preventable costs for society. Europe needs immigrants in order to ensure future productivity and welfare—and there are very good reasons to ensure the best possible health of the migrants right from their arrival in Europe.

Competing interests

The authors declare that they have no competing interests.

References


Migrant health: putting the economic argument into the context of deservingness debates

The main arguments for improving access to health care for marginalised groups, including migrants and ethnic minorities, have mostly been based on public health considerations, human rights claims and ethical principles of equity. However, the respective political debates often focus on economic arguments such as moral hazard, (presumed) health expenses, and the need to safeguard scarce resources. Acknowledging the role of economic arguments in political decision-making processes, researchers and activists have begun to pay more attention to the fiscal implications of limiting migrants’ access to care. As yet, however, empirical evidence on the economic implications of different policy responses to migration is scarce. As pointed out by Trummer and Krasnik,1 the ‘right to health care is acknowledged in many international declarations—however... only a few countries have adopted national policies on migrant and ethnic minority health to meet the challenges.’ They also cite several recent studies indicating that restricting access to care for those groups does not help save costs.

While we absolutely support the call for evidence of the economic consequences of exclusionary policies, we also want to point out the need for a better understanding of how economic arguments have been put forward within different contexts, and how such evidence can actually be moved into practice. According to our and others’ research,2,3 economic arguments are perceived and employed very differently in different contexts and in interrelation with a variety of other rationales.

Considering the central role of economic arguments in political decision-making generally, and considering furthermore the concurrent context of austerity specifically, one would expect that the costs of migrants’ exclusion will leave an impact on the political debate—all the more since they are corroborated by empirical evidence. Yet, in our experience economic arguments in support of migrants’ greater inclusion gain only scant attention; and suggestions for inclusive policy reforms continue to be regarded as impractical romanticism. More than that, the economic argument that, in an integrated health care scheme, migrants’ health needs would become a drain on the system continues to be used to justify exclusionary policies, although no empirical data is produced in order to verify it. In light of the evidence mentioned above the decision to maintain restrictions on migrants’ health entitlements seems self-defeating. Why not opt for a more inclusive alternative to resolve the tensions with international law and agreed-on ethical principles and, in the same breath, enjoy the economic (and public health) benefits of such policy reform? What are the reasons, really, that keep governments around the world from making such change?

In our view, what ultimately tips the scales in decision-making processes on migrants’ health entitlements are value-based, rather than evidence-based rationales; namely, discourses of deservingness. ‘[A]rticulated in a vernacular moral register that is situationally specific and context-dependent’4 these discourses demarcate right-holders from non-right-holders. Importantly, ‘deservingness debates often have less to do with empirical evidence than with... everyday responses to normative questions. These vernacular responses generally mix subjective attitudes and presumptions with taken-for-granted truths regarded as collective “common sense.”’ (ibid.) Moreover, these moral discourses are very different from universalistic human rights and public health ethical frameworks in that they absolutely discriminate; e.g. on the basis of national belonging or perceived contribution to society.

Are we arguing that these deservingness discourses are powerful enough to simply override all other factual and ethical arguments for migrants’ greater inclusion? Not exactly. The interaction between discourses of deservingness and other rationales is not straightforward in that evidence- and value-based arguments, knowledge and norms, ‘facts’ and ‘politics’ are interweaved in dialectic manners: not only do empirical facts influence the formation of normative positions; but also normative positions mold the generation and perception of factual ‘knowledge’, including in the field of health and evidence-based medicine.5 This interaction deserves further research. And more questions remain; e.g. why are discourses of deservingness so rarely invoked to legitimize exclusionary policy choices? What are the reasons that, instead, economic arguments that are unfounded or even belied by evidence are used to uphold exclusionary policies? How can we explain that these arguments persistently dominate the discussions on migrants’ access to care? And how can we explain that, by way of comparison, evidence-based arguments in favor of more inclusive policies barely succeed to attract political decision-makers’ interest? And finally: what are the consequences for us as researchers, if the influence of scientific evidence on political decision-making processes concerning...
migrant health policies is as limited? What role do we want (our research) to play? And how do we get there? We believe that, in order to gain relevance for the reality of migrant health policymaking, we will need to complement empirical evidence on the economic implications of restricted access to care with research that will try to answer the above questions from the perspective of different disciplines and different contexts.

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Granting health care to vulnerable groups of the population including asylum seekers is often regarded as a ‘benevolent handout (…) by state or third parties to ameliorate suffering of passive recipients of assistance’. As opposed to this, the notion of health as part of human rights obliges states—legally and morally—to protect, respect and fulfill their right to health. This includes the right to health care and the obligation of the signatory states with regard to the non-discriminatory realization of this right by refraining ‘from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum seekers and illegal immigrants, to preventive, curative and palliative health services’ (General Comment No. 14, emphasis not in original).

Asylum seekers, however, face legal restrictions with regard to their access to health care in many countries of the European Union (EU) as shown by the Report of the Migrant Integration Policy Index (2016). From a human rights perspective, restricting the access to health care based on residence status is a violation of the right to health and has to be abandoned. Opponents of this perspective usually counter that the probable only temporary stay in the reception country legitimates a temporary restriction of the right to freely access full health care services. In addition, resource constraints are frequently put forward by policy-makers to weaken the realization of economic, social and cultural rights, including the right to health. The argument of resource constraints legitimizes the different provisions for refugees in affluent and less affluent countries, but is commonly misused as excuse for discriminatory practices.

Resource constraints were also put forward by policy makers in Germany when the access to full health care for asylum seekers was legally restricted in 1993. The aim of the restriction was to reduce the budget spent on asylum seekers directly by reducing cash benefits and the access to health care and indirectly by deterring asylum seekers from migrating to Germany. Whether the (allegedly) temporary stay of asylum seekers allows for the denial of the full right to health care is still subject to juridical debates. Wherever it is not (yet) legally enforceable, its realization depends on scientific, public and political debate. A falsification of the common populist argument about resource constraints is a crucial step towards the non-discriminatory realization of the right to health and possibly even ignites further debates.

Empirical assessments in Germany show that the full realization of the right to health (care) for asylum seekers would not automatically increase the resources spent on their health—it might even reduce them. The average total health expenditure on asylum seekers in Germany between 1994 and 2013 was about 360 million Euro per year in absolute terms. Per capita health expenditures for asylum seekers subject to restricted care were on average higher than for those granted regular access comparable to the general population. This observation holds nearly throughout an observation period of two decades and is not compatible with the populist economic argument against granting full access to health care to asylum-seekers, namely that health care costs would rise or even skyrocket. On the contrary, these trends rather indicate that the legal restrictions may ultimately increase health care costs, e.g. due to delayed care, administrative costs, parallel structures, and the shift from primary to secondary or tertiary sector.

In order to prevent arbitrary violations of the human right to health, we see the need for a transparent decision making process in destination countries of asylum seekers who ratified the International Covenant on Economic Social and Cultural Rights. Such a process should consider core principles of a human rights approach including non-discrimination, participation, transparency and accountability. Gruskin and Daniels have developed such a process linking principles of procedural justice and human rights. Their idea of ‘accountability as reasonableness’ acknowledges the need for democratic decision making over scarce