ARE WE FORGETTING SOMEONE?
UNDOCUMENTED IMMIGRANTS AND HEALTHCARE

BY

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Abstract

The future of healthcare for undocumented immigrants (UIs) in the United States is bleak. Almost completely left out of healthcare reform, UIs are likely to comprise an increasingly greater portion of the U.S. uninsured population, with only limited options to meet their healthcare needs. Now more than ever, it is important to consider whether or not our exclusion of UIs from our healthcare system is justified, or whether we have an obligation to reevaluate our stance.

In this thesis, I consider the most important arguments for and against providing healthcare for UIs. Chapter 1 is a brief overview of UI demographics, both general characteristics of this population and healthcare-related characteristics. My next two chapters are overviews of the leading arguments for and against providing UIs with healthcare. Chapter 2 considers arguments against providing UIs with healthcare. I present an overview of each argument, then the main reasons one might support the argument, and lastly some responses a critic might levy against the argument. Chapter 3 follows the same structure, but is dedicated to arguments for providing UIs with healthcare. In Chapter 4, I put forward what I believe to be the most tenable position regarding UI healthcare. I argue that justice requires that society should strive to provide fair equality of opportunity for all of its members. Because health and opportunity are intimately linked, society’s commitment to fair equality of opportunity requires that it also promote the health of its members by providing healthcare. Lastly, I argue that society’s duty to provide healthcare to its members should be extended to UIs.
Introduction

On September 9th in 2009, President Obama addressed a joint session of Congress in support of the pending health reform legislation. At one point in the speech, President Obama addressed the implications of healthcare reform for undocumented immigrants (UIs)—immigrants who either entered the U.S. without valid documents or who are living outside the terms of their visa—saying, “There are also those who claim that our reform effort will insure illegal immigrants. This, too, is false—the reforms I’m proposing would not apply to those here illegally.” In one of the more memorable moments of the health reform debate, Congressman Joe Wilson of South Carolina yelled out, “You lie!” upon hearing the President’s words. Was Wilson right? What kind of healthcare do UIs have? And most importantly, what kind of healthcare should UIs have? These are the kinds of questions I hope to address throughout this thesis.

Ironically enough, this public moment of dissension between Wilson and Obama was, in reality, one of the few tenets of the law upon which Republicans and Democrats could agree. Although the Patient Protection and Affordable Care Act (ACA) will make a considerable dent in our uninsured population, UIs are unlikely to be among the newly insured. The ACA continues to restrict Medicaid access for UIs and explicitly bars them from participating in the new health insurance exchanges, even if they are willing to pay with their own money. Because of this, UIs will comprise an increasingly disproportionate share of the uninsured. This post-reform climate seems to be an opportune time to consider whether or not our general indifference to the healthcare of UIs is justified, or whether we need to reevaluate our position.

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In this thesis, it is my intent to identify the strongest arguments for and against providing healthcare to UIs. I attempt to consider the arguments in their most charitable forms, assessing both their strengths and their weaknesses. I conclude by providing what I believe to be the most tenable position regarding UIs and healthcare. I argue that the just society is obligated to promote the health of its members and that the healthcare of UIs is our society’s responsibility.
Chapter 1: Undocumented Immigrants—Who Are They and What Healthcare Do They Have?

Before I discuss the various arguments for and against providing UIs with healthcare, it is important that I develop a sufficient understanding of this group’s demographics. This first chapter will be dedicated to achieving this end, as I will attempt to paint a descriptive picture of the UI population. In the first part of this chapter I present an overview of some general characteristics of the UI population. I discuss their numbers and proportion of the population, trends in immigration, their distribution by state, their national origins and ethnic makeup, the age and gender distribution of the population, their general level of education, their role within the U.S. workforce, their income level, and the UI familial structure. In the second part of this chapter, I focus specifically on the state of UI healthcare and health. I provide an overview of disparities between UIs and other U.S. residents, the reasons for these disparities, the main sources of UI care, and the outlook for UI healthcare and health in the coming years. Let us now proceed to the first part of the chapter: a discussion of some general, demographic characteristics of the UI population.

General Characteristics of the UI Population

UI Numbers and Immigration Trends

There are currently around 40.2 million foreign-born individuals residing in the United States, 13% of the total population.\(^2\) Of these 40.2 million, 11.2 million are UIs and the remaining 29 million are legal immigrants—this includes 14.9 million naturalized citizens, 12.4

million permanent residents, and 1.7 million temporary residents.\textsuperscript{3} Thus, UIs comprise 28% of the foreign-born population and 3.7% of the total U.S. population.\textsuperscript{4} Although UI immigration has steadily increased for most of the past 20 years—the UI population increased from 3.5 million in 1990 to 12 million in 2007—this trend has changed in the past few years.\textsuperscript{5} Since reaching its peak in 2007, it has since leveled out and even witnessed a slight decline. This alteration can be predominantly attributed to the economic recession that began at the end of 2007, as immigration flow tends to stagnate or decrease in times of economic distress.\textsuperscript{6,7} If unemployment continues its steady decline from its high of 10% at the end of 2009 to its current 4 year low of 7.3%, it is possible that the influx of UIs will return to its pre-recession rate.\textsuperscript{8}

**UI State Distribution**

Although UIs are distributed throughout every U.S. state, they are highly concentrated in specific regions, with 77% of the UI population living in only 12 states.\textsuperscript{9} This is due primarily to the disproportionate existence of social networks and work opportunities in certain parts of

\textsuperscript{5} Passel-2011 2
\textsuperscript{6} Ibid
\textsuperscript{7} Ibid
\textsuperscript{8} The decline can partially be attributed to an increase rate of deportation, which reached an all-time high of 393,457 in 2009 and remaining high at 391,953 in 2011, up almost 40% from 246,431 in 2006, 280,974 in 2007, and 188,467 in 2000.
\textsuperscript{9} Passel-2011 14-16
the United States. California alone is home to over 2.5 million UIs, 23% of the entire UI population. Other states with high populations of UIs are Texas with 1.6 million, Florida with 825,000, and New York with 625,000. UIs comprise the highest percentage of the state population in Nevada, where UIs are 7.2% of the population. Certain states, such as Georgia and North Carolina, have in recent years witnessed a disproportionately high influx of UIs. The UI population in North Carolina, for example, has grown over ten-fold in two decades, from only 25,000 in 1990 to 325,000 in 2010.

**UI Countries of Origin**

An overwhelming majority of UIs in the United States are Hispanic, with 83% of the UI population emigrating from Latin America. Asian immigrants are the second largest group at 11%, followed by UIs from Europe and Canada at 4%, and lastly from Africa at 3%. The largest single country of origin is by far Mexico, with Mexican immigrants comprising 58% of the entire UI population. After Mexico, the largest immigrant populations by country of origin are those from El Salvador, Guatemala, the Philippines, and China.

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11 Passel-2011 14-16
12 Passel-2011 11
13 D'Emilia et al. 21
14 Passel-2011 11
Age and Gender

UIs differ in their demographic make-up by age and gender from the rest of the U.S. population. Males between the age of 18 and 39 years are over-represented in the UI population. 16 35% of UIs fall into this group, compared to only 14% of U.S.-born citizens and 18% of legal immigrants. Women, the elderly, and children are largely underrepresented in the UI population. Less than 40% of UIs are women, compared to over 50% of other U.S. residents. 17 Only 1.2% of UIs are 65 or older, compared to 12% of U.S.-born citizens and 18% of legal immigrants. 18 And although 27% of the U.S.-born population is made up of children, children only comprise 13% of UIs in the United States.

Education

UIs tend to be considerably less educated than both legal immigrants and the U.S.-born population. 19 Of adults between the ages of 25 and 64, 29% of UIs have less than a 9th grade education. This is almost 15 times greater than the percentage of U.S.-born citizens without any high school education and more than double that of legal immigrants. UIs comprise 35% of the entire population of U.S. residents without any high school education, nine times their proportion of the population. While 93% of the U.S.-born population and 77% of legal immigrants have at least a high school education, barely half of the UI population does. UIs make-up 22% of the population of U.S. residents without at least a high school degree, six times their representation in the overall population.

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18 Passel-2009 4-5
19 Passel-2009 10-11
Although young adult UIs, ages 18-24, fare better educationally than their adult counterparts, they still struggle in comparison to U.S.-born citizens and legal immigrants. 40% have not completed high school, a percentage five times higher than that of U.S.-born young adults and 2.5 times higher than legal immigrant young adults. Furthermore, only ¼ of UIs have some attended some college or received a college degree, compared to 60% of legal immigrants and 58% of U.S.-born individuals. A closer look at UI young adults, however, suggests a slightly different story. The level of education for young adult UIs is greatly dependent upon the age at which they immigrated to the U.S. Of UIs who were 14 years old or older when they came to the U.S., 46% have not completed high school and only 42% are in college or have attended college. These numbers for UIs who arrived before the age of 14 are dramatically higher, with only 28% of this group not completing high school and 61% in college or having attended college.

Role in the Workforce

UIs make up 5.2% of the U.S. workforce. This number steadily grew from 3.8% in 2000 until 2005, and has since remained fairly level, ranging from 5% to 5.5%. As might be expected, the states in which UIs account for the largest percentage of the workforce are the states with the highest populations of UIs. California, Texas, Florida, and New York are host to more than half of the undocumented workers in the U.S. Nevada has the highest percentage of UIs in the workforce at 10%, followed by California at 9.7%, Texas at 9%, and New Jersey at 8.6%.

UI men of working age are more likely to be in the workforce than either U.S born citizens or legal immigrants of working age—94% of UIs compared to 85% of legal immigrants.

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20 Passel-2009 12
21 Passel-2011 17
and 83% of U.S.-born citizens.\textsuperscript{22} This trend is the opposite with UI women. Only 58% of UI women of working age are in the workforce, lower than both the 66% of legal immigrant women and 73% of U.S.-born women of working age. This can be partially explained by UI family dynamics, with a much larger percentage of UI women citing the need to care for children at home as keeping them from working than other U.S. women. Despite their disproportionately large role in the workforce, UIs are also more likely to be unemployed than U.S.-born and legal immigrants.\textsuperscript{23} This has changed since 2005, when UIs had a lower unemployment rate than either group.

UIs are more likely to hold the blue-collar, lower-skilled jobs.\textsuperscript{24} At least part of the reason for this is the tendency for UIs to be less educated and thus less qualified for higher-skilled jobs. A disproportionate amount of UIs are service workers, construction workers, production/installation workers, and farming/forestry/fishing workers. 70% of UIs fall into one of these three categories, compared to only 31% of U.S.-born citizens. Although UIs are only 5.4% of the workforce, they account for 25% of farmworkers, 19% of builders/groundkeepers/maintenance workers, 17% of construction workers\textsuperscript{25}, 12% of food preparation workers, 10% of production workers\textsuperscript{26}, and 7% of transportation and material moving workers.\textsuperscript{27} On the other hand, UIs are drastically underrepresented in the white-collar

\begin{footnotesize}
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\item \textsuperscript{22} Passel-2009 12-14
\item \textsuperscript{23} This may seem confusing since UIs are disproportionately likely to work. How can they be both more likely to work and less likely to work? This has to do with how unemployment rate is defined. Someone is only part of the unemployed workforce if they are looking for work. The fact that UIs have higher rates of employment and unemployment has to do with the fact that the overwhelming majority of UIs are looking for work, compared to other U.S. residents.
\item \textsuperscript{24} Ibid
\item \textsuperscript{25} Builders and construction workers are often considered the same and used interchangeably. The distinction here has to do with the size of the project. A construction worker is more likely to be working on a larger site, such as a skyscraper or a railroad. A builder, on the other hand, is more likely to be working with a smaller sub-contractor on something like a house.
\item \textsuperscript{26} For those not familiar with this term, a production worker is one engaged in the production or handling of goods at a manufacturing facility.
\item \textsuperscript{27} Passel-2009 5
\end{itemize}
\end{footnotesize}
sectors of the economy.\textsuperscript{28} 62\% of U.S.-born citizens are in either sales & office and administration support or professional management, business and finance—only 22\% of UIs work in these areas.

**Income**

UIs are much more likely to be poor than other U.S. residents. 53.5\% of UIs have a household income below 138\% of the federal poverty level (FPL).\textsuperscript{29} One in every five UIs lives in poverty while only 13\% of legal immigrants and 10\% of U.S.-born citizens live below the FPL. Despite the fact that UIs have more workers per household, the median annual household income for UIs is $36,000, compared to $50,000 for U.S.-born households. Although UIs and their children\textsuperscript{30} account for only 5.5\% of the population, they still make up 11\% of children below the FPL in the United States. Studies have shown that the undocumented are more likely to be unable to pay rent, more likely to have experienced a period in which they lacked money, and more likely to spend some part of their lives homeless.\textsuperscript{31}

**Familial Structure**

Three quarters of UI households consist of some sort of family structure—either couples without children, couples with children, or adults with children.\textsuperscript{32} 47\% of UI households consist of couples with children, 15\% are couples without children, 15\% are other adults with children, and only 13\% of UI households are single-person households. Only 15\% of U.S.-born households contain couples with children while 30\% are single-person households. This phenomenon can

\begin{thebibliography}{9}
\item Passel-2009 12-14
\item Passel-2009 16-17
\item The poverty rate of the children of UIs is similar whether they are undocumented or US born (32 vs. 34)
\item Chavez, Leo R. “Undocumented immigrants and their use of medical services in Orange County, California.” *Social Science and Medicine* 74 (2012): 887-893; 891
\item Passel-2009 5-7
\end{thebibliography}
be accounted for, at least in part, by the relative youth of the UI population and the corresponding tendency to live with a spouse or partner and with children.

The number of children in the U.S. with at least one undocumented parent has been steadily increasing in the last decade, increasing from 3.6 million in 2000 to 5.5 million in 2010.\(^\text{33}\) Despite this increase, however, the number of UI children in the US has stayed constant, hovering at around the current level of 1.5 million children.\(^\text{34}\) Thus, the increase in the number of children of UIs can be attributed to the increase of U.S.-born children to UIs. This number has more than doubled in the last decade.\(^\text{35}\) The overwhelming majority of children with UI parents (80\%) live in two-parent households, a number much higher than the 71\% of children born to U.S.-born parents.\(^\text{36}\) The increase in U.S.-born children with UI parents has led to an increase in mixed status families. 8.8 million U.S. residents are in mixed status families—3.8 million are UI adults, 4 million are U.S.-born children, 0.4 million are non UI adults, and 0.5 million are UI children—over half of the 16.6 million UI and UI family member population.

**Conclusion**

This section has provided an overview of the demographics of the UI population of the United States. UIs comprise a large part of our population that, with the exception of the last several years, has grown rapidly. Most come from Latin American countries and live in a concentrated group of states. They comprise a disproportionately large share of the workforce and work predominantly in blue-collar, low-skilled jobs. Most UIs are male, working-age, uneducated, poor, and live with their families. With the more general UI demographic picture as background, I will now concentrate on the specific area of interest of this thesis: healthcare.

\(^{33}\) Passel-2011 13
\(^{34}\) Passel-2009 4
\(^{35}\) Passel-2011 13
\(^{36}\) Passel-2009 8
In the next and final section of this chapter, I provide an overview of the state of UI access to healthcare. This includes a description of the disparity in healthcare between UIs and other groups within U.S., a discussion of the reasons for these disparities, an overview of the kind of healthcare UIs do have, and finally a prediction of how UIs will fare with respect to healthcare access in the post-ACA healthcare climate.

