Irregular Migrant Access to Care: Mapping Public Policy Rationales

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Both the USA and Europe limit access to care by undocumented immigrants (‘irregular migrants’ or IMs). In the debate over what level of access to confer to IMs, there are various public policy rationales operating either explicitly, or below the surface, ranging from minimalist humanitarianism to full cosmopolitan equality, with several intermediate positions between these two poles. This article informs the international debate by providing a conceptual mapping of these underlying policy rationales. Each position is based on different lines of reasoning or bodies of evidence, and each leads to somewhat different conclusions about the extent to which IMs should have access to different types of health care.

It is unlikely that broad consensus will be achieved in this ongoing debate. However, by articulating the ethical, legal, pragmatic and conceptual reasons to support or oppose various positions, we hope to help determine where in the landscape of reasoned argument various positions lie, and how each position might be best supported or refuted. In particular, we see in this debate an illustration of Michael Walzer’s classic analysis of competing spheres of justice. Various positions depend to a considerable extent on whether their advocates approach this issue from the health policy sphere rather than the sphere of immigration policy, or whether they attempt to blend the two spheres.

Introduction

This article seeks to inform the international debate over access to health care for irregular migrants (IMs), by specifying the public policy rationales that underlie different positions in this debate. Through this conceptual mapping of reasons to support or oppose various positions, we hope to help determine where in the landscape of reasoned argument various positions lie, and how each position might be best supported or refuted. In doing so, we draw from examples and literature both in Europe and in the USA. But, because we are US-based, we start with a summary description of its current access policies for IMs and compare this briefly with the pattern reported in Europe.

In the USA, IMs do not qualify for any insurance coverage subsidized by the government. Legal immigrants become eligible for either public coverage (Medicaid, for those in poverty) or subsidized private coverage (through ‘Obamacare’s’ new insurance exchanges) only after they have had permanent residency status for 5 years (Kenney and Huntress, 2012; Glen, 2013). Short of that, low-income IMs receive care only through a patchwork of more-or-less voluntary ‘safety net’ programs and providers (Gusmano, 2012; Hall and Rosenbaum, 2012). By law, US hospitals (most of which are privately owned) must treat patients who are in serious emergencies regardless of their ability to pay or their citizenship status. Most US hospitals do more than this, however. Because they are nonprofit and claim tax exemption as charitable institutions, they provide a certain amount of elective care at greatly reduced rates for patients unable to pay, regardless of citizenship.

For primary care services and prescription drugs, IMs can receive care from federally funded community health centers that exist in or near most communities (Hall and Rosenbaum, 2012). They charge modest amounts based on income. Many communities also have free clinics staffed by volunteer providers that provide more limited services. What is seriously lacking, however, is organized access to specialist physician services (Hall, 2013). Moreover, this patchwork of safety net services has substantial geographic gaps (areas with no clinics or charitable hospitals), and existing safety net providers and programs often are not well coordinated among themselves.
A broad overview of IM access to care in Europe reveals an equally complex tapestry, but one that, from low-resolution/high-elevation view, does not differ dramatically from IM access in the USA. In Europe, very few, if any, countries provide IMs access to care on a basis that is equal or roughly equivalent to coverage by their national insurance systems (Dwyer, 2004; Romero-Ortuno, 2004; PICUM Platform for International Cooperation on Undocumented Migrants, 2007; European Commission, 2008; The Huma Network, 2009; World Health Organization, 2010; Bjorngren Cuadra and Cattacin, 2011; Rechel et al., 2011; Cuadra, 2012; Dauvrin et al., 2012; Gray and Van Ginneken, 2012; Martinez et al., 2015; Woodward et al., 2013). Instead, access is fairly universal only for emergency services or urgent care. IM access to primary care services is also fairly widespread, but for elective hospitalizations or specialist physicians, access in Europe is spotty, difficult or nonexistent (other than through charities).

