Bordering public institutions through the routinization of borderwork and datafication: internalized immigration regimes within UK health care and higher education

Abstract

The embedding of immigration checks into public institutions constitutes an integral part of contemporary bordering regimes. In this paper, we situate recent changes to the UK's internal borderscape in two parts of the public sector: higher education and health care. We argue that, analyzed from institutional perspectives, these changes reflect not only a dispersal and deterritorialization of the UK's border regime, but also the emergence of specific relations between the government department responsible for this regime – the Home Office – and other parts of the public sector and its institutions. We maintain that these relations have developed into two main *forms*: the routinization of borderwork within public sector employees' roles, drawing workers from across public institutions into relations with the Home Office and subordinating the needs of those institutions to the demands of the UK's internalized border regime; and the establishment of information systems for datafication, to enable reporting and sharing data between public sector institutions and the Home Office, which are exploited for surveillance purposes. Such relations not only vulnerabilize public sector institutions by draining their resources and destabilizing institutional cultures, but also drive ongoing changes in the bureaucratic field of the state.

Keywords

Bordering, Institutions, Migration, Healthcare, Higher Education

Introduction

The period since the end of the Cold War has been marked by a proliferation of bordering processes and practices, which has extended the gaze of geographers and other scholars away from border crossing points and into new empirical arenas (Jones and Johnson, 2016a). The growing 'disassociation between border functions and border locations' (Szary and Girault, 2015: 6) has led to a need to understand borders through a mobile epistemology (Burridge et al, 2017). Whilst all the interiority of the state becomes a potential space for border policing (De Genova, 2013), border processes and practices within states are not there for everyone (Jones and Johnson, 2016b) or experienced evenly (Yuval-Davis et al, 2019).

In this paper, we fix this gaze on bordering within public institutions. We present analysis of the implications of the internalization of the myriad of processes and practices which 'construct, reproduce and contest' borders, known as bordering(s) (Yuval-Davis et al, 2019: 1), or the rise of everyday bordering (Yuval-Davis et al, 2018) for institutions in parts of the UK's public sector – specifically health care and higher education. We argue that the UK's internalized immigration regime is characterized, in part, by an institutionalization of bordering. As immigration checks have been introduced into more routine encounters, administered by other residents, bordering has come to dominate contemporary life. This intensification is also shaping and disrupting the delivery of a range of services which everyday bordering ostensibly seeks to secure for a majoritized population – including those delivered by the welfare state, such as social security and healthcare (Guentner et al, 2016), as well as those provided in the private sector, such as bank accounts (Yuval-Davis et al, 2019).

This institutionalisation of bordering has also dispersed the burden of 'borderwork' (Reeves, 2014) away from state institutions primarily associated with the securitising functions of the state to those whose role might have historically been associated more with supporting wellbeing and development of the population. The 'creep' (Frowd, 2022) of borderwork into these areas not only shifts relations between state institutions, but also between the state and residents as both users of the services provided by such institutions and workers within them. These changes within the bureaucratic field (Bourdieu, 1994) have intensified the symbolic presence (Painter, 2006) of state border violence in parts of the public sector.

In this paper, we analyse primary and secondary data collected between 2013 and 2021. Primary data was generated from participant observation, semi-structured interviews and focus groups initially (2013-2016) with people subject to immigration controls and groups and organisations that supported them and then (2019-2021) with those working to administer immigration checks within UK higher education and the National Health Service (NHS). We triangulated the primary data gathered with secondary data from several sources, including the Hansard, media, reports from professional bodies and VCS organizations, and policy documents produced by public institutions.

We begin by exploring engagement with state institutions and their intersections with border and immigration regimes. We then identify the two key ways in which bordering has been embedded into public institutions: the routinization of borderwork within public sector employees' roles, which has drawn workers from across public institutions into relations with the Home Office and subordinated the needs of those institutions to the demands of the UK's internalized border regime; and the establishment of information systems for datafication, to enable reporting and data sharing between public sector institutions and the Home Office,

which are exploited for surveillance purposes. We conclude with what the emergence of these forms of bordering means for public sector institutions and the institutional geographies of the state.

Everyday bordering and public institutions

A wide range of academic literature engages with the intersections and layering of state power in and through public institutions. In this section, we summarize some of the key themes from this work: the relationship between 'securitizing' and 'welfare' functions of the state; the interconnection, bureaucratization and datafication of state bordering and welfare regimes within parts of the public sector; and the processes and practices that emerge from these intersecting regimes relating to the bordering of healthcare and higher education.

Institutional geographies of the state

Bourdieu (1994; 1999) suggests we explore the state as a 'bureaucratic field'; a varied and dispersed set of forces and actors negotiating control of public goods across a vast terrain. State authority is not homogenous, nor is sovereign power all-encompassing (Jones, 2012; Painter, 2006). One of the key arenas of struggle Bourdieu (1994: 9) identifies as forming part of the bureaucratic field is between the 'left hand', the social functions of the state such as welfare and housing, and the 'right hand', the functions concerned with enforcing economic discipline. Wacquant (2009; 2010) extends theorization of the 'right hand' to policing and criminal justice and argues that in the US the 'right hand' has come to dominate the 'left hand', not only in the reallocation of budgets to 'right hand' functions, but through embedding the punitive logics of the 'right hand' in the welfare state. For Wacquant (2010: 203) this shift has involved an 'operational convergence of the assistential and penitential poles of the bureaucratic field'.

The normalization of social insecurity bound up in Wacquant's description of the punishment of the poor (2009) is further supported by the production of an insecure, migrantized population through state bordering processes and practices (Mezzadra and Nielsen, 2013). This is an exercise in state crafting recognising the penal apparatus as a 'core organ of the state' (Wacquant, 2010: 211), which is able to drive widespread societal change rather than simply acting to enforce a particular form of order. In this paper, we view bordering regimes as part of this penal apparatus, which are enacting such change in and through public institutions.

