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Municipal Strategies for Integrating Healthcare Access for Illegalized Migrants in Germany: A Case Study of Ulm*

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Abstract

Illegalized migrants face systemic barriers to accessing basic human rights, including healthcare, due to restrictive migration policies that exclude them from the political community. In contrast, some municipalities actively counter these exclusions by granting access to social services. Through a case study of Ulm, a city in southern Germany, this paper examines how collaborations between civil society and local government actors attempt to circumvent federal restrictions and provide healthcare for illegalized migrants. While national laws in Germany prevent local governments from directly enacting policies to protect illegalized migrants from deportation, this paper argues that local practices, such as those offering access to healthcare, represent attempts to create alternative forms of urban belonging. These practices not only address gaps in service provision but also challenge exclusionary national migration policies. Analyzing the case through the legal, discursive, identity, and scale dimension, this paper explores how Ulm's initiatives reflect aspects of sanctuary city practices, while also confronting the limitations imposed by German federal law. The findings suggest that although local actors lack the legal authority to restrict cooperation with national authorities, their efforts have brought the issue of migrant exclusion into public discourse, emphasizing the city's responsibility for its de facto population. The paper shows how such local actions impact broader policy debates, particularly as local actors seek to extend these inclusive practices to higher scales of governance. Nonetheless, significant challenges remain, including bureaucratic barriers and the risk of reinforcing exclusion by addressing only healthcare while leaving other essential services untouched.

Keywords: migration; illegalization; healthcare; state; solidarity; sanctuary; cities; belonging; Germany

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Introduction

Illegalized migrants experience systemic barriers to assert their human rights, as they are de facto present within a nation-state but kept outside of the political community. By illegalizing their presence through residence law,[1] the nation-state places significant structural barriers between these migrants and access to basic social rights, such as education and health (Agamben, 2006; Benhabib, 2017; Meints, 2022). Illegalized migrants find themselves in a state of constant "deportability" (De Genova, 2002) and any contact with public authorities goes along with an increased risk of deportation. Systematic fear of deportation experienced by precarious status migrants results in significant gaps in accessing key services, including healthcare. This exclusion stands in contradiction to international and national legal frameworks that affirm the right to health, including Article 35 of the EU Charter of Fundamental Rights and Article 2 of the German Basic Law, which guarantees the right to life and physical integrity. The persistent gap in access to healthcare for illegalized migrants therefore raises fundamental questions about the implementation of these rights in practice.

However, numerous municipal efforts mitigate the risk of deportation for illegalized migrants. Such efforts include restraining cooperation between municipal and federal authorities and granting access to social services regardless of a person's status (Bauder, 2017b; de Graauw, 2014; Delvino, 2017; Kaufmann et al., 2022; Kuge, 2019, 2020). Often originating in civil society movements, numerous municipalities are demanding more autonomy from federal authorities to develop policies and services inclusive of illegalized migrants when it comes to migrants' right to stay. Using terms such as *Sanctuary City*, *Solidarity City*, or *Cities of Refuge*, cities are becoming actively involved in migration policy and service provision by collaborating with civil society and migrant organizations rather than implementing top-down solutions without meaningful consultations with civil society actors and migrants themselves (Darling & Bauder, 2019; de Graauw, 2014; Delvino, 2017; Heuser, 2023). The active efforts of sanctuary cities to include illegalized migrants raise the question of the extent to which social belonging can be conceptualized at the local level, independent from, and often in opposition to, national narratives and exclusionary.

In the US, arguably the most prominent example of sanctuary cities, municipalities have their own police forces who can be restrained from cooperation with federal authorities. This gives local governments a degree of discretion that may protect migrants from deportation at the municipal level (Bauder, 2017b; Kuge, 2020; Walker & Leitner, 2011). In Germany, municipal governments do not have a similar capacity when it comes to policing, as the police is partly provincially and partly federally governed and funded. Furthermore, under §87 of the German Residence Act (*Aufenthaltsgesetz*), employees of public institutions – except for those in schools and kindergartens – are generally required to pass on any knowledge of illegalized migrants to the municipal foreigners' office, which then notifies federal immigration authorities (Kanalan et al., 2018; Mylius, 2016). City governments do not have the ability to pass laws to protect illegalized migrants by restricting cooperation between municipal and federal authorities (e.g. Bauder & Gonzalez, 2018, pp. 129–130; Buckel, 2008; Schönwälder et al., 2004).

Despite these constraints, some German municipalities have found ways to support illegalized migrants' access to essential services. Among the various areas of local welfare provision, healthcare has received the most consistent attention from both civil society and policy initiatives, followed by legal counselling (Kaufmann et al., 2022). Since the 1990s, a growing network of voluntary and charitable actors has worked to provide free and anonymous healthcare service (Ataç, 2023; Castañeda, 2007; Heinrich Böll Stiftung, 2008; Huschke, 2013; Mylius, 2016;

[1] § 4 and § 14 of the German Residence Act (*Aufenthaltsgesetz*) prohibit entry and residence without a residence permit. Violations can be prosecuted with up to one year imprisonment and a fine according to § 95 para. 1 no. 2 and no. 3 *Aufenthaltsgesetz*.

Wilcke, 2018). These volunteer-based healthcare initiatives not only address the needs of illegalized migrants but also support a broader group of individuals who are excluded from regular access to the German healthcare system, including uninsured persons and certain legally residing migrants whose coverage does not extend to local services. In cities such as Berlin (Bauder & Weisser, 2019; Medibüro Berlin, n.d.), Frankfurt (Ataç, 2023), Freiburg (FRABS, n.d.), and München (Anderson, 2011), these efforts are supported by city administrations.

This paper focuses on the provision of healthcare as an entry point for analyzing municipal strategies of inclusion, because healthcare – more than other social services – has become a focal point of practical intervention and political debate around the rights of illegalized migrants. The case study is situated in the Southern German city of Ulm, where, at the time of fieldwork, civil society actors were actively engaged in dialogue with local authorities to enable public support for healthcare provision to the illegalized population. This setting offered direct access to an unfolding, dynamic process of policymaking, allowing for fundamental insight into the interactions between civil society and local government. By examining these efforts, the paper explores how municipal engagement in healthcare provision can be interpreted as a step toward municipalities articulating their own rules of belonging – negotiating local inclusion in tension with national immigration policy. While municipal governments in Germany cannot formally enact policies that protect illegalized migrants from deportation by limiting cooperation with federal authorities, this paper argues that local forms of migrant protection and belonging can nonetheless be implemented through diverse practices. Such practices on migrant's access to social services not only fill a much-needed gap in providing services but can also bring about social change by problematizing exclusionary and discriminatory aspects of migration policy. The case study serves to analyse how, and by whom, exclusions based on immigration status are negotiated within healthcare provision. The findings highlight how local practices aiming to include illegalized migrants into the provision of healthcare contrast and contest the nation-state's prerogative to define the rules of belonging to the political community. Lastly, this paper pays special attention to how the hierarchical order of geographical scales is renegotiated, as local actors engage not only at the city-level, but also – through campaigning, advocacy, and public engagement – impact provincial and federal policy-making.