For example, Spain had been among the most inclusive European countries until 2012. Prior to then, all residents, including undocumented migrants, were eligible to enroll with its national health service (Gray and Van Ginneken, 2012). To do so, however, they were required to show residency and identify documents to local officials, which exposed them to potential legal enforcement. In 2012, Spain restricted this requirement of equal access to cover only emergency services, pregnancy and children. Other European countries are even more restrictive. In Sweden, for instance, undocumented migrants ‘including children, pregnant women or persons in emergency situations or with serious infectious diseases, do not have any access to health care free of charge’ as a matter of national law or funding (The HUMA Network, 2009: 7). However, many local authorities and public hospitals in Sweden provide some, varying levels of access using their own funding.

These inequalities of access have produced ongoing and unresolved debates, in policy circles addressing both health care and immigration, about whether these limitations in access for IMs are ethically just (Dwyer, 2004; Viladrich, 2012). Reflecting the diversity of programs and practices that we have briefly summarized, there are a wide variety of arguments based in public policy that support or counter different levels of access for IMs. Based on our extensive literature review, this article categorizes and describes the most frequently encountered or conceptually distinctive public policy arguments, and analyzes their strengths and weaknesses.

We begin with the minimalist humanitarian position that supports only care in dire emergencies, and then consider arguments that would treat all residents on an essentially equal basis, without regard to citizenship or social status. After considering these two extremes, we survey several lines of argument that support more intermediate positions, giving both instrumental and normative rationales for compromising full access while providing substantial levels of care in at least some circumstances beyond dire emergencies. More than just tools to advance one’s predetermined position, this conceptual mapping can help to evaluate whether existing policies and practices actually adhere to prevailing notions of public policy, and how reasoned analysis might best address deficits and inconsistencies.

The Minimalist Humanitarian Position

The universal practice of providing IMs health care in at least emergency situations is supported by a widely shared and deeply felt humanitarian ethic, which compels individuals, institutions and society to come to the aid of any person in serious distress. There are numerous bases for this ethic, from religious, to empathic, to what might be viewed as a nonaltruistic distaste for witnessing avoidable suffering (Shepherd, 1996). A basic humanitarian ethic is also strongly supported by universal principles of medical professionalism and the deeply felt personal motivations of those who practice the healing arts.

The humanitarian ethic applies universally—regardless of citizenship status, deservedness or even the perverseness of conduct by the person in need. This ethic compels some level of care, at least in critical situations, for strangers, for tourists and even for those who would wish our own destruction. According to the Geneva Convention (Gross, 2006), soldiers in armed conflict ‘shall be treated humanely and cared for by the party to the conflict in whose power they may be, without any adverse distinction founded on . . . [nationality]. In particular, they . . . shall not willfully be left without medical assistance and care . . . Only urgent medical reasons will authorize priority in the order of treatment to be administered [as between one’s own soldiers and the enemy’s]’. This Convention may state a level of aspiration somewhat beyond realistic expectations for human behavior following the heat of battle, but its idealism captures the principle that an obligation for some basic level of humanitarian care applies to any person in need, regardless of their status or blameworthiness.

This humanitarian instinct is universally shared, however, only at the minimalist level of treating those who are in deep distress or critical suffering. Sometimes
referred to as the ‘rescue ethic’, this principle focuses on situations of acute crisis where any substantial delay or significant denial may cause loss of life or serious permanent injury. It does not address as clearly or universally the many components of care that help to keep acute medical crises from occurring, that lessen the burden of chronic illness, or that improve functioning within normal tolerable ranges.

An expanded version of the base humanitarian ethic could, more empathically however, reach beyond life- and-limb crises to include all situations of human suffering that medicine is capable of significantly relieving, especially when such relief is relatively easy and inexpensive to accomplish (Shepherd, 1996). We all agree that the starving person should be fed, but what about one who is hungry, even if not emaciated? Because we can easily empathize with this form of suffering, and because alleviating hunger is simple and inexpensive, few people would be so callous as to deny easily available food aid simply because in some sense it is not deserved or obligatory. But, at what point does suffering become tolerable (or even ‘character building’), and at what point does society’s or individual’s ability to ease suffering become impractical?

