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# 'Border Country': health law in a devolved UK

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## ABSTRACT

How are we to understand and research health law under devolution in the UK? Building on work in law and geography, we argue that the figure of the border is key to the production and implementation of devolved health law and the variety of forms that this takes. The utility of border thinking in this context is shown through a review of thematic areas, including infectious disease control, access to health care, and abortion, each instantiating a distinct bordering process. In each, we consider recent developments in policy and legislation, framed with reference to constitutional change, and the politics of devolution in the UK. Taking Wales as an exemplary site, we argue that health law produces borders in traditional and non-traditional places. It creates and blurs territories. It is equally constituted by pluralistic bordering practices. On the basis of this theoretically informed review, we conclude by proposing a cross-disciplinary legal, ethical, and socio-legal research agenda for future research.

**KEYWORDS:** Abortion, Borders, Covid-19, Devolution, Immigration, Law and geography, NHS

## I. INTRODUCTION: HEALTH IN THE *BORDER COUNTRY*

What is the nature of health law in the UK after devolution? How are we to research this emerging field? Health is defined in universal terms, but delivered nationally and locally. Health professionals partake of a universal science and ethic, spurning distinctions based on particularistic criteria, but the organization of health care and public health in practice is closely connected to particular states and their component parts. Its scope and effectiveness are often predicated on the relations between them. During Covid-19, the state and its limits came to the fore as citizens were locked down and incomers locked out, while vaccines were acquired for local populations first and foremost.[1] Universal or 'global' health was able to assert itself only belatedly, as multinational institutions tried with limited success to remedy

[1] See further, J Harrington, 'Between Empire and Nation: How the State Matters in Global Health' (2023) 43 Legal Studies 461.

the depredations of unjustified *cordons sanitaires* and the vaccine nationalism of the rich countries.[2] The pandemic showed that health law depends on borders and produces them, not just at the geographical margins, but throughout its field of operation. It deals in distinctions and discriminations, as much as symbioses and couplings. Thinking about health law has to be 'border thinking'.[3]

What is border thinking and what can it do for the study of health law in the UK? While it will not provide ready answers to questions of jurisdiction or 'conflicts of law', it can help us contextualize and grasp key processes underway since the advent of devolution in 1998. It draws our attention specifically to the 'territorialization' of the legal regimes under which health care has been delivered and public health provided for, the emergence, in other words, of discrete bodies of law for Wales, Scotland, Northern Ireland, and England.[4] More concretely, a focus on borders spotlights the contact zones—physical sites and specific legal issues—where processes of divergence and convergence, interaction, interference, and alignment can be observed and investigated. The present article is a preliminary, interdisciplinary attempt to map the terrain of devolved health law in this way. Parsing recent work in human geography, it specifies a conceptual vocabulary adequate to the distinct ways in which health law borders 'work' for states, professionals, patients, and citizens. It demonstrates the potential of this framework through a selection of short case studies, instances where health law borders are produced. In each case, we will observe what Delaney has called 'space in law' and 'law in space', ie the pervasive reliance on territorial idioms to articulate health law developments, along with the differential effects of legal doctrine on material arrangements for health.[5]

Each of our case studies concerns Wales in its relation to other parts of the UK, to the UK as a whole, and to the wider world. Why start from Wales? A comprehensive review of developments across the UK would not be feasible given space constraints. A representative selection from different countries would be possible, but that would limit our ability systematically to identify and compare the different bordering processes at work. Taking devolution seriously includes acknowledging the distinctiveness of developments in each of the constituent countries, while also accepting their salience for generating more widely applicable theoretical frames and research programmes on health law in the UK. It also requires us to move beyond the implicitly Anglo-centric framing of the field to date. Moreover, health has been a special focus for the exercise of devolved powers by the Welsh Government and Senedd Cymru. High profile reforms to the structure of the National Health Service (NHS), opt-out rules on organ donation, and the minimum pricing of alcohol have allowed legislative and policy divergence to be signalled to a wider Welsh population, and to political actors across the UK.[6] This was especially the case during Covid-19, with Cardiff suggesting that its approach to infection control was more cautious and science-based than that taken by the Westminster government for England.[7] Tensions between the devolved administrations and Westminster also highlighted the constitutional resonance of health law under devolution.[8]

[2] M Kornprobst and S Strobl, 'Global Health: An Order Struggling to Keep up with Globalization' (2021) 97 International Affairs 1541.

[3] WD Mignolo and MV Tlostanova, 'Theorizing from the Borders' (2006) 9 European Journal of Social Theory 205.

[4] D Delaney, *Territory: A Short Introduction* (Blackwell 2005).

[5] D Delaney, 'Beyond the Word: Law as a Thing of this World' in C Harrison and J Holder (eds), *Current Legal Issues: Law and Geography* (OUP 2003) 67, 68.

[6] J Harrington, B Hughes-Moore, and E Thomas, 'Towards a Welsh Health Law: Values, Divergence and Devolution' (2022) 73 NILQ 62.

[7] W Hayward, *Lockdown Wales: How Covid-19 Tested Wales* (Seren 2000).

[8] D Wincott, 'The Anglo-British State, Welsh Devolution and the Covid-19 Pandemic in England and Wales: Territorial Riddles, Mysterious Boundaries, and Enigmatic Identities' in V Molinari and P-A Beylier (eds), *Covid-19 in Europe and North America: Policy Responses and Multi-Level Governance* (De Gruyter Oldenbourg 2022) 211.

But Wales is more than simply a source of divergent health law initiatives. It has long functioned in itself as a signifier of marginality, essential to the construction of first the English, and then the British state: from the Norman conquest of its 'marchlands', to Victorian conceptions of the 'Celtic Fringe'; from the persistence of its linguistic distinctiveness, to its role as an extractive outpost of the imperial economy. If 'Welsh' meant the 'other people' to Anglo-Saxon settlers, Wales has endured in the official imagination as a liminal place, ready to be absorbed (as in the jurisdiction of 'England and Wales') or elided completely ('For Wales, see England', as the *Encyclopaedia Britannica* had it). Not only a devolved power centre within the UK and a source of legislative and policy variation, Wales is also a rhetorical *topos*, a place rich in historical associations, ideal for the study of health law borders within and around the UK.[9]

Our health law case studies are focussed on four distinct border phenomena. First, the demarcation of Wales from England through infectious disease control measures during the coronavirus pandemic in 2020 and 2021. Secondly, the effect of different rules on access to treatment as between the NHS in England and Wales, including the conditions imposed on cross-border mobility for treatment. Thirdly, the continued, uncontroversial application of the Abortion Act 1967 across all of Great Britain (though not Northern Ireland), without specific modification for Wales. Fourthly, and in contrast, the difference in approaches to asylum-seekers looking to access NHS care in Wales and England. Fifthly, the role of health law and policy in countering linguistic shift within Wales itself. In conclusion, we suggest ways to meet the challenge of researching the emerging field of devolved health law, which take seriously the central role of borders in its development. We argue that 'border thinking' and the analytical framework outlined here can help to ground a multi-method research programme, combining the analysis of positive law and ethical reflection with empirical socio-legal strategies adequate to this task. We are guided on our journey by Raymond Williams, whose work in cultural theory anticipates the methods adopted here, and whose fiction, most notably the autobiographical *Border Country*, echoes our concern with the social (and legal) production of boundaries and the territories they contain.[10]

## II. 'OVER THE EDGE': WHAT ARE BORDERS?

Our approach to health law borders under devolution builds on the work of legal geographers, who challenge us to 'splice' the socio-legal understanding that 'law is a presence and a force that makes things happen' to the insight from human geography that 'space is not just a mere surface upon which and though which power works'.[11] Rather, as Blomley has argued, law and space are involved together and simultaneously in territorializing specific patterns of social relations.[12] Borders are intrinsic to these processes of territorialization. They define the link between space and social ordering (Newman, 2006). Jurisdictional borders set limits to the enforceability of law; welfare and health care entitlements are co-terminous with national territories or administrative regions. International borders constitute states as sovereign entities, adjoining and equivalent to other states.[13] This modern view of the border as a singular 'edge' retains much analytical force. Escape to a borderless world is unlikely,

[9] For further discussion, see J Harrington, L Series and A Ruck-Keene, 'Law and Rhetoric: Critical Possibilities' (2019) 46 Journal of Law and Society 302.

[10] R Williams, *Border Country* (Parthian Books [1960] 2006).

[11] N Blomley, 'From "What" to "So What": Law and Geography in Retrospect', in C Harrison and J Holder (eds), *Current Legal Issues: Law and Geography* (OUP 2003) 17, 25.

