-makers who would otherwise look the other way, but using such threats too often can also be risky because it may undermine the possibility of effectively collaborating with public institutions in the future.

> *It happened to me more than once that I said 'Look, if you do not do this, we will go to the newspapers'. It is a measure of last resort, and sometimes it is necessary to use it. But when you do, then it is difficult to resume dialogue with those working in institutions. (I-18)*

#### Litigation

When neither lobbying nor advocacy provide satisfactory outcomes, CSOs can use strategic litigation. The objective is to identify remedies for the lack of rights and services that should be provided by public institutions.

> *First, we always try to use the path of dialogue, especially at the local level. Then, if they [public authorities] keep shutting the door in our face, we do something else. For example, we collaborate with lawyers, and it is important to create a good network of collaboration to tear down barriers … There have been some instances where we filed a lawsuit against regional governments because they were not providing services that should have been there. (I-21)*

In such cases, CSOs mobilise together with lawyers to hold public institutions accountable (for example, see: Asgi, 2020). The role of CSOs is important: they identify the gap between legal provisions and services on the ground, prepare reports and documentation that can be used during lawsuits, and try to get the endorsement of international bodies (e.g., European Commission against Racism and Discrimination, UN Human Rights Council). When successful, lawsuits serve the purpose of forcing public institutions to remove obstacles to the access of services.

Similar to lobbying and advocacy, litigation is expensive. It requires extensive processes of data and information collection, and legal fees are costly: smaller CSOs generally cannot afford them. Similar to advocacy, litigation may make it impossible for CSOs and public authorities to collaborate in the future. Finally, cases can take years before a final verdict is reached. For these reasons, litigation is rare and generally used only as a last resort.

## Doing more than "just healthcare"

Many of our interviewees expressed their work as about more than "just healthcare". Our argument is that CSO staff involved in the provision of healthcare for irregular migrants do not simply give services: they also play a political role. This is regardless of whether and how they deal with the humanitarianism-equity dilemma. On the one hand, CSO staff can work to hold public institutions accountable and advance a political discourse of comprehensive equity, rather than merely focusing on individual suffering. To do so, they can encourage greater involvement of the state and, where needed, integrate their services into public structures. On the other hand, CSO staff members can ignore the dilemma and act as replacements for public authorities. By doing so, they run the risk of consolidating a situation that is structurally unequal, with the exclusion of irregular migrants from public services and the creation of separate structures of care, despite the existence of universal entitlements on paper. Regardless of what CSO staff chose to do and how responsive public authorities are to their actions, when they provide services to irregular migrants they become part of political processes that draw the boundaries of who is included in, and who is excluded from, public services.

This argument may be problematic for individuals who work or volunteer for organisations that perceive their mandate in neutral, or apolitical terms. While such organisations abide by the ideas of non-interference, the work of CSO staff that protect the health of irregular migrants cannot be separated from broader discourses on solidarity and social justice. CSO staff who experience the humanitarianism-equity dilemma and want to mitigate it need to balance medical practices with political engagement.

CSO staff who promote collaboration with public authorities working as bridges may shy away from political engagements in the sense of public protest, advocacy, and strategic litigation to avoid jeopardising cooperation with public authorities. CSO staff who feel ignored by public institutions and want to do something about it can act as advocates and publicly denounce governments' shortcoming, either through advocacy or litigation.

> *We have an ethical commitment to heal the sick and a moral obligation to help in areas or at times where the state failed to provide basic services ... There was no advocacy goal when we started working. But it developed over time, as a necessity when we realised that the services we provide were not enough (I-2)*

