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Universal Access to Health Care for Migrants: Applying Cosmopolitanism to the Domestic Realm

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This article discusses cosmopolitanism as the moral foundation for access to health care for migrants. The focus is on countries with sufficiently adequate universal health care for their citizens. The article argues for equal access to this kind of health care for citizens and migrants alike—including migrants at special risk such as asylum seekers or undocumented migrants. Several objections against equal access are raised, such as the cosmopolitan approach being too restrictive or too permissive, or the consequences being undesirable; but the objections are largely refuted. Some special cases in which a restriction of equal access to health care might be justified are described: humanitarian crisis, short term tourism, and the case of a migrant or refugee who will stay only very briefly on a state's territory.

Introduction

Nationals and non-nationals do not have equal access to health services in many countries. For example asylum seekers are legally entitled to emergency care in only 10 of 24 European countries (Norredam *et al.*, 2006). The majority of countries also restrict access to health care for undocumented migrants in various ways (Cuadra, 2012). Italy, Spain and Canada have been examples for exceptions to this rule, in that they long provided universal health care for undocumented migrants and citizens alike. However, Spain has recently restricted health care for undocumented migrants—and was heavily criticized for this by the European Committee of Social Rights (Council of Europe, 2014). Similarly, the Canadian government has pledged to continue to attempt to scale back on medical entitlements to newcomers, even though its 2012 cuts to refugee claimants' health were found by a Federal Court to violate constitutionally protected rights (Black, 2014).

Such restrictive practices stand in stark contrast to international human rights law, as outlined in numerous conventions and declarations. These include among others the Universal Declaration for Human Rights, the Constitution of the World Health Organization, the

International Convention of the Rights of the Child, and the International Convention on the Elimination of All Forms of Racial Discrimination. The declarations emphasize a generalized duty to all persons based on human rights, which in turn are founded on a cosmopolitan ethics, which 'takes the individual to be the ultimate unit of moral worth and to be entitled to equal consideration regardless of her culture, nationality of citizenship, besides other morally arbitrary facts about her' (Tan, 2002, p. 431).

The Universal Declaration of Human Rights, for example, states that 'Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including [...] medical care [...], and the right to security in the event of [...] sickness, disability' (United Nations, 1948).

Similarly, Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) affirms the 'Right of everyone to the enjoyment of the highest attainable standard of physical and mental health' including not only 'the prevention, treatment and control of epidemic, endemic, occupational and other diseases' but also the 'creation of conditions which would assure to all medical service and medical attention in the event of sickness' (OHCHR, 1976).

More recently, binding legal interpretations of the normative content of the Right to Health focused on the need for non-discrimination when it comes to non-nationals. In relation to migrant health general comments from the Committee on Economic, Social and Cultural Rights (which monitors implementation of the ICESCR) set forth clear obligations by specifically prohibiting migration status as grounds for denying access to health services: ‘States are under the obligation to respect the right to health by, inter alia, refraining from denying or limiting equal access for all persons, including [. . .] asylum seekers and illegal immigrants, to preventive, curative and palliative health services’ (CESCR, 2009).

The obligation to ensure access to health care as outlined are met only partially, or not at all, in the majority of countries which provide universal health coverage for their citizens. The breadth of this gap between international law and domestic practice has received increased attention by activists concerned by lower levels of access to health care for migrants, and particularly from within countries that provide universal health coverage for their own citizens, given the obvious injustice of such double-standards.

Despite such attention, a detailed discussion of the normative grounds of the specific type or level of access to health care is almost entirely lacking. Although the empirical picture emerging from studies and reviews that are being conducted is one of great complexity, the normative one is much clearer: despite clear obligations set forth in international law certain groups of migrants do not have equal access to health care services in most countries, and this situation appears to be at risk of worsening rather than improving. Furthermore the number of people who are experiencing forced displacement is—for the first time since World War II—higher than 50 million (UNHCR, 2014). Never then, has scholarly discussion of the moral foundations of universal health coverage and of the questions of whether and how states should provide access to migrant health services, been more timely.