**UI Access to Healthcare**

**Extent and Nature of Healthcare Access Disparities**

By any measure of healthcare access, UIs lag behind other U.S. residents. Although insurance coverage is neither a necessary nor sufficient condition for receiving appropriate medical care, it has been well established as an important indicator of appropriate medical access and better health outcomes. UIs fare worse than other U.S. residents with respect to insurance coverage. Estimates put the uninsured rate of UIs at approximately 59%—6 million adults and 660,000 children. This comes out to about 44% of UI children and 60% of UI adults. The uninsured rate for UIs is far greater than for other U.S. residents, with only 24% of legal immigrants and 14% of U.S.-born citizens uninsured. UIs account for 17% of U.S. residents without insurance—over three-fold their proportion of the population. The vast majority of UIs who do have insurance have it through employer coverage, with 31% of UIs covered through their work. Only 362,000 UIs—3% of the UI population—purchase private coverage, in large

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39 Passel-2009 18-19
40 Capps 5, 16
part because of their poverty. Research suggests that when one controls for such variables as income, education, and employment, the difference in insurance coverage between UIs, documented immigrants, and U.S.-born individuals is diminished, but by no means eliminated. The rate of insurance is still more favorable for U.S.-born citizens than either documented or undocumented immigrants, and more favorable for documented than undocumented immigrants. For example, in a study by Stephen Zuckerman and colleagues, the regression-standardized uninsured rate for those living under the FPL was almost twice as high for UIs than for U.S.-born citizens—49.7% compared to 26.6%. Legal permanent residents fell in between these two groups with a regression-standardized uninsured rate of just under 40%.

Research also suggests that UIs spend less than other U.S. residents on health care. In one study that examined trends of healthcare spending from 2000 to 2009, it was found that U.S.-born citizens spent a whopping $1 trillion annually on healthcare, compared to only 15 billion annually for UIs. This 15 billion accounted for 1.4% of spending by all U.S. residents, considerably less than half of UIs’ 3.7% of the population. UIs spent less per person in almost every sphere of healthcare spending—UIs spent $54/year on emergency department care compared to $138/year for U.S.-born, and U.S.-born had six times higher outpatient costs than did UIs. When UIs do spend money on care, it is much more likely to be with private funds than public funds. Only 7.9% of UIs had spending for healthcare from public sources—$140/year per person. On the other hand, 30.1% of U.S. citizens had spending from public healthcare funding sources, totaling $1385/year per person. Whereas the U.S.-born have a 1.76:1 ratio of

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41 Capps 24
43 Zuckerman et al. 2001-2002
44 Stimpson, Jim P., Fernando A. Wilson, and Dejun Su. “Unauthorized Immigrants Spend Less Than Other Immigrants And US Natives On Health Care.” Health Affairs 32.7 (2013): 1-6; 3
private to public spending, the ratio for the UI population is 8:1. One area in which UIs do account for more in healthcare spending is in their receipt of uncompensated care. UIs were more than twice as likely as U.S.-born to receive uncompensated care during the study period.\textsuperscript{46}

Given the low rate of insurance and healthcare spending among UIs, it is hardly surprising that they also use fewer healthcare resources than the rest of the U.S. population. In one study comparing UI Latinos with other Latinos and U.S.-born whites, it was found that both documentation status, place of birth, and ethnicity played a role in determining healthcare access.\textsuperscript{47} UIs were less likely to have a usual source of health care, were more likely to have problems getting necessary healthcare, and visited the doctor less frequently. U.S.-born whites fared the best in each of these categories, followed by U.S.-born citizens of Mexican ancestry and other Latinos, naturalized Mexican and other Latino immigrants, and documented Mexican and other Latino immigrants. Another study, by Leo Chavez and colleagues in Orange County, CA, assessed differences in access among Latino individuals of varying documentation status and citizenship, drawing the same conclusions.\textsuperscript{48} UI Latinos were the least likely to have sought healthcare in the year prior to the study at only 54.8\%, followed by legal residents at 67.8\%, naturalized citizens at 78.4\%, and U.S.-born at 79.3\%. Vargas Bustamante and colleagues compared the use of healthcare among Mexicans of various immigration statuses and also found that UIs are considerably less likely than documented immigrants to access care.\textsuperscript{49} Only 56\% of UIs had at least one doctor visit in the previous year, compared to 76\% of documented

\textsuperscript{46} However, as the authors of this study note, given the rate at which UIs are uninsured, it may be surprising this figure is not more lopsided.


\textsuperscript{48} Chavez, Leo R. “Undocumented immigrants and their use of medical services in Orange County, California.” \textit{Social Science and Medicine} 74 (2012): 887-893; 891

immigrants. Furthermore, 68% of documented immigrants had a usual source of care when sick, compared to only 47% of UIs. This research strongly suggests that there is a disparity in access to healthcare between UIs and other U.S. residents. I now turn to the various reasons underlying these healthcare disparities.

**Why Do Disparities in Healthcare between UIs and Other U.S. Residents Exist?**

There are a number of factors that have contributed to the relatively poor healthcare access of UIs. For one, past state and federal policy has, intentionally or unintentionally, excluded UIs. UIs have severely limited eligibility for federally funded social insurance programs. Medicare is the federal social insurance program that provides care to the elderly, the disabled, and individuals with end-stage renal disease. UIs are not eligible to receive Medicare benefits. Medicaid is the joint federal and state means-tested social welfare program that provides insurance for certain individuals in poverty. UIs are generally not eligible to receive Medicaid benefits. Until a little over a decade ago, however, there were steps UIs could take to secure public benefits despite their immigration status. UIs were ineligible for Medicaid, but they could achieve eligibility if they qualified for Permanent Residence Under Color of Law (PRUCOL). As long as a UI’s presence in the U.S. was known by immigration services and that UI was deemed unlikely to be deported, they were eligible for Medicaid benefits. However, the growing public perception that UIs constituted an unnecessary and avoidable burden on

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52 This can apply to individuals living in the U.S. for the less than a year, persons who have been found deportable but certain factors make their deportation unlikely, persons who have been found deportable but who’s deportation has been deferred for humanitarian reasons, persons who are immediate relatives of a U.S. citizen or other legal permanent resident, and persons who have applied for a change in immigration status and are awaiting news.
public spending prompted a change in the legislative tide. In 1996, the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) was passed and yielded severe consequences for UIs and legal immigrants alike. Most importantly for UIs, it eliminated Medicaid eligibility for UIs qualifying for PRUCOL status. Some states have developed their own PRUCOL status and continue to provide some level of care for UIs that meet the necessary criteria, but the coverage must be supported by state funds. A few states, like California and New York, provide PRUCOLs with a level of care comparable to other Medicaid beneficiaries, but this is the exception rather than the rule. Most states are not as generous in their provision of care to UIs. There are two notable exceptions to the prohibition of federal Medicaid funds for UIs, both of which I will discuss later. For one, UIs are eligible to receive Emergency Medicaid coverage if they are able to meet other, non-immigration status conditions. For another, states can choose to cover pregnant UI woman under the State Children’s Health Insurance Plan (SCHIP) for prenatal care using federal funds.

In addition to UIs’ limited eligibility for public insurance, the relative poverty of UIs acts as a considerable barrier to health care access. The low income of UIs largely accounts for the very small number of UIs who are able to purchase private insurance. The cost of medical care without insurance can be unmanageable, especially for the poor, as hospitals often charge

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53 Rosenbaum 264
54 Gusmano “U.S. Health Policy and Access to Care.”
individuals without insurance at a higher rate. The fact that UIs generally have a lower income than other U.S. residents undoubtedly contributes to disparities in healthcare.

As mentioned earlier, even after we control for certain socioeconomic factors associated with a lack of insurance, documented immigrants have better access to care than undocumented immigrants. This suggests that the illegality of UIs contributes to the disparity in care between them and other groups. In one study of four different cities with high UI populations, Marc Berk and colleagues found that fear of deportation played a role in discouraging UIs from seeking care. 33% of UIs in Houston, 36% in Los Angeles, 47% in Fresno, and 50% in El Paso responded affirmatively when asked if they were afraid to seek care because of fears concerning their immigration status. Those answering in the affirmative were more likely to report difficulty obtaining care than those who did not express concern. This suggests that the documentation status of UIs and the corresponding risk of negative consequences do play a role in whether or not they access care, thus contributing to the disparity in healthcare access.

Another reason for the disproportionately low healthcare access among UIs is immigrant self-selection. The theory of immigrant self-selection states that the immigrants most fit to leave their country of origin and immigrate to the U.S. are likely to possess certain qualities that make the immigration process more feasible. A component of immigrant self-selection is the “healthy immigrant effect,” which postulates that in order for immigrants to be capable of immigrating and remaining in the U.S., they must be healthy. Travelling to a new

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58 Bustamante-2012 319
60 Berk 60
61 Bustamante-2012 319
country, working there, and adapting to a new environment, are all more easily done in youth and in good health. Thus, immigrants should be more likely to possess those qualities. If this theory is tenable, it would make sense that UIs are disproportionately healthier than the rest of the population, insofar as good health was a factor in enabling them to immigrate in the first place.

However, there is reason to believe we should not rely too heavily on the healthy immigrant effect to explain disparities in healthcare access. Some research shows that there is a discrepancy in recent immigrants’ perception of their health and their actual health. Immigrants may seem healthier, but this is partially due to their high likelihood of living with an undiagnosed medical condition. Furthermore, UIs tend to lose this health advantage the longer they remain in the U.S., indicating that any disparities in health that persist across time are less effectively explained by immigrant self-selection. How much healthier UIs truly are than other U.S. residents is a difficult question, but at least some of the disparity in healthcare access is likely due to less need in the UI population.

There are also a number of cultural barriers that prevent UIs from accessing healthcare. For one, immigrants have a tendency to be less familiar with the U.S. health system. Many must adjust to a U.S. health care system much different from that of their home country. Differences in structure—such as payment methods and delivery of care—can both make UIs more hesitant to seek care and make care more difficult for them to access. In addition to the structure of the health system, UIs often have language barriers that prevent them from accessing care. One study showed that over 10% of undocumented Hispanics reported a hard

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62 Stimpson 4
64 Ibid
65 Ibid
time understanding their physician during their last visit, compared to only 3.8% of U.S.-born Mexican-Americans, 2.7% of U.S.-born other Latinos, and 2.6% of whites.\(^6\) It is likely that these factors contribute to the disparity in healthcare between UIs and other groups.

I have provided an account of potential reasons for the disparity in healthcare between UIs and other U.S. residents. Although these disparities are pronounced, we must not forget that UIs do have some healthcare. I will now outline the sources of care to which UIs do have access and the kinds of services UIs use.

**What Kind of Healthcare Do UIs Have?**

Although UIs are predominantly excluded from federal benefit programs like Medicare and Medicaid, federal law does require hospitals to provide emergency care to all individuals, regardless of immigration status, under the Emergency Medical Treatment and Active Labor Act (EMTALA). The period of time preceding the passage of EMTALA was marked with widespread evidence that hospitals and physicians were practicing “patient dumping,” or the refusal to provide emergency care for patients without insurance or the means to pay.\(^6\) In an attempt to restrict this practice, Congress passed EMTALA, effectively forbidding the practice of patient dumping. EMTALA imposes two requirements on hospital emergency departments: the medical screening requirement and the stabilization requirement. The medical screening requirement is outlined in EMTALA as follows:

In the case of a hospital that has a hospital emergency department, if any individual comes to the emergency department and a request is made on the individual’s behalf for examination or treatment for a medical condition, the hospital must provide for an

\(^6\) Ortega 2357
appropriate medical screening examination...to determine whether or not an
emergency medical condition exists.\textsuperscript{68}

Under EMTALA,\textsuperscript{69} an “emergency condition” is defined as:

A medical condition manifesting itself by acute symptoms of sufficient severity
(including severe pain) such that the absence of immediate medical attention could
reasonably result in (i) placing the health of the individual in serious jeopardy, (ii) serious
impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.\textsuperscript{70}

If the medical screening indicates an emergency medical condition, then the hospital is required
to address the second part of EMTALA: the stabilizing requirement. The hospital is required to
provide “such treatment as may be required to stabilize the medical condition.”\textsuperscript{71} The
legislation defines “stabilized” as:

With respect to an emergency medical condition...that no material deterioration of the
condition is likely, within reasonable medical probability, to result from or occur during
the transfer of the individual from a facility.\textsuperscript{72}

Upon stabilizing the emergency medical condition, however, the hospital’s legal obligation is
fulfilled. Although EMTALA only applies to “participating hospitals,” or hospitals that accept
Medicare funding, Medicare accounts for such a substantial portion of most hospitals’ budgets
that to not “participate” would be inconceivable.\textsuperscript{73} Hospitals that fail to comply with EMTALA’s
requirements are subject to a civil monetary penalty up to $50,000 per violation.\textsuperscript{74}

\textsuperscript{68} 42 USC 1395dd(a)
\textsuperscript{69} And under other federal statutes, including Medicaid
\textsuperscript{70} 42 USC 1395dd(e)(1)
\textsuperscript{71} 42 USC 1395dd(b)(1)(A)
\textsuperscript{72} 42 USC 1395dd(e)(3)(B)
\textsuperscript{73} Zuber, Julianne. “Healthcare for the Undocumented: Solving a Public Health Crisis in the U.S.” J.
\textsuperscript{74} 42 USC 1395dd(d)(1)(A)
EMTALA’s requirement that “any individual” be covered has universally been interpreted to include all people, regardless of insurance or immigration status. Thus, at the very least, UIs are legally guaranteed a medical screening examination and care for the stabilization of an emergency medical condition. However, this is all that hospitals are legally required to do. As Sara Rosenbaum notes, “the obligations are merely to screen and stabilize, not to treat to the point of resolution.” Thus, a hospital has no obligation to provide anything like the standard of care to UIs who present themselves in the ED, merely the minimum required by EMTALA. Furthermore, there a number of potential loopholes within the legislation that hospitals can take advantage of without legal repercussions. For one, it is unclear whether or not a hospital’s obligation to stabilize under EMTALA applies once a patient has been admitted to the hospital. The Fourth, Ninth and Eleventh Circuit Courts have held that it does not, while the Sixth Circuit Court has ruled that it does. This would potentially allow patient dumping but only once the stabilized patient was admitted to the hospital. There are also cases of hospitals utilizing the practice of medical repatriation, deporting UIs without insurance to their home country to receive care. In conclusion, EMTALA ensures that UIs are provided emergency care in the ED, but may leave them vulnerable in situations beyond this bare minimum.

Although EMTALA establishes a legal obligation for hospitals to provide emergency care, it does not provide the funds necessary to pay for this care. UIs are, however, covered under Medicaid for emergency care. Since the passage of EMTALA, around $2 billion a year—a little less than 1% of the cost of Medicaid—has been allocated by the federal government to cover

75 Rosenbaum et al. 1749
76 Rosenbaum et al. 1751
77 Gusmano “U.S. Health Policy and Access to Care.”
uncompensated emergency care, most of which goes to UIs.\textsuperscript{79} Around half of this money goes to California, with the remaining predominantly divided among New York, Texas, Florida, North Carolina, Arizona, and Illinois. The definition of emergency care varies by state. For example, Emergency Medicaid in New York can be used to provide cancer treatment for UIs, and it can be used to provide dialysis in California, North Carolina, and New York. The only other federal funding that can be used to provide care for UIs is to pregnant women using SCHIP funds. In 2002, CMS amended its definition of a child under SCHIP regulations to include “the period between conception and birth.” Because the fetus is presumably going to be born in the U.S. with U.S. citizenship, it is eligible for SCHIP, and care to pregnant women can be construed as care to the fetus. This change essentially allows states to use federal funds to provide care to pregnant women.\textsuperscript{80} As of 2004, 7 states had chosen to take advantage of this option and extend coverage to pregnant UIs. These government program exceptions do provide some care to UIs.

