

Responding to critics

By Lorenzo Piccoli and Roberta Perna

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Introduction

What, if any, are the ethical dilemmas confronting staff of civil society organisations (CSOs) that provide medical services to irregular migrants in countries with universal healthcare systems? In our essay ([Piccoli & Perna, 2024](#)), we argued that those working or volunteering in such organisations confront a persistent dilemma between responding to immediate humanitarian needs and potentially perpetuating the systemic inequalities that make humanitarian intervention necessary in the first place. We called this the humanitarianism–equity dilemma.

The dilemma arises because the provision of healthcare outside the public system is politically ambivalent. On the one hand, CSOs respond to urgent and often otherwise unmet needs. Refusing to provide care in the name of a more equitable future would impose the costs of political principle on people who need treatment. On the other hand, by creating parallel systems of care for those who are effectively treated as second-class patients, CSOs may unintentionally stabilise the very unequal arrangements they seek to mitigate. Their interventions can make exclusion more tolerable and less visible, while relieving public institutions of some of the consequences of failing to provide genuinely universal care.

We are grateful to our critics who have engaged with these questions and have offered critical reflections on our argument ([Ataç, 2025](#); [Bazurli, 2025](#); [Castañeda, 2025](#); [Gottlieb & Schweitzer, 2025](#); [Refle et al., 2025](#)), and to those who have engaged with our essay since it was published ([Abdulrazeq et al., 2024, 2026](#); [Bonizzoni et al., 2025](#); [Devillanova & Spada, 2025](#); [Hanssen & Yerkes, 2025](#); [Junge, 2026](#); [Mittmasser et al., 2026](#); [Neumann et al., 2025](#); [van Hulst et al., 2025](#)). Rather than attempting to respond to every point, we concentrate here on several observations that we think push our initial reflection a little further and, based on these, we suggest how the research agenda on civil society and the medical care of migrant populations might be taken further.

Precarity and irregularity are not exceptions

One important extension of our argument concerns the structural character of this dilemma. As Gottlieb and Schweitzer (2024) emphasise, precarity and irregularity should not be understood simply as exceptional circumstances at the margins of otherwise inclusive liberal welfare states. They are, rather, built-in features of liberal economies. Therefore, the parallel provision of healthcare by voluntary groups and non-governmental organisations (NGOs) cannot be understood simply as a temporary response to an unfortunate gap in an otherwise universal system. Instead, it is an enduring component of welfare states.

In this sense, the humanitarianism–equity dilemma is not peculiar to migrant healthcare. It raises a broader question that has been confronted by welfare scholars: What should be the role of civil society in providing services that might otherwise be understood as responsibilities of the state? At what point does civil society provision complement public welfare, and at what point does it facilitate its privatisation or retrenchment?

The case of irregular migrants is important because their exclusion from public health rights, and delegation to civil society initiatives, can establish institutional and political precedents through which the right to health is progressively weakened. Gottlieb and Schweitzer show that what initially appears to be an exceptional arrangement for a politically weak population may become part of a broader transformation in the governance of healthcare, and welfare rights more generally.

Similar problems arise wherever civil society organisations compensate for gaps in formally universal welfare provision, for example, when food banks address food insecurity, or when charities provide shelter for homeless people. In each of these cases, meeting urgent needs may simultaneously reduce the immediate human costs of exclusion and make gaps in public provision more politically and institutionally sustainable. Hence, we believe that the humanitarianism–equity dilemma is a key political issue for welfare states.

Is the dilemma individual or organisational?

Refle et al. (2025) raise an important question: is the humanitarianism–equity dilemma fundamentally a dilemma experienced by individuals, or does it operate at the level of organisations? Our answer is: both. This requires clarification.