Much of the same can be said for medicine. In routine, primary care or urgent care situations, our ability to greatly relieve significant suffering with only modest expenditure of resources can compel undifferentiated inclusion of all people, even in nonemergency situations. But, as is so often the case, drawing administrable lines that define the limits of a shared humanitarian ethic can prove difficult. We might all agree to generic antibiotics for bacterial infections, pain medication for acute injury, bandages to stop bleeding and simple surgery to lance boils. But, what about repairing hernias, controlling arrhythmias, replacing worn joints or diagnosing complex and mysterious ailments? To seek broader and clearer consensus, we turn to additional public policy rationales.

Full Equality

The strongest egalitarian position is that IMs are entitled to full health care access on terms equal to that provided to citizens generally. Arguments have been framed on two distinct bases: ‘cosmopolitanism’ global justice (Wild and Heilinger, 2013), and fundamental human rights (Cole, 2007; International Organization for Migration, 2013). Cosmopolitan global justice argues that societies should not disadvantage immigration because people are entitled to move from place to place as they wish, without legal or social barriers. The argument based on human rights is that governments are obliged, and have agreed to, support and defend certain fundamental human rights regardless of citizenship or residence, which include the right to health, and a subsidiary right to equal access to care.

In broad summary, cosmopolitanism reasons that being born into the privilege and opportunity of citizenship in a developed democracy is a contingency over which we have little control (Carens, 1987). Because justice requires that fundamental opportunities should not be distributed on such an arbitrary basis, excluding immigrants is unjust. But, these arguments have proven difficult to defend in the face of the felt need to establish and maintain national sovereignty (Bosniak, 2006). There are many forceful counter arguments to the effect that societies are not only entitled to, but required to, create and defend borders.

There are several reasons why this is so, but perhaps the most compelling is that advanced by Walzer (1983): if governments fail to defend borders effectively, residents will do so themselves, but in locally enforced ways that are much more restrictive of liberty and social welfare than if done more collectively. Thus, it promotes liberty and welfare and promotes the integrity of a community for governments to define the conditions of citizenship and differentiate between members and nonmembers. Part of that differentiation, naturally, is entitlement to social services such as health care.

Although restriction of social services is broadly consistent with enforcing national immigration policy, denying all benefits is not necessarily an essential component of effective immigration policy. To the contrary, noncitizens are entitled to certain fundamental legal protections regardless of the legality of their status. For instance, they cannot be denied due process, tortured, summarily executed or subject to inhumane conditions of confinement. In the USA, the Supreme Court has ruled that it violates equal protection to charge parents of illegal immigrant children for the primary school education that citizen tax payers receive for free, because doing so would ‘perpetuat[e] . . . a subclass of illiterates’ (Plyler vs. Doe, 1982).

Does any level of health care access beyond emergency care merit the same human rights protection? James Nickel (1986) argues that a ‘humanitarian account . . . holds that all persons have moral claims against others to need assistance in obtaining the requirements of survival and a decent life’, and although it is unclear what level of health care such a requirement would entail, it does not argue for full, equal access to all care. To reach that extreme, we turn to the well-considered argument that human rights law requires fully equal health care access for IMs.
European countries (but not the USA) have signed the International Covenant on Economic, Social and Cultural Rights. Its article 12 recognizes ‘the right of everyone to the enjoyment of the highest attainable standard of physical and mental health’, and the obligation of states to ‘assure to all medical service and medical attention in the event of sickness’, as well as the ‘prevention, treatment and control of . . . diseases’. These provisions could have quite a broad range of meaning and import, so to clarify, the Convention’s Committee on Economic, Social and Cultural Rights has issued an authoritative ‘Comment 14’, which specifies that states are ‘under the obligation’ to refrain ‘from denying or limiting equal access for all persons, including . . . illegal immigrants, to preventive, curative and palliative health services’ and to refrain ‘from enforcing discriminatory practices as a state policy’.