This paper is divided into four sections. First, I present the theoretical framework the research is situated in. The second part introduces my case study and explain the methodological approach. In the third section, I present key findings and contextualize them in light of sanctuary and solidarity city literature. Finally, I summarize the main findings and relate them with specific typologies.

Background

To understand the complex relation between states aiming to exclude migrants and municipal efforts to circumvent these exclusions, the following section examines the nexus between the nation-state and migration. It then develops a conceptual perspective that reframes migration, no longer viewing it as a deviation from the normative order. In this way, multiple types of belonging become conceivable, one of them being local belonging. This chapter then depicts different concepts that serve to typologize the diversity of sanctuary and solidarity city policies and practices.

The nation-state and migration

Politically, today's world is divided into nation-states. Historically, the nation-state system can be traced back to the Treaty of Westphalia of 1648, and philosophically to the Age of the

Enlightenment and Social Contract Theory (Bauder, 2018; Herrmann & Vasilache, 2021). According to Enlightened philosophers such as Thomas Hobbes, John Locke, and Jean Jacques Rousseau, the state offers security from the lawless, and therefore dangerous, state of nature (Hobbes, 2020; Locke, 1983; Rousseau, 1997). To provide this security, the state needs a demarcated territory within which it can maintain peace, while chaos, the fight of all against all, prevails outside the state. The citizens of the state receive protection from the state of nature, and in return they submit to the state, which holds the monopoly on the legitimate exercise of violence (ibid.). Modern state theory assumes that the state is constituted of three elements: (1) state power, which includes a monopoly of violence; (2) state territory; and (3) state people, the demos that must form a unity for a state to be legitimate and assertive (Jellinek, 1905; Weber, 2010). This configuration assumes that a political community is constituted only by demarcation from an outside that is constructed as inherently different from the inside. This binary order is challenged by migration, as migrants, living on a state's territory long-term and participating in social life, disrupt the underlying idea of a homogenous demos. The act of cross-border migration can be regarded as a challenge to the claim to sovereignty: "Contemporary anxieties over the loss of control over cross-border migration relate to a particular interpretation of territorial state sovereignty as the natural order of things'" (Bauder, 2021, p. 681).

This perspective on the nation-state suggests that transnational migration is principally seen as the anomaly, following an implicit assumption that a population is static, and migration is not part of a typical life trajectory. Furthermore, knowledge production in the Global North has naturalized the nation-state as an analytical framework (Wimmer & Glick Schiller, 2003). As a result, migration is often seen as a self-contained process of movement between two closed and clearly demarcated spaces, each of them containing a different set of values, norms, institutions, and histories (Bojadzijev & Karakayalı, 2007). Such a perspective reinforces the notion of a country's population as a homogenous demos and ultimately fosters demands for the integration and assimilation of migrants in the host country, as critiqued by Karakayalı and Tsianos (2007).

The autonomy of migration approach challenges the understanding of migration as a passive movement of people and emphasizes that migrants are active subjects. This approach, however, is controversial because of its tendency to romanticize migration processes (Bojadzijev & Karakayalı, 2007; Karakayalı & Tsianos, 2005; Mezzadra, 2010; Papadopoulos et al., 2015; Papadopoulos & Tsianos, 2013; Rodríguez, 1996). For instance, Papadopoulos et al. (2015) describe migration as a "creative force within these [social, cultural and economic; FA] structures" (ibid., 203) and emphasize migrants' agency despite circumstances of migration processes being heavily shaped by economic and political macrostructures. Mezzadra (2010) cautions that such a viewpoint comes with the danger of negating structural constraints to which migrants are exposed. The autonomy of migration approach assumes a transnational perspective according to which migration is seen as the norm. Under this scenario, the distinction between migrants and non-migrants could disappear. In such a "post-migrant society" (Foroutan, 2021), migration no longer represents the line of differences within society. Contrary to the logic of the nation-state, multiple types of belonging and hybrid identities emerge – not only at the level of the nation state but at multiple scales (Griesinger & Runkel, 2021) – including the city, which has received considerable scholarly attention. In the following section, I explore how belonging is negotiated in the city.

The city as "dynamic battleground"

The city plays a crucial role in migrants' struggles for belonging and participation. During recent years, numerous municipalities have taken an active stand regarding asylum and immigration policy, often assuming positions that are in opposition to national policies and regulations. In Germany, this development has led to political and juridical debates about the distribution of

power within the federal system (Hailbronner, 2020; Heuser, 2023; Schammann, 2020). In a sense, cities are facing a dilemma. On the one hand, cities have the task to provide services and welfare for their residents (*Daseinsvorsorge*) and in doing so, they have a certain level of autonomy. On the other hand, through the obligation to report data on illegalized migrants to federal authorities, residence law prevents cities from providing services and welfare to their residents if they do not have residency status. In this situation, providing municipal services is each city administration's discretion.

Concerning healthcare, illegalized migrants fall under the Asylum Seekers Benefits Act (*Asylbewerberleistungsgesetz*), which only covers the costs of treatments in emergencies, acute pain conditions, pregnancy, and childbirth. Even accessing these basic healthcare services, however, comes with a significant risk of deportation due to the obligation to pass on data to the municipal foreign office, which then reports it to federal immigration authorities. An exception only applies in medical emergencies under § 6a *Asylbewerberleistungsgesetz*, where treatment must be provided regardless of insurance status or pre-approved cost coverage. In these cases, medical confidentiality is formally extended to include hospital administrations and the Social Services employees responsible for treatment cost reimbursement.[2] In practice, however, these protections are difficult to implement. The Social Services office is still required to assess financial need, a process that is hard to reconcile with the preservation of anonymity. In addition, both the necessary legal knowledge and administrative capacity are often lacking (BAG Gesundheit/Illegalität, 2019, pp. 3–11; Mylius, 2016, pp. 54–57). As a result, the gap between formal entitlements and their implementation not only restricts access to healthcare but also contributes to the reproduction of exclusionary boundaries within the city itself. In this context, borders materialize in hospitals and clinics – spaces typically associated with care and protection – making them sites of both control and contestation.