[12] N Blomley, 'From "What" to "So What": Law and Geography in Retrospect' in C Harrison and J Holder (eds), *Current Legal Issues: Law and Geography* (OUP 2003) 17, 30.

[13] D Newman and A Paasi, 'Fences and Neighbours in the Post-Modern World: Boundary Narratives in Political Geography' (1998) 22 Progress in Human Geography 186, 192.

as demonstrated by the intensification of exclusionary migration controls in the global north and claims to self-determination by states in the global south, as well as by non-state entities within them.[14] Nonetheless, it needs to be qualified in the light of theoretical advances, as well as 'real world' social and political change. These require us to take a post-modern view of borders, 'over the edge' as it were, which includes modern perspectives, but also goes beyond them in shaping an appropriate analytical framework.[15] A revised view includes the following insights.

*Borders are made, not pre-given*. They are achieved on an ongoing basis through processes of construction and affirmation, as well as contestation and transgression.[16] This is true of long established as well as newly created borders. 'Bordering' happens in four main ways: materially; normatively; ideationally; and socially.[17] The organization of health care provision and public health, contributes to bordering in each of these ways.[18] Territories such as 'the United Kingdom' 'Wales', and 'England' are produced on an ongoing basis by means which are material (eg location of medical facilities), normative (eg guidelines on differential health care entitlements); ideational (eg the imagery of a 'national' health service); and social (eg patterns of service use in border towns). The state is both a product and an agent of health bordering. It is not the only actor, however. Whether their mobility is encouraged, permitted, or subject to sanction, 'health tourists', refugees, and health care professionals, as well as their associations and regulators, also contribute to bordering.

*Borders are plural, overlapping, and superimposed.* The modern ideal of fully aligned political, legal, and social frontiers was never realized in practice. This is obviously true within federal systems and also as regards the many cultural and religious groupings, such as Muslims and Roman Catholics, defined in transnational terms. Plural bordering is evident in the UK as a result of the uneven and idiosyncratic nature of the devolution settlement. Some limits are functional. For example, conditions in Welsh prisons are the responsibility of the Home Office, but their medical care falls to the Welsh Government. This 'jagged edge' is due to the fact that health is devolved to Wales, while criminal justice is not.[19] Some are the result of the uneven alignment of regulatory systems, eg the High Court of England and Wales, the General Medical Council (cross-UK), NHS Wales, and the Human Tissue Authority (England, Wales, and Northern Ireland).

*Temporality is an essential, if neglected dimension of bordering.*[20] On the modern view, state borders define the territory of a unified national community, moving through time according to a singular history.[21] Origin stories of Britain's National Health Service in the shared sacrifice of war partake of this narrative form.[22] Again, however, this needs to be qualified in light of contemporary practice and post-modern theoretical perspectives. Thus, devolution both presumes and adds impetus to the sense of four distinct historic 'nations' within the UK each with a distinctive trajectory into the future. More mundanely temporal pluralization, through different hospital waiting times, eg can serve to 'thicken' territorial borders between them.[23] *Bordering takes place in a variety of locations.* Most notably, immigration control now

[14] É Balibar, 'The Borders of Europe' in É Balibar, *Politics and the Other Scene* (Verso 2001) 87.
[15] This specific understanding of the 'post-modern' is set out in P Anderson, *The Origins of Postmodernity* (Verso 1998).
[16] N Yuval Davis, G Wemyss and K Cassidy, *Bordering* (Polity 2019) 18.
[17] É Balibar, 'What is a Border?' in É Balibar, *Politics and the Other Scene* (Verso 2001) 75.
[18] For a historical view in the British context, see R Bivins, *Contagious Communities. Medicine, Migration and the NHS in Post-War Britain* (OUP 2015).
[19] R Jones and R Wyn Jones, *The Welsh Criminal Justice System. On the Jagged Edge* (University of Wales Press 2022).
[20] For an exploration of spatio-temporal interaction in the context of global infectious disease control, see J Harrington, '"We Can't Wait for the Bugs to Spread". Time, Space and Biosecurity in Global Health Law' (2018) 9 Transnational Legal Theory 85.
[21] B Anderson, *Imagined Communities. Reflections on the Origins and Spread of Nationalism* (Verso 1991).
[22] R Bivins, 'Serving the Nation, Serving the People: Echoes of War in the Early NHS' (2020) 46 Medical Humanities 154.
[23] S Mezzadra and B Neilson, *Border as Method, or the Multiplication of Labor* (Duke University Press 2013).

happens well beyond the traditional 'edge', at sites either wholly outside the national territory (eg through the off-shore processing of migrants, including health checks), or deep within it (eg through eligibility checks for accessing health care).[24] These locations can be termed *borderscapes*, drawing on Yuval Davis, Wemyss, and Cassidy.[25]

The following discussion of health law under devolution is organized with reference to three forms of bordering. *Boundaries* are the linear divisions that run between states, and between sub-state territories within them, ie the 'edges' discussed above. Externally, these sharp lines are the idealized markers of power over space and peoples.[26] Internally, they demarcate federal (or devolved) regions, while encompassing them within a greater whole. Increasingly, as we noted, they are found (or performed) at locations well beyond the geographical limits of the state. *Borderlands* are more extensive spaces on both sides of a boundary in which the lives of the local population are shaped by the interaction of dual bordering regimes.[27] The term captures the paradox that while borders divide regions, they simultaneously enable new patterns of exchange and mobility as between them (eg accessing health care). Borderlands may be more or less closely integrated across the boundary and their character can change over time, as boundaries harden or become more porous.[28] *Frontiers* are still less sharply defined.[29] In early colonial contexts they denote both the zone of indistinction between the possessions of imperial powers and the moving limit of external domination over indigenous peoples. In that sense, the frontier is a dynamic notion, suggesting territorial expansion driven by a vanguard of pioneers or settlers.[30] For each of the case studies discussed in the rest of this article, we consider: (i) the specific health law developments and controversies on which they are focused; (ii) the borderscapes in which they take place; (iii) their temporal dimension; (iv) the idioms and metaphors through which they are articulated; (v) the forms of bordering which they realize, and resistances to this.

## III. 'WE'RE CLOSED': COVID-19, BORDERLANDS, AND BOUNDARIES

The four nations of the UK took a harmonized approach to COVID-19 at the start of the pandemic in February and March 2020. All heads of government were included in meetings of the Civil Contingencies Committee (COBRA). Each agreed to collaborate in meeting the challenges posed by the oncoming pandemic. This cooperative and inclusive posture was evidenced by the terms of the Coronavirus Act 2020 passed by the UK Parliament, with a UK-wide lockdown declared on 23 March.[31] The 2020 Act conceded substantial power to the devolved governments as regards the passage and implementation of disease control measures, consistent with their broader competence in the area of health. It was accordingly approved by legislatures in Belfast, Cardiff, and Edinburgh. In contrast, the Civil Contingencies Act 2004 allowing for the declaration of a state of emergency, was not used. That Act would have largely centralized power in Westminster, permitting a more thoroughly UK-wide approach, but the future course and duration of the pandemic was thought to be too uncertain to justify its use.

[24] E Willmington, *Production of Ignorance and Co-Production of Resistance: Britain's Hostile Environment* (PhD thesis, Cardiff University 2022).
[25] N Yuval Davis, G Wemyss and K Cassidy, *Bordering* (Polity 2019) 18.
[26] Mezzadra and Neilson (n 23) 8.
[27] N Yuval Davis, G Wemyss and K Cassidy, *Bordering* (Polity 2019) 24.
[28] F Baud and W Van Schendel, 'Toward a Comparative History of Borderlands' (1997) 8 Journal of World History 211, 223.
[29] P Cuttitta, 'Points and Lines: A Topography of Borders in the Global Space' (2006) 6 Ephemera 27, 28.
[30] H Donnan and TM Wilson, *Borders: Frontiers of Identity, Nation and State* (Berg 1999) 49.
[31] G Evans, 'Devolution and Covid-19: Towards a "New Normal" in the Territorial Constitution? [2021] 1 Public Law 19.

While the harmonious implementation of lockdowns endured until early summer 2020, there were already signs of tension in the interim.[32] Welsh efforts to procure sufficient testing kits were allegedly pre-empted by Public Health England, while the UK government opened a major testing centre in Cardiff without notifying the Welsh authorities or ensuring that it could be integrated with NHS systems in Wales.[33] Lockdown rules diverged from 11 May, with the UK government lifting many restrictions on gatherings and travel in England, while the devolved administrations proceeded more slowly. For First Minister Mark Drakeford this caution was also justified by Wales's distinctive public health profile, with 15% of the population over 70, 25% living in poverty, and the highest prevalence of asthma in Europe.[34] Autumn saw further divergence. Rising case numbers led to Wales introducing a 'firebreaker' lockdown in September 2020, while English rules remained relatively relaxed. The situation was reversed in November month as the UK government adapted to new waves of infection in England, while Wales opened up.