Many fields of study intersect on the question of migrants’ access to health care and this article, although primarily concerned to apply an ethical theory known as cosmopolitanism, will draw from them. This is a necessity in part because the question has not been the subject of direct and discerning debate in any single field of school of thought more thoroughly. The rights of migrants have been widely discussed by political philosophers, for example, but the specific question of a right to access to health care for migrants has been only marginally addressed (Carens, 2013). Similarly, moral

philosophers have endeavored extensively to apply theories of justice to the health sector and health policy formulation (Daniels, 1985; Powers and Faden, 2008; Venkatapuram, 2011) but few have focused on the specific situation and vulnerabilities of immigrants. Scholars concerned with global health ethics have discussed—among other topics—what affluent states owe to people living in less affluent countries or to the development of their health system (Benatar and Brock, 2011), but much less has been written about what affluent states owe to non-nationals within their frontiers.

In the face of this general lack, Gillian Brock argues that a cosmopolitan ethics perspective could provide a convincing moral foundation for access to health care for migrants (Brock, 2015). According to her ‘cosmopolitans standardly believe that every person has global stature as the ultimate unit of moral concern and is therefore entitled to equal respect and consideration no matter what her citizenship status or other affiliations happen to be’ (Brock, 2015, p. 3). Thus, Brock suggests a global *justice*-based approach in order to define the level of health care for migrants, and hence a *moral duty* to provide health care, in comparison to the general but in her view mistaken *charity*-based approach, which results only in an *optional matter* at best. Brock claims that on the basis of cosmopolitanism: ‘we must be willing to address some of the ongoing vulnerabilities non-compatriots currently face. At least one effective way in which we can do this is through addressing the health needs of non-compatriots who are residents of our community’ (Brock, 2015, p. 8). She also claims that helping non-compatriots within borders is not only demanded by cosmopolitanism, but, as she says, ‘somewhat over-determined by various ethical frameworks, including those associated with Good Samaritanism, Obligations of Mutual Aid or the Duty to Rescue’ (Brock, 2015, p. 8) and that the burden of proof lies with those who deny the robust claim that affluent countries have a duty to help vulnerable migrants.

Brock’s paper offers a convincing start to address health of migrants through a cosmopolitan lens, but there are two problems.

First, the application of the cosmopolitan argument to access to health care for migrants is not spelled out in detail. It remains particularly unclear what *type* or *level* of access to health care her justice-based account demands for.¹

Second, and in relation to the first problem, there is an irritating tension in Brock’s argument. She expresses a need to find out, ‘which health needs count as urgent and what counts as a low to moderate

cost that we can reasonably be expected to bear' (Brock, 2015). This fits well with the Duty to Rescue or Good Samaritanism, which she also refers to. But isn't this indirect and maybe unintended implication of a lower level of health care for migrants as compared to citizens only a half-hearted embrace of cosmopolitan ethics?

In attempting to overcome some of these tensions I will use Brock's article as a starting point by expanding on earlier ideas (Wild and Heilinger, 2013) to use cosmopolitanism as the moral foundation for access to health care for migrants.

Another approach is a useful resource for this article. In Joseph Carens' work on the moral rights of undocumented migrants and temporary workers—such as basic human rights (e.g. freedom of speech or religion), children's rights, work-related rights and social and administrative rights—Carens argues why these rights should be equal to those of regular citizens (Carens, 2008, 2013). He provides a detailed analysis of rights related to earning, working conditions or child education and provides arguments why it is not justified to apply different rules for 'irregular migrants' or temporary workers as compared to regular citizens. His method of developing arguments and rejecting possible objections is convincing and a similar method is applied in this article. However, Carens mentions health care only very briefly. He merely claims, that every 'person has a right to receive lifesaving medical treatment' (Carens, 2008, p. 167) and calls emergency health care a human right (Carens, 2013, p. 253). Carens does not specify his claim further and many questions remain open regarding health.

This article is thus also inspired by Carens' ideas of equal rights of migrants and citizens, and it will try to explain why 'lifesaving medical treatment' or 'emergency health care' are not the appropriate terms to aim at.

The principal purpose of this article is to present arguments for a cosmopolitan ethics of migrant health. As mentioned above, for decades the international law has been based on a cosmopolitan approach, but this normative foundation has not been spelled out in more detail. Ultimately the article intends to answer the question: 'What type or level of access to health care migrants should receive?'. However, it can only be seen as one first attempt to spell out cosmopolitanism as the foundation for the provision of health care. More work needs to be done to broaden the debate, and contribute to critical thinking especially around emerging patterns of migration and alarming trends with regard to migrants' access to health care in high-income countries.

The first section provides some clarifications on definitions and the scope of the article.