This dynamic illustrates how actors within municipalities find themselves at the frontline of negotiating who belongs and who does not, often under the constraints of national immigration law. It is precisely in these local negotiations over service provision and access that the city may function as a site where alternative political logics of membership and belonging are articulated. Cities that seek to implement more inclusive policies and practices towards migrants thereby directly challenge the nation-state's monopoly on determining the rules of admission and membership in the political community. According to de Graauw (2014) the idea, "that only nation-states can confer citizenship status and rights, and that nationality is the basis for full societal membership" (ibid., 311) has to be reconsidered. At the local scale, civil society actors and city administration representatives act according to different principles as to who belongs to the city: they distinguish the de facto population from the de jure population (Bauder, 2016; Hess & Lebuhn, 2014; Kuge, 2020, 2022; Nail, 2019). By providing services to the de jure population, cities apply the principle of *jus domicilii* based on which the current place of residence is the key determinant for belonging (Bauder, 2016, 2017a). As Bauder argues, the principles of ancestry (*jus sanguinis*), or birthplace (*jus soli*) always put migrants in a disadvantaged position (Bauder 2016, 79). The domicile principle, on the other hand, does not tie the membership of a political community to the arbitrariness of birthplace or ancestry, but "recognizes people's right to mobility and choice of community" (ibid., 85).

When the domicile principle is applied at the urban scale (Bauder, 2016; de Graauw, 2014; Gebhardt, 2016; Hess & Lebuhn, 2014; Kaufmann, 2019; Varsanyi, 2006), the city becomes a "dynamic battleground", as Ataç and Schilliger (2022, p. 324) note in reference to Hajer and Ambrosini (2020, p. 199), where belonging is negotiated. Challenging the assumption that citizenship cannot be enacted by non-citizens, citizenship is seen as a bottom-up process by

[2] This protection is based on the so-called *verlängerter Geheimnisschutz*, codified in section 88.2.3 of the General Administrative Regulation to the Residence Act (*Allgemeine Verwaltungsvorschrift zum Aufenthaltsgesetz*), and referred to as *Notfallhelferparagraph*.

grassroots activists, aiming to create alternative forms of sociocultural and political membership (de Graauw, 2014; Hess & Lebuhn, 2014). Potentially, this encompasses a “fundamental democratization of urban life in the sense of a general right to the city for all” (Ataç & Schilliger, 2022, p. 324). At the same time, Ataç et at. (2021) draw attention to the risk of “romanticizing the city as a space of progressive politics (especially in counter to more xenophobic national politics)” (ibid., 925). This romanticization could trivialize the precariousness of being an illegalized migrant within a community (ibid., 925). Shifting the focus of belonging towards the city should not be associated with underestimating the power the nation-state has when it comes to granting and revoking residence permits.

Urban Citizenship, Sanctuary City, or Solidarity City

Across Europe and North America, many cities are attempting to counter migrant exclusions on the nation-state scale, through diverse policies and practices. While the term sanctuary city is mostly used in North America, in Europe, both activists and scholars often refer to the phenomenon using the term solidarity city. However, numerous other terms exist, such as *Welcoming Cities*, *Safe Harbors* and *Cities of Refuge*, and in the European context, prominent examples include cities such as Barcelona, Palermo, Amsterdam, and Zürich (Ambrosini, 2021; Antoniadis & Meier, 2023; Ataç et al., 2020, 2021; Ataç & Schilliger, 2022; Bauböck & Permoser, 2023; Bauder & Gonzalez, 2018; Bauder & Weisser, 2019; Delvino, 2017; Gebhardt, 2016; Kaufmann, 2019; Kaufmann et al., 2022; Kuge, 2019). Despite the differences between these concepts, they all share the underlying idea of challenging the assumption that citizenship, or membership to the political community, are exclusively defined by the nation-state. Scholars and activists advocating for the idea of citizenship from below often framed this as urban citizenship. Yet the term citizenship – despite efforts to reconceptualize it – still tends to evoke formal, nation-state-based membership. To avoid these connotations and to emphasize the broader idea that inclusion can also be locally constituted, this paper uses the term urban belonging. This choice allows for a more flexible analytical lens across diverse contexts, without invoking the definitional specificity and institutional weight often associated with citizenship. To locate this case study within the manifold examples of urban belonging, I introduce two heuristics.

Bauder (2017b) proposes a classification of sanctuary and solidarity cities along four dimensions: legality, discourse, identity formation, and scale. The first refers to restrictions on cooperation between authorities regulated by local legislation – for instance, by so-called Don’t Ask, Don’t Tell (DADT) policies in the USA and Canada (ibid., 180). The dimension of discourse refers to “challenging exclusionary narratives that portray migrants and refugees as criminal and undeserving" (Bauder & Gonzalez, 2018, p. 126). Here, Bauder emphasizes the connection between discourses on migration and refugees on the one hand, and laws and administrative regulations concerning migrants' rights on the other. In many cases, as for instance in the UK, urban belonging is mainly implemented on a symbolic dimension aiming at shaping a city as a welcoming place of solidarity towards illegalized migrants (Darling, 2010; Squire & Bagelman, 2012). The dimension of identity refers to a "formation of collective identities expressing unified membership in an urban community" (Bauder & Gonzalez, 2018, p. 126). Identity formation through sanctuary and solidarity policies and practices reflects the notion of citizenship as a form of political subjectification. The scalar dimension refers to local and nation-state scales contesting each other about the right to determine the rules of membership. Hence, Bauder (2017b) proposes that urban sanctuary and solidarity are “the attempt to rescale migration and refugee policies and practices from national to urban scales." (ibid., 181) Through such processes of rescaling, municipalities assert a political voice and thus challenge sovereignty.

Bazurli and de Graauw (2023), on the other hand, introduce a typology to explain the various forms of urban solidarity and sanctuary by looking at the policy contexts. Arguing that an

understanding of both local and supra-local conditions should be considered, they propose a two-dimensional framework: policy content and policy harmony. The former refers to a range from symbolic to substantive, while the latter ranges from conformist to confrontational. This leads to four ideal-typical forms of sanctuary or solidarity cities: in *symbolic-conformist* cities, a welcoming and solidarity-based approach is mainly discursive and rhetorical, whereas laws remain unchallenged; in *symbolic-confrontational* cities, laws explicitly include illegalized migrants into the community at the municipal level; *substantive-conformist* cities grant access to social services, such as healthcare and education, for illegalized migrants; and *substantive-confrontational* cities have both access to services, and non-cooperation between local police forces and national immigration authorities enshrined in municipal policies (ibid., 5).