The dilemma is certainly experienced most immediately by individuals, including doctors, nurses, volunteers, lawyers, social workers, and other practitioners, who may have to decide in real time whether to prioritise an urgent need or a longer-term rights-based objective. Often, practitioners are aware that their moral discomfort is generated by institutional arrangements that force such choices: restrictive eligibility rules, insufficient public provision, and the delegation of responsibility to civil society. What appears at the individual level as guilt, frustration, or ambivalence may therefore reflect an accurate perception of the contradictory institutional position practitioners have been asked to occupy.

At the same time, the dilemma clearly operates at the organisational level too. CSOs must decide how to allocate scarce resources between immediate service provision and lobbying, advocacy, protest, strategic litigation, or other efforts to alter the policies responsible for exclusion from public services. These choices affect whether organisations

accept government contracts, how closely they cooperate with public authorities, whether they publicly criticise those authorities, and how they balance humanitarian assistance with political positioning.

Clearly, individual and organisational dimensions are intertwined. At the same time, individual motivations cannot simply be inferred from an organisation's formal political orientation, just as organisational strategy cannot be reduced to the motivations of individual staff members. Our initial contribution focused on individual motivations. Future research could pay closer attention to the relationship between the two: how organisational contexts structure practitioners' ethical choices, and how the experiences and commitments of practitioners can, in turn, reshape organisational strategies.

From civil society organisations to a politics of civil society

Several contributors rightly point out that our original formulation risks treating CSOs as a more homogeneous category than they actually are (Ataç, 2025; Bazurli, 2025; Castañeda Heide, 2025; Refle et al., 2025). Indeed, the humanitarianism–equity dilemma does not manifest itself identically across organisations. Instead, it largely depends on organisational resources, political orientations, funding structures, relationships with the state, and the institutional environments in which organisations operate.

This is why it is important to pay more attention than we did in our initial contribution to the kind of CSOs involved in medical provision. Some organisations present themselves primarily as politically neutral humanitarian providers. Their principal objective is to fill gaps in existing provision, and they may deliberately avoid overt political confrontation. Others occupy an intermediary position. They provide services but simultaneously make demands on local authorities for greater recognition, resources, or institutional responsibility. Still others understand service provision explicitly as part of a transformative political project, using their encounters with excluded populations to expose deficiencies in existing institutions and demand systemic change.

Ataç's (2025) distinction between different organisational orientations, ranging from neutral gap-fillers through intermediary or autonomous organisations to more transformative organisations, is particularly useful here. This builds on previous excellent work by de Jong and Ataç (2017), and on an important book by Agustín and Jørgensen (2019). Other dimensions matter as well. Refle et al. (2025) suggest that a more systematic distinction between forms of engagement, for example, should consider organisations fulfilling public contracts and those engaged in political activism. This would reveal important differences in how practitioners from different CSOs interpret and evaluate their work.

Organisational characteristics matter because they affect the ways in which political action can complement service provision. Organisations that depend on public contracts may possess privileged access to administrators but face constraints on public confrontation. Autonomous organisations may have greater freedom to criticise governments but less institutional access. Organisations combining professional expertise with advocacy may be particularly well positioned to translate clinical encounters into credible evidence about structural problems. All these structural conditions clearly have effects on how the humanitarianism–equity dilemma manifests itself and is experienced.

This points toward the need for a more developed study of the politics of civil society: an analysis that asks more systematically what kind of organisations they are, how they relate to public institutions, what political strategies they pursue, and under what conditions service provision either stabilises exclusionary arrangements or becomes a platform for challenging them.

Civil society demanding political change

Perhaps the most important challenge raised by the contributions concerns our characterisation of the dilemma as seemingly irresolvable. Several authors suggest that hybrid forms of civil society engagement may provide at least a partial route beyond the opposition between humanitarian provision and systemic transformation. Providing healthcare to undocumented migrants does not inevitably contribute to welfare-state retrenchment. As Bazurli (2025) argues, service provision can itself become a basis for demanding systemic change and holding public institutions responsible. The crucial issue, then, is not simply whether CSOs provide services, but what they do politically with the position that service provision gives them.