In the second section I argue for universal access to basic health care for citizens and migrants alike on a given territory, unless there are justified objections. I provide one possible way of interpreting the cosmopolitan argument, and develop the central thesis in three steps:

- (1) Health is a primary good that—*prima facie*—generates a cosmopolitan obligation for meeting health care needs for each human being equally.
- (2) The current global health situation is, evidently, far from ideal given how a large number of human beings do not even receive basic access to health care, but for some states it is easily practicable to provide equal and sufficiently adequate access to health care for all human beings within its own territory.
- (3) The easy practicability of fulfilling cosmopolitan demands within borders justifies the moral obligation especially for affluent countries to provide universal access to health care for migrants and citizens alike, unless there are justified objections.

The third section will challenge this central thesis by discussing possible objections, such as the approach being too restrictive or too permissive, or the consequences being undesirable. The discussion of the objections will ultimately help to enforce the central thesis of equal access to sufficiently adequate health care for all who are within a state's territory.

Clarification of Scope

Some clarifications regarding scope and definitions are necessary:

First, as many *migrants* are naturalized citizens or as they have a residence permit, they are often entitled to the same ways or levels of accessing health care as citizens are. Thus, not all 'migrants' per se are excluded from certain health services. Those who are at risk of receiving restricted access to health care (in some countries, not in every country) and are therefore at increased risk of illness and the complications of untreated illness or injury, are those without a full residence permit. There is a multitude of subcategories defining such groups, and the definitions vary from country to country. Migrants that fall into this category are for example refugees, temporary workers, asylum seekers, undocumented migrants, rejected

asylum seekers, persons with exceptional leave for humanitarian reasons etc.² This article specifically encompasses the situation of these migrant and refugee groups and I will refer to them in the following as ‘migrants at special risk’.

Second, I will focus only on *access to health care*, not on health in general. Health in general is a much wider field, and requires a far more comprehensive approach, such as theories of social justice in health (Powers and Faden, 2008) or theories of just health (Daniels, 2008), part of which I have addressed elsewhere in relation to health of asylum seekers (Wild, 2013). Access to health care is only one aspect, and possibly not the most determinative one, of the relationship between health and the broader social determinants of well-being, including housing, employment, education, etc. Furthermore, equal access to basic health care does not ensure equal treatment, but this is again an issue beyond the remit of this discussion.

Third, by equal or universal access to health care I imply that there must be a *sufficiently adequate* health care package provided by the state or entailed in a health insurance scheme.³ Thus, the argumentation in this article will inevitably focus on states that can ensure such kind of health care, for example through universal health care provided by the government funded by taxes (e.g. UK); universal health insurance, paid by employee and employer, and government paying for those who cannot afford it (e.g. Germany); universal health insurance, paid by the citizens who choose from a selection of private plans, and government paying for those who cannot afford it (e.g. Switzerland); or systems which combine elements of these three types (e.g. Canada). Despite differences in many details, all these systems have in common that some kind of *universal basic health care* is provided for all, and—if necessary—providing access to the universal health care also for those citizens who would not be able to afford fees for health insurance. State subsidies to provide access for the poor are usually funded by citizens’ taxes.

I will claim that the content of such a sufficiently adequate health care package should be equal for citizens and migrants alike, hence the type of diagnostic, selection of covered diseases and possible treatments. It may be that different administrative ways of accessing this health care package are necessary for migrants at special risk, for example by using a different insurance card or insurance model to protect undocumented migrants from discovery, but it should be ensured that the access is barrier-free and even if by a different insurance

model, no hindering steps should have to be taken to access this sufficiently adequate health care package.

Arguing for Universal Access to Basic Health Care

As mentioned above the cosmopolitan approach as such has not been well developed in relation to health care for migrants. In the following I propose that health is a primary good that underwrites human capabilities or opportunities. Health care thus counts as a fundamental need that justifies both the basic right to have one’s needs met and a universal cosmopolitan obligation to attempt to meet the basic needs of every human being within a single national jurisdiction (i.e. making access to health care blind to citizenship as a matter of justice). The universal importance of meeting health needs along with specifying the role of the state and the rationale for this role, support the normative claim of equal access to health care. The claim I make is straightforward and involves three steps:

1. *Health is a primary good that—prima facie—generates a cosmopolitan obligation for meeting health care needs for each human being equally.*

My argument starts from the widely held premise that health is a so-called special or primary good. The importance of health derives from it being an essential and primary contribution to laying the ground for a decent life. Sudhir Anand (2006) shows that this claim has been made throughout the ages, from ancient Greek texts to this day. Amartya Sen, for example, very prominently classifies health ‘among the most important conditions of human life and a critically significant constituent of human capabilities which we have reasons to value’ (Sen, 2006, p. 23). The special importance then to *meet* health needs derives from the existential importance of health itself (Walzer, 1983, pp. 86–91; Daniels, 2001). I follow these accounts and presuppose a primary ‘importance to meet health needs’.