Geographical institutional research has not only explored everyday life within institutions, but has crucially made connections between institutions, as well as relationality to wider social, political and economic processes (Philo and Parr, 2000; Painter, 2006). Unpacking the politics and spatialities of institutions through ethnographic research is a crucial element to better understanding of political, economic and social relations (Billo and Mountz, 2016). Institutional ethnography 'offers the possibility to study up to understand the differential effects of institutions within and beyond institutional spaces and associated productions of subjectivities and material inequalities' (ibid: 215).

Interdisciplinary research on institutions offers detailed engagement with the differing intensities of care and control in public institutions, which are also important to understanding the institutionalization of everyday bordering. Questions of control and care (Disney and Schliehe, 2019) and their enfolding spatialities (McGeachan, 2019) have been the focus of ongoing work in institutional geographies (Philo and Parr, 2019; 2000). There is a need to pay attention to purpose, power and particularity when exploring personal and

institutional care (Tronto, 2010); recognizing that care is relational (Koggel, 1998; Nedelsky, 2008). Health care as an integral part of the welfare state, is the institutional embodiment of the relationality of care between the state and people residing within its territory. Who the state chooses to care for (as well as the extent of that care) is, in part, delimited through the bordering of state welfare institutions. If we are to understand care as situated and entangled in place (Puig de la Bellacasa, 2017), then institutions responsible for providing state-funded health care form particular settings for and of care with specific entanglements. Care cannot be disentangled from the messiness of its *situ*, which is becoming increasingly tied to immigration and border regimes in the UK context.

Crewe (2011: 511) has suggested that there has been a softening of penal power, which involves situating prison regimes within paperwork. In institutional settings, healthcare professionals play a role in the coercive potential of these regimes through the assessments they carry out. For example, in structured clinical interviewing, prisoners are often forced to fit their stories into the 'information system', which is too rigid to capture the complexity and ambiguity of their lives and their experiences (Franko Aas, 2014). Like prisoners' stories, border practices and representations cannot always be sorted into neat narratives (Bauder, 2011). In this paper, we analyze information systems relating to immigration status for everyday bordering within higher education and health care, and consider how they have created potential for coercive border control in and through the UK's public institutions. These institutions, we argue, are being differently situated within regimes of care and control to those that have previously been considered within the literature.

Internalization, bureaucratization and datafication

Bordering the public institutions constituting the welfare state or 'welfare bordering' (Guentner et al, 2016) is part of a wider shift from institutionalizing the perimeter of nation-states to multiple or transversal borderings cutting across the perimeter (Sassen, 2015). The UK has introduced increasingly complex regulations to determine access to health care, education and state support. These might be understood as practices of 'limited inclusion' that create spaces of compromise (Su & Cai, 2020). Decisions on eligibility for health care and education are routinely being made by other UK residents, who restrict access for those with uncertain immigration status and other non-citizens, as well as settled populations who are unable to prove their status (Yuval-Davis et al, 2019). 'Welfare bordering' describes what is being bordered rather than telling us anything about the role of bordering in (mis)shaping public institutions.

Efforts to deter migrants in the US (Castaneda, 2011) and Germany have also focused on welfare and social security with 'immigration and labour regulations enforcement had become much stricter' (Huschke, 2014). As in the UK, these regimes (ibid) exclude those who are unable to participate in documentation processes and prove their right to access a range of everyday services. Consequently 'undocumented migrants cannot count on institutionalized forms of social security' (ibid: 2022).

Forcing residents working in the public sector to undertake state borderwork through internalized state bordering regimes also makes public institutions key sites of counter-hegemonic borderscapes (Brambilla, 2015). Some people refuse to submit to an imposed territorial order and carry on living their lives (Jones, 2012). The opening up of national

borders strengthens a range of transversal bordering capabilities, including activist networks (Sassen, 2015).

The embedding of bordering practices and processes into public institutions within nation-states has also shifted and proliferated the bureaucratic procedures governing migration management, described as a form of 'administrative bordering' (Könönen, 2018). These procedures contribute to a broader set of bureaucratic processes within public institutions and have to be negotiated by bordered people. Border regimes therefore engage processes and practices of bureaucratization, which engender a 'paper curtain' (Lavenex and Ucarer, 2004) or a 'wall of documents' (Broeders, 2011) for would-be border crossers.

This bureaucratization is not comprised solely of formal requirements made within border and immigration regimes, but also the 'informal requirements' that emerge in the settings where these regimes are enacted (Scheel, 2017). In negotiating their crossing of the 'paper curtain', some people are forced to falsify or manipulate supporting documents. This approach is a form of appropriation (ibid); a dynamic entanglement of control and subversion/contestation, as part of which the state frequently refines its government and control measures over mobility in response to this appropriation. Scheel's appropriation is not about acts of resistance, the intention is not to change the regimes, simply to affect a performance that enables border crossing. Appropriation of the bordering regime hollows it out from the inside.

Borderwork has, therefore, been rescaled across space and time and different jurisdictions, with the most extensive borderwork shifting inside nation-state territories (Moffette, 2018). Numerous actors are drawn into borderwork, including police officers, municipal and central

government civil servants, bureaucrats and judges. This marks what Moffette calls an ongoing struggle over the management of migrants' presence across different levels of government. In the US, state and local government have 'enthusiastically entered the immigration policymaking fray since 2005' (Marrow, 2012: 846). Yet research from the UK (Author A, 2020a; Yuval-Davis et al, 2019) shows how borderwork winds on beyond arrival and extends beyond migrant groups.