The main source of care for UIs is the U.S. healthcare system’s safety net, defined by the Institute of Medicine as “those providers that organize and deliver a significant level of health care and other related services to uninsured, Medicaid, and other vulnerable patients.”\textsuperscript{81} The healthcare safety net is comprised of a variety of different components, including disproportionate share hospitals (DSH), federally qualified health centers (FQHC), and migrant health centers (MHC).\textsuperscript{82} DSHs are hospitals that provide, as the name suggests, a disproportionate amount of care to indigent populations, including UIs. Hospitals are provided

\textsuperscript{79} Galewitz, Phil. “Medicaid Helps Hospitals Pay for Illegal Immigrants’ Care.” Kaiser Health News. 12 Feb 2013. <http://www.kaiserhealthnews.org/stories/2013/february/13/medicaid-illegal-immigrant-emergency-care.aspx>. One study in North Carolina found that 99% of those qualifying for Emergency Medicaid were undocumented immigrants. The remaining are homeless individuals and legal immigrants in the country for less than five years.

\textsuperscript{80} Fremstad 2011


\textsuperscript{82} Gusmano “U.S. Health Policy and Access to Care.”
additional funds for reimbursement by Medicaid and Medicare proportional to the additional care provided to indigent populations. This framework allows hospitals to provide some care for UIs, even if they know they are uninsured or cannot pay, because of the assurance that they will be reimbursed as a DSH. In order for a patient to qualify for charity care, one need not provide proof of citizenship or a green card, simply meet certain criteria, such as a sufficiently low income and ineligibility for Medicaid.

In addition to DSHs, the safety net also includes FQHCs and MHCs. FQHCs are non-profit organizations funded by the federal Health Resources Services Administration. They offer primary care in all areas of the U.S. to low-income patients regardless of insurance or, most importantly for our purposes, immigration status. Many FQHCs are free, while many provide heavily subsidized care on a sliding fee schedule system. They have received a generous amount of support from both George W. Bush’s administration and Barack Obama’s administration, with funding jumping from $750 million to $2.2 billion from 1996 to 2010. As of 2010, there were 1,214 FQHCs. MHCs have almost identical qualities to FQHCs, the one exception being that MHCs exclusively serve seasonal and migrant farm workers and their families. There are currently 159 MHCs. Together, these entities provide the bulk of care to UIs.

UIs use all kinds of different types of healthcare services. They access private doctor’s offices, hospital outpatient clinics, health centers and clinics, as well as hospital emergency departments, much like the rest of the population. The difference is the frequency with which different kinds of U.S. residents use these services. One study in Orange County showed that the frequency of services used differed greatly for UIs compared to other U.S. residents. Only

83 Jerome-D’Emlia 22-23
84 Gusmano “U.S. Health Policy and Access to Care”
86 Gusmano “U.S. Health Policy and Access to Care”
87 Chavez 891
29.7% of the care UIs received was at a doctor’s office, compared to 87.4% for U.S.-born whites, 73.8% for U.S.-born Latinos, and 49.3% for legal residents. Over 60% of UI care received was from hospital outpatient clinics, health centers, and public health clinics. U.S.-born whites only receive 8% of their care from these outlets. Lastly, although UIs received almost twice as much emergency care as whites in this study, it was still only 6.9% of all care they received.

This section has provided an overview of the kind of access to healthcare UIs currently have. However, with the full implementation of the Affordable Care Act just around the corner, the entire healthcare landscape is about to change. It is likely that healthcare for UIs will look rather different in the coming years. In the final section of this chapter, I make a few predictions concerning what we can expect for the future of UI healthcare access.

**What Kind of Healthcare Will UIs Have?**

The ACA will affect the healthcare that UIs receive in multiple ways, some foreseen and some unforeseen. Most importantly, UIs remain ineligible for Medicaid, Medicare, and SCHIP.\(^{88}\) The Medicaid expansion is ACA’s most significant step to reduce the number of uninsured in the U.S., and UIs are explicitly excluded from benefiting from it. The ACA also prohibits UIs from participating in the health insurance exchanges. Not only are UIs ineligible for the subsidies provided to make insurance coverage more affordable,\(^{89}\) they are also barred from the exchanges even if they can afford to purchase insurance with their own money.\(^{90}\) Their exclusion from the exchanges will have the obvious effect of precluding them from purchasing insurance in the preferred way, but it may also have the less obvious effect of limiting their existing coverage through their employers. A disproportionately high number of UIs work in

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\(^{88}\) Jerome-D’Emilia 21  
\(^{89}\) PPACA §1412(d)  
\(^{90}\) PPACA §1312(f)(3)
smaller firms. Many of these employers will be tempted to take advantage of their exemption from the employer mandate, encouraging their employees to seek coverage in the exchanges.\textsuperscript{91} Because UIs cannot participate in the exchanges, they will lose their coverage through their employer but be unable to purchase it through the exchanges. Other employers will choose to offer insurance through the exchanges where, due to expected increased scrutiny regarding immigration status, UIs may either choose not to accept their employer coverage or their employer will choose not to offer it. Although larger firms will be penalized in proportion to how many employees they do not cover, this may not apply to UIs.\textsuperscript{92} The law penalizes employers for those employees not offered insurance who would be eligible through the exchanges. Since UIs are not eligible for insurance through the exchanges (and should not be, by federal law, employed in the first place), it is unclear whether or not large employers will be compelled to offer insurance to UIs. All of this should exacerbate the already low level of insurance coverage for UIs. The Urban Institute estimates that, if the ACA were fully implemented today, 25% of the remaining uninsured would be UIs.\textsuperscript{93} This is 50% higher than their current percentage of the uninsured population and seven times their percentage of the overall population.

The ACA also has several provisions that make changes to the healthcare safety net. For one, the ACA calls for diminished federal funding for DSHs. Medicare DSH payments will be reduced by 75% and Medicaid DSH payments by 20%.\textsuperscript{94} The rationale behind these cuts is that, with the expected decrease in the number of uninsured, these hospitals have less need for

\textsuperscript{91} Bustamante 318-319
\textsuperscript{94} Hall 802
federal money to help recoup their losses from providing uncompensated care. The question of whether or not the legislation leaves enough funding to ensure that DSHs can continue to provide charity care for the remaining uninsured—including most UIs—remains to be seen. The risk of DSH payments falling short will be greatest in the 21 states that are currently refusing to participate in the Medicaid expansion. In these states, the DSH payments will be cut, but the need for charity care will remain the same. The needs of UIs are more likely to go unmet in these states.

Although the DSH payment cuts should hurt the safety net, the ACA also makes an effort to bolster the safety net by providing funds for FQHCs. The ACA calls for $11 billion to expand FQHCs, a step that should help UIs access care in the coming years. In addition to this increased funding, a higher percentage of FQHC patients will now have insurance, increasing the potential revenue for FQHCs. Despite this increased funding, there may still be reason to be concerned for the adequacy of the safety net. When Massachusetts enacted its healthcare reform, the increased rate of insurance resulted in an increased strain on FQHCs. Although these health centers have traditionally appealed to the uninsured, they are also an appealing healthcare option for the low-income insured. Massachusetts saw a 31% rise in patients at FQHCs in the four years after its reform. We should expect to see a similar bump nationwide. It remains to be seen whether the increased funding via both additional federal funds and a higher rate of insured patients will provide adequate funding to accommodate the added patient load. The future state of healthcare for UIs will largely depend on the strength of the safety net.

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96 Hall 802
97 Jerome-D’Emilia 23
The latter part of this chapter has reviewed the types of healthcare that UIs have received and will receive in the future. In the next chapter, I will consider the main arguments against providing healthcare for UIs.
Chapter 2: Arguments against Providing UIs Access to Healthcare

Chapter 1 provided background information about UI demographics, both in general and in healthcare. In this chapter, I will begin to address the main topic of the thesis—whether a society should or should not provide its UIs with healthcare. This chapter will examine some of the main arguments against providing healthcare for UIs. My description of each argument will include three sections. First, in the Argument section, I explain exactly what the argument is and how it supports the conclusion that UIs should be denied healthcare. Next is the Support section. Here I discuss the pros of the argument, defending the argument in its strongest form and in a maximally charitable light. The final component is the Responses section, where I will discuss the argument’s weaknesses, levying against the argument any and all objections.

1. UIs Are in Violation of U.S. Law and Should Be Disqualified from Receiving Healthcare

Argument

This is a common argument for denying healthcare access to UIs. It holds that UIs are in violation of our immigration laws and that such disregard for the law must have consequences.

Let us consider the argument in a more formal structure:

1. UIs are in violation of U.S. immigration law.

\[98\] It is important to note that, in both Chapters 2 and 3, there may seem to be important arguments that I fail to consider. For example, Chapter 2 has no argument that UIs do not have a right to healthcare, and thus society has no obligation to provide it to them. That is because this argument is found in the Responses section of the “UIs Have a Right to Healthcare” section in Chapter 3. I could also have put a section in Chapter 3 discussing why UIs are not a drain on society, but that argument comes out in the Responses section of “UIs Are a Drain on Society.” All that is to say, if you believe an argument to be noticeably absent, sit tight, because you may find it in the Responses section of another chapter.
2. Violations of the law should be punished, not rewarded.

3. Providing UIs with access to healthcare would constitute rewarding UIs for their illegality.

4. Therefore, we should not provide UIs with healthcare access. 99

Support

The support for this argument should be quite clear. We have laws in this country and those laws are meant to be followed. If those laws are broken, then the perpetrators must be willing to suffer the consequences. If we do not enforce the law, then people begin not to follow the law, and society begins to suffer. UIs have broken the law by immigrating to the U.S. illegally. If we were to provide them with healthcare, we would be essentially rewarding their bad behavior. Should we not be punishing their bad behavior instead? Our immigration laws are important and UIs have failed to respect them, and for that, they must suffer the consequence of being barred from healthcare access in the U.S.

Responses

One obvious response to this argument is that, even if it is sound, it only justifies denying healthcare to adult UIs who knowingly violated U.S. immigration law. Surely we would not be justified in denying healthcare to UI children who were brought to the U.S. by their parents. 100 They had no choice over their parents’ decision to illegally immigrate to the U.S., and surely the proponent of this argument would not recommend we punish UI children for the

99 This argument, like many in this thesis, does not have one particular scholarly advocate. Rather, I have gleaned this argument from a variety of academic sources and general public opinion. For those arguments that do have specific sources, I will cite them at the end of each Argument section. For those that do not have a citation, it can be assumed they have no specific source.
100 Nickel, James W. “Should Undocumented Aliens Be Entitled to Health Care?” The Hastings Center Report 16.6 (1986): 19-23; 23
sins of their parents. This argument certainly seems less persuasive when applied to children who violated U.S. immigration law without choosing to do so.

Another response to this argument is that the notion of denying healthcare to UIs as a consequence of their bad behavior is entirely the wrong way to look at healthcare. A murderer may be forced to spend years behind bars, isolated from the rest of society, but we continue to feed and provide healthcare for the prisoner. We do not constitute the delivery of these basic necessities as a reward for bad behavior, we simply think some things are too important to give or take away as a form of punishment. Surely, the critic of this argument might say, healthcare for UIs falls into this same category. 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.”

Surely committing murder is a more egregious act than immigrating to the U.S. without permission, or overstaying one’s visa, yet we provide our convicted murderers healthcare and not our UIs? Murder is a severe enough crime that the denial of healthcare to murderers may not elicit much outrage. But consider a more benign crime akin to violating immigration law, such as working off the books and avoiding paying taxes on some income. Almost every college student I have encountered has done some work for money under the table at one time or another, yet it is a violation of tax law not to declare all of your income. Surely, however, we would find it inhumane to screen every individual applying for social benefits or healthcare to ensure that they have not worked off the books at one time or another, but this would seem not entirely different from what the proponent of this argument suggests regarding UIs. Perhaps there are good reasons that working off the books and immigrating illegally are sufficiently different acts

as to merit a distinction in the provision of healthcare. However, a separate argument would be needed to supplement this argument, and it seems clear that breaking the law is not a sufficient condition for the denial of healthcare. The proponent of this argument must seriously consider the implications of denying healthcare access as a means of punishing UIs for circumventing our immigration system.

Furthermore, one must wonder whether or not it is the role of healthcare policymakers and our healthcare system to act as enforcers of immigration. It is the responsibility of the immigration sphere to control immigration, not our healthcare sphere, and the critic of this argument could argue that these spheres should remain separate. It is not the role of physicians, insurance companies, or anyone else in healthcare, to act as border patrol officers. Rather, it is the responsibility of those in healthcare to provide care to the sick, whether they be black or white, male or female, undocumented or documented. Thus, healthcare policy should recognize this important distinction and avoid muddling the roles of immigration officers and healthcare professionals.

One could also respond to the proponent of this argument by considering some potentially absurd implications of the argument. Although we do currently provide UIs with emergency care, it seems that this argument could, and perhaps even should, be used to justify its denial. If immigrating to the U.S. illegally is a sufficiently heinous crime to disqualify UIs from deserving healthcare, why not deny the UI gunshot victim who staggers into the emergency room? Perhaps it is reasonable to allow a UI woman to die in childbirth because she decided to immigrate to the country illegally. Surely we think that letting someone die simply because she immigrated illegally is too drastic a punishment. What then is the proponent of this argument’s

Glen, Patrick J. “Health Care and the Illegal Immigrant.” Health Matrix 23 (2013): 197-236; 229
reason for distinguishing between the two? One would need an account of why it is appropriate to deny some healthcare and not other care on the basis of UIs’ violation of immigration law.

2. Social Benefits Will Encourage Illegal Immigration

Argument

The contention of this argument is that providing healthcare access for undocumented immigrants will act as a magnet for UIs, increasing the rate of immigration to an unsustainable level. To provide healthcare access for UIs would provide one more reason for UIs to immigrate to the U.S., and we do not need to create additional reasons for UIs to immigrate. The argument goes something like this:

1. Our current level of illegal immigration is too high.

2. Our society should not take any steps that would increase the rate of illegal immigration.

3. Providing healthcare access to UIs would increase the rate of illegal immigration.
   a. If we provided healthcare access to UIs, some around the world would have better healthcare options in the U.S. than they do in their home country.
   b. Healthcare is of great importance to many potential UIs.
   c. If healthcare is of great importance to a potential UI, the provision of better healthcare to UIs in the U.S. than they would receive in their home country will act as an incentive to immigrate.