Traditionally it has been argued on the basis of the fundamental importance of meeting health needs that it is within the responsibility of the state to provide access to health care for its citizens. Most theories of justice in health care have incorporated this view, and argue on the basis of domestic theories of social justice. Commonly, such theories use the word ‘citizen’ when arguing for rights and duties in health care, but the argument here is that a modest extension of this argument about the fundamental importance of meeting health is

needed. Since health needs are independent of nationality, the traditional focus on *citizens* who require health care has to be extended to include *all human beings* on a state's territory.

This argument is similar to Shlomi Segall's luck egalitarian argument about the non-excludability of health care: 'The nonexcludability of medical care, we may say, is spatial rather than personal. That is to say, it is impossible for us to withhold medical treatment from the needy, not because of her identity of membership (as a citizen opposed to noncitizen) but because she happens to be within the political boundaries over which we exert responsibility for meeting basic needs [...]. In other words, it is the space and not the identity of the individual that tracks our obligations here' (Segall, 2010, p. 80). This form of luck egalitarianist logic which seeks to compensate for disadvantages that do not lie within the responsibility of individuals, offers instructive insight. It specifies how, within a territory, the exclusion of some, for contingent reasons like place of birth is unjust. In this regard, Segall's version of luck egalitarianism also endorses the universalism at the core of cosmopolitan thinking, namely that each individual everywhere and at any time is an ultimate unit of equal moral concern and deserves to be taken into account as such by all agents, both political and individual.

Equal moral standing however, generates responsibilities. Brock's understanding of cosmopolitanism highlights the responsibilities to people we do not know, suggesting that citizenship or other affiliations should be made independent from the entitlement to equal consideration (Brock, 2015). Since it is largely uncontested that states are in various ways and at least to some degree responsible for the provision of health care, it can thus be argued that *ideally*, if the cosmopolitan account is taken seriously, states should find mechanisms to provide equal access to health care for every person within their jurisdiction, no matter what residence status the person has, simply because of the primary and universal importance to meet health needs.

The core idea of this article is thus that the importance to meet health needs applies to every human being equally. This universality of needs invites a universality of access to health care, which is to say in a non-discriminatory way, i.e. independent from morally arbitrary factors such as gender, religion or social status, place but also of birth, nationality, residence status, migration history etc.

2. *The current global health situation is, evidently, far from ideal given how a large number of human beings do not even receive basic access to health*

care, but for some states it is easily practicable to provide equal and sufficiently adequate access to health care for all human beings within its own territory.

In an ideal world, equal access to health care for all could be realized if states were to agree to a division of labor which entails to care for every person under its jurisdiction. With such a division of labor it would be feasible to provide health care for all equally.

But even if the countries wanted to adhere to this ideal better, in the non-ideal world of today, countries can only provide access to health care if there actually is some kind of organized health care that one can have access to. Many countries are not able to provide such kind of health care and therefore cannot (yet) contribute to the moral division of labor I described.

Thus, in our non-ideal world there are only a certain number of rather affluent countries that can actually participate in the division of labor of providing health care on a sufficiently adequate level, and those are the countries, which have functioning health care systems and sufficient resources. Following the cosmopolitan approach these countries have the moral obligation to offer equal access to health care for all on their territory, including migrants at special risk. Additionally, resources should be collected especially from the more affluent countries to secure health care provision also in poorer countries.

It might be perceived as an unjust burden for the more affluent countries to have a stronger moral obligation to secure health care provision for all on their territory, whereas poorer countries, where universal coverage does not exist or is inadequate, might be exempted. However, it is a widely held view in contemporary cosmopolitanism that more affluent countries have a 'large share of the remedial responsibilities' (Brock, 2015) in caring for the underprivileged due to 'the combined force of our patterns of benefit from the deprivation (and the ways in which the benefits exacerbate deprivation), our capacities to assist and to absorb costs, our ongoing contributions to sustaining the harm, and our moral responsibilities not to harm the deprived' (Brock, 2015).