The Drakeford administration's more restrictive measures achieved some success and were notably popular across Wales.[35] This was not the case, however, in the immediate borderlands with England. With over 138 million crossings annually, 90% of the Welsh population and 30% of the combined English and Welsh population live within 50 miles of the border.[36] The latter had figured in the public mind to then in largely historic and cultural terms, ie Offa's Dyke, a 1,200 year-old earthwork, built the length of Wales to secure Saxon kingdoms to the east, or the six nations rugby competition. During the pandemic this boundary was effectively hardened as a result of the temporal variability of lockdown measures adopted by Cardiff and Westminster respectively. Divergence was made visible through official signage that 'Welsh COVID-Rules Apply' and advising motorists to turn back, and graffiti stating 'We're Closed' sprayed across 'Welcome to Wales' signs.[37] Settlements such as Llanymynech, which straddles Powys and Shropshire, saw pubs and shops closed in one half, while open in the other, with the reverse applying as rules changed.[38] Chester City Football Club, though playing in the English league, were for a period unable to access their ground which lies just over the border.[39] Similarly, residents on the Welsh side were unable to take up priority delivery slots from supermarkets located in England, as the relevant arrangement was with the UK government only.[40] The sense of spatio-political disorientation produced by these health law bordering processes was articulated by one resident: 'From my point of view I thought we were the United Kingdom, and it seems very bizarre that we can end up in a situation more than once this year where we've got two totally separate sets of rules and having the border run right through the middle of place is just weird'.[41]

[32] J Sargeant, *Co-ordination and Divergence Devolution and Coronavirus* (Institute for Government 2020).
[33] W Hayward, *Lockdown Wales: How Covid-19 Tested Wales* (Seren 2000) 72, 55.
[34] ibid 75.
[35] Estimates suggest that 57% of the Welsh population—were affected by COVID-19 compared to 71% in England, with excess deaths 20% lower: BBC News, 'Covid: Wales' restrictions led to fewer infections than England' (7 October 2022) <https://www.bbc.co.uk/news/uk-wales-63170249> accessed 23 January 2024. See also S Morris, 'Mark Drakeford: A Steady Operator Thrust into the Spotlight by Covid' *The Guardian* (London, 13 December 2023) 4.
[36] House of Commons Welsh Affairs Committee (2013) *Crossing the Border: Road and Rail Links between England and Wales*. Third Report of Session 2012–13, 5.
[37] J Rogers, 'For the first time, Wales has been able to flex its muscles'—could coronavirus tear England and Wales apart?' *The Guardian* (London, 17 June 2020) 3.
[38] M Hughes and S Burkitt, 'Life on the border of Wales and England where two different lockdowns are separated by just a few steps' *Wales Online* (8 November 2020) <https://www.walesonline.co.uk/news/wales-news/lockdown-england-wales-firebreak-chepstow-19236756> accessed 23 January 2024.
[39] BBC News, 'Covid: Chester could move Game amid England-Wales Row' (6 April 2022) <https://www.bbc.co.uk/news/uk-wales-59930918> accessed 23 January 2024.
[40] W Hayward, *Lockdown Wales: How Covid-19 Tested Wales* (Seren 2000) 75, 50.
[41] BBC News, 'Lockdown: What does it mean for People on the Border?' (5 November 2020) <https://www.bbc.co.uk/news/uk-wales-54811936> accessed 23 January 2024.

Health law bordering and re-bordering during the pandemic also registered at intergovernmental level within the UK, particularly after the initial period of harmonious working. As has been confirmed by evidence to the UK Covid-19 Inquiry, ongoing at the time of writing, after announcement of the first lockdown Westminster reduced the level and frequency of communication with counterparts in Belfast, Cardiff, and Edinburgh.[42] Requests that residents of highly infected English regions be dissuaded from travelling to locally locked down areas of Wales were ignored, for example, with Cardiff's health minister having to impose formal restrictions on entry.[43] Downing Street briefings incorrectly implied that England-only restrictions were applicable across all four nations with UK Prime Minister and other speakers flanked by the union flag and making frequent undifferentiated reference to 'our nation'.[44] The 'jagged edge' produced by the uneven devolution of powers was evident in the Treasury's refusal to extend the furlough programme to Wales at a time when it, but not England was under lockdown. The availability of payments to employees unable to access their workplaces was thus predicated only on decisions taken for England alone. Equally the terms of the Coronavirus Act 2020 allowed the devolved administrations to impose quarantine on entrants from outside the UK, even though Westminster had opted for no restrictions. Vaccine development and procurement was led from London, while vaccine roll-out (notably successful in Wales) was organized at devolved level.[45] The public health, fiscal, and international borders of the UK and its nations were thus plurally produced, out of alignment, and often tension with each other. In this regard former Prime Minister Boris Johnson and Health Secretary Matt Hancock have confirmed their regret at the concession of pandemic response powers to the devolved nations.[46] Informed observers have gone further, seeing in their government's persistently 'abrasive' approach an example of the 'hypercentralization' and the blurring of English and British frames of reference which has marked state practice and constitutional orthodoxy since the 19th century.[47] Westminster's 'muscular unionism' was consistent with its more general stance in the aftermath of the UK's departure from the European Union, as evident in the Internal Market Act 2020. This concentrates regulatory power at the expense of both supra- and sub-state levels, strengthening the external boundary, while blurring those within.[48] From the perspective of Cardiff, at its outset Covid-19 presented an opportunity to acknowledge the re-territorialization of legislative and executive powers, while pragmatically co-operating on policy design and implementation.[49] Ultimately, however, it proved to be a further attempt by means of health law to push back the frontier of devolution in favour of a unified, spatio-temporal frame for pan-British government and governance.

[42] Hayward (n 40) 62.

[43] J Searle, 'Coronavirus: FM, Drakeford's Full Letter to Boris Johnson' *South Wales Argus* (13 October 2020) <https://www.southwalesargus.co.uk/news/18791211.coronavirus-fm-drakefords-full-letter-boris-johnson/> accessed 23 January 2024.

[44] For a contemporaneous overview of the issues discussed here, see R Shrimsley and others, 'Will Coronavirus Break the UK?' *Financial Times* (London, 21 October 2020) 8.

[45] ITV News, 'Wales, Covid-19 Vaccine Rollout "One of the Best in the World" - But How has it Got there?' (8 June 2021) <https://www.itv.com/news/wales/2021-06-08/wales-covid-19-vaccine-rollout-one-of-the-best-in-the-world-but-how-has-it-got-there> accessed 23 January 2024.

[46] See C Mason, 'Contrite, Shorn of Theatrics - Johnson's First Day at Inquiry' *BBC News* (6 December 2023) <https://www.bbc.co.uk/news/uk-politics-67643903> (accessed 23 January 2024); A Browne, 'Covid Inquiry: Wales Powers Illogical says Matt Hancock' *BBC News* (1 December 2023) <https://www.bbc.co.uk/news/uk-wales-politics-67566139> accessed 23 January 2024.

[47] D Wincott, 'The Anglo-British State, Welsh Devolution and the Covid-19 Pandemic in England and Wales: Territorial Riddles, Mysterious Boundaries, and Enigmatic Identities' in V Molinari and P-A Beylier (eds), *Covid-19 in Europe and North America: Policy Responses and Multi-Level Governance* (De Gruyter Oldenbourg 2022) 211, 212.

[48] J George, 'Devolution: Why was the UK Internal Market Act 2020 So Controversial?' *Constitutional Law Matters* (10 May 2022) <https://constitutionallawmatters.org/2022/05/devolution-why-was-the-uk-internal-market-act-2020-so-controversial/> accessed 23 January 2024.

[49] G Evans, 'Devolution and Covid-19: Towards a "New Normal" in the Territorial Constitution?' [2021] PL 19.