4. Therefore, we should not provide UIs with healthcare access.
Support

The form of the argument is fairly simple. Premise 1 makes an assertion that many, if not all, in the U.S. would hold to be true, namely that the rate of illegal immigration in this country is simply too high. The UI population has been steadily increasing in recent years, with the number almost quadrupling from 3.7 million in 1990 to 12 million in 2007.\footnote{Passel-2011 2} If we agree that the rate of illegal immigration is too high, then the logical next step is to ensure that the rate does not increase. This is a fairly modest move to make. One could go even further and argue that steps should be taken to decrease the rate of immigration, which I take it many would support. However, this argument need not be that far-reaching. All it needs to work is to establish that the rate of illegal immigration should, at the very least, go no higher than it already is.

Premise 3 is, as one might expect, the most controversial premise of the argument. I do believe, however, that an argument can be made that providing healthcare would encourage immigration. Imagine a woman from El Salvador is considering whether or not to immigrate to the U.S. She is pregnant and due in a couple of months, but the healthcare to which she has access in El Salvador is well below the standard she would want for her delivery. She hears from a friend that the U.S. will provide care to pregnant woman regardless of their immigration status. Upon hearing this news, she immediately begins the trek to the U.S., solely because she wants access to healthcare. Does that not seem like a plausible story? With the level of healthcare currently offered UIs, this story is quite possible with the emergency prenatal care many women receive. If we provided UIs with even more access to healthcare, the potential for more of these stories could increase. Imagine a diabetic in Guatemala finding out the U.S. has just begun to offer care to residents regardless of immigration status. Could this not serve as a
compelling reason for the diabetic to emigrate from his home country? It seems quite possible that there is a subset of the potential UI population whose immigration is dependent upon the level of healthcare access they expect to receive upon immigrating to the U.S. As long as there is one individual whose decision to immigrate to the U.S. is dependent upon the level of healthcare provided, this premise is true. If Premises 1-3 are all true, then the conclusion necessarily follows and UIs should not be provided with healthcare access.

Responses

I will not spend much time on the first two premises mainly because my thesis is less about immigration and more about how society should treat immigrants once they arrive in the U.S. It is not the purpose of this thesis to make an argument for or against raising our current level of illegal immigrants. So, for the sake of argument, let us grant that the rate of illegal immigration is too high or high enough and that no steps should be taken to increase the level of illegal immigration. The argument now hinges entirely on Premise 3.

Even if the critic grants the first two premises, there remains one obvious point of attack to which the proponent of this argument is vulnerable: do social benefits play a large role in encouraging over-immigration? Sure, we can think of hypothetical examples in which it would make sense for an immigrant to immigrate to the U.S. for healthcare, but the extent to which these hypothetical cases actually happen is an empirical question. There is evidence to suggest that healthcare access does not play a big role in inducing immigrants to come to the U.S. I referenced a study earlier conducted by Mark Berk and colleagues surveying the UI populations of Houston, Los Angeles, Fresno, and El Paso. One of the findings in this study was that almost no immigrants—less than 1%—cited obtaining social services as the main reason for immigrating
An overwhelming majority of respondents cited work and family as being the predominant reason for immigrating. Other studies have looked at trends in interstate migration to see if the varying social benefits of different states have had an effect on immigrant movement. The welfare reform legislation of 1996 provided a natural experimental setup, with states implementing new policies related to immigration healthcare of varying generosity as a result of the federal legislation. Although it remains difficult to measure whether or not benefits are truly influencing immigrants’ decisions to move from state to state, the studies conducted have shown that social benefits play little to no role in immigrants’ decisions to migrate. If Premise 3 were correct, we would also expect to see UIs utilize public services at a high rate, but that does not seem to be the case. UIs utilize healthcare resources at a disproportionately low rate, the opposite of what we would expect if their main reason for immigrating is healthcare access.

I do not believe that the critic’s responses are ultimately devastating to the argument. This argument’s claim is so modest that if healthcare access contributes to immigration at all, the argument holds up. None of the previous data suggests that social benefits do not play any role, only that they do not seem to play a very large one. However, even if this argument is difficult to completely tear down, these responses do seem to diminish its persuasiveness. If providing healthcare access to UIs has a minimal effect on the immigration of UIs, is that small effect sufficient justification to deprive all existing UIs of healthcare? Alone, this argument does not seem strong enough to justify such an action, although it is impossible to deny that social services probably incentivize UIs to some extent.

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105 Berk 56
107 Berk 57-60
108 Look to “Extent and Nature of Healthcare Disparities” in Chapter 1
3. Preserving the Integrity of the Immigration Process

Argument

This next argument holds that providing UIs access to healthcare undermines the legitimacy of the immigration process. If the same benefits are provided to both UIs and documented immigrants, citizens and non-citizens, then of what value is adhering to the proper immigration channels? Why would a prospective immigrant bother to respect the documentation process if the benefits received are equal regardless? Let us consider this argument in its formal structure:

1. Society has the right to control the flow of immigration across its borders.
2. Because of this, society is allowed to protect against the potential diminishment of its ability to exercise this right.
3. Providing UIs access to healthcare would undermine the integrity of the immigration process, diminishing society’s ability to exercise its right to control immigration.
   a. If UIs and other U.S. residents have the same healthcare benefits, then the incentive to respect the process is diminished.
   b. If the incentive to respect the immigration process is diminished, then so is the integrity of the process and society’s ability regulate immigration.
   c. Providing UIs access to healthcare would make the benefits for UIs and other citizens too similar.
4. Therefore, society should not provide UIs with healthcare.\(^\text{109}\)

My first exposure to this argument was in this article, although the formulation and defense of this argument are my own.
Support

A strong case can certainly be made for this argument. For one, it is a definite presumption in today’s international climate that state sovereignty gives each society the right to control the flow of immigrants across its borders. Inherent to a state’s sovereignty is the power to admit or exclude aliens in accordance with the state’s perception of its own interests. To undermine the immigration process is to forfeit this inherent right of a sovereign state and to compromise a society’s ability to carry out its own interests. Without a viable immigration process, we could not do a number of things essential to a flourishing a society. For one, immigration preserves the ability of a society to maintain its cultural and moral identity. As communitarians are quick to point out, we cannot even understand justice and morality outside of our identity as a community. Who we are and what we hope to achieve can only be understood through our communities, which makes maintaining and shaping our communities of the utmost importance. The immigration process is an essential tool in preserving our identity as a society. Immigration control is also a necessary component of national security, allowing a nation to admit or not admit individuals who pose a threat to the U.S. Individuals may attempt to enter a country with the intention of harming its citizens or its institutions, and preventing their entry is of the utmost importance. Lastly, controlling immigration enables a society to prevent overcrowding. Especially in our current global climate of gross inequality, the opening of U.S. borders would no doubt result in an influx of immigration that would over crowd the U.S. to the point that no residents would be able to flourish.

Premise 2 is fairly straightforward. If we grant that a right exists for a society to regulate its borders, then it seems perfectly reasonable that a society should work to preserve that right.

111 Beauchamp, Tom L., and James F. Childress. Principles of Biomedical Ethics. 6th ed. New York: Oxford UP, 2009; 244-245
We must take steps to protect things of societal value, and insofar as the ability to regulate immigration is one of those things, a society must be permitted to preserve it.

Premise 3 is the heart of the argument and is probably the argument’s most contentious claim. However, I believe a strong case can be made for its legitimacy. Imagine that a potential immigrant from Mexico is deciding whether or not to immigrate to the U.S. legally or illegally. Because there is value to the immigration process, we would want the potential immigrant to immigrate via the appropriate channels. But imagine that there was nothing to be gained by immigrating legally. UIs, documented immigrants, and citizens all receive the same healthcare, social security benefits, voting privileges, and so forth. Why would the immigrant choose to do so legally? Presumably the process would be longer, the request could potentially be denied, taxes would be higher if the immigrant could be monitored via documentation status, and so forth. It would be in the best interest of the potential immigrant not to immigrate to the U.S. legally. If the incentives for benefits in the U.S. are such that it is no better to be a citizen than a documented immigrant, or a documented immigrant than a UI, then it seems the system is completely undermined. There is no reason to follow the appropriate channels and the state’s ability to regulate immigration is undeniably diminished.

I believe I have developed a compelling stance in favor of this argument, but I do not believe it is without flaws. Let us consider some potential responses to this argument and point out some weaknesses.

Responses

I believe there are a number of responses a critic of this argument could make that would need to be addressed by the proponent of this argument. One option would be to deny Premise 1 and hold that society does not have a right to regulate immigration. Joseph Carens
provides an especially compelling case in favor of a society opening its borders.\textsuperscript{112} The central focus of his position considers applying John Rawls’ theory of justice to the global scale and deriving a right to migrate. First, I will briefly summarize Rawls’ theory.\textsuperscript{113} His theory holds that, in order to discern what principles of justice should govern society, we must imagine a society choosing these principles at the original position. At the original position, each member of the society is behind a veil of ignorance, unaware of their personal situations, including natural ability, class, race, gender, and so forth. These characteristics are, according to Rawls, “arbitrary from a moral point of view.” It is not appropriate for a person to determine matters of justice based upon an arbitrary characteristic simply because that person possesses those characteristics. Thus, for the original position to be truly fair, the members of society must come to decisions concerning justice without the knowledge of their personal situations. Rawls concludes that two principles would be decided upon by the society at the original positions: all persons would be guaranteed equal liberty, and inequalities would be permitted only insofar as they benefitted society’s worst-off.

Carens believes that extension of Rawls to the international scale leads us to question the legitimacy of a country’s right to control the immigration process.\textsuperscript{114,115} Imagine an international original position, where each individual is ignorant of additional personal characteristics: country of origin, political character of their society, the distribution of the world’s natural resources, and so forth. Surely each person would choose to permit the free migration from country to country in case they ended up in a society that did not enable them to flourish. It seems a right to migrate would be established as an essential liberty at the

\textsuperscript{112} Carens 255-262  
\textsuperscript{114} Carens 255-262  
\textsuperscript{115} It is important to note that Rawls himself does not extend his original position on an international scale, instead preserving the existence of sovereign nation-states.
international original position, rendering the stringent immigration laws of most countries unjust.

Carens’ response essentially holds that the classic response to immigration—these are our borders and we can do whatever we want with them—is insufficient. To be born into the privilege and opportunity of American citizenship is a contingency over which we have little control, and under the veil of ignorance, social benefits and liberty should not be distributed on that basis. One of the more pronounced sentiments that underlies arguments against providing healthcare to UIs is that we as Americans have a privileged status that gives us the right to decide which immigrants stay or go and what kinds of benefits they receive. But how can our good fortune to be born in the U.S. justify this right to hold so much sway over the UIs unfortunate enough not to be born in the U.S.? If Carens is correct, the state’s sovereignty and the corollary right to regulate its own borders should take a backseat to the liberty of immigrants. Note that this argument essentially denies the right of each country to regulate immigration. If we deny Premise 1, then our concern that providing UIs healthcare for UIs will undermine the immigration process is unfounded, insofar as the state’s right to regulate its own borders is nonexistent.

Carens’ argument should be seriously considered by the proponent of this argument. However, a denial of the value of the immigration process would be a tough sell in a world that so heavily relies on the regulation of immigration. A much easier premise to attack would be Premise 3. Let us assume that the immigration process is a right of each society, and thus is valuable and worth protecting. Do we have good reason to think that providing UIs with healthcare access would undermine the immigration process? I believe there are several reasons to question this claim. For one, the argument assumes that healthcare access is a central concern of potential immigrants, and that there is a substantial correlation between the
level of healthcare access for UIs and the number of potential immigrants who choose to immigrate illegally. In order for providing healthcare access to undermine the immigration process, whether it is provided or not would have to have significant bearing on the amount of people who choose to circumvent the system. As discussed during the previous argument, there is evidence to suggest that social benefits such as healthcare are not high on the list of priorities of would-be immigrants.\textsuperscript{116} It stands to reason that the degree to which healthcare access plays a role in an immigrant’s decision to immigrate will correspond to the degree to which it plays a role in the immigrant’s decision to immigrate legally.

Even if one grants that healthcare does play a role in whether or not a potential immigrant goes through the process legally or illegally, it seems safe to assume it would not be the only factor. Even if healthcare access was equal for documented immigrants, citizens, and UIs, there would remain different benefits unrelated to healthcare for each type of resident.\textsuperscript{117} A UI would still have to fear deportation, would be unable to vote, would have to make the dangerous trek to the U.S., would be ineligible for most other government benefits, and so forth. It seems that healthcare access for UIs could only undermine the immigration process in a limited way, assuming that other differences associated with documentation status remain the same. Because this discussion only concerns healthcare, we can assume that the distinction between documentation statuses in other areas remains the same. There would still be considerable incentive for a potential immigrant to utilize the proper legal channels.

One final consideration for the proponent of this argument concerns the extent of healthcare for UIs being discussed. This argument is strongest if we are considering completely equal healthcare access for citizens, documented residents, and UIs alike. However, the

\textsuperscript{116} Berk 56
See the previous argument against providing UIs with healthcare access, “Social Benefits Will Encourage Over-Immigration.”

\textsuperscript{117} Glen 230
argument is less strong if there remain differences in the level of care provided to different types of residents. For example, if UIs were to receive a lower level of subsidy assistance in the ACA’s new exchanges than documented immigrants, there would remain an incentive to respect the immigration process. The greater the difference in benefits between different documentation statuses, the less convincing the case that healthcare access for UIs would undermine the immigration process. The proponent of this argument would have to consider the extent to which defining the level of healthcare for UIs weakens her argument.

4. **UIs are a Drain on Society**

**Argument**

This is another of the more common arguments used to justify not providing UIs with healthcare. This argument holds that providing healthcare for UIs puts an unjustified strain on our healthcare system and on society as a whole. Before we go in depth to the evidence in favor of this argument, let us consider the argument in its formal structure:

1. Because UIs pay minimal taxes and cannot pay for their own healthcare, they are limited in their ability to contribute to the financial viability of our healthcare system.

2. Providing UIs with healthcare disproportionately allocates resources to UIs with respect to their contribution.

3. If society provides UIs with a disproportionate amount of resources, then we will drain ourselves of much needed resources.

4. Denying UIs healthcare will alleviate the drain of much needed resources.

5. Therefore, we should not provide UIs with healthcare access.\(^{118}\)\(^{119}\)

Support

This argument is slightly more nuanced than some of the previous arguments, so we will take our time going through the premises step-by-step. Premises 1 and 2 go hand-in-hand. Premise 1 establishes the lack of contributions that UIs are able, or willing, to make in exchange for the healthcare they might receive, while Premise 2 explains the imbalance of providing UIs healthcare given their lack of contribution. If UIs do not pay sufficient taxes, then the benefits provided by federal and state governments (including healthcare benefits) will outweigh the amount UIs are paying in. When this occurs, the UIs become a net financial burden on society. There is considerable evidence that this is in fact the case. The Federation for American Immigration Reform (FAIR) conducted a comprehensive assessment of the burden UIs place on our society and found that the burden is considerable.\footnote{FAIR 79} UIs cost the federal and state governments around $110 billion annually, but only pay an estimated $12.5 billion in taxes, yielding an annual burden of almost $100 billion dollars, costing each native-born household nearly $1,000 per year.\footnote{FAIR 2-3, 55-57} Of the $110 billion, approximately 10\%—or $11 billion—is spent on healthcare.\footnote{FAIR 33, 41, 73-75} According to FAIR, although UIs do pay taxes—including income, sales, social security, Medicare, excise, and property—they pay far less than other U.S. residents.\footnote{FAIR 79} As a result, they pose a financial burden on other U.S. residents.