Despite this crystalline clarity, non-compliance with the Convention’s edicts is widespread (Romero-Ortuno, 2004; Platform for International Cooperation on Undocumented Migrants (PICUM), 2007; Cuadra, 2012). Perhaps the interpreting committee has over-reached. Although some level of health protection is an aspect of fundamental human rights, many people are not convinced that states must provide the ‘highest attainable’ level of health, regardless of circumstance. Certainly this is not how states behave, and there are strong reasons to think that attempting to achieve such idealism would be foolhardy, even for citizens. Adding to this utopian ideal, a mandate to provide equal access to undocumented immigrants is even more implausible and inconsistent with established practice and social policy. Arguing the case legalistically—that full equality is mandatory because countries agreed to be bound by subsequent interpretations—is not likely to win many heartfelt converts (Dwyer, 2004). Even those who believe in the principle might correctly object that other aspects of health promotion—such as environmental threats or social determinants of health—are more pressing, and should receive greater priority, than access to health care.

In short, arguments for full equality of access struggle to find convincing footholds in widely held public policy rationales. Thus, we next turn to additional arguments that might support a lesser, but still fairly robust, level of health care access.

**Instrumental Middle Grounds**

Access to care by IMs is often argued on bases that are explicitly or implicitly instrumental. Perhaps a certain level of access is not obligatory or entitled on its own merits, but providing health care might serve other important interests or objectives. See, for instance, Ziv and Lo, 1995; King, 2007; Nandi et al., 2009; Zuber, 2012; Glen, 2013.

**Nonmedical Instrumental Reasons**

One instrumental justification for not refusing IMs is simply that to identify who is and is not a legal resident would require that all people seeking care establish their valid credentials. In emergency settings, this is impractical. In other settings, institutions or citizens might prefer to dispense with credential checking simply to avoid the annoyance or intrusiveness of everyone having to validate themselves. It is roughly on this basis that community health centers in the USA provide primary care access to IMs. Many do this not so much from an affirmative policy of serving this population as from an institutional policy of operational simplification that dispenses with any status or citizenship documentation. This style of argument become less convincing, however, as health care services become more specialized and expensive.

A counter-instrumental position focuses on immigration policy. Some argue against expanding health care access because doing so encourages more illegal immigration, or, stated in the converse, denying care would deter illegal immigration. Denying health services based on immigration status can also be reasoned on more overtly normative grounds, as an aspect of punishment for law violation. We explore this perspective below. Here, we consider only the limited version of the illegality argument that focuses in a strictly instrumental fashion on whether denying health care deters illegal immigration or granting access encourages this.

As such, this strictly instrumental version of the illegality argument lacks strong empirical support. Various studies have failed to confirm that immigrants enter host countries primarily to receive better health care (Berk et al., 2000; Yang and Wallace, 2007). Instead, the dominant motivations for immigration have been shown strongly to be seeking better economic opportunities or avoiding political or other forms of persecution (International Organization for Migration, 2013). Or stated in the converse, denying care is not likely to deter illegal immigration. Illegal immigrants have many other things to fear more than limited access to health care, starting with the physical hazards of border crossing, detention, deportation and living lives in the shadows of society (Glen, 2013: 230). It lacks plausibility that failing to expand health care
access would add measurably to a potential immigrant’s utilitarian calculus.

Medical Instrumentality

The most obvious version of medical instrumental reasoning is that granting IMs expanded access might cure or prevent infectious disease (Zuber, 2012: 270). Immigrants sometimes bring in diseases that have either been eradicated from the host country or have taken on a new form to which residents might be especially susceptible (Pelner Cosman, 2005). And, for communicable disease already present in a host country, refusing to treat IMs might increase citizens’ exposure by reducing the population’s ‘herd immunity’ (Nandi et al., 2009). This may be a compelling public health argument, but clearly it extends only to the treatment or prevention of communicable conditions.

Instrumental considerations also can support, however, a degree of access to primary care or specialist services that would avoid or reduce the need for emergency services. Considering the pervasiveness of the base humanitarian ethic, described above, a community can expect to bear at least the costs of care in true emergencies, but many such emergencies might be avoidable through earlier and less-expensive interventions (Kullgren, 2003; Nandi et al., 2009). For instance, maternity care reduces the costs of premature delivery. Moreover, in the USA, all newborns automatically become citizens and thus are immediately eligible for publicly subsidized care; this provides an instrumental basis for maternity treatment that can minimize congenital defects, for instance.