As I will show, the actors in this case study pursued practical strategies to improve healthcare access for illegalized migrants, without explicitly drawing on concepts such as sanctuary city or urban citizenship. While, as outlined above, there are initiatives and movements across Europe operating under labels such as *Solidarity Cities*, the actors in my case were, in some instances, not even aware of these frameworks. The two heuristics proposed by Bauder (2017b) and Bazurli and de Graauw (2023) are therefore employed here to examine the extent to which the case study can nonetheless be situated within the broader conceptual frame of urban belonging.

Methods and data

The empirical research was conducted in March and April 2023. The case study is situated in the city of Ulm, located in the the south of Germany, within the federal state of Baden-Württemberg. Ulm lies directly on the border with Bavaria, separated by the Danube River from the city of Neu-Ulm. While Ulm itself falls under the jurisdiction of the Alb-Donau district's health department, its proximity to Bavaria adds a further dimension to the case. Bavaria is characterized by a long-standing conservative political tradition; the Christian Social Union (CSU) has governed the state continuously since 1957, holding an absolute majority for over four decades. Compared to other federal states, Bavaria has the lowest naturalization rates and a more restrictive stance on migration (Gesemann & Roth, 2015; Weigl, 2016). These administrative and political contrasts make Ulm and its surroundings a particularly compelling case for examining how local belonging is negotiated within and across state boundaries.

To provide at least rudimentary healthcare for illegalized migrants, a network of voluntary actors exists in Ulm, called *Medinetz Ulm.* It offers a counselling centre for persons without health insurance and refers them to a network of cooperating doctors or to the hospital. These doctors collaborate with *Medinetz* on a voluntary basis and offer anonymous treatment without being paid. *Medinetz* has an unofficial agreement with Ulm's university hospital where illegalized migrants can give birth anonymously, with the costs being split between *Medinetz* and the hospital.[3] While Medinetz has been an important actor in supporting illegalized migrants, its activities go beyond this group. The network also aims to assist individuals who, for various reasons, are excluded from access to the public healthcare system – such as EU migrants whose home-country insurance does not cover the relatively high cost of treatment in Germany, or people in precarious socio-economic situations without insurance coverage. In this way, Medinetz responds to broader structural gaps in the German healthcare system that affect a wide range of vulnerable populations. This local intervention has to be seen against the backdrop of a decentralized yet highly fragmented German healthcare system, which – despite high per-capita spending and a comprehensive welfare framework – has shown persistent inequalities in access and outcomes (Zeeb et al., 2025). Studies have also pointed to a lower use of healthcare services among status-

[3] Personal email communication with university hospital official, April 24, 2023.

holding migrants, often resulting in a disproportionately low health status compared to the general population (Brzoska et al., 2015; Klein & von dem Knesebeck, 2018). Thus, local actors like Medinetz are filling a crucial void in a system that formally provides universal coverage but in practice leaves some residents without care.

At the time of research, *Medinetz* had submitted a request to the city council to explore the possibility for establishing a city-funded counselling centre for persons without health insurance and include the required funds in the city's budget for the following year. This counselling centre would be able to issue an "anonymous treatment certificate" to persons without health insurance, including illegalized migrants. This proposal was accepted by all parties of city council. At the time of writing, a roundtable was given the task of discussing necessary and useful steps for establishing the counselling centre.

In addition to a review of academic and grey literature, I conducted four semi-structured, problem-focused interviews with five key actors involved in the efforts to introduce the anonymous treatment certificate in the city of Ulm. I interviewed two activists of *Medinetz*, a member of Ulm city council, a city administration official, and a doctor volunteering with *Medinetz*. The interviewees were selected based on their active role in the process of trying to establish a publicly-funded counselling centre as well as their willingness to participate in my research, since not all actors contacted agreed to participate or responded to the request. Initial contacts were established through background research and outreach to Medinetz, who also supported the identification of further interview partners through a snowball sampling approach. All interviews were conducted in German; citations in this paper are my own translations.

My field research examined how illegalization is negotiated within and through the field of healthcare, taking a closer look at conflicting spatial logics in this context. As the actors involved did not, at the time oy my research, explicitly refer to concepts such as solidarity city, I chose not to ask direct questions about these ideas during the interviews. Instead, I designed the interview guide to elicit participant's perspectives on existing gaps in healthcare provision for illegalized migrants from both professional and personal viewpoints. I then asked how they assessed the potential of introducing an anonymous treatment certificate as a means to address these gaps, and what challenges they anticipated would remain unresolved. Finally, I invited them to articulate their vision of an ideal solution for improving access to healthcare in this context. This approach was guided by my interest in how local practices of care may implicitly align with or diverge from broader notions of urban belonging and the domicile principle, even when not framed as such by the actors themselves.

For the analysis of the interview transcripts, I applied a coding procedure that was both theoretically and thematically structured. The coding process was guided by my research questions and areas of focus, which included categories such as key actors, activities, issues, solutions, administrative levels, and political systems. This framework was further developed into a detailed coding system. It is important to note that the answers provided by the interviewees reflect a certain bias, as all participants were actively involved in the process of trying to establish a publicly funded counselling centre. Although I made efforts to engage with individuals or institutions critical of this initiative, I was unable to get interviews with them. As a result, perspectives critical of this initiative, which could have offered contrasting views on inclusive policies for illegalized migrants, were not represented in the sample.

Findings

In this section, I present the findings from the interviews, which are set in relation to the corresponding research. I organize the findings into four sections. These are the supply gap in healthcare when it comes to illegalized migrants, the anonymous treatment certificate as an

approach to finding a solution for this gap, the aspect of networking and rescaling within *Medinetz'* activism, and finally, the role the city plays in these matters.

The supply gap in healthcare

The legal constellation outlined in the introduction creates a supply gap that has several dimensions. For treatments that are not an acute emergency, illegalized patients are required to pay privately in advance of treatment.[4] In those cases, *Medinetz* tries to find doctors who are willing to treat patients without health insurance voluntarily, without getting paid for it. According to the interview participants from *Medinetz*, finding a doctor is particularly difficult when specialists are needed, as well as when patients come from rural areas. In the majority of cases, treatments only take place in medically urgent cases, whereas basic care including preventive check-ups and therapies are rarely possible. As medical help is often delayed until an absolute emergency exist, an illness that could easily be prevented often worsens. As a representative of *Medinetz* puts it: "That's the perfidious thing, that we have to wait for emergencies until the people get a treatment."[5] Additionally, the interviewees of *Medinetz* emphasize that fear plays a major role as an impeding factor for illegalized migrants in making use of any kind of healthcare services:

> I think the problem starts with the very fact that these people are just scared. They are afraid of being discovered by the authorities, especially in the case of illegalized migrants (…). And we also fear that we do not even notice a lot of these people, because they do not really turn to us, (…) we believe that a lot happens covertly.[6]

This observation is also affirmed by research elsewhere in Germany. Huschke (2013) even calls this tendency to avoid and delay medical treatments as long as possible as the "principle of illegality" (Huschke, 2013, p. 240). Often, this delay leads to medical conditions becoming life-threatening (Anderson, 2003, pp. 34–35; Ataç et al., 2023, p. 35; Bommes & Wilmes, 2007, pp. 74–78; Huschke, 2013, pp. 140–146; Krieger et al., 2006, pp. 99–103; Kühne, 2009, pp. 220–221; Zanders & Bein, 2022, p. 5).