Apart from such *remedial responsibilities* the argument of *practicability* speaks for the obligation to assist those who are on a certain state's territory as 'we are well placed to help because they [i.e. the non-citizens who are residents of our community] are geographically proximate' (Brock, 2015). The migrants at special risk can be easily reached by functioning health care systems. Many migrant groups are formally registered, the place of

living is known, a health care system exists, and thus there is no logistic, formal or technical barrier to include them into the existing system. Even those who are undocumented can be reached through offices that could provide anonymous health insurance cards and that are not observed by the migration officials (such or similar mechanisms exist for example in Italy). Hence, a state that offers universal and adequate health care for its citizens should also be capable of expanding the services to others on its territory due to the geographical proximity and the administrative and logistical competence over such service institutions. Currently there are no structures with which a country could provide *equal* access to health care for people outside of their nation borders too. So, even though a cosmopolitan responsibility towards every person in the world who is in need may be a desirable ideal, technically only those who are within the jurisdiction of a sovereign state can easily be included into an existing and sufficiently adequate universal health care package. I hence come to my conclusion, that:

3. The easy practicability of fulfilling cosmopolitan demands within borders justifies the moral obligation especially for affluent countries to provide universal access to health care for migrants and citizens alike, unless there are justified objections.

Discussing Possible Objections

According to my central thesis the provision of basic health care should be *equally* granted to citizens and migrants (including migrants at special risk) within a given country, unless there are justified objections. In this section I will explore and dismiss various objections.

Objection 1: The scope of 'equal treatment' is too small: Cosmopolitan duties apply worldwide, special responsibilities towards people within borders are not justified.

I have already briefly mentioned this objection above, but would like to take it up in slightly more detail as it touches upon the core idea of cosmopolitanism and the duty not to discriminate between human beings.

In our non-ideal world, it is obvious that many people outside the borders of a given affluent state do not receive access to health care. Can a cosmopolitan account really acknowledge special responsibilities toward people within borders or is this rather a view that is more coherent with statism or domestic principles of social justice?

First of all, I understand cosmopolitanism precisely so that the state's responsibility does not end at its borders, but that it must be expanded globally. Adding a prioritarian element to it, cosmopolitanism may even come along with a special focus on the underprivileged. Undoubtedly, states should think about strategies how to improve people's unmet health care needs in other countries too. My central thesis entails such a global responsibility, but it is not made more explicit here because the global realm is not the focus of this article. Just because migrants at special risk are being cared for in the domestic realm does not preclude a state from putting efforts into meeting health care needs of other people in need outside of its borders. This demand undoubtedly derives from a cosmopolitan perspective, and I would claim that even most reasonable statisticians would agree with this thought in general. It is the specific content of duties, and the extent of responsibilities in which both accounts differ. Just as a statist's account that recognizes states' duties outside of its borders is not flawed, a theoretical foundation based on cosmopolitanism is not flawed if it recognizes a certain special responsibility toward people (compatriots and non-compatriots) within borders (Miller, 1995, p. 111; Brock, 2015). As mentioned above, the very simple argument for this special responsibility for all people within borders is the practicability to define and provide access to health care *only* within the own jurisdiction as—given the current political structure of the world—*only* there exist the relevant political, legal and social mechanisms.

Objection 2a: The selection of beneficiaries is unfair: It is unjustified to use taxes from taxpayers for equally benefitting non-taxpayers.

Many countries with universal health care provide assistance to those citizens who—for whatever reasons—are otherwise not eligible for health care. One might argue that the inclusion of migrants at special risk as beneficiaries of such welfare is unjust. The general understanding of welfare states is that there must be some state income to distribute, which is collected through taxes. Some might argue that this should result in a tax-paying in-group which should profit in return for paying taxes, and a less well taken care of a non-taxpaying out-group whose needs ought to be satisfied for example on the grounds of charity (if at all). This argument is for example brought forward by Andrea Sangiovanni who argues that equality is a demand of justice only between citizens. He follows what he calls a reciprocity based internationalism: 'We owe obligations of egalitarian reciprocity to fellow citizens and residents in the state, who provide us with the basic

conditions and guarantees necessary to develop and act on a plan of life, but not to noncitizens who do not' (Sangiovanni, 2007, p. 20).