The internalisation and bureaucratisation of borderwork is facilitated by and in turn shapes processes and practices of datafication (Broeders & Dijstelbloem, 2015). Leese et al (2022: 6) argue for 'an urgent need to empirically engage with the power dynamics and effects of processes of datafication and analyse their implications'. As Aradau (2019) has concluded, datafication also necessitates the development of new conceptual and analytical tools. This involves redirecting our gaze to who has access to data and what these actors do with/through such access (Tazzioli, 2022). Given the different ideologies underpinning data, as well as the multiple actors – institutional and individual – involved, this is a complex task (Leese et al, 2022). Analysis has shown that those subject to border controls can play different roles in processes of datafication, i.e. as sites of data extraction, but also as active participants in data productions (Tazzioli, 2022).

Whilst the literature on datafication in relation to borders acknowledges the role data plays in who can/cannot move, everyday bordering (Yuval-Davis et al, 2019) or the deterritorialization of bordering practices and processes (Lahav and Guiraudon, 2000) shift our gaze to the role of data in these dispersed (Huysmans, 2011) assemblages of control on the lives of bordered people. In the UK, for example, the sharing of transaction data is a prerequisite for receiving state support as an asylum seeker (Martin & Tazzioli, 2022). We

would argue that there has been not only a proliferation of data (Leese et al, 2022) but also the sources of data that are being drawn upon to border states. Research should explore both the politics (Bigo et al, 2019) and ethics of data and the ways in which it is obtained. Assembling data is not merely a technical operation, even though many involved in tasks related to this may not be fully apprised of the political projects that this data does or will come to underpin (Tazzioli, 2022).

Data have been described as an influential actor in decision-making in relation to the UK border (Hall, 2017), illustrating the need to account for human-data assemblages, within which it can be difficult to create accountability (Leese et al, 2022). In border regimes where cultures of disbelief (Griffiths, 2012) pervade, data from a range of sources are often valued more highly than migrant people's own accounts of their lives and circumstances (Scheel, 2022).

Data assemblages are, of course, also not unified and homogenous in and of themselves, and their operation can be cumbersome (Tazzioli, 2022). They are partial (ibid) but also comprised of various elements, which are produced in differing *situs* (Sohn, 2016). Analysing these *situs* enables us to explore shifting power relations within and between states and the role that data infrastructures, including those that might be invisibilised (Tazzioli, 2022), play in them. The databases that facilitate and shape bordering, just like states themselves, are not monolithic and impermeable, but fragile and breachable (Sontowski, 2018). When such infrastructures fail or breakdown (Leese et al, 2022), the impacts on bordered people can be disorientating as there is often little transparency in how they as individuals can address or correct such failures (Tazzioli, 2022; Aradau, 2017).

Bordering healthcare and higher education

Of the public institutions forming the 'left hand' of the state, considerable attention has been paid to healthcare in scholarly research. The structural exclusion of migrants from healthcare can be understood to have two key purposes: firstly, to reduce costs for healthcare providers; secondly, to remove the 'alleged magnet' that healthcare is suggested to represent to migrants in policy and media discourses (Chavez, 2012). In the US, healthcare as a federal arena has become 'decidedly hostile' for undocumented migrants (Newton and Adams, 2009: 422). The US has been restricting access to healthcare for undocumented migrants since the 1970s (Marrow, 2012). Policy-making on healthcare for migrants reflects an erratic policy-making approach to immigration more generally (Hoffman, 2006). Various schemes to provide care to those without insurance since the 1980s have specifically excluded undocumented migrants (Holmes, 2012). Many countries now have two-tier health systems, which has proliferated administrative work for healthcare providers (Castaneda, 2011). This bifurcation in care has arisen as a result of incongruous state and international policies.

Institutional actors exercise discretion in enacting bordering policies but are heavily influenced by the rules and bureaucratic processes operating in healthcare settings (Marrow, 2012). Institutions and their bureaucrats are differently positioned on the service-regulation continuum, and this shapes how they operationalize this discretion and ultimately whether they enable undocumented migrants to access care (ibid, 2009). Healthcare represents a 'space of refusal […] where sovereign state practices interact with alternative ways of seeing, knowing and being' (Jones, 2012: 687).

Bordering processes are mapped onto existing bureaucratic procedures and practices, which were not conceived to deal with the needs of particular groups, such as undocumented

migrants. For healthcare professionals, immigration checks within healthcare settings often conflict with professional norms of providing care on the basis of need (Marrow, 2012). The 'clinical gaze' is often trained on symptoms and the body rather than the wider context of a patient's life (Holmes, 2011 after Foucault, 1994). The perspectives of healthcare providers – institutional and individual – are important as they affect the care given (Holmes, 2011). Thus, state sovereignty is being negotiated on an everyday basis within healthcare settings, where state strategy meets with local tactics (Jones, 2012).

International students have been a keen focus of marketized higher education institutions in some of the wealthiest countries in the world for a number of decades (Kauko and Medvedeva, 2016; Molesworth et al, 2011). Universities have worked with governments to ensure that border and immigration regimes allow routes by which international students are able to access higher education. Reductions in funding for universities as public institutions due to neoliberal policy-making has meant that the sector is now economically dependent on revenues from these students (Macklin, 2022). The importance of these revenues became apparent during the Covid-19 pandemic, when universities (whose teaching and learning activities had predominantly moved online) petitioned governments for special consideration for international students to enter territories in person, in spite of stricter border controls (ibid).

At the same time, post-compulsory education has also been an important site of bordering, as those with particular immigration statuses residing within a territory have been refused 'home student' status, effectively barring them from entering due to high costs and lack of support from state-sponsored funding programmes (Oliver and Hughes, 2018). Immigration status impacts upon future possibilities and aspirations by truncating access to post-compulsory

education (Gonzales, 2016; Abrego and Gonzales, 2010). Bordering higher education (even if only temporarily) does not, therefore, impact people solely in the short-term, but becomes highly significant in the longer-term; impairing labour market prospects and also shaping a sense of (non)belonging (Oliver and Hughes, 2018). Post-compulsory education workers responsible for making decisions on the eligibility of applicants are overwhelmed by the complexity of the regulations they are tasked with administering (Oliver and Jayaweera, 2013). However, there are also shoots of resistance to bordering education on a local level in opposition to the hostility of national policy-making (Oliver and Hughes, 2018), which resonates with other work on sanctuary policies at an urban level in North America (Squire and Bagelman, 2012) and the UK (Author A, 2020b). Analyses of both bordering healthcare and post-compulsory education do not yet incorporate the institutional perspectives that form the focus of this paper.