There are several possible mechanisms through which this can occur. Organisations can use the knowledge generated through service provision to change how migrant healthcare is understood. By documenting unmet needs, identifying recurring institutional failures, producing expertise, and making otherwise invisible populations visible, CSOs can help structure the terms of political debate about healthcare for irregular migrants. One important example can be found in the Covid-19 pandemic, when a coalition of Italian CSOs successfully pressured the government to include irregular migrants in the population eligible for free access to Covid-19 vaccinations.

Political conflict over migration can create opportunities for local governments and public officials to align themselves with civil society demands and distinguish their position from that of more restrictive governments. Recent resistance to Sweden's proposed reporting obligations of irregular migrants for public-sector workers illustrates this dynamic: municipalities and regions joined professional associations and CSOs in opposing the measure, contributing to the eventual exemption of doctors, teachers and social workers from the reporting requirement.

CSOs can also influence policy through less visible relationships with public administrations (Bazurli, 2025; [De Graauw, 2016](#)). Their expertise, personnel, data, and practical knowledge can provide municipal bureaucrats with material, cognitive, and human resources for designing and implementing public policies.

The humanitarianism-equity dilemma therefore also depends on the institutional arrangements and strategies through which they are pursued. The question we ask next, therefore, could be more specific: Under what conditions can the private or voluntary provision of medical services generate leverage for expanding rights rather than becoming a substitute for them? Civil society provision changes the political and administrative consequences of exclusion. Depending on how CSOs are organised and how they interact with public institutions, this may either reduce pressure on governments to expand public

provision or generate information, expertise, constituencies, and political pressure that make expansion more likely.

Conclusion: toward a research agenda on the politics of migrant healthcare

Castañeda (2025) draws attention to the “unquestioned institutionalisation of CSOs in the migrant health sector” that took place since she began work on this topic in the early 2010s. Perhaps the next step is precisely to question this institutionalisation, not by assuming that civil society involvement is either inherently emancipatory or inherently complicit in welfare-state retrenchment, but by making its politics an object of systematic investigation.

The humanitarianism–equity dilemma remains useful for this research agenda because the underlying competition between two values cannot simply be wished away. Someone who needs medical treatment today cannot be asked to wait for the construction of a more equitable healthcare system tomorrow. Yet, responding to that immediate need can contribute to institutional arrangements in which unequal access to healthcare becomes durable, administratively convenient, and politically less visible.

At the same time, the contributions to this debate suggest that the dilemma should not be treated as mechanically producing the same outcome everywhere. CSOs differ substantially, political opportunities change, and relationships between public authorities and civil society vary too. Private provision of healthcare may conceal exclusion in one setting while generating the evidence, expertise, coalitions, and political pressure necessary to challenge it in another. This opens some space for a research agenda focused less on asking whether civil society provision is good or bad, and more on identifying the conditions under which different political trajectories emerge, with what consequences.

Such an agenda should examine organisational type and funding; relationships with municipal, regional, and national authorities; connections with political parties and social movements; the role of migrant-led organisations; professional identities; and the strategies through which practical knowledge acquired in clinics is converted into political claims. Indeed, several studies already contribute a strong backbone against which this research agenda could be further developed ([Ambrosini, 2015](#); [Ataç et al., 2024](#); [Cabot, 2016](#); [Hanssen & Yerkes, 2025](#); [Junge, 2026](#); [Vandevoordt, 2019](#); [Vandevoordt & Fleischmann, 2021](#)).

Healthcare professionals deserve particular attention in this respect. Physicians and other medical professionals working with irregular migrants occupy an unusual position as both participants in systems of care and authoritative observers of the unintended consequences of their work. Professional prestige and expertise can provide them with a capacity for public intervention that many marginalised populations themselves are denied. Whether and how that position is mobilised politically remains an important empirical question.

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About the “Dilemmas” project

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