These instrumental arguments provide some basis for a middle ground of access that lies between a minimal humanitarian ethic for only emergency services and the full-throated egalitarian ethic described in the next section. This middle ground is limited, however, by the extent and strength of its supporting consequentialist arguments or evidence. Much preventive care does not actually reduce later health care costs, or does so only for categories of patients who are at elevated risks (Neumann and Cohen, 2009). We are accustomed to pointing to such potential savings to bolster the argument for screening, prevention or earlier intervention, but frequently those positions are ones formed primarily out of a concern for improving health. If cost savings can help advance the health promotion goal, then all the better, but those making this argument usually do not mean to limit optimal care to only services that actually reduce overall costs. Instead, they aim to improve health through whatever means are achievable.

Thus, we turn next to address the egalitarian arguments head on. Based either on the rights or the well-being of IMs, should they receive access to care that is the same or similar to that enjoyed by most citizens?

Partial Entitlement

Returning now to normative arguments, we next consider arguments based on individual entitlement or deservingness. These arguments are not entirely distinct from arguments based on social obligation, but they are cast in a somewhat different fashion that generates additional insights. One starting premise is that societies should aspire to treat members equally if they are equally entitled to or deserving of social benefits. This, naturally, begs the question of what entitles one to health care access in a particular society. In a market-based society, ability to pay determines entitlement, and so IMs should not be denied private insurance if they are able to pay market rates. But that hardly needs to be said since market economies are unlikely to bar those with means to pay.

For social insurance that is publicly funded, society itself defines the terms of entitlement, which typically equates to some definition of membership in the society, such as citizenship or long-term legal residence. Whether IMs are entitled therefore conflates with whether IMs should be regarded as full members of society. By definition, IMs are not regular members and so do not qualify (Kershnar, 2002). But, are the social rules that determine regularity (and thus entitlement) themselves not well justified? On this question, multiple positions exist.

Communitarianism

From the more inclusive perspective, IMs should be regarded as entitled or deserving members for at least some purposes because they often contribute to social welfare in the same ways that other productive members of society do, including paying at least some taxes (Nickel, 1986; Dwyer, 2004). This claim is often doubted (Pelner Cosman, 2005; Martin and Ruark, 2010; Zuber, 2012; Stimpson et al., 2013), but when disputed it is sometimes well supported by the available evidence (Nickel, 1986; Mohanty, 2006; Glen, 2013; Heavey, 2013). Earning their keep is an especially defensible claim to make with regard to health care, considering evidence from many countries that immigrants, including irregulars, use much less health care than the general population, even when provided full access (Goldman
trespassing, shortchanging the tax-collector and the crime. Citizens violate laws every day—by speeding, necessarily convert one’s very existence into an ongoing noncompliance with legal requirements does not necessarily count, it must be as an aspect either of punishment or deservingness. A punishment rationale can be an aspect of retributive justice, or simply a delineation of the status that determines initial eligibility for access. Here too, conflicting positions abound.

Opposing the argument for punishment is the observation that having entered or remained in technical noncompliance with legal requirements does not necessarily convert one’s very existence into an ongoing crime. Citizens violate laws every day—by speeding, trespassing, shortchanging the tax-collector and the like—but they remain fully entitled to basic social services. As Ruth Faden puts it, ‘People who are in this country illegally have broken our laws, but the magnitude of their crime does not justify depriving them of the basic right to health care coverage while they are in our midst’ (Faden, 2009). Moreover, one can question whether it is the role of health care providers and institutions to act as enforcers of immigration laws. Certainly, many physicians and hospitals do not want to act as border patrol officers while caring for the sick.