Methodology

Bourdieu (1994) argues that we need to pay attention to the complex, dynamic (re)making of the bureaucratic field. The struggles in this field are where we locate the emerging priorities and technologies shaping the work in and of public institutions. Institutional ethnography (IE) can enhance geographical research 'about the many structures, effects, and identities working through institutions as territorial forces' (Billo and Mountz, 2016: 200).

We need to approach institutions as not only *situated* in particular time-spaces but also as being brought forward or rather constructed through specific discursive practices (Del Casino et al, 2000). Institutions are not bounded sites; their effects are widely felt but everyday institutional life is also shaped by those that might be 'outside' of the institution (Billo and Mountz, 2016). Therefore, when we refer to public institutions in this paper, we understand

these to be comprised of their materialities, policies and structures, as well as multiple actors including employees and users. This paper draws upon primary and secondary data collected between 2013 and 2021, corresponding to work on two different research projects. Primary data collection took place in two phases in 2013-16 and then from late 2019 until April 2021. The first phase involved analysis of bordering in everyday life primarily in the UK with colleagues as part of the [*redacted*] project. The second was part of a project specifically exploring bordering and its contestation within public institutions in the UK. Our approach began in 2013 with analysis of emerging and existing border and immigration policies, that sought to embed immigration checks into these areas of the public sector. From 2013 to 2016, this policy analysis was augmented by insights into migrantized communities' experiences of these institutions through interviews, focus groups, participant observation and media analysis primarily in the South East and later the North East of England.

The initial phase focused on developing a deeper understanding of everyday bordering in the National Health Service (NHS) and involved three semi-structured interviews, a focus group and initial contact and discussions with staff working in the NHS and a number of voluntary and community sector (VCS) organizations based in and around Newcastle-upon-Tyne in the North East of England. The second phase involved fifteen narrative interviews with public sector workers from the NHS and universities in England,[i] whose jobs contributed both directly and indirectly to the administration of immigration checks within their services, as well as two further workers from VCS organizations supporting asylum seekers and refugees, who frequently advocated with local NHS Trusts to support service users.

Secondary data collection involved searches of the Hansard, online news and other media, as well as reports published by professional bodies and VCS organizations, and policy

documents produced by universities and NHS Trusts. Collection and analysis of secondary data began in 2016 and continued into 2021, with the most intensive periods being in 2016-17 and 2020.

The routinization of borderwork within UK public institutions

Formal or state borderwork in the UK is now a required element of the job roles of many more residents, as a result of the increasing internal reach of bordering processes and practices (Yuval-Davis et al, 2018). This growing incorporation of people into state borderwork is far more extensive than the voluntary reporting on others undertaken by 'citizen-detectives' (Vaughan-Williams, 2008), and has been accompanied by increased sanctions – civil and criminal – for those who do not comply (Yuval-Davis et al, 2019; Author A and Anon, 2022). Borderworkers within public institutions may also be subject to sanctions from their employer for a lack of compliance or any mistakes made in administering the border regime.

Reeves (2014: 6) defines borderwork as 'the messy, contested, and often intensely social business of making territory "integral"'. Here, we explore how territory and its making through borderwork became integral to institutions in the UK's public sector. As Reeves highlights, 'the work of state spatiality is not confined to the physical edges of the cartographic limits, or those wearing the border guard's uniform' (ibid: 245). We analyze the forms that this borderwork took in public sector institutions as decision-makers attempted to embed the UK's border regime into existing institutional mechanisms. Where such mechanisms were found to be insufficient, they were transformed and/or entirely new processes and practices were put in place. These changes were uneven and led to growing inequities impacting not only those seeking to access care and education, but also those

working within them and undertaking borderwork. As Burridge et al (2017) note, much borderwork is really about trying to reconcile the inconsistencies of bordering policies and legislation in the context of everyday life.

Bordering through attendance monitoring in higher education

In 2012, the then UK Borders Agency (UKBA)[ii] decided to revoke the licence issued to a London university to recruit international students. These licences were the result of changes made to immigration policy in 2008,[iii] when a points-based system (PBS)[iv] for the issuance of student visas was introduced. Whilst administrators and teachers in universities and colleges had begun to monitor attendance, progress and (to some extent) paid work undertaken by international students earlier in the 2000s (Yuval-Davis et al, 2019), the new legislation formalized this relationship. By issuing private and state-funded educational institutions with licences to sponsor visas, the UKBA shifted responsibility for compliance with student visas to universities and introduced an audit culture through which they oversaw the performance of universities and colleges in their compliance role.

As part of the government's plans to cut so-called net migration changes were introduced to visas issued via the points-based system (including revisions to the Tier 4 or student visa route).

> The current system is based on a sponsorship regime that trusts educational institutions to assess the quality and ability of students, and puts the responsibility on the institution to ensure that the student is in fact studying and obeying the immigration rules. That trust has been well placed in some sectors: universities, independent schools and publicly funded further education colleges mostly take their

> sponsorship duties seriously and act responsibly. But some, particularly in the private FE sector and parts of the English language college sector, are not exercising the due diligence we expect. Those institutions make up the largest single group on the sponsor register. […] Although some of them are legitimate, for many their product is not an education, but immigration, together with the ability to work here. (Theresa May, 22nd March 2011, HC Deb, Col. 856).