Additionally, the interviewees pointed out a lack of information among multiple actors involved: First, illegalized migrants are often unaware of their right to emergency medical care or the existing support structure offered by *Medinetz.* For this reason, public awareness efforts are a central pillar of *Medinetz's* work, along with the provision of treatment and advice. Second, frequently, hospital administration employees lack information regarding the possibility of anonymous billing in cases of emergencies. This knowledge gap is affirmed in the wider literature (Ataç, 2023; Huschke, 2013). Also, sometimes the social services office does not accept a declaration as emergency and passes on personal data or rejects the cost reimbursement. In consequence, the hospital has to cover the costs. Based on such experiences, some hospitals decide to directly reject patients who ask for an anonymous treatment (Ataç, 2023, pp. 272–273; Gesellschaft für Freiheitsrechte & Ärzte der Welt e.V., 2021, pp. 13–15; Huschke, 2013, pp. 222–234). Consequently, the availability of anonymous and free treatment frequently depends on the personal discretion migrants within the healthcare system. Both *Medinetz* and the doctor confirmed that passing on personal data happens frequently, due to ignorance on the part of hospital staff.[7]

In Ulm and its surrounding district, healthcare for illegalized migrants is almost entirely provided by *Medinetz* referring patients to volunteering doctors. *Medinetz* consists of medicine

[4] Personal email communication with university hospital official, April 24, 2023.
[5] Interview No. 1 with two representatives of *Medinetz*, April 4, 2023.
[6] Ibid.
[7] Interview No. 4 with doctor, volunteering with Medinetz, April 4, 2023.

students mostly, which comes with certain challenges: the interviewed participants emphasize that they are non-professionals, trying their best to further educate themselves on legal and bureaucratic aspects of the issue while keeping up with both counselling patients and their own studies at the same time. They experience this amount of work and responsibility as challenging. For instance, during intense exam periods at university, it cannot be guaranteed that patients find the right advice or reference to a doctor with the right specialty.[8] Furthermore, reliance on voluntary structures means reliance on individuals rather than institutions, who often move away after finishing their studies. If no new persons join *Medinetz*, then its work will cease, and support for illegalized migrants will be discontinued.[9] In addition to the enormous time commitment for volunteers invested in counselling and mediation, the doctors face high expenses for their treatment that they cover by themselves.[10] Thus, in the case of healthcare for illegalized migrants in Germany, the fundamental right to health effectively depends on individual benevolence.

The anonymous treatment certificate

All interviewees presented an anonymous treatment certificate issued by a municipality-run counselling centre for persons without health insurance as a way of making the provision of healthcare simpler, faster, and – in connection with corresponding public education – with less obstacles and fear of deportation. For instance, the city administration official states:

> For me, it is absolutely plausible, and, in my eyes, a wonderful way to be able to help people in precarious life situations as quickly as possible. And I'm also very convinced that our healthcare system in Germany would be improved a great deal if such simple solutions were just implemented and supported across the country.[11]

Participants also pointed out a necessity for more professionalization in the provision of healthcare for illegalized migrants, which would provide a much-needed relief for the volunteering actors. While such professionalization might help including illegalized migrants into the healthcare system to a certain extent, it would also create another kind of exclusion on the local scale: residents of the city of Ulm would have access to healthcare, whereas residents of the neighboring Neu-Ulm, would not. The provision of healthcare at a municipal level comes with the risk that the exclusion of illegalized migrants shifts from the national to the local scale. Arguably, the fundamental problem of exclusion from the healthcare system would only be solved if an anonymous treatment certificate was available nationwide.

Furthermore, people entering the healthcare system with an anonymous treatment certificate would still have a special status within this system. Even with a well working system of an anonymous treatment certificate, illegalized migrants would still feel their being “special patients” in as much as they entered the healthcare system in a different way than everyone else. As a representative of *Medinetz* notes: “A particularly big concern for me is de-stigmatization so that people can seek medical help without fear and without being portrayed as somehow special or different.”[12] Access to medical care would still be associated with a considerable bureaucratic effort – the exclusion is thus mitigated, but still noticeable for the persons concerned.

At this point, the issue of a parallel healthcare provision becomes apparent, what Huschke (2013, 197) calls a "socio-political fig leaf" and Castañeda (2007, p. 37) calls "paradoxes of providing aid." These terms refer to the normalization of status quo of unequal treatment by

[8] Interview No. 1.
[9] Interview No. 2 with city council member, April 6, 2023.
[10] Interview No. 1 and 4.
[11] Interview No. 3 with city administration official, April 5, 2023.
[12] Interview No. 1.

providing social services in parallel to the regular care system. As a result, a hierarchical order of people who provide aid and people who need it is perpetuated. Interviewees from *Medinetz* report that their voluntary work would obscure the issue of insufficient healthcare to an extent that some political decision-makers would not recognize the healthcare situation for illegalized migrants as problematic, and therefore see no need for action.[13] The interviewees emphasize that in the long term, all *Medinetze* in Germany are striving to no longer be needed. They see political activism as very much part of their work. Hence, their demands should not only be regarded as concerning the healthcare system but also as intrinsically political; they call for an end to the exclusion of illegalized migrants from social participation.

Medinetz strives to break down the strict division between citizens and non-citizens (Nyers & Rygiel, 2014, pp. 206–210). *Medinetz* activists are not only interested in supporting illegalized migrants in finding ways out of their illegal status within the existing system (e.g., by cooperating with legal counselors), but their efforts also seek to establish political participation in social process through which access to rights and services is achieved (Ataç et al., 2023, p. 37). All interviewees problematize not only the exclusion of illegalized migrants from healthcare but also illegalization as a general failure of federal immigration policy and an underlying exclusion mechanism as the root of the problem of the supply gap in healthcare. The city council representative emphasizes:

> It starts with the fact that we simply don't have any immigration regulations, and this remains one of the many big issues that people always prefer to pass on to the next government [...]. And in my eyes, the mistake is that we don't think about it, which ultimately leads to the fact that we almost force people into illegality.[14]

This interviewee calls for critical reflection on how society treats illegalized migrants and to identify where this treatment undermines their ability to fully participate in society: “There simply have to be other laws – how do we deal with people who live here illegally? How do we make it possible for these people to have access to our society? [...] Every person who lives here must have the right to develop according to his personality.”[15] All interviewees agree that volunteer work currently fulfills a crucial role as a pragmatic tool to improve the healthcare situation of illegalized migrants. However, they emphasize that the anonymous treatment certificate can only serve as an interim solution, while structural changes from higher level authorities are necessary.