## IV. 'OUR NHS': CROSSING THE BORDER FOR TREATMENT

Rules on access to health care and controversies around them have also contributed to production of the border between Wales and England. Indeed, they have served to create a discrete health law borderland marked by shared, but also conflicting interests on the part of funders, providers, and patients. The organization of the NHS has diverged considerably since devolution in 1998. England retained and intensified reforms to introduce market and market-like practices to the NHS. The Health and Social Care Act 2012 led to the establishment of over 200 Care Commissioning Groups (CCGs) purchasing care from Hospital Trusts with payment by results, subject to fixed tariffs.[50] Under the NHS England Constitution, patients were accorded the right to choose their secondary care provider, and there was a strong focus on reducing hospital waiting times. By contrast, Wales abolished the internal market in NHS care and returned to an integrated and planned approach to provision at all levels, led by seven Local Health Boards (LHBs). Hospital funding is by way of block grants based on historic usage. With the prioritization of population health in the first five years of devolution, waiting times lengthened relative to those in England. Patient voice in the health planning process through Community Health Councils, was preferred to individual rights.

Patient mobility for treatment is particularly significant given that 90% of the Welsh population lives within 50 miles of the Wales–England border, while 30% of the combined English and Welsh population live within 50 miles of the border.[51] The distribution of settlements means that approximately 21,000 English patients are registered with Welsh GPs, while approximately 15,000 Welsh patients are registered with English GPs.[52] On the other hand, the relative scarcity of secondary and tertiary facilities in mid and north east Wales means that, in 2014–15 for example, over 56,000 Welsh residents were admitted to an NHS England hospital, in contrast to less than 11,000 English patients being admitted to an NHS Wales hospital.[53]

The costs of providing primary care across the border lie where they fall, being dealt with via a 'knock for knock' arrangement which is understood to balance out sufficiently while avoiding costly recovery systems. Secondary care arrangements are more complex, generating considerable friction which a series of protocols developed jointly by the UK Department of Health, NHS England and the Welsh Government have sought to address. The most recent, a Statement of Values and Principles, looks to retain (some) common guarantees and establish a framework to manage mobility, while acknowledging the legitimacy of policy divergence. Thus, the Statement partially erases the Wales–England boundary, preserving a minimum common core of entitlements to secondary care, in so far as it commits both sets of authorities to promoting 'the best interests of all patients' and to ensuring that 'emergency care will be available for all patients without regard to the border', as well as guaranteeing that treatment will not be delayed owing to uncertainty over which body is responsible for funding.[54]

[50] The changes set out here are discussed further in SL Greer and D Rowland, *Devolving Policy, Diverging Values? The Values of the United Kingdom's National Health Services* (Nuffield Trust 2007).

[51] House of Commons Welsh Affairs Committee, *Crossing the Border: Road and Rail Links between England and Wales.* Third Report of Session 2012–13, para 5.

[52] NHS England and NHS Wales, *England/Wales Cross-Border Healthcare Services: Statement of Values and Principles* (2018) <https://www.england.nhs.uk/wp-content/uploads/2018/11/cross-border-statement-of-values-and-principles.pdf> accessed 23 January 2024.

[53] P Watkins, *Research Briefing: Cross-Border Healthcare* (National Assembly for Wales Research Service 2016) <https://senedd.wales/media/w1bmfctk/rs16-029-eng.pdf> accessed 23 January 2024.

[54] NHS England and NHS Wales, *England/Wales Cross-Border Healthcare Services: Statement of Values and Principles* (2018) <https://www.england.nhs.uk/wp-content/uploads/2018/11/cross-border-statement-of-values-and-principles.pdf> accessed 23 January 2024.

As regards responsibility for commissioning, planning, and funding other types of secondary treatment, the Statement distinguishes border from non-border patients. The former are defined as those resident in a series of listed Welsh counties and English CCG areas; the latter live further afield. For border-patients residing in Wales, but registered with a GP in England, the CCG which covers their GP practice will commission and fund health services, but legal responsibility remains with their Local Health Board (LHB). For border-patients residing in England, but registered with a GP in Wales, the reverse applies, with the relevant LHB commissioning and funding health services, while legal responsibility remains with their CCG. Controversy arose in the latter type of case when LHBs refused to fund treatment in English hospitals when it was available in Wales. *Action4OurCare*, a group of Gloucestershire residents registered with Welsh GPs, argued that this infringed their rights as specifically English patients to choose providers and left them subject to Wales's longer standard waiting times. Cross-border protocols could not overwrite the NHS England Constitution, they argued. Drafted in response to a report of the House of Commons Welsh Affairs Committee (2015) on cross-border health arrangements, the Statement of Values and Principles now confirms that 'English and Welsh residents are legally entitled to be treated in accordance with the rights of their country of residence' regardless of where they are registered.[55] In this case, as Mezzadra and Neilson argue, the 'care migrant' from England to Wales and back again brings the border with them.[56]

The dispute over the rights of English patients resulted from the concern of LHBs to conserve resources within their own regions and within Wales as far as possible. In the converse case, this has been the impetus for attempts to subject Welsh-resident patients receiving secondary care in English hospitals to (longer) Welsh waiting times. Objections to this division, based on the temporality of the waiting list and performed within the borderscape of the clinic itself, have been raised by the relevant Hospital Trusts, for administrative reasons. The BMA joined in the criticism, invoking a borderless universal ethic for medicine with their assertion that doctors are unwilling to differentiate between patients purely on the basis of their geographic origin.[57] The unwillingness of Welsh LHBs to pay according to English tariffs has led to North Bristol NHS Trust and the Countess of Chester NHS Hospital Trust respectively refusing for periods to accept referrals from Wales.[58] Orderly settlement of these disputes is encouraged by the Statement, which provides moreover that Welsh and English authorities will pay attention to the overspill consequences of their funding and planning decisions for the functioning of each other's health services, as well as a commitment at government-level that no CCG or LHB should suffer financial shortfall as a result of providing cross-border care.[59]

Away from the borderland produced by the Statement and more detailed administrative provisions, responsibility for commissioning and paying for primary and secondary care for non-border patients remains with the LHB or CCG where the individual defines their usual place of residence.[60] Again however, variable standards on waiting times and financial

[55] NHS England and NHS Wales, *England/Wales Cross-Border Healthcare Services: Statement of Values and Principles* (2018) <https://www.england.nhs.uk/wp-content/uploads/2018/11/cross-border-statement-of-values-and-principles.pdf> accessed 23 January 2024.

[56] S Mezzadra and B Neilson, *Border as Method, or the Multiplication of Labor* (Duke University Press 2013) 76.

[57] House of Commons Welsh Affairs Committee, *Cross-Border Health Arrangements between England and Wales.* Third Report of Session 2014–15, 95.

[58] House of Commons Welsh Affairs Committee, *Cross-Border Health Arrangements between England and Wales.* Third Report of Session 2014–15, para 40.

[59] NHS England and NHS Wales, *England/Wales Cross-Border Healthcare Services: Statement of Values and Principles* (2018) <https://www.england.nhs.uk/wp-content/uploads/2018/11/cross-border-statement-of-values-and-principles.pdf> accessed 23 January 2024.

[60] NHS England and NHS Wales, *England/Wales Cross-Border Healthcare Services: Statement of Values and Principles* (2018) <https://www.england.nhs.uk/wp-content/uploads/2018/11/cross-border-statement-of-values-and-principles.pdf> accessed 23 January 2024.

planning, both produce the Wales–England border and incite patients to try to cross it. This was dramatically highlighted by case of Mariana Robinson who was seeking treatment for a life-threatening pancreatic condition.[61] Required to seek authorization, her request to the Aneurin Bevan LHB to fund treatment in Bristol was turned down, and she was placed on the Welsh waiting list. Classified as needing a 'routine procedure', Ms Robinson could not invoke the special scheme for accessing novel therapies or those directed at rare conditions. Her very difficult case became the focus for partisan debate in the House of Commons, featuring in Prime Minister's Question Time where David Cameron agreed that she was 'a victim of the Labour-run NHS in Wales' and that Offa's Dyke, had 'become the line between life and death'.[62] This echoed a long running trend of Conservative representatives, at Westminster and in the Senedd, using statistics on the performance of the health service in Wales to attack Labour opponents. This view is amplified in much of the London-based media, with the *Daily Mail* predicting forced migration by 'NHS refugees' and a 'mass exodus' of Welsh patients to England'.[63] In an echo of cold war idioms, a socialist government in Cardiff tries to close the border, but they are betrayed Welsh patients seeking better care in England and their rights as UK citizens paying the same taxes. Reference to Labour's neglect of 'our NHS in Wales',[64] suggests an endowment from the central British state being squandered by the devolved administration.