The new legislation required all educational institutions be vetted and gain 'highly trusted sponsor status'. Once this status was lost, as in the case of the London university in 2012, it would have to be reapplied for in order for an institution to enrol international students once more.

Whilst the initial focus of this legislation was privately funded colleges, the 2012 revocation shows that universities were also directly impacted, and experiences of these changes were not uniform across the sector.

> [E]very university will have attendance monitoring procedures, some are looser than others, depending on the type of university […] and depending on their experience with the Home Office in terms of audits that they may have had, and whether they pass them or not. And also, how many international students they have. In my old role, I had 1400 tier 4 students. In my current role, I've got 35. So there's a big difference, but at [current post-92 university][v], there's a lot more – dare I say – paranoia about the whole tier 4 issue, because they have actually failed an audit (AA, July 2020).

The threat of licence revocation has ushered in internal changes to universities and colleges. As AA explains, most universities have embedded visa compliance into attendance monitoring. Fitting UK Visas and Immigration (UKVI) visa compliance into existing attendance policies created uncertainty.

> But the way the UKVI view universities' attendance policies is, they want to know […] that you've got a clear procedure in place to contact students who aren't engaging. Then you can evidence that you follow up the students that aren't engaging, and that there's an end outcome where you've exhausted every possibility, and you are not keeping a student on a programme when they're clearly not here. And, I mean universities often tie themselves up in knots with that, because the guidance that the UKVI put out there […] kind of leaves it a little bit vague (OU, May 2020).

The impression is one of high expectations, which are not evident in accounts of those undertaking borderwork within the Home Office itself, where staff reveal pressures often lead, 'to an exhausted and demoralized workforce – one likely to make mistakes' (Anonymous, 2021: n.p.).

From this institutional perspective, borderwork is not just the act in the moment of undertaking the checks on immigration status or even visa compliance, but emerges as institutional processes are forcibly adapted and (mis-)shaped in order to meet the demands of the Home Office. Institutionalized borderwork becomes a dialogical process, through which the already varied and contested needs of universities are subordinated to the demands of the UK's border regime.

> So what we did was we made a point of running our policy past them at every stage. […][E]very institution has a key account manager with the UKVI, so we've already cleared [it] with them (OU, May 2020).

Having drawn universities into this dialogical relationship, UKVI makes them bear the costs by offering educational institutions with 'highly trusted sponsor' status a 'premium customer service' for £8,000[vi]/year. This service provides access to a named premium account manager (PAM), who enables universities to work more closely with UKVI, as OU describes. The double burden placed upon universities is apparent: they must implement the guidance and undertake borderwork on behalf of the Home Office, but they must also pay the Home Office to enable them to effectively undertake this work and avoid any potential sanctions being placed upon them.

Another interviewee described the introduction of a portal through which staff at universities could get in touch with UKVI with queries.

> [B]efore all the queries used to go just through me; [..] whereas now on the portal you can add users, so I've added people in admissions, people in compliance and people in the welfare team. […] [W]e used to be very, very careful about how we worded things. We didn't want them to have an insight into problems or, you know it was all very structured, some cases were hypothetical […] because we felt like historically they were a link to our licence […]. (LU, February 2020).

LU describes how the Home Office is facilitating the extension of borderwork to more and more staff within their institution and that this has led to greater engagement with the Home

Office for individual members of staff. The portal enables more routinized engagements between university borderworkers and the Home Office.

The changes made to attendance monitoring, whilst driven by bordering international students, have implications for all students. In everyday life, border regimes cannot be contained to impact only upon those they target, i.e. non-citizens, but shape a range of everyday encounters (Yuval-Davis et al, 2019), including those between staff and students in universities.

> I didn't want us to treat international students any differently within this. […] [T]hey wouldn't know that this was even wrapped up in the UKVI compliance. It would appear to them as though this was all about their support, their learning, getting them back on track. (OU, May 2020).

As the work of some staff within universities became further embedded with that of the Home Office and the UK's bordering regime, it was clear that the structural changes within the institutions intentionally sought to mask this proximity and differentiation from students. In obscuring the institutions' borderwork and their relations with the Home Office, universities have put in place much more intensive systems of surveillance and control, which coalesce around discourses of care, concern and welfare.

> And I would say there's a massive shift […]. It's very student friendly. It's very pro-student [..].We've reworded a lot of our correspondence to say, even just to start with a sentence to say "I hope you are well", or even at the bottom, "If you have any questions", you know, or "If this is concerning to you". There is more of a push to

> understand that we aren't a hostile environment. The Home Office is. And the Home Office really wants us to be (LU, February 2020).

As LU explains, there has been a shift to showing more care and concern for students in communications with them. Universities seek to mask the hostility of the UK's bordering regime, which necessitates more work. Visa compliance is most often located within teams or departments responsible for student support, and welfare and borderwork has been (re)imagined as a routine aspect of institutions' care of and for students.

Bordering through defining the 'ordinariness' of residency in health care

The infrastructure for bordering within the NHS was created in the 1949 NHS (Amendment) Act, which designated the power to charge people not 'ordinarily resident' in Great Britain for health services.[vii] The power to charge for NHS services was not meaningfully operationalized until 1982 when regulations on eligibility for NHS hospital treatment were created. Charges for care were initially only made in hospitals, and primary care and community care remained free 'by default'. Determining who is 'ordinarily resident' in the UK, and therefore entitled to free health care, is usually the role of Overseas Visitors Offices (OVO) based within NHS Trusts.[viii]

Prior to the 2014 Immigration Act's implementation, being 'ordinarily resident' in the UK was based upon whether an individual was living there lawfully, rather than upon any minimum time requirement. The 2014 Act changed this definition, so that 'ordinarily resident' would require indefinite leave to remain, which is contingent on five years' residency in the UK (Grove-White, 2014). This move removed the right to freely access healthcare for certain sections of the population. Those who are not 'ordinarily resident' are

expected to pay up-front for non-urgent care, whilst urgent care is provided but the costs are then recouped by hospitals' OVOs.[ix] However, there is an array of exceptions by which some people who do not meet the criteria of being ordinarily resident are given either free access to healthcare, e.g. asylum seekers, or some forms of care due to how they came to need it, e.g. maternity care for survivors of FGM and sexual violence/rape.