But, short of denying all access, should the simple illegality of one’s immigration status carry at least some social onus? Full analysis requires a much more developed analysis of the bases for immigration rules, the structure of social programs (not just for health care but for other institutions and services) and the general purposes of punishment. Space certainly does not permit all of that here, but even if it did, we are very unlikely to identify any bases for broad consensus.

What we can say, however, is that many intermediate positions lie between the two poles of making illegality completely disqualifying and denying that it has any relevance. An impure compromise is much more achievable than a highly principled victory or defeat. And, once again, particular social conditions matter a great deal. Some countries (e.g., Finland, Sweden, Bulgaria, Romania) attach less legal and social significance to irregular immigration status than do others (such as Italy, France, Portugal and The Netherlands), and this attitude can change over time within a country (Cattacin and Chimienti, 2007; Willen, 2012), as it has over the past few years in the USA. In some social settings, irregular status is more or less openly tolerated as long as immigrants are otherwise law abiding, because of their economic and social contributions (filling essential but undesirable jobs). In other settings, society feels the need to restrict immigration laws and more strictly punish their violation, out of concern that immigrants are depleting economic and social resources. These malleable conditions and attitudes understandably influence opinions on deservedness for social services.

Conclusion

Base humanitarianism and full equality bracket the two extremes in the range of arguments for and against access to health care for IMs. The minimalist position supports only essential care in acute emergencies where life and limb are immediately at stake. The full egalitarian position regards health care as a basic human right that should be assured to everyone, regardless of status...
or circumstance. In between these polar positions are a wide variety of intermediate positions—some based on pragmatic consequences and others based on normative principles. These middle grounds more accurately capture the complexity of access to care that developed democracies actually choose to provide to IMs. However, they do not cohere around a dominant rationale.

In each of these categories of argument, one can note different blends of reasoning based on considerations of either health policy or immigration policy. Some arguments primarily reference concerns about human suffering, public health and the roles and responsibilities of medical professionals. Other arguments focus primarily on the legal status of immigrants and the need to control borders and enforce laws. Still other arguments combine elements from both sets of considerations.

Michael Walzer (1983) famously wrote about the different social and political spheres in which theories of social justice are constructed and implemented. Eschewing any grand scheme to achieve an overarching theory of justice, he argued that justice principles must be constructed more pragmatically to meet the felt needs and complex conditions of different economic, social and political arenas. The same can be said for public policy more generally. It is not inconsistent or irrational for one set of principles to govern ordinary product markets and another to govern labor markets, for schools to function differently from churches or political parties.

The difficulty we face in reaching clearer resolution of IM access to care is uncertainty over which policy sphere should govern. Should access be subsidiary to principles in the immigration sphere, or to those in the health care sphere or a blend of both, and if so in what proportions or priority?

Although there is broad commonality among developed countries in the general levels of health care access they actually provide to IMs, there is great diversity in the rationales used to support these levels, and debates over whether or not existing access is justifiable. Differences in these reasoned positions exist to a considerable extent because of the proponents’ implicit or explicit frames of reference. Starting from the assumption that IM access is an issue of health care policy is likely to lead to a markedly different conclusion than viewing IM access as needing to fit within a framework of other immigration policies. Because no overarching theory is likely to convince us which sphere governs, fundamental differences in perspective are bound to persist. It is not our purpose here to resolve these differences, but rather to encourage continued debate that is thoughtful and well-reasoned over IMs’ access to care.

Notes

1. Terminology in this field can be confusing and difficult to define precisely, due to the variety of non-citizen categories that exist in different countries. In general, we mean to refer to noncitizens people who are not legal permanent residents. Many of them will be in the host country illegally (which we refer to as being ‘undocumented’), either because they entered without permission or they overstayed an entry that initially was legal. Other IMs, however, are in the host country legally, but only temporarily.

2. Cuadra (2012) claims that 10 European countries do not provide emergency care to IMs, but they refer to free care rather than willingness to treat regardless of ability to pay. In many countries, including the USA, hospitals will charge patients for the emergency services they receive, but what is essential for our analysis is that, universally, hospitals will provide emergency patients at least some treatment regardless of their ability to pay.

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References