## V. 'HOSTILE ENVIRONMENT/NATION OF SANCTUARY': IMMIGRATION AND ACCESS TO CARE

Immigration remains reserved to Westminster as regards all three devolved administrations. Indeed, the power to police border-crossing by migrants is a definitive marker of traditional sovereignty. However, its interaction with the exercise of non-reserved competences in health by Cardiff, Edinburgh and Belfast has led to more complex and contested bordering processes.[65] Immigration has been the focus for conspicuous and repeated activity by UK governments over the past 25 years. Most recently, the Nationality and Borders Act 2022 sought to extend the offshore processing of asylum seekers and the deportation of 'failed' applicants to third countries, such as Rwanda,[66] while the Illegal Migration Act 2023 allows detention and removal of anyone entering the UK by 'illegal means' regardless of the strength of their asylum claim. These interventions, at and beyond the outer boundary of the UK, have been complemented by internally-facing measures designed to create 'a really hostile environment for illegal migration', to quote then Home Secretary Theresa May in a 2012 interview.[67] Thus, the Immigration Acts 2014 and 2016 place duties on landlords, schools, universities, vehicle licensing agencies, businesses and others to check the

[61] BBC News, 'Welsh Patient Mariana Robinson wants NHS Treatment in England' (14 March 2014) <https://www.bbc.co.uk/news/uk-wales-south-east-wales-26541331> accessed 23 January 2024.

[62] ibid.

[63] See eg D Martin, 'Welsh "NHS Refugee" Begs to be Treated in England: Artist with Life Threatening Pancreatic Condition Pays for Private Doctor in Bristol after Months Waiting for Biopsy' *Daily Mail* (London, 2 April 2014) 8; J Chapman, S Marsden and I Bains, 'Welsh Patients in Mass Exodus to England: As Labour Blocks International Inquiry into Crisis-Hit Welsh NHS, Thousands Cross-Border for Life-Saving treatment' *Daily Mail* (London, 20 October 2014) 11.

[64] BBC News, 'Welsh Patient Mariana Robinson wants NHS Treatment in England' (14 March 2014) <https://www.bbc.co.uk/news/uk-wales-south-east-wales-26541331> accessed 23 January 2024.

[65] S Moran, 'A Nation of Sanctuary: Wales and Afghanistan' *Senedd Research* (Cardiff 8 September 2021) <https://research.senedd.wales/research-articles/a-nation-of-sanctuary-wales-and-afghanistan/> accessed 23 January 2024.

[66] In November 2023 the Supreme Court held that implementation of this scheme contravened the international law principle of non-refoulement: *R (on the application of AAA (Syria) and others) v Secretary of State for the Home Department* [2023] UKSC 42. At the time of writing revised legislation to implement the plan was being considered by the UK parliament.

[67] See J Kirkup and R Winnett, 'Theresa May Interview: "We're Going to Give Illegal Migrants a Really Hostile Reception"' *Daily Telegraph* (London, 25 May 2012) 15.

immigration status of those with whom they engage as service providers, employers and so on.[68] Non-fulfilment of these duties is subject to criminal penalties, including imprisonment.

The NHS has also been enrolled in the production of the 'hostile environment', with hospitals, clinics and administrative facilities functioning as borderscapes for immigration control. While primary care is available to all regardless of immigration status, free access to secondary care is based on 'ordinary residence'.[69] In this regard the charging of non-UK resident patients has been permitted since 1963, but the regime in England has been intensified considerably by the Immigration Act 2014 and subsequent regulations.[70] Cabinet members at the time re-iterated the complaint that rules on access to the NHS acted as 'a draw to health tourists', making of it 'an international, rather than a national service'.[71] The result is a tiered system of access to care in the English NHS, ranging from the lawfully resident, including refugees and asylum seekers whose claims are still being processed, as well as Irish citizens and migrants from mainland Europe with 'settled status' and, therefore, rights under the Agreement on the withdrawal of the UK from the EU (no charge), to other visitors to the UK (a greater charge), and asylum seekers whose claims have been rejected (up-front charge at 150% of costs).[72] Some exceptions are made to the latter in the case of infectious and sexually transmitted diseases, mental health and maternity care, and the effects of human trafficking and domestic violence. Nonetheless, as public health experts and campaigners have argued, charging contradicts the founding values of the NHS and has negative consequences on the health of affected individuals and the wider community.[73] Concern was increased by a 2017 Memorandum of Understanding between the Home Office, NHS England and the Department of Health requiring English Trusts to share data concerning the immigration status of patients, until an outcry from health care professionals led to its withdrawal in 2019.[74]

Much of the charging regime set out above for England also applies in Wales, with visitors subject to levies prior to accessing secondary care depending on their origin. However, the Welsh rules for unsuccessful asylum seekers are different: any individual who has made a formal application for asylum is entitled to access free secondary care regardless of the outcome.[75] Moreover, NHS Wales routinely refuses to share patient details with the Home Office for immigration purposes.[76] These steps are complemented by a duty on Welsh local authorities to include all asylum seekers in needs assessments,[77] by research funded by Public Health Wales on the experiences of refugees and asylum seekers in accessing health care, and, more generally, by a mandate for systematic consideration of the distinct health

[68] N Yuval Davis, G Wemyss and K Cassidy, *Bordering* (Polity 2019) 102ff.

[69] JV Mc Hale and EM Speakman, 'Charging "Overseas Visitors" for NHS Treatment, from Bevan to Windrush and Beyond' (2020) 40 Legal Studies 565, 573.

[70] NHS (Charges to Overseas Visitors) (Amendment) Regulations 2017.

[71] Theresa May MP, then Home Secretary, and Jeremy Hunt MP, then Health Secretary, in 2013, quoted in A Shahvisi, 'Austerity or Xenophobia? The Causes and Costs of the "Hostile Environment" in the NHS' (2019) 27 Health Care Analysis 202, 205.

[72] Department of Health and Social Care, *Healthcare for EU Citizens Living in or Moving to the UK* (22 February 2024) <Healthcare for EU citizens living in or moving to the UK - GOV.UK (www.gov.uk)> accessed 24 February 2024; A Shahvisi, 'Austerity or Xenophobia? The Causes and Costs of the "Hostile Environment" in the NHS' (2019) 27 Health Care Analysis 202.

[73] H Burn, 'Returning our Ebola Medals: Our Opposition to the Hostile Environment within the NHS' (2018) 68 British Journal of General Practice 580; SJ Weller and LJ Crosby, 'The Negative Health Effects of Hostile Environment Policies on Migrants: A Cross-Sectional Service Evaluation of Humanitarian Healthcare Provision in the UK' (2019) 4 Wellcome Open Research 1.

[74] I Bertolini, 'By What Means are Medical Professionals able to Reject Hostile Environment Policy within the NHS' (2021) 86B Studies in Law, Politics, and Society 23.

[75] National Health Service (Charges to Overseas Visitors) (Amendment) (Wales) Regulations (2020).

[76] C Wyn Edwards and V Wisthaler, 'The Power of Symbolic Sanctuary: Insights from Wales on the Limitations and Potential of a Regional Approach to Sanctuary' (2023) 49 Journal of Ethnic and Migration Studies 3602.

[77] Welsh Government, *Nation of Sanctuary. Refugee and Asylum Seeker Plan* (Cardiff 2019); Social Services and Well-Being (Wales) Act 2014, s 19.

challenges faced by this group across health care and health promotion systems.[78] Each measure has been adopted explicitly in order to 'welcome' migrants to Wales pursuant to its declared status as the world's first 'Nation of Sanctuary'.[79] The intended effect of Welsh measures is to puncture the hard border favoured by Westminster.[80] While the 'hostile environment' makes access to free health care dependent on the temporality of the asylum claim, the 'nation of sanctuary' predicates it solely on clinical need. While the former operates in the borderscape of the clinic and the hospital, the latter looks to uncouple medical work from immigration control. We might label this situation one of 'antagonistic bordering'. Though critics have pointed to the symbolic and 'nation-building' aspects of Welsh initiatives, a more comprehensive view would accept the real-world effect of the symbolic in shaping everyday bordering practices.[81] It would also recognize the serially performative and equally 'nation-building' nature of the UK government's immigration policies, from signs in waiting rooms saying 'NHS hospital treatment is not free for everyone' to the notorious van urging migrants to 'go home or face arrest' in 2013.[82]

## VI. 'NOT A DEVOLVED ISSUE': ABORTION AND THE NON-BOUNDARY

Abortion care has been a focus for bordering within the UK since the exclusion of Northern Ireland from the provisions of the Abortion Act 1967. Devolution in 1998 has seen access impacted by processes of re-bordering, but also de-bordering due to changes in the legal regimes within and as between the four nations. Thus, until recently Northern Ireland retained a highly restrictive approach, with termination of pregnancy lawful only where the grounds in *R v Bourne*[83] were made out.[84] Repeated efforts by pro-choice campaigners and sympathetic MPs at Westminster to override this regime and remove the 'border in the Irish Sea' were thwarted until 2019, when the collapse of power-sharing in Belfast provided an opening for change. This took the radical form of partial decriminalization, rather than the creation of exceptions to criminal liability, which is the case under the 1967 Act.[85] As a result, the grounds for lawful abortion in Northern Ireland now match and are in some cases more generous than those in Great Britain.[86] In contrast abortion was a reserved matter, explicitly under the Scotland Act 1998 and implicitly under the Government of Wales Act 1998. Since then power to legislate in relation to abortion was devolved under section 53 of the Scotland Act 2016, with the result that Cardiff is now the only administration without this competence.