In addition, a health surcharge for non-EEA citizens staying in the UK for over six months was introduced in April 2015. This was £624/year[x] as of October 2020. The surcharge has to be paid upfront for all years of the visa, e.g. £1872[xi] for a 3-year visa. Those who come to the UK on tourist visas are not required to pay the levy, but will be fully liable for the costs of any NHS treatment they receive.

As with higher education, how NHS Trusts chose to develop and embed everyday bordering was differentiated; building on and transforming existing processes, including the administration of patients' care. Most Trusts ask those that have been resident in the UK for less than a year to complete a form when they come in to access a facility or service. This form is usually passed by administrative staff within the service to the OVOs, who are ultimately responsible (in collaboration with the Home Office) for making a decision on whether a patient is chargeable for their care. In cases where care is not deemed immediately necessary, this may result in a patient not receiving treatment until they have paid for it.

> The purpose of the [form] is to capture information from the patient that may support their entitlement to hospital services free of charge […] as quickly as possible. The patient must complete the sections of the form that relate to their reason for being in

> the UK and sign to say they understand the declaration contained in the form. (Overseas Visitors policy document, anonymized NHS Trust, September 2019).

The form is a gateway to a range of administrative processes, extending beyond the NHS Trust and its OVO. The same policy document goes on to explain that, 'When the patient completes and signs the [form], they give their consent to the Trust to contact other official bodies to verify information they have provided'. Thus, the form becomes a starting point from which the Trust must engage with other public bodies in order to undertake borderwork, including the Home Office. The phrasing of the policy is very much in line with the discourses embedded in the immigration legislation; patients must prove they are exempt from charging and the Trust will pursue 'documentary evidence' of this. In this case, unlike universities, the host is not actively seeking to hide or conceal borderwork, but taking on more of the Home Office's characteristics.

> The Patient may be contacted for various supporting documents to show they are entitled or establish dates when charges have applied or ended. Where a person is claiming exemption from NHS charges, it is their responsibility to prove they are entitled to hospital services without charge. The Trust is entitled to ask for documentary evidence from the patient. (Overseas Visitors Policy document, anonymized NHS Trust, September 2019).

These policies do not solely place a burden on patients in terms of documentation, but also impact healthcare professionals working within the NHS as well. Whilst the decision as to whether a patient is deemed chargeable lies with the OVO, Trusts also make clear in their policies that ward staff must support the OVOs in this work.

> If staff identify on or after admission that a patient may not be ordinarily resident in the UK, then they must ask the patient to complete an Establishing Entitlement to NHS Treatment Form and send the completed form with photocopies of any relevant documents that the patient offers, to the Overseas Visitors Team. (Overseas Visitors policy document, anonymized NHS Trust, January 2019).

Borderwork stretches across institutional structures and beyond the confines of the OVO, as staff on the wards are asked to engage in monitoring and surveillance, which may feel very much like intelligence-gathering for purposes beyond their primary role of delivering care.

In addition to these pressures being placed on ward staff, clinical staff are asked to determine whether treatment is urgent, immediately necessary or non-urgent. In cases where treatment is non-urgent, there is an expectation that the patient will either receive this treatment after they return to their country of 'residence' or they will have to pay upfront if they decide to have treatment in the UK. Such borderwork is highly complex. For example, clinical decision-making relating to those who are described as 'undocumented' may not be straightforward as a return date may not be available. One policy suggests that borderwork must be undertaken on a 'case-by-case basis'.[xii]

> For undocumented (those with no valid leave in the UK) migrant patients, including refused asylum seekers, the likely date of return may be unclear and the patient may have been in the UK and have been receiving treatment for a number of years. The lead clinician/consultant will have to judge on a case-by-case basis whether treatment needs to be given. In making this judgement the clinician, with guidance from the

> Overseas Visitors Team, will give consideration to whether the patient may be prevented by travel or entry clearance restrictions in their country of origin, or other conditions beyond their control. (Overseas Visitors policy document, anonymized NHS Trust, January 2019).

Whilst clinicians' borderwork does not formally involve judgments about the eligibility of patients for free care, they are expected to notify patients of their need to pay for care and all staff are warned not to indicate that treatment is free until this has been confirmed by the OVO. In addition to difficulties determining the urgency of treatment, policies also note that such decision-making will not be static, i.e. that this must be monitored and could change during a course of treatment. Borderwork in the NHS does not conclude, but winds on across the course of the patients' interactions with a healthcare provider. Trusts' policies suggest that one conclusion could be the provision of sufficient treatment to stabilize a patient and enable them to return to their home country. Borderwork plays a dynamic role in shaping treatment plans and patients' recovery.

> I […] remember a man who was from South East Asia or of South East Asian origin […] I think he'd been in the UK for quite a long time actually, but didn't have clear status, and pretty much everything I proposed, investigation or treatment, he would sort of ask me whether he was going to have to pay for that. So, it […] changes the nature of the conversation a little bit. It […] makes your conversation a bit more stilted, and you're more aware of their anxiety, not just about their own health but about their financial status as well. (RA, Junior Doctor, North-East England, February 2020)

Having conversations about charging did impact on discussions between patients and clinicians; Marrow (2012) noted that in the US context doctors also felt that bringing in immigration status to healthcare settings impacted on the care patients received. This marked a distinct shift for many clinicians working within a state healthcare system founded on the principle of being free at the point of access on the basis of need, rather than ability to pay. In some cases, concerns emerged that led to further work for clinicians to de-border care for their patients. The delineation in responsibility between that of the OVO and ward and clinical staff was not as clear as hospitals' policies would suggest.