\footnote{Pelner Cosman does make this argument, although her evidence is less robust than that of Martin and Ruark.}


In addition to the lower taxes UIs play as a result of their illegality, UIs are also less likely to pay using their personal resources for any care they do receive, further increasing their burden on the population. Because of their aforementioned disproportionate likelihood to be impoverished and uninsured, UIs are over twice as likely as U.S.-born residents to receive uncompensated care.\(^\text{124}\) Hospitals are collectively spending around $2.25 billion a year in unpaid medical expenses for UIs.\(^\text{125}\) Many hospitals in Texas, New Mexico, Arizona, and California have been forced to close their doors, lest they face bankruptcy because of the uncompensated care provided to UIs.\(^\text{126}\) Madeleine Pelner Cosman estimates that, between 1993 and 2003, sixty California hospitals were forced to declare bankruptcy, something she attributes largely to UI uncompensated care.\(^\text{127}\) The ‘Anchor Babies’ of UI mothers—babies that are born to illegal mothers in the United States and immediately qualify for U.S. citizenship—place an additional burden on U.S. society because of their citizenship.\(^\text{128}\) Pelner Cosman estimates that between 300,000 and 350,000 so-called anchor babies are born each year, an additional $2.4 billion for U.S. taxpayers on Medicaid alone, not to mention any other government benefit programs they qualify for as U.S. citizens.\(^\text{129}\) Due to the uneven balance between care received, taxes paid, and care paid for, UIs currently place a burden on our society.

The conditional of Premise 3 brings the entire argument together. Insofar as UIs are not contributing sufficiently to the pool of resources that allows healthcare to be delivered, the healthcare that they receive over their contributions will put a strain on society. We cannot provide more care than we pay for without running a deficit which, all things being equal, is

\(^{124}\) Stimpson et al. 3  
\(^{125}\) Zuber 365-366  
\(^{126}\) Zuber 362  
\(^{127}\) Pelner Cosman 6  
\(^{128}\) Pelner Cosman 9  
\(^{129}\) Pelner Cosman 9
economically undesirable. So, to the extent that UIs receive more care than they pay for, our societal resources are drained. The strain that UIs place on our society adversely affects us. Ideally, we spend as much as a society as we take in, so for every dollar we spend on UIs more than they are contributing, their presence constitutes a financial burden that precludes us from functioning optimally as a society. Because of this, the argument concludes, we should not provide UIs healthcare.

Responses

There are a number of responses one could make to this argument that I believe the proponent of this argument must address. For one, I believe we must be careful not to exaggerate the extent to which UIs do not contribute to our society, as well as the extent to which they overuse healthcare services. As mentioned in the previous section, UIs do pay taxes. Their illegality may save them from paying the full range of taxes they would be subject to as a citizen or a documented immigrant, but they still contribute significant resources via taxation. In addition to the taxes they pay, they make other substantive contributions to our society. They work hard and contribute to our economy in jobs that many other members of our society would never do. To ignore the profound contributions UIs make to our society is to neglect reality for the sake of promoting this argument.

In addition to keeping in mind the contributions UIs make to society, it is important not to forget how infrequently UIs take advantage of healthcare in the U.S. It is inaccurate to portray the UI population as greedily taking advantage of the healthcare resources our society has to offer. As has been mentioned throughout this thesis, UIs use considerably less healthcare than other populations within the U.S. It is tempting for the proponent of this argument to paint a picture of the lazy, illegal immigrant rushing to take advantage of all the social benefits
the U.S. has to offer. Such a depiction misses the mark. UIs do contribute a lot to our society, and they do not seem to be deliberately trying to overuse our resources. We must be careful not to mischaracterize the UI population for the sake of promoting this argument.

A second response to this argument is that it is drawing the wrong conclusion from the evidence before it. Often two individuals looking at the same evidence can come to wildly different conclusions. Once could accept the first three premises of this argument yet take the rest of the argument in a different direction. Perhaps denying UIs with healthcare is not our only course of action. Let us take the alleged lack of contribution UIs make to society. Perhaps the solution is not to deprive them of healthcare, but to allow them to contribute more to society and to their own healthcare. How could they do this? If they were granted amnesty, they could come out of the shadows and contribute to society in a manner like that of other U.S. residents. Not only would this reduce the burden they put on society, it might actually have long-term economic benefits for our society. A 2005 report by the National Foundation for American Policy found that the contribution to the Social Security system by current legal immigrants would provide a net gain of $407 billion to the system over the next 50 years. The National Resource Council estimates that immigrants add as much as $10 billion to the economy each year and that, over the average immigrant’s lifetime, $80,000 more is paid in taxes than is consumed in social benefits. Perhaps the solution is not to deprive UIs of access, but to grant them citizenship or protection from deportation so that they could function as more legitimate members of society, further contributing to the financial viability of our healthcare system.

131 Glen 231
A second alternative conclusion that could be drawn from the evidence is that, instead of providing UIs with less care, they should be provided with more care. Because UIs do not have health insurance and are afraid to seek care, they are more likely to delay receiving needed care. Chronic diseases like asthma, diabetes, and hypertension are cheap to treat via preventive care but expensive to treat when care is delayed. When UIs do receive care, they are likely to be too late to treat the condition effectively, leading to higher medical bills and a larger strain on society. Providing better rounded care would not only enable us to treat UIs more effectively for their ailments, but it would allow us to do so in a maximally cost-effective manner. Imagine instead of only providing UIs with emergency care, providing them with more comprehensive care and asking them to pay more for it. They would be more likely to receive preventive care, increasing their chance of remaining healthy. Because UIs are more healthy than other populations already, their inclusion in the insurance pool would likely drive down the risk of the overall population. The exchanges need more people, not fewer, and UIs can help bear the burden the sick of our society will place on our healthcare system. Harvard researchers assessed the impact that legal immigrants have had on Medicare, finding that they put far more into the program than they take out, netting a surplus of $115 billion from 2002 to 2009 compared to the $28 billion deficit created by U.S.-born residents in the same period of time. Perhaps if UIs were allowed to participate in the exchanges, Medicaid, and Medicare, they would make healthcare in the U.S. more sustainable. The drain on the system produced by UIs

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132 Capps 25
134 Kullgren 1632
could potentially be alleviated by including them more in the system, not less. Allowing them to pay for comprehensive care, both through the purchase of insurance and through taxation, could potentially help increase the longevity of our healthcare system.

Presumably the conclusion of this argument, the denial of healthcare to UIs, would also decrease the burden UIs place on the system. However, the proponent of this argument should carefully consider which of these options is better. Do we cut off all care for UIs, including emergency care, in order to reduce the burden they place on society? Or, do we further include them in our healthcare system, both enabling them to pay into the system and increasing their care? I am not sure, but the argument as outlined fails to take into account all of the options with which society is presented. Denying healthcare to UIs is not the only way to reduce the burden and drain they place on society.

Another potential response to this argument is that it inappropriately portrays government as a private business venture, in which we pay a certain amount into it and expect to get a certain amount out of it.\textsuperscript{137} Although one could argue this is the proper way to view some things, such as Social Security, it is decidedly the wrong way to conceive of other institutions. We do not all pay into Medicaid in proportion to how much we get out of it, nor do we think a grave injustice has been done when someone does get more out of Medicaid than they put in. The healthcare safety net is something to which we all contribute to take care of our poor and downtrodden. To give a non-healthcare example, we all pay to support the fire department, yet we do not all use enough to make our investment worth our while. To the unfortunate few that have to utilize the fire department, we do not perceive them as taking advantage of the system because they got more in fire department assistance than they paid for. Rather, we view that as the proper role of the fire department, to help some more than

\textsuperscript{137} Dwyer 37
others in accordance with need, even if the assistance exceeds one’s initial contribution. That is the purpose of these institutions, to be there for those who need them in times of trouble. Healthcare, it seems to me, should be conceived of in this way. The proponent of this argument would have to seriously consider all of these responses.

6. Diversion of Valuable Healthcare Resources

Argument

This argument considers the relative claim of UIs to society’s healthcare resources compared to other U.S. residents. The argument concedes that it might be desirable to give UIs healthcare, all things being equal, but all things are not equal. We have limited resources and it is not appropriate to divert valuable healthcare resources to UIs. Let us take a look at this argument more closely:

1. Society has limited healthcare resources.
2. Because of our limited healthcare resources, society must make the difficult decision of choosing who will receive these resources.
3. A society has a responsibility to allocate resources to those residents with the highest priority.
4. UIs have a lower priority than other U.S. residents.
5. Therefore, we must not provide healthcare to UIs.

138 Dwyer 37
Support

This argument is interesting because it focuses less on UIs’ absolute lack of desert to healthcare and more on the relative desert of UIs compared to other U.S. residents. The evidence for Premise 1 and 2 is difficult to ignore. The U.S. is plagued by a continual and unsustainable rise in healthcare costs. It would be one thing if these costs yielded excellent health benefits, but that is not the case. We spend considerably more than any country in the world, yet we have one of the highest rates of uninsured residents and only average health outcomes. We simply cannot continue to use our healthcare resources on anything and everything, which means that some difficult decisions have to be made. This much, at least, seems to be beyond dispute.

If difficult decisions concerning the allocation of our healthcare resources have to be made, how should we go about making them? Premises 3 and 4 hold that we have to prioritize the allocation of resources by type of resident. Society has a responsibility to take care of its own first and foremost, not those that have immigrated to this country illegally. We may have obligations to UIs, and one of those may even be healthcare (all things being equal), but surely our obligations to our citizens are greater. The proponent of this argument could grant that healthcare for UIs would be ideal, but we have to draw the line somewhere. If the decision is between a U.S citizen and a UI, surely we must give priority to the citizen. It is regrettable that our healthcare resources are finite, but in light of this finitude we have a responsibility to be smart with our decisions. It is simply not fair to compromise the healthcare of citizens and legal immigrants in order to increase the care for UIs. For every dollar we allocate for UI healthcare, a dollar is diverted from a poor American with diabetes, or an elderly legal immigrant in need of a pacemaker.
Responses

One potential response to this argument is that it presents us with a false dichotomy. We do not necessarily have to choose between healthcare for UIs and healthcare for other U.S. residents for several reasons. Why can we not have both? Although this argument is right to point out that we have to make choices concerning the allocation of our resources within society, it is wrong to suggest that we are locked into a certain healthcare budget. If healthcare for UIs were a high enough priority for our society, we could divert funds from the military budget to increase the care for UIs without compromising care for other citizens. The proponent of this argument may not want to take this route either, but it is at least an option that this argument inappropriately fails to take into account.

I think it is also relevant what kind of healthcare the more deserving U.S. residents we would be sacrificing if we were to provide UIs with care. I grant that every dollar to UIs is a dollar taken from somewhere else, but if the dollar was going to go to making Viagra for American men more affordable instead of going to providing UI woman with prenatal care, this might indeed be a trade-off many would be willing to make. We do not necessarily have to choose between essential care for UIs and essential care for other U.S. residents, but instead essential care for UIs and less essential care for other residents.

One final point of contention concerns this argument’s claim that UIs are of the lowest priority within a society. This may be true if our only criterion for the distribution of healthcare resources is immigration status, but surely other considerations might be relevant. Perhaps we should consider the health behaviors of residents when deciding how to provide healthcare. Perhaps those who smoke, eat poorly, or fail to exercise are less deserving of our healthcare resources in virtue of the poor decisions they have made. Perhaps we should look at criminal record and distribute resources in accordance with the magnitude and severity of each...
resident’s past crimes. One could think of countless other criteria by which healthcare allocation decisions could be made. One might respond by saying healthcare should not be denied to people simply because they fail to eat healthy or because they committed a crime. However, if one is going to take that line of reasoning, one would need an accompanying explanation of why it is okay to distribute on the basis of immigration status and not nutritional decisions or criminal history. If these other methods of distribution are legitimate, then the proponent of this argument would need to restructure this position in a way that accounts for these other criteria.
Chapter 3: Arguments for Providing UIs Access to Care

We have now heard one side of the story—why UIs should not be provided with healthcare. In this chapter, I will consider arguments for why we should provide UI with healthcare. The format of this chapter will be identical to the previous chapter. First, I will lay out the argument. Then, I will provide the most compelling case in favor of the argument. I will conclude each section by considering any potential objections or concerns that a proponent of the argument would have to address.

1. Public Health Dependent upon Healthy UIs

Argument

I will classify the first few arguments of this section as prudential arguments rather than moral arguments, insofar as they argue for providing UIs with healthcare on the basis of the benefits that would be provided other members of society, rather than because of the benefits provided to UIs in themselves. The first of these arguments concerns public health. The argument is that, if UIs do not have adequate healthcare, other members will be susceptible to the spread of communicable diseases. The following is an overview of the argument:

1. If UIs do not have healthcare, they are likely to suffer from communicable diseases.
2. If UIs suffer from communicable diseases, other members of society will be susceptible to the spread of communicable diseases.
3. It is the responsibility of society to protect its members from the spread of communicable disease.
4. Providing UIs with healthcare will protect the members of society from disease.

139 Nickel 20
5. Therefore, we should provide UIs with healthcare.

Support

This is a simple argument but it has some definite force to it. The most vehement supporters of denying UIs healthcare tend to do so on the grounds that we should promote policies that support citizens and legal immigrants over policies that support UIs. However, this argument, and other prudential arguments, makes a case for providing UIs with care that presumably both sides of the aisle could appreciate. There are a number of reasons that we should be concerned with the transfer of dangerous diseases from UIs to other U.S. residents. For one, UIs are more likely to bring diseases in undetected than are other immigrants. Because UIs immigrate illegally, they do not undergo the medical screening to which other immigrants are subjected. For another, UIs will often bring in diseases that have either been eradicated from the U.S. or have taken on a new form to which U.S. residents might be especially susceptible. There are a number of diseases UIs could potentially spread to other residents, including, but not limited to Tuberculosis, STDs, Chagas disease, leprosy, Dengue fever, polio, malaria, and the hepatitis. Tuberculosis is one of the more discussed examples, so let us further consider it as an exemplary case study. First of all, it is dangerous, killing 1.3 million people worldwide in 2012. The early 1990s saw the near eradication of TB from the U.S., but it has since seen a recent surge. Estimates from the CDC hold that 42% of all new TB cases are

140 Zuber 369-371
141 Glen 224-225
142 Nandi et al. 433-436
144 Zuber 370
145 Pelner Cosman
147 Zuber 370-371
in foreign-born individuals,\textsuperscript{148} with the top three countries of origin being Mexico, the Philippines, and Vietnam.\textsuperscript{149} Not only are UIs more likely to carry TB, they are also more likely to carry Multi-Drug Resistant TB (MDRTB), rendering the treatment of the disease difficult and quite expensive.\textsuperscript{150} The high incidence of MDRTB is due in large part to the fact that UIs delay treatment, a practice which has been linked to the development of drug-resistant strains of diseases.\textsuperscript{151} In addition, UIs are reluctant to utilize our healthcare system, prompting them to buy drugs from the black market, another practice that has a tendency to promote resistant strains of diseases.\textsuperscript{152}

UIs have diseases that have the potential to spread throughout the U.S. and harm U.S. residents. The CDC has said that a key component to the eradication of diseases like TB is the reduction of its prevalence in the foreign-born population.\textsuperscript{153} The more we restrict UIs from accessing both preventive measures, such as immunizations, and treatment, the higher the incidence of these diseases in our population. And the higher the incidence of these communicable diseases, the greater the threat they pose to our society.\textsuperscript{154} Providing healthcare to UIs, so the argument goes, would be to the benefit of all individuals in society.