However, in welfare states that value social solidarity it is self-evident that funds collected through taxes are redistributed also to people who are not paying the full amount of taxes themselves. These could be for example homeless, unemployed, children or people with severe disabilities. Domestic justice theories provide the moral reasons for this kind of redistribution to the socially disadvantaged. However, the group to which domestic justice applies is usually defined as the citizens or residents of a certain state. If theories of domestic justice would explicitly claim that they apply to every person on a state's territory, independent from migration or residence status, such theories might be sufficient for arguing for universal access to health care for citizens and migrants alike. However, as domestic justice theories do not emphasize the moral insignificance of nationality, the cosmopolitan account seems to be more suitable as its core principle is precisely the insignificance of nationality or residence status. Hence, what the cosmopolitan approach explicitly adds to a domestic understanding of justice is that everybody, independent from nationality, is included into the sphere of responsibility of a given state. There is no other morally justified way than including all people that can technically be reached (*practicability*) through health policy and measures for access to health care. Hence, taxpayers, and non-taxpayers who are within the jurisdiction of a state should be included.

Objection 2b: The selection of beneficiaries is unfair: Undocumented migrants should be excluded as they are committing a crime.

Migration that trespasses the regular migration formalities is regarded in most places as unlawful. It is politically debated whether such an undocumented migration actually constitutes a crime or not. Whether or not it does is irrelevant for my argument. As I suggest, the inclusion criteria for states into the universal health care package should be based on the facts that health is considered as a *primary good* resulting in the importance to meet health care needs; and the *practicability* for the state to provide equal access to health care. Just as it is irrelevant whether a citizen is convicted of a crime or not for receiving health care, it should be irrelevant whether a migrant enters the country regularly or irregularly. To punish undocumented migrants for a (debatably) unlawful behavior by denying them access to health care therefore would therefore conflate two fields that should be explicitly separated (Ashcroft, 2005;

The Lancet, 2007): Migration policy and possibly legal repercussions on the one side and the provision of access to health care on the other. Carens spells this 'firewall argument' out in detail by arguing for firm legal principles that ensure that the enforcement of migration law on the one side and the protection of human rights on the other are separated from one another (Carens, 2013, p. 133).

Hence, from a cosmopolitan perspective everybody should be included in universal health care who is on a state's territory where such a system exists; and in order to secure this, health policy and migration policy should be detached from another.

Objection 3a: The consequences are undesirable: Provision of equal access to health care will function as welfare magnet and more migrants at special risk can destabilize a nation.

To evoke the argument of welfare magnetism is an empirical claim and therefore difficult to refute, as empirical facts are the product of multiple influences and can change over time. Even though some try to empirically prove that good health care does not function as a welfare magnet for the poor (Kingreen, 2010), I will not take this path in my argumentation. The part of the argument that is richer in content is a nationalist claim that 'too many' migrants at special risk might destabilize a nation's security or identity. Excessive nationalism has produced and is producing extraordinary misery, and will not be considered as a notable contrasting theory here. In contrast, very plausible theories of nationalism or statism endorse the view that a nation has an ethical value worth of protection. Therefore there are certain special and justified obligations toward people belonging to a given nationality or culture, and this also provides the conditions for (social) justice (e.g. Miller, 1995). However, whether or not migrants might interfere with a nation's identity (and if I were to discuss it here I would conclude that they do and should as this can be an enrichment for all, see e.g. Carens, 1987) is not genuinely decisive for the question of health care. As I have claimed above health and migration policy should be detached, and a possible restriction of health care should not be used as deterrence for other migrants at special risk entering the country (Ashcroft, 2005). The argument of the importance to meet health needs trumps other politically motivated considerations.

Objection 3b: The consequences are undesirable: Citizens will revolt against a policy that allows access to health care for migrants at special risk.

Some states include migrant groups at special risk into regular basic health care, but some do not. States of the latter sort might experience frictions during a transition period toward a more inclusive welfare model, ‘since that may evoke resistances of a much higher order than would arise if people were used to it and had had their expectations formed by it’ (Nagel, 1991, p. 59). As an empirical counterargument, there is evidence that public resistance against more *restrictive* welfare models is also possible. For example, during the war in former Yugoslavia in the early 1990s the numbers of people seeking asylum in Germany rose to approximately 150,000 per year. These high numbers motivated the German government to change the constitution in order to reduce and contain the numbers of applicants. The new law implemented restrictions on many aspects of living, such as restricted access to health care. This change was accompanied by strong public protests *against* it. Ultimately the law was challenged by the German constitutional court in 2012, and in the process of revising the law, the public engagement *for* more inclusive rights for migrants rose again considerably (e.g. BAGFW, 2014).