[78] See further A Khanom, W Alanazy and L Couzen, 'Asylum Seekers' and Refugees' Experiences of Accessing Health Care: A Qualitative Study' (2021) *BJGP Open* <Asylum seekers' and refugees' experiences of accessing health care: a qualitative study | BJGP Open> accessed 24 January 2024.

[79] Welsh Government, *Nation of Sanctuary. Refugee and Asylum Seeker Plan* (Cardiff 2019).

[80] F Bernhardt, 'Othering the Sovereign Host: Welsh Responses to the British Politics of Asylum and Resettlement after the 2015 European Refugee "crisis"' (2019) 12 Hospitality and Society 223.

[81] C Wyn Edwards and V Wisthaler, 'The Power of Symbolic Sanctuary: Insights from Wales on the Limitations and Potential of a Regional Approach to Sanctuary' (2023) 49 Journal of Ethnic and Migration Studies 3602, 3606. For an important review of the gap between aspiration and achievement in a related field, see A Tarrant, 'Devolution and the Difficulty of Divergence: The Development of Adult Social Care Policy in Wales' (2023) 43 Critical Social Policy 676.

[82] H Jones and others, *Go Home. The Politics of Immigration Controversies* (Manchester University Press 2017) 44, 2.

[83] [1939] 1 KB 687 (MacNaghten J). *Bourne* held that termination was permissible under the Offences Against the Person Act 1861 where it was necessary to preserve the life of the woman.

[84] M Fox and S McGuinness, 'In the Matter of an Application for Judicial Review by the Northern Ireland Human Rights Commission (2015)' in E Rackley and R Auchmuty (eds), *Women's Legal Landmarks: Celebrating the History of Women and Law in the UK and Ireland* (Hart Publishing 2018) 619.

[85] S Sheldon and others, *The Abortion Act 1967. A Biography of a UK Law* (CUP 2022) c.5.

[86] J Parsons and EC Romanis, *Early Medical Abortion, Equality of Access, and the Telemedical Imperative* (OUP 2021) 23.

Devolution of power over abortion to Scotland was debated in largely constitutional terms at Westminster.[87] Scottish National Party (SNP) MPs argued that its exclusion from devolved health powers in 1998 was merely anomalous. Surprisingly a number of Conservatives, normally pro-union, agreed, though this was traced to a hope that the influence of the Catholic church in Scotland would lead to a more restrictive approach to termination.[88] Against both, Labour posed its objections in terms of individual rights threatened by health law bordering within Great Britain. Yvette Cooper MP feared 'a fragmentation of important healthcare rights, which won't be good for women in Scotland or England and Wales', with individuals being forced to engage in cross-border travel for care at 'a vulnerable time'.[89] This was met with SNP reassurances that Scotland would favour choice which have proven true to date.[90]

Unlike Northern Ireland and Scotland, abortion has not been a matter of controversy in Wales. This is so, even though Cardiff has been active since 1998 in securing a shift from executive to full legislative competence, and from a conferred to a reserved powers model. It also runs counter to the Welsh Government's activism on other health issues such as organ donation and alcohol pricing. Thus, no mention of abortion was made in party political submissions to the Silk Commission, whose report underpinned the Wales Act 2017 including the reservation of this power to Westminster. Indeed, the question has been discussed only once in the National Assembly for Wales (now Senedd), in 2012. On that occasion, Plaid Cymru raised the possibility of ending the exclusion, but only in the event that Westminster itself sought to reduce the time-limits for access to termination, and not on constitutional grounds. In response, Labour's Health Minister affirmed that abortion 'is not a devolved issue' and that the 1967 Act as passed 'has worked'.[91]

Welsh lawmakers have, thus, framed the devolution of abortion as a matter of women's rights rather than constitutional ordering. In doing so they have endorsed a 'non-boundary' around Wales, as regards the application of the 1967 Act. A more general 'anti-bordering' stance was also evident in Cardiff's decision, like that of Westminster and Edinburgh, to fund terminations for women travelling from Northern Ireland prior to the reforms of 2019. This approach, taken by a normally assertive devolved administration, runs counter to the widely observed tendency to build nations through the territorialized control of human reproduction.[92] In contrast, in so far as we can speak of a 'moral geography' of Welshness, it tends in this context, as in that of immigration, more toward a placeless universalism, than the 'gendered production of state borders'.[93]

However, the line between Wales and the rest of the UK is not the only significant borderscape in this context. Looking away from formal criteria of lawfulness, the operation of the Abortion Act 1967 by medical professionals functions to produce spatio-temporal borders conditioning access to termination *within* Wales. Waiting times for consultations vary as between regions.[94] Moreover, an official review found that in practice Local Health Boards operated varied gestation time limits for provision of both medical and surgical terminations.[95] The inequity of this 'post-code lottery' was compounded by the fact that obstetrics and gynaecology departments in Wales will only manage abortions under clauses A, B, and

[87] DS Moon, J Thompson and S Whiting, 'Lost in the Process? The Impact of Devolution on Abortion Law in the United Kingdom' (2019) 21 British Journal of Politics and International Relations 728.
[88] J Thomson, 'Abortion Law and Scotland: An Issue of What?' (2017) 89 Political Quarterly 100.
[89] Y Cooper, 'This Threat to Abortion Law Must be Fought by MPs of all Hues' *The Guardian* (London, 8 November 2015) 7.
[90] Thomson (n 88) 100.
[91] Jane Hutt AM, National Assembly for Wales, 9 October 2012.
[92] N Yuval-Davis, *Gender and Nation* (Sage 1997).
[93] S Calkin, 'Healthcare not Airfare! Art, Abortion and Political Agency in Ireland' (2019) 26 Gender, Place and Culture 338, 346.
[94] Julie Morgan AM, National Assembly of Wales, 17 April 2018.
[95] Public Health Wales, *A Review of Sexual Health in Wales. Final Report* (NHS Wales 2018) 8.

E of the Guidance[96] up until the late mid-trimester, even though these grounds are not time limited under the 1967 Act. Women not covered by this practice have to travel to England for their treatment, though they are often 'the most vulnerable of all patients'.[97] By presuming a border, but also its crossing, this practice instantiates what Fletcher has called 'peripheral dependency' on abortion care delivered outside the territory.[98]

As originally passed, the Abortion Act 1967 made a borderscape of the clinic itself, as the only lawful site within which terminations could be carried out. However, this discrete spatialization of medico-legal power is threated by developments in early medical abortion procedures, with a twin course of abortifacient pills now *practically* capable of being taken anywhere.[99] The Act states, however, that *legally* all such procedures must be carried out in 'a class of place' approved by the responsible health minister. In 2017, the Scottish Government provided that the second medication, misoprostol, could be taken at home, as long as the first, mifepristone, had been taken at a clinic. The Welsh and Westminster administrations followed suit, with the latter effectively imposing this liberalizing measure on Northern Ireland.[100] Subsequently mobility restrictions during Covid-19 led to the authorization of the home use of mifepristone across all four nations as well.[101] Again however, debordering has its temporal and spatial limits. For one thing, use outside the clinic is only lawful up to 9 weeks and 6 days from the start of gestation. For another, 'home' is defined as the place 'where a pregnant woman has her permanent address or usually resides'.[102] This re-bordering move prejudices women who are unable to reside at their permanent addresses, due to domestic violence, for example.[103] Moreover, since both the home residence and the clinic prescribing the medication must be located 'in Wales', this effectively bars Welsh-residents who cross the border to access care at English clinics from taking the medication.[104]