There are some important examples of how political action in this field can lead to better integration of services. In Spain, in 2022, the network of CSOs 'Yo sí Sanidad Universal' pushed the government of Madrid to remove bureaucratic hurdles for irregular migrants and remove the requirement to have had a three-month-old *empadronamiento* (registration of domicile with the local authorities). In Italy, in 2018, the CSO InterSOS opened two mobile clinics to provide health services to irregular migrants, asylum seekers, and seasonal workers living in three informal settlements in the province of Foggia. In 2019, a memorandum of understanding was signed with the local sanitary services of Foggia, with the aim of increasing the usability of local services for the inhabitants of the settlements (I-18). There are also instances beyond the contexts under analysis in this paper. In Finland, medical centres created by CSOs to compensate for the lack of public healthcare services for the irregular population were transformed into public services in 2023

(PICUM, 2023). These are some cases of CSOs that combine the provision of services with lobbying and advocacy. The projects they developed were not simply understood as moral, or ethical, but also had a political goal: pressuring public authorities to integrate irregular migrants and other groups of the population in their healthcare services.

## Conclusions

Even in countries where healthcare is universal there is often a gap between entitlement on paper and implementation in practice. In such cases, when the public provision of healthcare is either insufficient or absent, a dilemma about whether to 'step in' arises for CSOs. On the one hand, CSO staff adhere to the humanitarian value of taking all possible steps to prevent or alleviate human suffering, thus promoting a decent quality of life that includes access to both emergency and non-emergency healthcare. On the other hand, CSOs run the risk of supplementing public authorities and contributing to the consolidation of a system where care is provided by separate organisations for separate populations. In other words, the value of humanitarianism today cannot be easily reconciled with the pursuit of equity tomorrow. This is what we call 'the humanitarianism-equity dilemma.'

The dilemma arises when CSO staff interpret their role as 'supplementing' public health provision. Where the work of CSOs is understood as complementary to that of public institutions, humanitarianism can indeed be compatible with equity; and when CSO staff accepts to substitute public institutions in the provision of services, then the dilemma does not even arise. By contrast, when CSO staff recognise that the state should bear responsibility for delivering healthcare to irregular migrants but does not do so, they play a supplementary role; and this is when the dilemma arises.

When CSOs become involved in such situations, they are political actors whether they like it or not. In the cases we discuss here, we show that CSO staff that provide care for irregular migrants have two options. On the one hand, they can ignore the dilemma and act as replacements for public authorities, subscribing to a tiered system of healthcare provision. On the other hand, they can push their CSOs to lobby public authorities where cooperation promises better outcomes while also maintaining their independence; and protest through advocacy or litigation where government policies need to be changed. We acknowledge that these operations are not without problems. Depending on the relationship developed with public authorities in the contexts in which they operate, advocacy and litigation may compromise CSOs funding. These strategies may also be difficult to implement because they are expensive and time-consuming. Yet, it is through these actions that CSO staff feel they can impact the broader social context in which they are situated.

In this article we have interviewed individuals who operate in countries with universal healthcare. However, the humanitarianism-equity dilemma can arise in a broad set of situations, every time CSO staff perceive that they are supplementing other authorities in the provision of social services that should be public. For example, we can imagine that in countries with no universal healthcare, the government passes legislation to include irregular migrants in specific health services but does not enforce such legislation. In such cases, CSO staff that want to step in would face the humanitarianism-equity dilemma. Our findings also apply to CSO staff working with other groups of the

population that may be left out of public services, such as the homeless, drug users, and sex workers. Indeed, the logical extension of our argument is that CSO staff are always confronted with this dilemma when they feel they are supplementing the provision of services for populations that have a right on paper but whose implementation is not effectively provided by public institutions. Further work on the humanitarianism-equity dilemma with different groups of the populations, policy domains, and political contexts would help better understanding the meaning that CSO staff attribute to it and the strategies they adopt to mitigate its effects.

## Supplementary Information

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**Additional file 1.** Characteristics of the CSOs included in the sample.

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LP had the original idea, LP and RP wrote the manuscript together.

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**Availability of data and materials**
Data are available from the authors upon reasonable request. A full list of the interviews conducted for this study is available in the Additional file 1: List of interviews by country, title of the interviewee, date, place.

## Declarations

**Competing interests**
The authors declare that they have no competing interests.

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