Apart from such an empirical counterargument the claim that there might be even a strong irritation of some people during a transition period does not result in the moral argument for equal access to basic health care itself being flawed, but might lead to some practical adjustments. Assumptions of possible public resistances during the implementation of more expansive health care should be taken seriously, and circumspect policies should be considered in order to reduce possible frictions, for example through transparent decision processes and information campaigns explaining the policy decisions.

Objection 4a: Less than the regular health care package will meet needs well enough: Provision of emergency care is enough.

Some might argue that the call for equal treatment, including migrants at special risk, will result in too ambitious aims and that a less than equal access to health care for some is equally well justified, or even morally superior e.g. because it might save expenses within a national health care system. As I have claimed above, it would be a denial of the cosmopolitan theory to offer two different levels of access to health care for reasons of nationality or residence status, *unless there are justified objections*. Can we, hence, find an objection that justifies emergency care for some only? One possible scenario could be for example a sudden influx of large numbers of refugees, for example in the case of war or other

humanitarian catastrophes. In this case the technical practicability to reach everyone equally might not be given as hospitals and staff would not be equipped to provide universal health care for everyone. Hence, if a country rapidly sets up refugee camps in order to accommodate thousands of refugees who arrive simultaneously it might only be feasible to provide as good health care as possible in order to reach the highest number of people in need of medical care. In this case some principles of disaster ethics might apply, which could entail to care for urgent conditions as a priority (O’Mathúna *et al.*, 2014).

Another justification for providing emergency care only might be if a person stays for a short and defined time on a given territory, for example in the case of tourism. Such a tourist could, in case of a chronic disease or elective surgery, bring sufficient medication for the duration of the trip or return to her home country in order to receive adequate treatment.

Also, in some cases of migration it could be assumed that the decision will be rapidly made whether a person can stay in a country (as a refugee) or whether she has to leave the country again (e.g. as a rejected asylum seeker). The person could then seek medical care for more than emergency care, such as chronic or preventive measures, in the new place of residence. However, evidence shows that many asylum seekers stay for months or years in a given country, despite regulations to process requests quickly, before any kind of decision of the future itinerary of that person is made. In any other case (than a humanitarian disaster or the case that a person will leave the country very soon again), a plausible division of emergency care from basic health care cannot be justified from a cosmopolitan perspective.

There is an additional reason, independent from cosmopolitanism, that argues against a restriction of universal health care to, e.g., emergency care only, which I will call the argument of implausibility, as I will explain now.

If, in general—independently from the discussion of migrants—a state with universal coverage decides upon a basic health care package that will be covered, the state will most probably not *only* include emergency care into this package for several reasons:

First of all, it is in the interest of the individual person affected that diseases are being treated properly (as entailed in most basic health care packages) and not only in emergency cases. Most importantly, it alleviates personal suffering and provides the conditions for a decent life.

Second, it is not state of the art in medicine to provide emergency care only, if an acute condition might just be

an exacerbation of a chronic condition, and if this is not the case, if it might be that there is reason to suspect other than the presented acute condition. If a physician is aware of an underlying or an additional condition needing more than emergency care and if she has the technical means to treat, it is her professional duty to treat or to make sure someone else will care for it. It would create a professional conflict for the physician to demand that only the given acute condition is treated even though the infrastructure for diagnosis and treatment of an underlying cause or any other condition are technically available and if the person affected has no other alternative to access this infrastructure.

Moreover, it is well established that it is in the interest of the public health to treat people living together in a certain community not only in emergency cases, but to also provide preventive care, to vaccinate and to monitor and treat any other health condition properly so that possible factors that might negatively affect the public health can be cared for efficiently.

There is hardly any evidence comparing whether it is more cost effective to treat chronic conditions regularly or to treat acute exacerbations only, but one can assume that the latter will be more costly on the long run. In any case, it is well proven that it is more cost-effective to treat conditions outside of emergency rooms if possible (Weinick *et al.*, 2010).

It is therefore plausible for a state to include treatment for acute, chronic and preventive conditions in universal health care packages, and it is not plausible from an individual, medical, public health and very likely also from an economical perspective to provide emergency care only. The reason for not separating emergency from more expansive or chronic care is thus its implausibility.

If a country decides to offer only a restricted health care package to certain groups (even though it would be technically feasible to include them), I assume this can only be understood as a deterrence, as a disincentive for the others to become a member of this 'out-group'. In the case of migrants at special risk, a restriction of access to health care would function as a deterrence to enter the country or as an incentive to leave it soon again. This brings me back to my two arguments of the need to detach health care from migration policy, and the importance to meet health care needs, which both ask for the inclusion of migrants into the regular basic health care packages.