> I've been actually asked to be involved in the paperwork for […] asking someone to pay. […] I remember they had a sort of sheet on the front of their notes saying, you know, this patient is gonna be charged, so […] make sure you document what you've done with them, or something to that effect. Which, again, […] I found quite difficult, […] and I therefore spent quite a bit of time with that person trying to understand whether they actually did fit the criteria for charging or not and see whether they could register with a GP. So, I guess it's quite a use of health professionals' time, which I feel could be better spent doing other things (RA, Junior Doctor, North-East England, February 2020).

As with universities, the proliferation of borderwork and its embedding within the NHS is reshaping institutional cultures and structures. The entanglements of clinical and borderwork and the new relationships being developed between NHS Trusts and the Home Office are also unfolding within hospital settings, as clinical and administrative staff and those working within the OVO attempt to meet the demands of the UK's internalized bordering regime.

Bordering through datafication

As we have described, relations between the Home Office and other public institutions have shifted through the embedding of a range of borderwork into the roles of their employees. However, we observed that relations between the Home Office and these institutions move beyond simply the delegation of borderwork, and also incorporate the growing use of data extracted from these institutions as part of borderwork, which develops and enhances systems of surveillance and control. As bordering becomes embedded in institutional information systems that increasingly stretch across the public sector, not only do questions emerge surrounding 'fitting' within these systems (Franko Aas, 2013), but also concerns around the use of data collected under the auspices of education, health care and social security for bordering and immigration purposes (Gulland, 2017). Data gathering is a deterrent to seeking timely healthcare and treatment for undocumented people, even when there is no sense that this data will be shared beyond the individual institution (Marrow, 2012). As Amoore (2021) has highlighted, processes of institutional datafication also feed machine learning, which forms the 'deep border'.

For most patients visiting a secondary or tertiary care NHS facility or service, their entry into the border information system comes through the asking of a baseline question upon admission. This question appears simple: whether a patient been resident in the UK for the last 12 months or not. Even those that answer 'yes' to this question may not be entitled to free treatment/care, but their lack of entitlement will be detected at a later stage, in another part of the information system. For those resident less than 12 months, most Trusts immediately ask patients to complete a form, as detailed above, containing more data and information about themselves in order to establish their entitlement to free NHS care. The data being gathered

here is solely for the purpose of border control and although it may not be extracted by the Home Office itself, it enables NHS Trusts to do their designated borderwork.

Once a patient's data is in the system, it is stored with NHS Digital,[xiii] and becomes available to the Home Office, which had been able to request information on patients by writing directly to general practitioners (GPs)[xiv] since around 2005 (Gulland, 2017); however, these requests were often refused. The Home Office therefore sought to gain easier access to this data to aid in border surveillance activities by secretly drawing up a Memorandum of Understanding (MoU) with NHS Digital in November 2016, which became operational and was made public in January 2017. Under the MoU (until its suspension in May 2018), the Home Office was able to request a patient's name, address, date of birth, GP details, and date of NHS registration from NHS Digital. It was estimated that in 2017, the Home Office extracted data from NHS Trusts on 3000 patients via the MoU. The MoU was suspended after concerns were raised by a number of organizations, including the UK's General Medical Council (McCall, 2017; Gulland, 2017). However, the Home Office continued to request data in cases where someone was being sought for deportation after conviction for a serious crime (Griggs, 2018).

Individual NHS Trusts are also obliged to report any debts of more than £500 that have been outstanding for more than three months.

> The form advises those patients who are visiting the UK […] (usually on a 'Visitors Visa'), that if they incur charges for hospital services of over £500, and the debt is outstanding for 3 months or more, it will be reported to the Department of Health, and

> may affect future or current visa applications. (Overseas Visitor Policy, NHS Trust, December 2019).

Given that some migrants are being incorrectly identified as being chargeable for their care (Maternity Action, 2019; MedAct, 2020), this may involve visas being refused on the basis of incorrect data from the Trusts.

Meeting the Home Office's demands for data has also become a routine part of the work of visa compliance teams within universities.

> [T]o maintain our licence, we have to send certain reports to the Home Office about when students complete their course, who doesn't enrol, who changes course, there's a report about ATAS [Academic Technology Approval Scheme], so that, once all the enrolment's done and the CAS[xv]es are [done] the main part of the compliance team's role is all of the reports (LU, March 2020).

Unlike in healthcare, data are not extracted by the Home Office directly but actually extracted from HEIs' systems by staff and *pushed* into Home Office systems from via reporting mechanisms. As LU states, developing relations through datafication in and of itself is essential in order for universities to be spared sanctions that may impact on their highly trusted sponsor status. However, when introduced to Home Office systems, the data morphs; identifying those that are deportable, and thus creating a basis on which Home Office Immigration Compliance and Enforcement teams can act.

> [A] bulk report will go to the Home Office to say, and it's very basic, it just says, 'we are no longer sponsoring this student'. It doesn't say they didn't attend on X, Y and Z, because we can stop sponsoring for a whole host of reasons, so non-payment of fees, if a student's record is changed to say, set to a certain code, it just means they're no longer a student, that'll pull through, we'll see it's for non-payment of fees, then we just report, 'no longer sponsoring' (LU, March 2020).

As LU explains, deportability data is embedded within a bulk report and a student is identified by a 'no longer sponsoring' status. Thus, data on students is pushed by universities into the border information system as part of a regular or routine yet unidirectional form of communication.