## VII. 'MWY CARTREFOL/MORE HOMELY': DEMENTIA CARE AND THE LINGUISTIC FRONTIER

Language produces borders. Territory is demarcated culturally by variation in spoken languages and materially by changes in road signage, for example. The difference between official and community languages can also function as a barrier for individuals seeking health and social care. In the UK this is the case as regards English, the dominant language of the state, and minoritized languages, including Welsh, Scottish Gaelic, and Irish. The barrier is particularly prominent in the case of dementia, which is associated with progressive reversion to their first language on the part of bilinguals.[105] Where that language is not spoken by care staff, individuals are faced with growing difficulties in communicating their wishes and needs, in understanding medical advice and in expressing their feelings. Moreover, diagnostic tests and cognitive assessments are less reliable where conducted in another language.[106]

[96] Julie Morgan AM, National Assembly of Wales, 17 April 2018. Grounds A, B, and E correspond to those set out in Abortion Act 1967, ss 1(1)(b),(c) and (d).
[97] Public Health Wales (n 95) 8.
[98] Parsons and Romanis (n 86) 160.
[99] S Calkin, 'Towards a Political Geography of Abortion' (2019) 69 Political Geography 22, 23.
[100] For a detailed review of these developments, see Parsons and Romanis (n 86) 60ff.
[101] The Abortion Act 1967—Approval of a Class of Place for Treatment for the Termination of Pregnancy (Wales) 2020. Originally a temporary measure, this was made permanent in 2022.
[102] ibid, s 1.
[103] Parsons and Romanis (n 86) 39–40.
[104] We are grateful to Jordan Parsons for pointing this out. Equivalent 'national' limits are provided for in England, Scotland, and Northern Ireland.
[105] A McMurtray, E Saito and B Nakamoto, 'Language Preference and Development of Dementia among Bilingual Individuals' (2009) 68 Hawaii Medical Journal 223.
[106] Alzheimer's Society Cymru, *Consultation Response: Together for a Dementia Friendly Wales 2017-22* (2017) 23.

Studies have shown that the absence of linguistic congruity in care situations is associated with a negative effect on well-being.[107] Equally, communication in their first language along with music, storytelling and so on, can revive comforting memories and positive emotions, allowing people with dementia 'access to a homely, safe place in their own biopsychosocial structure'.[108] The difference in this regard, between English, associated with official institutions, and Welsh was pointed-up by the resident of a care home in rural North Wales:

> Ma'n gymuned fwy clôs, efo ni yn y Gymraeg. Dio'm yn 'mhoeni i, de, siaradai i Susnag, de, dwi di bod yn yr armi, neud fy national service, Susnag odd ran fwya ohono nhw, de. Ond da chi'n fwy gartrefol yn yr iaith [gyntaf].
>
> [*It's a closer community, with us in Welsh. It doesn't bother me, you know, I'll speak English, I've been in the Army, done my national service, they were mostly English. But you're more homely in the [first] language*].[109]

Experience in this regard is uneven, to say the least, and replicated in the wider context of primary and secondary care, as well as mental health and paediatrics.[110] There are insufficient numbers of medical and care staff with Welsh language ability and they are unevenly distributed across Wales. As a result, provision through English is often the only option, a tendency that is reinforced by the referral of complex cases to facilities in England, on the one hand, and the reluctance of patients to seek service in Welsh for fear of appearing 'difficult' or due to their vulnerable situation, on the other.[111] The care home and the clinic, thus, function as borderscapes, sites where the language barrier is reproduced, impeding access to care and the promotion of well-being, whether through active discrimination, or, more often, insufficient capacity, unaddressed at organizational level.

Legal and policy steps to dismantle the language barrier in Wales have increased in detail and range, particularly since the advent of devolution. The Welsh Government's strategic framework and action plan for health and social services, entitled *More than Just Words*, aims to transform institutional capacity and operational practices, as well as the individual dispositions of staff. Accordingly: language congruity is identified to be a matter of need not choice; health boards and care providers are required to plan for language needs; visual markers used to identify Welsh speaking staff; language skills acquisition is to be integrated into staff training courses.[112] Most notably, provision is oriented by the concept of the 'Active Offer', according to which service should be provided through Welsh without the patient or resident having to ask for it. This is a priority for children and young people, older people, mental health service users, people with learning disabilities, people living with dementia and people accessing stroke services.[113] These have been reinforced by the Welsh NHS workforce language planning strategy and the Welsh Language Commissioner's inquiry into

[107] CJ Burant and CJ Camp, 'Language Boards: Enabling Direct Care Staff to Speak Foreign Languages' (1996) 16 Clinical Gerontologist 83.
[108] C Martin, *Culturo-Linguistic Congruity in the Residential Care of the Elderly and Cognitively Impaired in North Wales* (MRes Thesis, Bangor University 2021) 76.
[109] ibid 106.
[110] A Misell, *Welsh in the Health Service: The Scope, Nature and Adequacy of Welsh Language Provision in the National Health Service in Wales* (Welsh Consumer Council 2000); I Madoc-Jones, 'Linguistic Sensitivity, Indigenous Peoples and the Mental Health System in Wales' (2004) 13 International Journal of Mental Health Nursing 216.
[111] For evidence, see B Jones and L King, 'Welsh Language Speaker, 82, with Dementia being Moved 130 miles to England' *Daily Mirror* (London, 6 December 2019) 7; Welsh Language Commissioner, *My Language, My Health. Inquiry into the Welsh Language in Primary Care* (Cardiff 2014) 63, 85.
[112] Welsh Government, *More than Just Words. Five Year Plan 2022-27* (Cardiff 2022) 9.
[113] ibid 8.

primary care.[114] Bangor University is being funded to develop standard Welsh language diagnostic assessments and a nationally available set of standard assessments for Welsh speakers with dementia.[115]

More is at stake here than the language barrier to individual care, which is also faced by migrant speakers of other languages after all. Contemporary Welsh commitments in the health and care sectors need to be understood in terms of more generally contested territorialities, themselves the effect of historic bordering strategies. Thus, from 1536 until 1942 the speaking of Welsh in court was prohibited.[116] In the 19th century the school room was similarly produced as an Anglophone space through interventions such as the 1847 Report of the Commissioners of Enquiry into the State of Education in Wales and the use of corporal punishment.[117] The long run consequence has been a decline in the numbers of Welsh speakers, accelerating in the 20th century, with the absolute number falling from 977,000 in 1911 to 562,000 in 2011.[118] This decline is represented cartographically as a shrinking of the area in which Welsh is spoken as a community language, pushing it into heartland areas in the rural north and west of the country.[119] The spatio-temporal ideation of loss and encroachment is nicely achieved in Gillian Clarke's poem 'Border', written in 1989:

> It crumbles
> where the land forgets its name
> and I'm foreign in my own country …
> Fields blur between the scar
> of hedgerow and new road.
> History forgets itself.
> At the garage they're polite.
> 'Sorry love, no Welsh.'[120]

The intervening period has seen the devolved Welsh Government acting to reverse this retreat. In particular, its overarching strategy affirms that 'the NHS, social services and social care is [provided] by nearly 200,000 staff, and in the NHS alone, patients interact with the service 20 million times a year', meaning that 'this sector has the potential to make a valuable contribution to our aim [of increasing opportunities for citizens to speak the language]'.[121] Equally the Welsh Language Commissioner's report on Primary Care, while emphasizing the needs of the individual patient, explicitly emphasizes the broader policy context.[122] Expanding on our previous conclusion, we can say that the clinic and the care home are borderscapes wherein the national linguistic frontier is produced and resisted in the same moment as the individual language barrier.

[114] Health Education and Improvement Wales, *Workforce Planning for the Welsh Language* (Cardiff 2022); Welsh Language Commissioner, *My Language, My Health. Inquiry into the Welsh Language in Primary Care* (Cardiff 2014) 28.
[115] Welsh Government (n 112) 8.
[116] The ban was introduced by the 1536 Act of Union and the Laws in Wales Acts 1535 and 1543, and reversed by the Welsh Courts Act 1942.
[117] GA Williams, *When Was Wales? A History of the Welsh* (Penguin 1985) 208ff.
[118] Welsh Government, *Cymraeg 2050. A Million Speakers* (Cardiff 2017) 20.
[119] Welsh Government, *Welsh Language in Wales (Census 2021)* (Cardiff 2022).
[120] G Clarke, 'Border' (1989) <https://www.poetrybyheart.org.uk/poems/border/> accessed 23 January 2024.
[121] Welsh Government, *Cymraeg 2050. A Million Speakers* (Cardiff 2017) 54.
[122] Welsh Language Commissioner, *My Language, My Health. Inquiry into the Welsh Language in Primary Care* (Cardiff 2014) 28.