\textsuperscript{149} Zuber 370-371
\textsuperscript{150} Pelner Cosman 8
\textsuperscript{151} Glen 227
\textsuperscript{152} Glen 227
\textsuperscript{153} Centers for Disease Control and Prevention, Division of Tuberculosis Elimination. “Reported Tuberculosis in the United States.” (2010)
\textsuperscript{154} Nandi et al. 435
Responses

There are a number of responses to this argument, many of which have application to other prudential arguments. The evidence presented in support of this argument could be used in support of another conclusion. Madeleine Pelner Cosman believes that the risk of communicable disease that UIs carry is a compelling reason to support stricter immigration laws, specifically with respect to border control. Providing healthcare to UIs might lessen the risk of the spread of disease throughout society, but an even better option would be for them to never come to the U.S. in the first place. All of our fears of the health risks posed by UIs would dissipate if there were no UIs in the U.S. This response could be used against every prudential argument in favor of providing UIs healthcare. If our only reason to provide UIs healthcare is that they pose a threat to us, then the best option is to eliminate the threat through stricter immigration laws, not to simply reduce the threat through the provision of healthcare.

Another question one might ask the proponent of this argument is what level of healthcare an argument like this would support. It would be in society’s best interest to provide UIs only with healthcare necessary to prevent the spread of communicable disease, and no more. Any other healthcare—treatment for diabetes, hypertension, and so forth—could not be supported by the public health argument. If the proponent of this argument has hopes of identifying an argument to justify extending comprehensive healthcare to UIs, I fear they will be disappointed. Only healthcare necessary to preserve the health of other citizens is justified, and the majority of healthcare does not fall into that category.

A final point applicable to all of the prudential arguments I will consider is excellently summarized by James Dwyer below:

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155 Pelner Cosman
The public health argument has a serious failing, if taken by itself. It avoids the big issue of whether illegal immigrants should be considered part of the public and whether public institutions should serve their health needs. Instead of appealing to an inclusive notion of social justice, the argument suggests how the health of illegal immigrants may influence citizens’ health, and then appeals to citizens’ sense of prudence. The appeal to prudence is not wrong, but it avoids the larger ethical questions.\textsuperscript{156}

The public health argument has its merits and many may find it persuasive, but it may fail to approach the argument from the proper angle. It seems that the argument we should be making in favor of providing UIs with healthcare would have something to do with needs of UIs. This argument shows no concern for the rights of UIs or their well-being, only for the well-being of those whom they might affect. It is understandable that the proponent of this argument is searching for a reason to provide healthcare to UIs that a majority of people could understand and endorse: liberals and conservatives, pro-immigration and anti-immigration. But the prudential argument misses what I believe to be the core of the issue, it ignores the issue of whether we, as a society, should provide UIs healthcare \textit{for the sake of UIs}. As one might expect, this objection will be applicable for all of the prudential arguments. Prudential arguments may have their merits, but this final response is one that the proponent of this argument must address.

\textbf{2. Diminution of the Long-Term Societal Burden Argument}

The next prudential argument I consider is not concerned with the health of society, but rather with the negative effects that unhealthy UIs have on the financial stability of a society.

\textsuperscript{156} Dwyer 37-38
The idea is that sick UIs and their offspring are more expensive than healthy UIs, so by providing UIs with healthcare, we diminish the burden they place on society. Here is the formal structure of the argument:

1. Society has a legitimate interest in diminishing any financial burdens placed on it.
2. Unhealthy UIs place a burden on social structures that outweighs the cost of providing them healthcare.
3. Providing UIs with healthcare would diminish the burden that they place on society.
4. Therefore, society has a legitimate interest in providing healthcare for UIs.\(^{157}\)\(^{158}\)

Support

This argument shares many of the virtues of the public health argument. If all of these premises are true, presumably a vast majority of Americans would be willing to throw their support behind the delivery of healthcare to UIs. If non-UI U.S. residents would be benefited by providing UIs healthcare, then it would be in society’s best interest to do so. The most controversial premise is Premise 2, so let us look at some potential reasons it might be true.

Imagine a pregnant undocumented woman is unable to access prenatal care, and this restriction leads to complications in the pregnancy that result in the child being born with a disability.\(^{159}\) This child will be a U.S. citizen and qualify for a number of federal, state, and local benefits as a result of his/her disability. Would it not have been more prudent to simply provide prenatal care in the first place and save society the trouble of addressing the disability? It is better for

\(^{157}\) Nickel 20-21
\(^{158}\) Glen 226-227
\(^{159}\) Glen 227
society to have healthy, productive individuals who are not dependent on public support, and the best way to do this is to provide UIs with healthcare.\footnote{Nickel 20}

**Responses**

Many of the responses to this argument will be similar to the responses to the public health argument. One response would be to tighten our borders. If our only concern is for the well-being of U.S. citizens and legal immigrants, then reducing their numbers would limit the magnitude of their burden.

Another response, again, concerns the extent of healthcare this argument guarantees. If we are only providing enough healthcare to limit the stress UIs place on society, how much healthcare are we providing? Because UIs do not qualify for most healthcare benefits in the U.S., they do not have the option of taking advantage of our resources when they get sick. They have emergency care and safety net resources, but for the most part, a disabled immigrant or sick immigrant is not much more expensive to U.S. society than a healthy one. I think the most compelling evidence for this argument does come in the area of prenatal care because of the benefits to which the children of UIs do have access. But, if that is the only place this argument makes sense, it could at best support providing prenatal care to UIs, which many states do already. One could also make the argument that, considering the work UIs do for our society, it is best for them to be healthy so that they could continue to work. Again though, what about undocumented children or elderly? It seems that, insofar as they have nothing to offer from a labor perspective, they would not qualify for healthcare under this argument.

One must also question the truth of Premise 2. Is it really the case that providing healthcare for UIs would be less costly than not providing them with healthcare? This argument
rests on an empirical claim. The only healthcare that would be justified by this argument is care that saves society money. It is not clear which services, if any, would ultimately be provided. For further discussion, look back to the argument “UIs are a Drain on Society.”

Lastly, I am concerned that this argument too misses the ethical crux of this issue. As with the public health argument, once the threat to other members of society is lifted, UIs no longer have any claim to healthcare. It seems the question whether to provide UIs with healthcare must ultimately rest on concern for the UIs themselves, and on whether justice requires that society take care of its undocumented members.

3. Effects of Denial of Care to UIs on Non-UIs

Argument

This final prudential argument considers the negative implications that denial of care to the UIs might have on other U.S. residents. For one, processes that attempt to verify documentation status can have the unintended effect of acting as a barrier to care for non-UIs. Furthermore, healthcare access has a strong familial component, with individuals less likely to have insurance if other members of their family do not have it. Consider the following argument:

1. Society should promote the health of its citizens and documented immigrants.

2. Denying healthcare to UIs has the effect of restricting healthcare access to citizens and documented immigrants.

3. Providing UIs healthcare would promote the health of our citizens and documented immigrants.
4. Therefore, society should provide UIs with healthcare.  

Support

There are a number of potential restrictions to healthcare for UIs that have the unintended effect of hindering access for others. The first way I will discuss concerns emergency care. If we were to amend EMTALA to restrict access to UIs, we would need to implement a verification system that ensures those accessing medical care are legal residents. Such a system might limit access to individuals who are meant to have access to emergency rooms in two ways. One, the screening process would involve time, and in an emergency situation, time is in short supply. In order to avoid discrimination, every patient would have to be screened to ensure legal residence in the U.S., costing each patient precious time that could be used to treat the emergency condition with optimal effectiveness. In addition to the waste of valuable time, there is also the potential that the verification process would exclude the wrong people from receiving essential care. Certain individuals may be less likely to have documentation on their person—such as children, the mentally ill, or those with dementia—and these individuals may have important care denied as a result of their inability to demonstrate their legality. Furthermore, some documented immigrants could lack the requisite proof of legality and be denied emergency care as a result.

There are other spheres in which the denial of care to UIs could adversely affect the benefits provided other residents. In 2006, as part of the Deficit Reduction Act, Congress mandated that providers submit proof of their patients’ citizenship in order to be reimbursed by

161 Ziv and Lo 1097  
162 Glen 227-228  
163 King, Meredith L. “Immigrants in the U.S. Health Care System: Five Myths That Misinform the American Public.” Center for American Progress (2007); 3-4  
164 Ziv and Lo 1097
Medicaid.\textsuperscript{165} This legislation resulted in a drastic drop in claims, much of which was due to the inability of many legal residents and citizens to provide the requisite proof.\textsuperscript{166} There is little evidence that the legislation was effective in catching UIs. A study of six state Medicaid programs in 2007 found that the extra efforts cost the government an additional $8.3 million and only caught eight UIs.\textsuperscript{167} It seems clear that, at least in this case, the denial of benefits to UIs resulted in the denial of benefits to other eligible groups.

The last point that can be made in favor of this argument concerns the health of families with mixed immigration statuses. As mentioned in Chapter 1, approximately 4 million U.S.-born children live in a mixed status family. 37\% of UIs have children who are U.S. citizens.\textsuperscript{168} Despite the fact all U.S.-born children are eligible for SCHIP, UI children in mixed status families have health outcomes that are similar to UI children, who are not eligible for SCHIP.\textsuperscript{169} What accounts for this? Part of it is due to confusion experienced by immigrants over the eligibility of themselves and their children, and part of this disparity in health outcomes could certainly be alleviated with conscious efforts to educate these families. Other contributing factors, however, are more difficult to address as long as UIs are without healthcare. The research is clear that parents without health insurance are less likely to have children who are insured.\textsuperscript{170} Parents without healthcare are also sicker and, as a result of their illnesses, are less able to take care of their children. Undocumented parents also fear that seeking healthcare for their children will lead to their deportation or potentially hinder them from obtaining legal resident status at a

\begin{thebibliography}{99}
\bibitem{King} King 3-4
\bibitem{Glen} Glen 227-228
\bibitem{NILC} NILC 3
\bibitem{Gusmano2012} Gusmano 2012
\end{thebibliography}
later date. It is clear that denying healthcare access to UIs results in worse healthcare for their U.S.-born children.

The denial of care to UIs results in the diminished healthcare access of many who are deserving of care. If this argument is correct, then any argument for denying healthcare to UIs must come with a supplementary argument justifying why the subsequent denial of care to other U.S. residents is worth the denial of care to UIs.

Responses

The first response one might have for the proponent of this argument could be, “Who cares?” This argument could go one of two ways. First, one could contend that the amount of care denied to deserving citizens is far outweighed by the care denied to UIs. Maybe there are some unfortunate citizens and legal residents unable to access care through Medicaid or the hospital emergency department because they lack the requisite proof, but almost all of those unable to show proof of legal residence are those who do not have legal residence. Just because not many have been caught trying to access services does not mean that system is not working. The massive reduction in Medicaid claims is evidence that the process is working, with UIs less likely to attempt to access services. A critic of this argument can choose to accept the small number of individuals hindered by the more cumbersome legislation in exchange for the great benefit of restricting the healthcare of UIs.

Second, one could question whether or not those who are being denied care are truly deserving of the care in the first place. For example, some argue that a more appropriate interpretation of the 14th amendment would exclude those born to UIs from obtaining U.S. citizenship.\footnote{Pelner Cosman 9} Perhaps the injustice to the U.S.-born children of UIs is not as great as it might at
first seem, insofar as the children of UIs do not have much of a claim to our healthcare resources. The other group most affected would probably be documented immigrants. Although they are here legally, they are probably more likely to struggle providing the requisite proof than other legal residents. To many, this is less troubling than it would be if citizens or U.S.-born individuals could not get access, insofar as immigrants of any kind have less of a claim to our resources than citizens. Perhaps, the critic of this argument might say, we are not losing enough to be concerned by denying care to UIs.

A second response to this argument, also mentioned in response to other prudential benefits, concerns the scope of benefits. What level of healthcare does this argument justify? The portion of the Support section that concerns the children of UIs, for example, could at best justify providing care for UIs with children. If the only reason it is undesirable to provide UIs with care is that children in mixed-status households do not get care, then this argument only justifies the provision of healthcare to those in mixed-status families, or those with children who are citizens. No claim is generated for single UIs or UIs with undocumented children, insofar as denying them care would not be detrimental to the health of U.S.-born children. The emergency care portion could, at best, justify the provision of emergency care to UIs (which is already the case in the U.S.). The proponent of this argument must be careful not to conclude more than the argument gives license to conclude. As with the other prudential arguments, the only level of care that can be justified is the level that, if not provided, has negative effects on other members of society.

Lastly, I wonder again whether or not this argument justifies providing care to UIs for the right reason. As I will argue in what follows, I believe a more compelling argument for

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Her argument is that the language of the amendment “All persons born or naturalized in the United States and subject to the jurisdiction thereof, are citizens of the United States and the State wherein they reside,” suggests that they are under the jurisdiction of the mother’s citizenship, not the U.S.
providing care to UIs can be based on concern for their well-being, not the well-being of peripheral residents. We now shift from our focus on prudential arguments to moral arguments for providing healthcare to UIs.

4. Professionalism and the Obligations of Physicians to Patients

Argument

This argument considers the effects that denying healthcare to UIs will have on the profession of medicine. Denying healthcare to UIs, so the argument holds, requires physicians to deny care to patients in need, to the detriment of the medical profession. The argument is as follows:

1. Physicians have a professionalism obligation to work to promote the well-being of the sick.
   a. Medicine is a moral enterprise.
   b. Physicians, as the moral agents if the medical profession, have obligations to further the ends of medicine.
   c. One of medicine’s ends is to promote the well-being of the sick.

2. If society decides not to provide UIs with healthcare than physicians would be required to refuse care to UIs.

3. Requiring physicians to refuse care to UIs would necessitate that physicians violate their professional duties.

4. If society forces physicians to refuse care to their patients, we fill force them to compromise their moral integrity.

5. Society has a vested interest in upholding the moral integrity of physicians.
6. Therefore, society should provide healthcare for UIs.  

Support

Section IX of the AMA’s Principles of Medical Ethics says, “A physician shall support access to medical care for all people.” Notice, it does not say all people with the ability to pay, or all people from the U.S., or—most importantly for our purposes—all people with an appropriate immigration status. At the heart of this argument is the notion of medicine as a moral enterprise, one committed to promoting the health of society. Physicians are the moral agents that comprise this community, acting as moral agents to fulfill the ends of medicine. We give physicians a lot—autonomy, education, power, money, and so forth—and in exchange we expect them to remain committed to their professional obligations. A precise list of the physician’s professional obligations is perhaps difficult to nail down, but it seems that we can at least agree that the physician has a responsibility to promote the welfare of her patients. As Edmund Pellegrino and David Thomasma put it, “the existence of a genuine medical need constitutes a moral claim on those equipped to help,” and physicians are required to adhere to this maxim. That the physician has moral obligations is beyond dispute, but how would denying healthcare to UIs force the physician to shirk her moral responsibilities?