Networking and rescaling

Medinetz cooperates closely with a network of local doctors, the university hospital, and various local counselling centres, including those supporting people in debt, unhoused persons, and sex workers, as well as the German Red Cross. This cooperation reflects the activists’ awareness that illegalized migrants face not only barriers to healthcare but a complex set of problems that result from multidimensional exclusions linked to their legal status. However, *Medinetz*’s efforts reach beyond the local scale. They also build on nation-wide networking and cooperating. *Medinetz Ulm* is networking nation-wide with actors involved in providing healthcare for illegalized migrants and raising awareness and publicity for the issue, such as the Federal Task Force on Health and Illegality (*Bundesarbeitsgruppe für Gesundheit / Illegalität*), various associations (e.g. *Ärzte der Welt e.V.*), and initiatives and campaigns (e.g. *GleichBeHandeln*). Together, they aim to raise awareness of the supply gap in healthcare, facilitate exchange and knowledge dissemination and contribute to the collection of data on the issue (e.g. Bader & Offe, 2022; BAG

[13] Interview No. 1.
[14] Interview No. 2.
[15] Ibid.

Gesundheit/Illegalität, 2008, 2018, 2019; BAG Gesundheit/Illegalität & BACK, 2023). For instance, the *GleichBeHandeln* campaign supports the case of an illegalized person with chronic heart disease, who is suing the City of Frankfurt for not granting access to vital medication without risk of deportation. Backed by the association *Ärzte der Welt*, the campaign aims at an injunction from the Administrative Court against the social welfare office, prohibiting the transfer of data to immigration authorities. In the long term, the case is intended to prompt the Federal Constitutional Court to conduct a fundamental review of the legal obligation to report data under German residence law (Ärzte der Welt e.V., 2021). A broad alliance of civil society actors is supporting a petition, which calls for creating a legal clause in residence law that exclude the health sector for the obligation to report data. In this context, it is considered a success that the issue was included in a coalition agreement with a commitment to revising residence law to ensure that seeking medical treatment would not lead to the risk of deportation (Bundesregierung, 2021, p. 139).[16]

In most cases, local civic society actors such as *Medinetz* initiate action, advocating for more inclusive policies regarding access to social services (Ataç, 2023, pp. 276–279; Huschke, 2013, p. 197). Through public awareness efforts and strategic engagement with municipal actors, *Medinetz* addresses not only the improvement of the healthcare provision, but also seeks to hold public authorities accountable for providing service to their de facto population. This approach entails a more inclusive policy that effectively counters exclusion by the nation-state. Consequently, by a process of rescaling, the hierarchy between the national and the local scale is challenged. However, all interviewees have an ambivalent assessment to which extent the municipal scale presents an opportunity to implements practices that counter policies on the national scale: on the one hand, they emphasize the potential of local politics; on the other hand, they stress the limits of the local scale. The city council member says that in general, at the municipal level a lot is possible, emphasizing their enthusiasm for local politics. Yet, for the efforts to improve the healthcare situation for illegalized migrants, the respondent stresses: “But without the support of the federal and provincial governments, it won't happen, that's for sure. And I would really appeal to them to put a little bit more into it.”[17] Similarly, the city administration official recognizes the potential to initiate action at the local scale, as it is often possible to act quicker and face less obstacles compared to the provincial and national scales: “If, there are people behind it, like myself, who, at least to a certain extent, because of their function in the public sector, are able to initiate small-scale solutions for municipalities or communities or similar bodies, then I believe that a process may be starting that is also increasing on a large scale.”[18] Nonetheless, this interviewee stresses the importance that a process originating at the local scale is taken up at the provincial and federal levels. There is a need for “nationwide regulations that just allow us to have what I consider to be an honest handling there”, rather than just ad-hoc approaches.[19]

The city as an arena of conflicting interests and struggles about agency

My interviewees generally describe very positive attitudes towards the efforts of establishing a counselling centre with the possibility of issuing an anonymous treatment certificate. The city council and city administration representatives say that even the mayor, who is member of the

[16] Unfortunately, no legislative changes were enacted to implement this commitment. Instead, during the same legislative period, the federal government introduced measures tightening asylum law, further restricting the situation of asylum seekers and illegalized migrants (Zielke et al., 2024).
[17] Interview No. 2.
[18] Interview No. 3.
[19] Ibid.

conservative Christian Democratic Union of Germany, is very committed to the project.[20] The city administration official emphasizes that implementing measures to enhance the overall healthcare situation of the city's population very much corresponds with the city's social planning objectives: “I say, we don't need to close our eyes now, let's rather sit down at a table and think about how we can perhaps establish accessible support structures which actually help many people.”[21] This statement demonstrates that at the municipal level, there are actors who see it as self-evident to consider the wellbeing of the de facto population as a central goal, rather than just focusing on the de jure population. The city administration official, however, acknowledges that such a perspective is not uncontested within the city administration. Some actors adopt a more bureaucratic stance, arguing: “Well, from a purely legal point of view we don't have this problem, because they shouldn't really be here at all".[22] Here, a clash of logics occurs: from an administrative legal perspective, there is no need for action on the part of the city, because persons without residency status are not supposed to exist. Consequently, it would not be the city's task to take care of them. Conversely, there is the logic of social welfare and public order, indicating that it is in the city’s interest for all residents, regardless of their status, to have access to healthcare. According to interviewees, the perspective that the city should provide healthcare for the de facto population prevails in the city administration. Nevertheless, this very question of underlying logics of belonging to a city is crucial when it comes to the scope for action in terms of solidarity-based and inclusive policies and practices on the local scale.

A significant challenge regarding the idea of a counselling centre and an anonymous treatment certificate lies in the question of the responsibility for funding. The city council representative stresses that the city cannot not bear all the costs and underscores the role of health insurance providers in contributing to funding. However, so far, the health insurance providers have not attended the roundtable meeting. The question of who is entitled to a consultation and getting an anonymous treatment certificate is yet unresolved. Especially in the cases of unhoused patients and persons who do not wish to give any personal data to the consultation centre, it is difficult to trace where they live. Thus, the provision of social services to the de facto population at the local level faces a dilemma: On the one hand, they fear that illegalized patients from surrounding communities seek counselling at the centre at the cost of the providing municipality; on the other hand, hardening of the city’s borders would create another mechanism of exclusion.