## VIII. CONCLUSION: RESEARCHING HEALTH LAW IN THE *BORDER COUNTRY*

Our investigation has provided evidence for the pervasive influence of material and discursive bordering processes on health law in the contemporary UK, and for the significant contribution made by health law to those processes in turn. Delaney's couplet of 'space in law' and 'law in space', mentioned at the outset, are both instantiated in devolved health law. Admittedly, this relationship of mutual implication is nothing new. Infectious disease control, for example, has worked through legally ordained techniques of spatial separation since the origins of quarantine in late mediaeval Italy. Borders also featured within the pre-1998 UK, which was by no means a unitary state.[123] Health policy then was significantly shaped by the decentralization of administrative, if not legislative or executive decision-making, to Wales and Scotland, and by fully fledged devolution to Northern Ireland between 1921 and 1972. Internal national boundaries were not the only ones that mattered either. The so-called 'post-code lottery' in allocating resources has been a matter of reproach to the NHS since its foundation in 1948.[124] Over this period too, the UK's external border has been softened or hardened to migrant health workers from the territories of the former Empire and the European mainland, depending on the relative influence of anti-immigration opinion and persistent labour shortages.[125] What has changed with devolution is the prominence of these bordering processes and their complexity. Historically, workforce measures could be implemented at the notional edge of the UK: ports, airports, and immigration offices around the world. Local variability in access to health care could be framed as properly the subject of administrative or technocratic resolution. In contrast, the establishment of devolved administrations with law-making and implementing powers has increased the impetus towards explicit health policy variation and created political fora in which this can be articulated, challenged, and defended.

The review of thematic areas throughout this article confirmed the purchase and utility of a post-modern view of borders 'over the edge' in understanding devolved health law. Thus, the boundary between England and Wales was *produced* by Covid-19 restrictions, but *ignored* by Cardiff's failure to seek devolved powers over abortion. The divergence, as regards access to health care, between Wales's 'nation of sanctuary' policy and Westminster's 'hostile environment' produced a situation of *plural and overlapping* borders in some tension, if not outright struggle. Time-limited variations in the imposition of pandemic restrictions and in access to lawful pregnancy termination highlighted the inherently *spatio-temporal* nature of health law bordering. The latter was seen to happen in a *range of locations* at, but also beyond formal boundaries, including care homes serving Welsh speakers and English hospitals delivering secondary care to Welsh-resident patients.

Each of the substantive areas of health law considered—infectious disease control, mobility for treatment, immigrant access to the care, abortion, and dementia care—confirmed the increased prominence of devolved authorities, and of Westminster in its relation with them. In each, we noted the influence of changes in the UK's territorial constitution on law and policymaking. Indeed, health law was both a site and a means for pursuing larger constitutional goals, to do with material, fiscal, and jurisdictional boundaries, as seen during Covid-19 (eg 'muscular unionism', or the assertion of national distinctiveness). These struggles are not external to health law, but shape its content and the manner in which it is experienced and engaged with by individuals, as in the case of patients seeking to move across borders

[123] N McEwen, 'State Welfare Nationalism: The Territorial Impact of Welfare State Development in Scotland' (2002) 12 Regional and Federal Studies 66.
[124] K Syrett, *Law, Legitimacy and the Rationing of Health Care* (CUP 2007).
[125] R Bivins, *Contagious Communities. Medicine, Migration and the NHS in Post-War Britain* (OUP 2015).

for treatment. Equally, however, our review confirmed the theoretical insight that borders are produced at multiple sites and at varying scales, including but going beyond the 'national' level. In each case, we observed dynamic pluralistic health law bordering processes, which were often marked by unintended outcomes (as in recent rules on access to non-medical abortion) or outright antagonism (as between the 'hostile environment' and the 'nation of sanctuary' approach to free NHS care). Not all of these developments are due to the outworking of grand constitutional struggles. Indeed, co-ordination and co-operation between instances and across scales are both desirable and possible (as during the early months of pandemic or in the evolving reciprocal mechanisms for care and reimbursement in borderland areas).

Devolution, then, has the signal benefit of directing our attention to bordering as a persistent and pervasive mode of creating, implementing, resisting, and changing health law. As such, our study also points to an agenda for health law research in the UK. In brief, and without ambitions to be exhaustive, we suggest a four-fold focus. Doctrinal scholarship, drawing on comparative law techniques, is needed to map and compare the extent to which health law is diverging or not as between the four nations. The representation of each as a discrete, self-contained corpus is insufficient, however. Border-crossing, whether by patients, professionals or materials, is facilitated (or hindered) by overarching norms and adjustment mechanisms. These do not function cleanly in every case and they will not be always arranged in neat hierarchies. Their applicability may itself provide occasion for further dispute, as was seen in relation to the territorial reach of the guarantees to English patients under the NHS Constitution. Private international law (or more aptly, the 'conflict of laws') will provide an important conceptual resource for this work.[126] Empirical socio-legal research is needed to investigate the understandings and practical strategies of diverse health law actors under devolution. Focussed qualitative studies can move beyond the quotations provided in our article, to trace the development of specific legal consciousness and identity formation in borderland regions and beyond, as well as in policymaking and professional milieux. Recent studies on Brexit and health governance, and on mobility for abortion care, offer powerful exemplars of how the creativity and agency of individuals and communities in producing and resisting borders can be taken seriously.[127] Further guidance is offered by empirical research in transnational law which attends to the concrete outworking of pluralistic and conflict-driven globalization processes at community and state level. Ethical reflection is indispensable in furnishing a means for clarifying and arguing about health law values under devolution. The latter entails increased potential for divergence in the rights and duties recognized and imposed by positive law. The specific content of legal norms and their application will continue to be a proper focus for applied (or bio-) ethics. But health law devolution also poses questions for general moral philosophy. Ongoing work on the claims of 'national priority' or 'cosmopolitan justice' in the global context can also aid critical reflection on the justifiability of divergent entitlements of citizens and migrants as between the four nations.[128] More speculatively, meta-ethics points us to the diverse sources of value as between them, drawing our attention back to distinct national traditions, as well as the common stock of norms underpinning health law and health care delivery across the UK.[129]

[126] See eg KJ Hood, *Conflict of Laws within the United Kingdom* (OUP 2007).

[127] S Calkin, 'Healthcare not Airfare! Art, Abortion and Political Agency in Ireland' (2019) 26 Gender, Place and Culture 338, 346; T Hervey and others, *Not What The Bus Promised: Health Governance after Brexit* (Hart Publishing 2023).

[128] D Miller, *On Nationality* (OUP 1995); P Singer, 'Famine, Affluence and Morality' (1972) 1 Philosophy and Public Affairs 229.

[129] SL Greer and D Rowland, *Devolving Policy, Diverging Values? The Values of the United Kingdom's National Health Services* (Nuffield Trust 2007).

At the outset of our article, we recalled the Encylopaedia Britannia's laconic suppression of diversity: 'For Wales, see England'. The very name of the encyclopaedia, founded in Edinburgh in 1768, attested to the reality of a recently united kingdom, one which enfolded peripheral nations in an Anglo-British political and cultural dispensation. The National Health Service, in its original format, both presumed and reproduced that singular order.[130] Health law scholarship until recently has had similar rhetorical effects: erasing the time and place-bound culture of elite legal and medical professionals by conflating it with the universal.[131] Against this, devolution has forced us to take seriously the historically contingent nature of health law, revealing its boundaries, its many frontiers and the borderlands which it shares with other disciplines and normative orders. Border-thinking, attending to the concrete in all its complexity, is now essential, not only as a means of accounting for marginal phenomena, but in comprehending the totality. Raymond Williams, who pioneered the cultural study of British state-formation, put it well:

> One of the central advantages of being born and bred among the presumed Welsh is the profusion of official identities … England-and-Wales: that administrative, legal and even weather-forecasting area. Wales for rugby, but All-England for cricket. Welsh Wales and English Wales. Wales and Cymru. To anyone looking for an official status it was a nightmare. To anyone trying to think about communities and societies a blessing: a native gift.[132]

All health law is health law in a devolved setting. All of the UK is border country. For England, and the UK, see Wales.

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[130] See further, J Harrington, *Towards a Rhetoric of Medical Law* (Routledge 2017).
[131] Encouragingly recent editions of standard textbooks have begun to dedicate extended discussion to health law and devolution, see eg AM Farrell and E Dove, *Mason and McCall Smith's Medical Law and Ethics* (12th edn, OUP 2023).
[132] R Williams, *Who Speaks for Wales? Nation, Culture Identity* (DG Williams ed, University of Wales Press 2008) 67.

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