173 Ziv and Lo 1096
174 Kullgren 1630-1633
175 DeMaria, Anthony N. “Immigration Policy and Health Care.” Journal of American College of Cardiology 15.10 (2005): 1729-1730
178 Pellegrino and Thomasma 36
Imagine that a physician is working at a clinic in inner-city Los Angeles serving low-income patients. Congress passes a law forbidding the provision of healthcare to UIs and requires all physicians to ensure that all of their patients are legal before providing care to a patient. Now, before providing needed medical care, the physician is required to check to make sure the patient is in line with immigration law. If not, the physician is required to refuse care because of an edict passed down by the government. Is this the kind of society we want to live in, one in which physicians are required to refuse care to needy patients because of the agenda of the state? One of the more important lessons of the Holocaust is that the medical community’s moral compass must function independently of the goals of the state. The physician’s obligation is to the sick, not the select sick whom the state gives the physician permission to serve.

One may find the example I have provided a little extreme, but legislation similar to the legislation in my example was passed in California in 1994. Although California’s Proposition 187 was found unconstitutional and never implemented, it would have required physicians to deny care to UIs and report them to the proper immigration services. Even if legislation such as Prop 187 is never passed in another state or at the federal level, one can imagine other laws that would have a similar effect. What if EMTALA were revised to bar UIs? Would those seeking emergency care have to pass an initial screening process before being treated by a physician? Policies that currently exist, although less explicitly involving physicians, make them complicit in the denial of care to UIs. In a system that essentially requires insurance as a prerequisite for accessing care, our exclusion of UIs both from the exchanges and from government benefits is most certainly a denial of care to UIs. Although physicians might not be explicitly turning people away because of immigration status, they are turning people away without insurance, a group

179 Ziv and Lo 1096
that is increasingly more likely to be undocumented. As Pellegrino and Thomasma put it, “No order can be carried out, no policy observed, and no regulation imposed without the physician’s assent...the physician is therefore *de facto* a moral accomplice in whatever is done for good or ill to patients.” Denying care to UIs requires physicians to violate their duty to their patients, else they face state enforced penalties or bankruptcy for providing care to UIs.

In addition to being wrong because we are harming physicians, this harm could have negative effects on society as a whole. In cultivating a culture in which the moral integrity of physicians is damaged, we are disrupting the moral foundation of medicine. If medicine cannot function as a moral enterprise, then it is at risk of failing to fulfill its goal of healing the sick. Is it not of the utmost importance to protect the moral integrity of medicine and physicians from deteriorating? The proponent of this argument thinks it is, and insofar as denying care to UIs damages the moral standing of the medical community, it cannot be allowed. Thus, we should provide medical care to UIs.

**Responses**

As appealing as I find this argument, there are a number of criticisms I believe it must address. One response questions whether or not this argument has not misconstrued the duties of the physician. In the Support section I cited an AMA principle that holds the physician has a duty to support universal medical care access. Another AMA principle, however, states that “A physician shall...be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care.” This principle suggests that a physician denying care to UIs might be well within her rights. That being said, this principle could be wrong-headed—the AMA does not have a monopoly on medicine’s professional ethics. Plus, if a physician wanted to

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180 Pellegrino and Thomasma 44
181 AMA “Principles of Medical Ethics”
provide care to a UI yet society forbade it, both of these principles would be violated. At the very least, this response correctly encourages us to reflect on exactly what obligations the physician has and whether society denying care to UIs forces physicians to violate their obligations.

Even if we accept that the obligations of the physician are at odds with a societal refusal to provide care to UIs, there remain some potentially troubling implications of the argument. This argument seems to hold that the sick should be served solely on the basis of their medical need. Documentation status, insurance status, ability to pay, nationality, race, gender, and any other characteristics one can think of, should not matter at all from a moral standpoint. However, do we not accept a number of practices that distribute care on the basis of some of these factors? The most obvious one is the ability to pay, the United States’ method of rationing for many years now. Those unable to pay or lacking insurance have limited options within our healthcare system. Now, one may respond by saying that this practice is certainly wrong, thus the passage of the ACA which hopes to rectify this immoral status quo within the medical community.

This is not, however, the only aspect of medicine it seems would have to be changed. How could private practice possibly be moral, with physicians accepting and denying patients in order to maintain a financially stable practice? One might also wonder whether or not the abundance of quality physicians in the U.S. relative to other, less-developed countries constitutes a moral failure on the part of the medical community. What makes the U.S. so special, that we should have so many great physicians and that underprivileged nations like Haiti should be so bereft of adequate medical care? If documentation status is irrelevant, then surely someone’s place of origin is also irrelevant. Should physicians be required to move to the area

\[182\] Dwyer 38
of the world with the most medical need? It seems that we would call such an act morally commendable, but surely not obligatory. I do not believe that failing to move to Haiti to provide medical care diminishes the integrity of the medical community. All that is to say, we clearly have considerations in the delivery of care beyond only medical need. Perhaps this is wrong, but we would have to reevaluate more than just UI healthcare if we were to base our entire conception of the medical community’s professional obligations solely on medical need.

Perhaps the proponent of this argument can respond by saying the physician has obligations to his/her society that lessen potential obligations to other peoples. The physician’s professional obligations are often conceived as being derived from the physician’s relationship with society. Farrah J. Mateen writes, “In return for the high degree of autonomy society grants physicians, including licensure and self-regulation, the profession is expected to serve patients’ interests.” Society helps to provide physicians for many other things as well: a great education, high pay, prestigious social status, and much more. The physician is able to practice medicine in the manner she wants because of the conditions provided by society. Thus, the physician’s obligations are to his society. Although this may save the proponent of this argument from my previous objection, I think we run into another one. I wonder, if the physician’s obligations come from the benefits bestowed on the profession by society, does not society also maintain some role in defining the kinds of obligations the physician has? It would seem strange that the physician has obligations because of what she owes to society, but then once society asks physicians to do something (like deny care to UIs), the physician cannot because of his obligations? Insofar as professional obligations are derived from society, this

183 Mateen 541
184 One might responds by saying that medical students, or their parents, pay plenty for their education and owe nothing to society. I can think of a number of ways, however, that society helps make medical school possible. We provide loans and grants to students so they can afford it, we provide state and federal funds to sustain medical schools, we donate our bodies to science, we allow medical students and residents to deliver treatment so that they can better learn, and so forth.
argument seems not to work. It seems that the proponent of this argument runs into trouble in every direction, and these concerns must be addressed.

5. UIs Have a Right to Healthcare

Argument

In many ways, this entire discussion has danced around the central issue at stake in this argument: do UIs have a right to healthcare, and if so, does society have an obligation to recognize that right. As important as the prudential arguments and the professionalism argument are, this question truly strikes at the heart of the debate. What would this argument look like?

1. UIs have a right to healthcare.

   a. Certain dimensions of well-being are so integral to the good life that individuals have a right to these dimensions and it is the responsibility of society to provide them.

      a. Health is one of these dimensions of well-being.

      b. Healthcare is an important component in the promotion of good health. 185 186 187

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186 Nickel 22-23
187 This leap here from health to healthcare is somewhat implicit throughout the paper, but here is the first time I specifically make it. One could argue that, if the health of UIs is the central focus of my paper, why do I not focus on initiatives that promote health apart from healthcare? The relationship between health and healthcare is far from a perfect correlation, with a number of other factors—such as nutrition and socioeconomic status—playing large roles in the health of individuals. Because of this, I think it is necessary for me to explain the reason I have chosen to focus my paper on healthcare instead of other initiatives that promote health. For one, a specific discussion of healthcare seemed to be the most relevant discussion to have given the recent enactment of healthcare reform. So much time has been spent discussing whether or not a right to healthcare exists and so, because I want this discussion to add UIs into that discussion, I chose to focus this thesis along those same lines. For another, healthcare does play an important role in promoting health. It is most certainly true that a number of other factors play a massive role in health promotion, but the importance of healthcare remains paramount. It is not my intention, however, to imply that healthcare is the only important factor in health promotion, or even
2. Society has an obligation to address that right and provide its resident UIs with healthcare.
   a. In order to discern appropriate principles of international justice, we should extend the original position to an international scale.
   b. At the international original position, a right to migration would be established.
   c. Under the right to migration, distinguishing between different immigration statuses in order to distribute benefits is unjust.
   d. Without immigration statuses, our society would definitively include UIs.\textsuperscript{188}

OR
   a. An individual is a member of a society insofar as that individual sufficiently contributes to the fabric of that society.
   b. UIs contribute to the fabric of society by working undesirable jobs, paying taxes, and being members of our communities.
   c. Society has an obligation to those who qualify as members of society.\textsuperscript{189}

3. Therefore, we should provide UIs with healthcare.

Support

The main argument is short but each premise is both controversial and complex. Of course, the discussion of whether or not healthcare is a right is one of the more extensively debated issues of bioethics and I cannot provide a comprehensive overview of the entire

\textsuperscript{188} Carens 255-262
\textsuperscript{189} Nickel 21-22

Nickel’s discussion here has this argument, but I have expanded on it a little bit to encourage the adoption of a broader understanding of UIs’ contributions to society.
discussion. I do, however, put forth one of the most compelling accounts for why all individuals, including UIs, have a right to healthcare.

One of the most promising arguments for a right to healthcare is what I will call the humanitarian argument. This argument’s conclusion is clearly and succinctly encapsulated by James Nickel: “A humanitarian account of claims holds that all persons have moral claims against others to need assistance in obtaining the requirements of survival and a decent life.” The idea here is that some things are so important, so integral to human flourishing and well-being, that it is a moral failing for a society when some of its members are deprived of them. The sheer magnitude of some needs generate a humanitarian obligation that society must address. Many things are not nearly as essential and, because of this, the good society does not necessarily provide these things to its members. The good thing for the society to do is allow these things to be distributed naturally, and no moral failing has occurred if a member is unable to attain them. For those things that are of great importance, however, the good society does not stand idly by if its members are unable to attain them.

Madison Powers and Ruth Faden provide a list of six dimensions of well-being that fall into this category: health, personal security, reasoning, respect, attachment, and self-determination. Powers and Faden argue that each of these dimensions is of such importance to the good life that a just society should promote them for all of its members, ensuring the right to each dimension of well-being for each individual in a society. Thus, a right to health exists, and because of the important connection between health and healthcare, a right to healthcare must exist as well.

Premise 1 is contentious, but it is controversial not only in its application to UIs, but to all individuals. Premise 2 is more of an issue specifically for UIs. One could grant that a right to

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190 Nickel 22
191 Powers and Faden 16
healthcare exists, but with a strict application. Perhaps it only applies to those within a country’s borders, or to the actual members of that society. It does not extend to all individuals, including UIs. Premise 2 is necessary because it ties the rights of UIs to a corresponding duty society has to provide healthcare to UIs. What reasons do we have to suppose that society owes something specifically to UIs? I believe there are two separate arguments that could be employed as evidence for this premise.

The first one comes out in the work of political scientist Joseph Carens, whose position has been discussed earlier in this thesis.192 His theory bears repeating, however, insofar as it is relevant to Premise 2 of this argument. He makes a compelling case arguing against strict immigration laws using a broad interpretation of Rawls’ theory. Carens believes that extension of Rawls to the international scale would render our current immigration policies unjust. He imagines a global original position whereby those under the veil of ignorance are ignorant of their country of origin, documentation status, and so forth. Nobody at the original position knows the type of government he was born into, what kinds of resources her country has been blessed with, or anything of that nature. Carens argues that the freedom to migrate from one place to another—whether for the purpose of pursuing economic opportunities or to travel and live with a loved one—would fall under Rawls’ first principle of justice. Because nobody would know whether or not his/her country of origin provided a favorable environment for flourishing, they would all want the ability to migrate should such a move serve their best interests. To be born into the privilege and opportunity of American citizenship is a contingency over which we have little control, and under the veil of ignorance, social benefits and liberty should not be distributed on such an arbitrary basis. If Carens is correct, then the distinctions we draw between undocumented, documented, and citizen are illegitimate. Once we do this, any

definition of society will include citizens and UIs alike, our obligations to each other equal and
binding. Insofar as the distinction between different immigration statuses is unjustified in the
original position, a definition of society that excludes UIs and relieves society of any obligations
to UIs is also unjustified. Carens’ argument gives us reason to support Premise 2.

A second argument in support of Premise 2 is related to the contributions that UIs make
to our society. One notion of justice considers one’s claim to the benefits of society
proportional to one’s contribution to society. Although UIs are often conceived as being lazy
drains on society, this conception is not accurate. For the most part, UIs do make considerable
contributions to our society. UIs work hard in difficult jobs at low wages, jobs that few others
want to do. They pay sales and property tax, and many have social security and income taxes
withheld from their paychecks. Lastly, they are our neighbors, friends, colleagues, and
employees, contributing to the fabric of our society in immeasurable ways. Reasonable people
can disagree about the relative contributions of UIs to other U.S. residents, but it is impossible
to deny that they make a substantial and positive contribution to society. Because they do
contribute to society, society has a responsibility to acknowledge them as members of society.
And insofar as they are members of society, society has a duty to recognize their right to
healthcare.

If this account is correct, then society ought to provide UIs with healthcare; UIs have a
right to healthcare and society has a duty to provide it to them. Now we consider some of the
most compelling responses to this argument.

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193 Nickel 21-22
Responses

Premise 1 of this argument has one particularly pressing response the proponent would have to address. One might respond to this argument by conceding that a humanitarian obligation to help may be generated by disaster or emergency, but this creates only a limited obligation of society to provide healthcare for UIs. Notice that the humanitarian argument only justifies an obligation for society to help its members meet “requirements of survival and a decent life.” The strength of the argument hinges upon some intangible connection between those in dire need and those able to help, that when someone is unable to secure a decent life, society has done something wrong. However, one might object that this intuitional claim gets weaker and weaker the less basic the level of healthcare. It does seem that a humanitarian obligation requires that we save the UI dying of an emergency condition at the foot of the hospital, but beyond pressing emergency care, I think the case is more difficult to make. I think the proponent of this argument would have a tough time arguing for why primary care or minor procedures are necessary for survival and a decent life. The humanitarian argument is compelling when applied to individuals with truly devastating medical conditions, but less convincing when applied to a more comprehensive level of care.

The right to healthcare is a contentious issue, with reasonable and thoughtful individuals on both sides of the argument. If no right to healthcare exists, then this argument falls flat. Even if a right to healthcare exists, however, there remain criticisms of this argument that one could make. Let us move onto criticisms of Premise 2. I will take each of my three arguments in support of it in turn, considering objections to each one.

First, let us consider the denial of the legitimacy of the immigration system and the subsequent distinctions between various immigration statuses. The first response I believe can

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Nickel 22
be made to this argument is that it fails to take into account an important qualification to Rawls’ promotion of liberties. Some liberty can be restricted if a failure to restrict that liberty would lead to the deterioration of the public order. In the ideal world, where all states are comprised of just institutions, it seems unlikely that any foreseeable trends in migration could upset the public order. However, in a nonideal world (the one in which we live) there is far greater reason for many to migrate. We live in a world where many nations are plagued by unjust institutions and there exist massive inequalities on every scale between rich and poor nations. The sheer volume of potential immigrants to a relatively just society like the U.S. could most certainly threaten the public order without at least some restrictions to immigration. If the public order is compromised, then the liberty of everyone in the society is diminished. Furthermore, not all individuals are just. Many might try to immigrate to the U.S. with intention of harming our citizens or destroying our institutions. Thus, under the original position, one could reasonably expect a society to agree upon state sovereignty and the preservation of an immigration system. If that is the case, then the distinction between UI and citizen becomes relevant again and, once this concession is made, the obligations of society to individuals with different immigration statuses might vary.