Conflicts about financing also touch upon the question in how far a city can or cannot openly position itself as willing to provide services for illegalized migrants. Here, the city is caught between conflicting interests: parts of municipal authorities, such as the foreigner’s office, are more bound by state and federal regulations than others, such as the social planning sector. Thus, discretionary powers and agency are in constant friction with regulations coming from higher scales. The city administration official puts it this way: “it [the German immigration policy; FA] basically forces the municipalities to establish systems, which, however, rather correspond to a prevention policy […]. And I cannot really accuse my colleagues of doing their job, which is exactly what the legislator wants.”[23] This contradiction cannot be resolved politically. Rather, it is mitigated through a mesh of social relations. The actors involved depict diplomatic skills, a culture of dialogue, and good relationships, especially with the municipal foreign office, as crucial for efforts to include illegalized migrants in social services. Centrally, this diplomatic approach includes rhetorically framing the anonymous treatment certificate not as something dedicated only to illegalized migrants:

[20] Interview No. 2 and 3.
[21] Interview No. 3.
[22] Ibid.
[23] Interview No. 3.

> Our primary interest isn't to establish support structures for illegalized migrants, but we would like to establish support structures for all people living in Ulm. And illegalized migrants play a small role, but they definitely play a role as well. So, I just want to emphasize that again, because otherwise the tension with the in-house foreign office would suddenly become predominant, and I don't want to be understood this way.[24]

The tendency not to publicly name policies that aim to facilitate illegalized migrants' access to social benefits, is also referred to as *shadow politics* (Ataç, 2023, p. 276). Even though this practice is slowly changing, for a long time, local efforts to give illegalized migrants access to social services have been carried out rather unofficially and kept away from the public as much as possible (Buckel, 2008, p. 36). As Huschke (2013) points out, this practice can be contextualized with a general anti-migration political atmosphere that was prevalent in Germany in the 1990s, when series of far-right terror attacks and murders (Hoyerswerda in 1991, Rostock-Lichtenhagen and Mölln in 1992, and Solingen in 1993, etc.) were discursively framed by both media and political parties as a consequence of a high number of asylum seekers. Subsequently, the substantive right to asylum was abolished and replaced by the *Asylbewerberleistungsgesetz*, limiting access to social services (Bangel, 2022; Franka, 2022; Speit, 2021), which created the supply gap in healthcare. Furthermore, it was not until 2009 that the General Administrative Regulation to the Residence Act was issued, clarifying in section 88.2.3 (commonly referred to as the Notfallhelferparagraph) that providing medical care does not constitute a criminal offense of aiding unauthorized stay (Huschke, 2013, p. 197).

Discussion

Healthcare for illegalized migrants presents itself as a policy field in which different logics of belonging are negotiated. The de facto exclusion of irregular migrants from the healthcare system is rooted in a concept of state sovereignty based on the unity of the monopoly of violence, territory, and demos. From this perspective, border defense, such as migration control, is seen as a necessary means for establishing and maintaining sovereignty. Based on this logic, borders are manifested in hospitals and medical practices and thus transferred to the urban scale through the obligation to report data on illegalized migrants. Although civic society organizations, such as *Medinetz*, attempt to provide healthcare outside the regular system, they also create new boundaries of care, potentially exacerbating supply gaps in rural regions and smaller cities. This exclusionary logic embedded in residence law not only conflicts with internationally and constitutionally protected rights to health, life, and physical integrity, it also stands in tension with the municipal responsibility to ensure basic services for all residents within their territory.

This paper has approached healthcare as an entry point for analyzing municipal strategies of inclusion. While the actors in this case focused primarily on improving healthcare access for illegalized migrants through practical, status-blind solutions, it became clear – both implicitly and explicitly – that many of them think far beyond the scope of healthcare and fundamentally question exclusionary logics rooted in residency law. This will now be illustrated by drawing on heuristic concepts of Bauder (2017b), and Bazurli and de Graauw (2023) to examine the extent to which the practices observed in Ulm can be situated within broader debates on urban belonging and local contestation of national immigration regimes.

By looking at the four dimensions, legal, discourse, identity, and scale, as proposed by Bauder (2017b), it becomes clear to what extent the case study can be seen as an example of a sanctuary city, and where its limits lie. Regarding the legal dimension, there is almost no room for municipal legislation in Germany that would protect illegalized migrants by prohibiting any

[24] Interview No. 3.

cooperation with federal authorities. The obligation to report any knowledge of illegalized migrants to the foreign office, as enshrined in residence law, cannot legally be circumvented. As long as no corresponding exception is included in residence law, withholding information remains a criminal offence.

In contrast, when considering the discursive dimension, the case study reveals certain elements of the idea of urban belonging. *Medinetz*'s work brings both the gap in healthcare provision and the generally precarious living conditions of illegalized migrants to public attention. The outsourcing of healthcare to voluntary organizations is problematized, and the public sector is held accountable. In addition, representatives from city administration and city council emphasize that they regard caring for the de facto population as their responsibility, thereby implicitly including illegalized migrants.

Regarding the dimension of identity formation, this case study presents ambivalent findings. In particular, *Medinetz* emphasizes that it is not only concerned with adequate healthcare, but also with ensuring actual equal treatment, aiming to guarantee that illegalized migrants do not experience any notable difference in accessing the healthcare system compared to non-migrants. The dominance of voices within the city administration in favor of introducing an anonymous treatment certificate – and thereby guaranteeing healthcare access for illegalized migrants – can likewise be interpreted in this direction. However, one cannot speak of an actual rupture of the "demarcation line of difference" (Foroutan, 2021, p. 57). Especially concerning the city administration, the conflict with the municipal foreigners' office remains significant, as evidenced by the repeated emphasis that the counselling centre and anonymous treatment certificate are not primarily intended for illegalized migrants. This contradicts the notion that illegalized migrants are self-evidently regarded as belonging to the city of Ulm and as such entitled to social services on the same basis as other residents.

On the scale dimension, this case study has shown that actors advocating for healthcare for illegalized migrants also aim to extend these inclusive policies to higher scales over the long term. Moreover, such local struggles for healthcare provision for illegalized migrants have an impact beyond the healthcare sector itself, through public relations work and networking among involved actors. The precarious living conditions of illegalized migrants are brought into the public eye not only locally but also at higher scales.