Legislation also intervened to ensure compliance with the Home Office's data demands from healthcare providers. Prior to new regulations in 2014, NHS Trusts had discretion in charging 'overseas visitors'. However, after 2014 NHS employees were compelled to carry out ID checks and identify migrants from outside the EU who must pay for most non-emergency or primary care NHS treatments. Trusts failing to meet this obligation could have funding withheld. In addition to penalizing trusts for not undertaking sufficient checks to identify those chargeable for their care (Author A and Anon, 2022), the UK government has also sought to incentivize Trust managers to extract this data by permitting them to charge those not eligible for free care 150% of the actual cost of their care. Therefore, extracting the data in this way also potentially captures value for NHS Trusts (Martin and Tazzioli, 2022).

The Home Office uses not only the inequity of the UK's policy-making borderscapes but also its role as a central organ in the bureaucratic field, in order to shape and create mechanisms

through which to extract data and information from these institutions to monitor and control bordered people living within the UK. That the systems capturing this data may be insufficiently flexible to accommodate all the information required, or that some of the data may be erroneous, does little to deter the further development of these mechanisms. In the case of NHS trusts, the data extracted from borderwork also has financial value to them, as they are able to charge those identified in excess of the cost of their care.

Conclusions

We have argued in this paper for a more sustained engagement with the institutionalization of everyday bordering, specifically through a focus on public institutions. Whilst there is significant work exploring the impacts of border and immigration legislation in certain parts of the public sector, particularly healthcare, wider analysis of how bordering is shifting the landscape of the public sector and the institutional formations of the state is needed. For us, analysis of contemporary bordering and borderscapes must include these institutional perspectives because we have seen a rise of everyday bordering as a form of governance that is shifting the 'bureaucratic field'. Such analysis is also urgent given the proliferation of policy-making in relation to borders and immigration; since 2014, the UK parliament has passed five substantive pieces of border-related legislation.

We have shown, through analysis of higher education and health care, that the embedding of the UK's border regime into public institutions has two main *forms*: the routinization of borderwork within the roles of public sector workers and systems of administration; and the use of public institutions to generate and access data that can be used for immigration and border control purposes. We believe that this analysis shows a shift in relations between the Home Office and other public institutions.

So much of the work of the UK's immigration and border control is now being undertaken by institutions that fall under the remit of other government departments. Their employees do borderwork scrutinized by Home Office staff, and they change or create internal systems and mechanisms to provide the Home Office with more and more information and data. Borderwork intersects with and is embedded in other forms of work performed within public sector institutions more than ever before. This situation renders workers in these institutions not only complicit with but actively engaged with these forms of state violence. Consequently, we believe that if we are to prevent public institutions and their resources from becoming exhausted then there is a need to intervene quickly to stem and ultimately dismantle these relations.

Due to the primary importance given to border and immigration policies by nation-states, other areas of the public sector are being fundamentally reorganized as the Home Office draws more and more upon their resources. Bordering, as one of the key areas of the 'right hand' of the state, is coming to further dominate the 'left hand' through these relations. The linking of different databases of information regarding individual residents also engenders new possibilities for surveillance and control stemming from these securitising institutions of the bureaucratic field. In our analysis, there is little or no benefit derived for public institutions whose primary functions are healthcare and higher education in undertaking this work, in sharing this data.

However, in becoming embedded within other parts of the UK public sector the Home Office is able to cut its own costs in line with the reductions demanded by the austerity agenda (Author A, 2018). Border and immigration regimes become further dispersed and distanced

from the Home Office itself; the Home Office is able to 'govern at a distance' (Castaneda, 2011), or at least to achieve governing effects (Harvey, 2005). Bordering is obscured within the enfolding spatialities of care and control (McGeachan, 2019) in public sector institutions. It is clear that we have yet to uncover fully what bordering and its forms identified here mean for the future of public sector institutions, but the relentless demands placed by the Home Office on other public institutions suggests that if policy-makers and the wider public wish to see them continue and be able to care for and educate people living in the UK, then interventions must be made on a systemic level.

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[i] Although border and immigration policies fall under the remit of the Westminster government and, therefore are UK-wide, certain areas of policy-making with respect to health care, higher education and social security are controlled by the national governments of Scotland, Wales and Northern Ireland. This means that there are differences in the ways in which bordering is embedded within institutions in the public sector across the constituent nations of the UK. Mapping these differences is beyond the scope of this paper and we are, therefore, drawing solely upon data relating to institutions in England.

[ii] Then a part of the Home Office.

[iii] The policy was not implemented until 2009.

[iv] Non-EEA nationals wishing to come to the UK to study for more than six months to study had to apply for a Tier 4 (PBS) visa. To enter under the Tier 4 route, the student must apply for entry clearance overseas after having been issued a Confirmation of Acceptance for Studies (CAS) by an education provider that is registered as a Tier 4 sponsor. Tier 4 criteria including minimum English language requirements must be met and in certain circumstances students can work, bring dependants and extend their stay in the UK.

[v] This refers to a group of institutions (predominantly polytechnical), which were granted university status in 1992 and are also sometimes referred to as 'new' or 'modern' universities to distinguish them from UK universities that received their status prior to 1992.

[vi] Approximately US$11,070 based upon exchange rates in August 2021.

[vii] Ordinary residence is a concept taken from common law in the UK.

[viii] Trusts are the units within which NHS healthcare services operate on a local level.

[ix] This reflects the system used in Germany, described by Huschke (2014), where emergency care must be provided regardless of whether a patient as a German insurance card, but hospitals/providers can apply for the costs of treatment to be reimbursed through the social welfare office.

[x] There is a reduced rate of £470/year for students and some other visa types.

[xi] Approximately 2570 USD based on exchange rates in October 2021.

[xii] This level of case-by-case decision-making in relation to borderwork is something that we do not see being undertaken even by the Home Office itself. For example, those who seek asylum in the UK from a country deemed 'safe' by the UK government have their claim summarily dismissed.

[xiii] The digital records service for the NHS, responsible for patient data and records.

[xiv] Family doctors or primary care physicians.

[xv] Confirmation of Acceptance for Studies (CAS).