Objection 4b: Less than the regular health care package will meet needs well enough: this could be founded on principles of charity instead of a cosmopolitan account.

The scope and definition of charity versus justice is contested. In an attempt to structure the debate, Buchanan classifies justice as a matter of rights. In contrast, duties of charity are duties to help others in need where the kind and amount of aid are left to the discretion of the benefactor (Buchanan, 1987). Hence, in the provision of health care, one could argue that it is merely a duty of charity to provide health care for migrants, and that—as the amount of aid is left to the discretion of the benefactor—it could be justified to provide e.g. emergency care only.

However, again, the importance of meeting health needs makes it impossible to consider it as a duty of charity or to consider it as covered by providing emergency care only. The distribution of such an existentially important good cannot be left to the discretion of the benefactor. Moreover, the implausibility of dividing emergency from chronic and/or preventive care, which I have shown above, can also be held against a charity-based approach that claims emergency care to be sufficient.

Conclusion

I have refuted statist theories and charity-based approaches to define the exact level of health care for migrants. The theoretical approach that comes closest to a cosmopolitan account for providing health care for migrants are theories of domestic justice. They are well prepared to provide a plausible argumentation for universal access to health care for all within a given jurisdiction. However, theories of domestic justice have so far failed to explicitly claim that they apply to anyone, regardless of migration or residence status. This is the reason why cosmopolitanism, which puts the insignificance of nationality at the center of its theory, seems to be most appropriate to address the question at hand.

As the ideas developed in this article have not yet been widely discussed, this article seeks to stimulate that discussion by trying to posit a clear and firm, if preliminary, argument. Many complex questions remain, including: Should responsibilities to include migrants within health care coverage be the same for each country with universal health care coverage or do more affluent countries have more responsibilities? Could reciprocal billing among affluent states also be an option to meet cosmopolitan demands? How should special cases be approached, such as a migrant whose visa has expired or soon will expire and who needs an organ transplant, but whose life will thereafter depend on medicines that are unavailable in her home country? And how should

affluent countries respond to the refusal of other wealthy nations to recognize even a minimal respect for the human rights of irregular migrants, as is, for example, current Australian policy, which seems to categorically reject cosmopolitanism itself (McNeill, 2003; Henderson, 2014)?

A particularly crucial challenge to the approach developed in this article lies in ensuring that gains in health justice do not come at the expense of losses elsewhere: whether, for example, the focus on health care might risk exacerbating other exclusionary practices in other domains, such as support for migrants in adequate housing, education, or whether it might lead to harsher immigration policies. Although this article argues for a cosmopolitan approach to deciding the level of migrant access to health care, this does not mean that this should result in a trade-off with different social goods. Claiming that health is a primary good does not mean that it is the *only* primary good, or that it should trump other rights, such as to seek asylum, or to adequate housing and education. On the contrary, to argue for a cosmopolitan approach in health is implicitly to argue for a cosmopolitan approach in all other domains as well. Again, such questions remain largely underdiscussed, and demand further ethical and political debate to see how the various rights of all people can be justifiably accommodated.

In sum, this article has taken Brock's cosmopolitan argument for health care for migrants as a starting point (Brock, 2015) and it has expanded on Carens' argumentation for equal rights of citizens and migrants (Carens, 2008, 2013). It has tried to combine and develop both approaches by spelling out in fuller detail the cosmopolitan argument and using that to answer the question of what level of health care is owed to non-nationals.

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Notes

1. Brock leaves this explicitly open. In order to determine the type of level of access to health care, she calls for robust empirical data in order to determine specific duties.
2. I sum up these groups very roughly here, there are many more variations or overlaps of migrants' status. I explicitly include refugees under the very broad term 'migrant' in this article too. This differs from the definition the UNHCR uses, which separates migrants (who, according to their definition 'choose to move') from refugees (who are 'forced to flee') (see UNHCR on Mixed Migration: <http://www.unhcr.org/pages/4a16aac66.html>, last accessed 24 April 2015).
3. It goes beyond the scope of this article to discuss what constitutes a sufficiently adequate health care package. One possibility is to define this domestically. According to Walzer, for example, there is no absolute amount of health care that should be distributed, instead, the specific sufficiency thresholds should be identified through democratic processes in a given country (Walzer, 1983, p. 90).

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