Applying the typology introduced by Bazurli and de Graauw (2023), the efforts undertaken by the actors in Ulm can be classified as progressing from *symbolic-conformist* to *substantive-conformist*. The supra-local context, encompassing both national immigration policy in Germany and regional legislation in Baden-Württemberg, is unfavorable to illegalized migrants. Germany has strict residence laws and the scope for contesting policies on the municipal level is rather small due to the obligation to report knowledge on illegalized migrants to federal authorities.

Nonetheless, the local context in Ulm can be considered comparatively favorable. Financially, the city is well positioned: In 2020, Ulm had the 13th highest GDP among German cities (Statistische Ämter des Bundes und der Länder, 2022). Given Germany's federal structure, which grants municipalities considerable autonomy over their budgets, proposals such as the establishment of a counselling centre that issues anonymous treatment certificates can be debated and approved by the city council. In less affluent cities, however, the financial burden would likely have prevented the realization of similar initiatives, as the city council member argues.[25] Moreover, Ulm benefits from a dense infrastructure of civic society organizations, which works closely together with numerous voluntary and charitable stakeholders to provide care for vulnerable groups – including people in debt, sex workers, and unhoused persons. Politically, the local environment was similarly supportive: The fact that *Medinetz's* proposal was actively supported by all city council parties and by the mayor shows a political climate that is generally favorable towards granting illegalized migrants more substantive rights. However, a fundamental

[25] Interview No. 2.

tension persists between, on the one hand, the city's interest in providing the best possible services to its de facto population and, on the other hand, the municipal foreigner's office, which, at the local scale, represents and enforces national immigration policy. This open contradiction is mediated through a dense network of relationships: all municipal actors involved emphasize the critical importance of a willingness to engage in dialogue and to maintain good cooperation across departments.

Such collaboration enables negotiations in individual cases and reveals that, despite the formal constraints of residence law, there are practical spaces for discretion. Within these spaces, the city is able to pursue a health policy that is more inclusive towards individuals without legal residency status, even though it ultimately remains in tension with federal immigration regulations. This illustrates that even when actors do not explicitly invoke concepts such as sanctuary city or urban citizenship, a logic of urban belonging can nonetheless emerge. In the case of Ulm, the strategic use of discretion – particularly by refraining from publicly framing their efforts as a direct opposition to national migration policies – allowed municipal actors to navigate formal restrictions while advancing inclusive practices. The tendency not to openly name these policies as supporting illegalized migrants, as seen in *Medinetz's* approach and within parts of the city administration, reflects what has been described as "shadow politics" (Ataç, 2023, p. 276), where silence or ambiguity becomes an important tool for enabling access to social services in restrictive contexts.

This strategic ambiguity underlines an important implication for future research and practice. In times when restrictive migration policies are tightening at national scales in Germany and elsewhere, municipalities are becoming increasingly important arenas for contesting exclusionary practices – not necessarily through open opposition, but often through quiet, pragmatic actions. Cases like Ulm demonstrate that even small and less internationally visible cities can serve as important sites of urban belonging, if local actors creatively use their administrative discretion. Therefore, future studies on urban citizenship and migrant inclusion should expand their focus beyond prominent "sanctuary cities" and examine smaller or less politically conspicuous municipalities. Conceptual frameworks like those proposed by Bauder (2017b) and Bazurli and de Graauw (2023) are particularly useful for analyzing these often overlooked, but highly significant, forms of local contestation.

At the policy level, the findings from Ulm suggest that inclusive policies can be successfully developed within the existing municipal competences – particularly when there is strong collaboration between civic society actors and city administrations. Financial resources certainly matter, and Ulm's comparatively strong financial position has made it easier for local actors to justify expenditures for people without health insurance. However, examples from less affluent cities in Germany that have successfully established at least partly city-funded counselling centres shows that political will and administrative creativity are equally crucial (Bundesverband Anonymer Behandlungsschein und Clearingstellen für Menschen ohne Krankenversicherung (BACK), 2024). Networking among supportive cities and organizations, as actively pursued by Medinetz, can amplify these efforts and offer models for replication elsewhere. A particular structural advantage exists in Germany's three city-states – Berlin, Hamburg, and Bremen – where the fusion of city and state governance has created a somewhat more favorable legal framework for funding healthcare initiatives for illegalized migrants. In Berlin and Hamburg, public funding for counselling centres and anonymous treatment certificates was introduced relatively early, while Bremen, despite its more limited financial resources, followed in 2022. These cases illustrate how the federal structure can open up additional opportunities for implementing inclusive policies at the urban level, particularly in cities with larger populations. While the broader research and policy implications outlined above highlight the importance of municipal discretion and multi-scalar contestation, it is equally important to assess the concrete tool introduced in Ulm: the anonymous treatment certificate. In the following, its potential and limitations will be briefly discussed.

Conclusion

The introduction of an anonymous treatment certificate, issued through a municipality-run counselling centre for persons without health insurance, represents a pragmatic step towards integrating illegalized migrants into the local provision of healthcare. Municipal actors have been affirmative towards its introduction, emphasizing the city's responsibility to provide for the de facto population and thereby challenging the exclusivity of national migration policy. However, numerous aspects remain unresolved when aiming to fully implement the idea of urban belonging. Bureaucratic barriers to accessing healthcare remain significantly higher for illegalized migrants compared to people with regular health insurance, and practical hurdles persist – for example, the uncertainty over how long public funding for the anonymous treatment certificate can be sustained.

Moreover, even with a functioning system of anonymous treatment certificates, illegalized migrants would continue to experience stigmatization as "special patients" entering the healthcare system through parallel structures. As highlighted by Huschke (2013) and Castañeda (2007), such parallel systems can serve as a socio-political "fig leaf," normalizing the exclusion of certain groups rather than fundamentally challenging it. Access to medical care would thus be improved, but still marked by difference and bureaucratic complexity for those affected. Furthermore, the anonymous treatment certificate only addresses the health sector, leaving other essential areas, such as housing, education, and employment untouched. By addressing healthcare in isolation, there is also a risk that political decision-makers may perceive the situation of illegalized migrants as sufficiently improved, thereby reducing the momentum for broader reforms in equally essential areas. In addition, the anonymous treatment certificate may create new spatial exclusions: while the national-scale barrier of residency status is partially circumvented, access to healthcare now becomes contingent on residence within the city limits. Overall, while the anonymous treatment certificate marks an important improvement, it cannot fully compensate for the broader structural exclusions that illegalized migrants face.

Finally, while the anonymous treatment certificate constitutes a significant advancement at the local level, it can only serve as an interim solution. Structural exclusion mechanisms rooted in federal immigration policy remain intact, and truly equal access to healthcare and other social services for illegalized migrants ultimately requires changes at higher political levels. Without such broader reforms, municipal initiatives, however well-intentioned, can only partially mitigate the systemic inequalities faced by illegalized migrants.

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