Another response to this first argument in favor of Premise 2 draws on the communitarian ideals of Michael Walzer. Walzer, along with other communitarians, is critical of the egalitarian liberalism of Rawls, specifically its reliance upon the individual and the existence of universally binding conceptions of morality. For Walzer, morality and justice can only be understood through the specific lens of a community. The standards of distributive justice, therefore, are determined within a community and apply to the members of the community. Although Walzer does not believe that any and all restrictions on immigration are

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195 Rawls 212-213
necessarily just, he does believe that maintaining the integrity of the community is essential for any theory of justice. The first argument for Premise 2 fails to take into account the importance of maintaining this distinction and preserving the moral character of a society. If we accept that the distinction between citizens and UIs is important, then the potential to differentially treat these groups becomes justified.

Lastly, we have the inclusion of UIs as members of society because of their substantial contributions to society. The most compelling case against this claim is that UIs already receive more from society than they give to it. The critic of this argument can agree that one’s societal desert should correspond to one’s contributions, but argue that the contribution of UIs have not been sufficient to justify the receipt of healthcare. The argument “UI’s Are a Drain on Society” described in Chapter 2 makes the case that the contributions of UIs do not justify providing them with healthcare.

A final point I believe needs to be brought up in response to this entire argument is the scope of the healthcare that should be guaranteed UIs. Let us grant all of the arguments for both the existence of a right to healthcare and society’s correlative duty to provide it to UIs. What does that even mean? If it simply means emergency care, as discussed in the previous paragraph, then the U.S. is currently in compliance with its duty to provide healthcare to UIs. Surely, however, the proponent of this argument hopes to convince us of more than that. Do UIs have a right to any healthcare they desire? Surely the right is not quite that extensive. Does a 93 year-old terminally ill UI have a right to a pacemaker, or one in a permanent vegetative state the right to dialysis?\(^{197}\) Especially given our rising consumption of healthcare and limited resources, this seems like an impossible level of healthcare to promise. But if our obligation is not only emergency treatment and not any and all medical services, then what is the nature of

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\(^{197}\) Peters Jr., Philip G. “Health Care Rationing and Disability Rights.” *Indiana Law Journal* 70.2.3 (1995): 491-547; 491
our obligation? Do we define the right as that which is ‘medically necessary’? This concept is difficult to define, and it seems strange to assert a right to something that we cannot adequately explain. If the proponent of this argument is to have anything coherent to contribute to the discussion, then the scope of healthcare guaranteed as a right would have to be appropriately defined.

6. Societal Obligation to Promote the Health of UIs

Argument

This is the final moral argument I consider, and the structure is quite similar to the “UIs Have a Right to Healthcare” argument. The key difference is that it has a different first premise. This argument is as follows:

1. Society has an obligation to provide healthcare in order to promote fair equality of opportunity for its members.
   a. In order to discern what the appropriate principles of justice are, we must imagine the members of our society at the original position and under the veil of ignorance.
   b. At the original position, society would agree to only allow inequalities that would benefit everyone and with positions that everyone would have the fair equality of opportunity to pursue.
   c. Necessary to the preservation of fair equality of opportunity is healthcare.

2. The societal obligation to provide healthcare extends to UIs. 198

3. Therefore, we should provide UIs with healthcare. 199

198 The justification for this premise is identical to the justification for Premise 2 of the “UIs Have a Right to Healthcare” argument. In order to avoid redundancy, I do not repeat it here.
Support

The support for Premise 1 comes from the work of John Rawls and Norman Daniels. I provided a brief summary of John Rawls’ *A Theory of Justice* in the Responses section of the argument “Preserving the Integrity of the Immigration Process” in Chapter 2. Recall that Rawls attempts to discern the correct principles of justice by imagining the members of our society convening in an “original position” under a “veil of ignorance,” unaware of personal characteristics and qualities. Rawls argues that, in this original position, two principles would be agreed upon: each person in the society would be permitted the maximum amount of basic liberty compatible with a similar measure of liberty for others, and any inequalities in social primary goods would be allowed only if they benefited everyone. A caveat of the latter principle is that all positions in the just society should be open to all and based upon fair equality of opportunity.

The concept of fair equality of opportunity is an influential part of Rawls’ theory, and this concept was expanded upon by Norman Daniels in the area of bioethics. Daniels argues that, because of the integral relationship between health and opportunity, healthcare would be provided in a just society to ensure that individuals’ opportunities were not unfairly diminished because of poor health. Thus, society has a duty to provide healthcare insofar as good health promotes the fair equality of opportunity in society.

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199 Rawls *A Theory of Justice*


201 Rawls *A Theory of Justice*

202 Daniels 146-179

203 It is important to note that Rawls himself did not extend his theory of justice to include healthcare. Daniels’ work is necessary to justify this progression.
Responses

The most obvious move for the critic to make is to put forth an alternate theory of justice that does not include an obligation to provide healthcare. The libertarian theory of justice is one alternate theory of justice and has been arguably the most prevalent in determining the U.S.’s delivery of healthcare.²⁰⁴ Robert Nozick was an influential political philosopher who has provided the most compelling and comprehensive defense of libertarianism.²⁰⁵ Under this view, healthcare is a commodity. There exist no societal obligations apart from those that promote the freedom of individuals to pursue their own goals in the way that they see fit. For Nozick, justice is not outcomes based. It does not seek to promote a certain kind of distribution of wealth, an equal amount of opportunity, or a specific level of health outcomes for all individuals. Rather, justice seeks to promote three principles: justice in acquisition, justice in transfer, and justice in rectification. As long as these principles of individual freedom are upheld, justice is achieved.

For the libertarian, the proponent of a societal obligation to provide healthcare has a bloated conception of justice. Justice is not about pursuing some ideal end. Justice is only about protecting individual freedom, and to seek some illusory just end at the expense of individual freedom is, for the libertarian, the antithesis of justice. If this argument is correct, then no societal obligation to provide healthcare exists. UIs are free to buy whatever healthcare they can afford, but to say that society has a duty to provide healthcare is false. If society has any obligation to UIs, it is to ensure that they have the freedom to acquire and transfer their wealth, nothing more. The proponent of a Rawlsian justification for a duty to provide healthcare would need an account for why her theory of justice is preferable to others.

²⁰⁴ Beauchamp and Childress 245-246
Not only does Nozick have a distinct account of justice that is contrary to Rawls’ view, he also has a direct criticism of Rawls’ project. Nozick grants that the outcomes of the social and natural lottery are indeed arbitrary. Where he disagrees with Rawls is that he does not believe the arbitrariness requires that we address the resulting disparities. Whether my being born intelligent or into a rich family is arbitrary or not does not change the fact that I am entitled to whatever flows from these qualities. Tristram Engelhardt expands on this criticism of Rawls by making a distinction between what is unfair, and what is simply unfortunate. In order for there to be a societal duty to ameliorate inequalities, including health, society would have to be in some way responsible for these inequalities. But because the arbitrary outcomes of the social and natural lottery are nobody’s fault, there can be no societal duty to address healthcare disparities.

Chapter 4: Finding a Defensible Position on UI Healthcare

Now we come to the culmination of the thesis: do we or do we not truly have an obligation to provide UIs with healthcare? Up until now, we have considered a variety of potential angles from which we could address the issue, but in this chapter, I will state and defend a specific position. I will revisit each argument and try to answer several questions: what should we take from each argument, what should we leave, which arguments are strongest, which arguments are weakest? I will conclude with what I believe to be the most tenable position regarding UI healthcare.

1. UIs Are in Violation of U.S. Law and Should Be Disqualified from Receiving Healthcare

I believe that Ruth Faden’s critique of this argument is ultimately devastating. There are no examples of people being denied healthcare because of a crime they have committed, and we do in fact think that to refuse someone healthcare because of crime would be archaic and inhumane. In addition, the crime of immigrating illegally seems to be a rather mild crime, at least compared to many other crimes like murder or rape. Even if there were examples of a crime that disqualified someone from receiving healthcare, that would not make it right. Denying something as important as healthcare to someone solely because they violate immigration law seems to be patently wrong. There should be differences between how we treat those who adhere to the immigration process and those who do not. However, health is too essential and too important to be used as a punishment for violating immigration law.
2. Social Benefits Will Encourage Over-Immigration

The main reason I believe we must reject this argument is because the evidence we have simply does not support it. All of the evidence that we have suggests that social benefits are not the reason that immigrants come to the U.S. Work and family overwhelmingly out rank social benefits. The fact that UIs use a disproportionately low amount of healthcare also seems to indicate that they are not immigrating in order to use up healthcare resources. To deny them healthcare based on a premise that is not only unsubstantiated, but probably untrue, would be unjustifiable. As I mentioned earlier, it would be impossible to deny that healthcare does not affect immigration at all, but it seems to play such a minor role that it provides an insufficient basis on which to deny healthcare.

3. Preserving the Integrity of the Immigration Process

The central sentiment of this argument must hold: the immigration process has to be preserved. For the reasons mentioned in this section, without borders and an immigration system of some sort, society would crumble. Who would acquire or maintain citizenship if there did not exist any difference in benefits between the citizen and the undocumented immigrant? If you could continue to vote, receive social benefits, and so forth without going through the proper immigration channels, why would any people document themselves? You could avoid paying the full range of taxes, the draft, jury duty, and other inconveniences of documentation by flying under the immigration radar. It might even be in the best interest of citizens to forfeit their citizenship in order to avoid these inconveniences as well. But if everybody preserved their undocumented status and avoided taxes, we would be unable to support the government budget. Even if we were able to support the budget, it would be on the backs of those silly
enough to live under the scope of the IRS, and such a state of affairs does not seem particularly just. In addition, without any borders whatsoever, we would get an influx of immigrants at an unsustainable rate. The sheer volume of immigrants would be unmanageable for our system, ultimately hurting immigrants and U.S.-born citizens alike. There would be far more people than jobs and a devastating drain on social benefits. Lastly, a lack of an immigration process would cripple national security. Far too many individuals might seek the destruction of the U.S. institutions and people to permit completely open borders. We need an immigration process to prevent the entry of violent and destructive individuals.

Despite these concerns, I think this argument falls short in justifying the denial of healthcare to UIs. Although I agree that preserving the immigration process is an important societal tool, I disagree that the denial of healthcare is necessary to its preservation. I think there is an equivocation here of “equal healthcare benefits” and “equal in all imaginable respects.” There is no reason that healthcare cannot be provided at equal levels while maintaining other differences that preserve the distinction between UIs and other residents. As long as these other differences remain, the integrity of the immigration process would remain intact. The potency of the immigration process might be diminished, but by no means destroyed.

I think Carens’ argument is compelling enough that a minimal undermining of the immigration process is perfectly acceptable. I think we wave around a nation’s right to protect its borders far too flippantly, when in reality the right to regulate one’s borders only exists in a minimal sense. We have a legitimate interest in achieving certain societal goals that make the immigration process necessary, but we do not have a robust right to accept or deny potential immigrants for any reason at all. As long as the integrity of the immigration process is maintained in a limited sense, it can still function sufficiently to achieve the goals we have
discussed. In order to be successful, this argument needs to show why the denial of healthcare to UIs is necessary to the successful preservation of the immigration process. Because I believe it falls short of reaching this end, I think the argument ultimately fails.

4. UIs Are a Drain on Society

I believe that the first three premises of this argument must be accepted. It would be inaccurate to deny the claim that UIs use more care than they pay for. However, I agree with the Responses section of this argument that encourages us to consider all perspectives from which we could assess the evidence. Of course UIs consume more healthcare than they pay for—we have designed a system that almost ensures that this is the case. If poor UIs are denied Medicaid benefits yet guaranteed emergency care, then they are going to disproportionately utilize expensive and unpayable emergency care. To make matters worse, the ACA is restricting the participation of UIs in the health insurance exchanges, forbidding UIs from trying to contribute to the healthcare resources pool. So, we are upset that they are consuming more healthcare than they are paying for, yet we are refusing to allow them to pay for it! The proponent of this argument seems impossible to please, unfairly chastising the UI for draining the system yet insisting that UIs be prevented from paying for their care in the preferred and most efficient manner.

It seems that there are a number of different routes we could take that would limit the drain UIs place on the system while providing them with healthcare. Substituting Premise 4 of this argument with a different premise radically alters the conclusion drawn from the same evidence. We could grant UIs amnesty and a path to citizenship, requiring them to pay additional taxes and shoulder the burden of their own healthcare. We could enable them to obtain insurance coverage and utilize less costly and more effective preventive services, thus
reducing the drain. We could permit them to participate in the exchanges, lowering the overall risk of the insurance pool and reducing the strain that everyone’s healthcare needs place on society. The proponent of this argument needs an account of why their conclusion is better than these conclusions. There is nothing inherent to the argument that makes it apparent that society should deny UIs healthcare rather than selection one (or all) of these other options I have posited. Without such an account, this argument fails to be convincing.

The last point I think needs to be made was also noted in the Responses section. Could this same argument not also be levied against all middle to lower class residents of the U.S.? We have a progressive tax system that requires the wealthy to pay a higher share than the poor. The wealthy use fewer resources relative to their contribution than the poor do. All Western societies have systems in which the rich are expected to pay more into society than those who have less. Why should it be any different for UIs? UIs occupy a lower economic status and could not possibly be expected to contribute as much to the societal pool as Bill Gates or Warren Buffet. If we wanted to switch to a flat sales tax where everyone paid the same rate of taxes, UIs would be compelled to contribute the same as poor citizens and Bill Gates. However, I do not see our society adopting that economic structure any time soon, nor should it. It seems inappropriate to say that all residents should pay their fair share or be denied social benefits when discussing healthcare for UIs, yet maintain a societal structure that otherwise fails to adhere to that principle. For these reasons, I believe we must reject this argument.

5. Diversion of Valuable Healthcare Resources

In a situation where we only have one treatment regimen of dialysis and two patients—one UI and one U.S. citizen—I understand the rationale for arguing that it should be provided to the U.S. citizen. We potentially have a stronger ethical obligation to those more a part of our
society (citizens) than those less a part (UIs). Even if we consider UIs as part of our society to some degree, surely U.S. citizens are a more integral part and more deserving of societal resources. Thus, when push comes to shove, we may have to make the hard decision of denying dialysis to the UI in order to provide it to the citizen.

The problem with this argument is that the dialysis example I gave above is unrealistic—these ethical dilemmas concerning the allocation of scarce resources never happen completely inside a vacuum. We most certainly need to consider our societal level of healthcare spending, but there is reason to think it does not need to come at the expense of UI healthcare. For one, UIs only comprise 3.7% of the population and they are relatively healthier than the average U.S. resident. To cover them would only require a slight increase in U.S. health expenditures. Furthermore, the example above imagines providing a UI with a certain kind of care and denying a U.S. citizen the same care. It would be much more likely that the kind of care we would be denying to U.S. citizens would be less important than the care we would be providing to UIs. I gave the example of Viagra earlier, but we can think of plenty of services provided to most insured individuals that are less important than some care we could be giving to UIs. Instead of covering almost everything for citizens and almost nothing for UIs, we could strike a balance by covering less than everything for citizens in exchange for some more essential services for UIs. This argument therefore fails because it presents us with a false dichotomy. We do not have to choose between care for UIs and care for citizens. Instead, we could cover UIs while giving up healthcare services of relatively less importance to citizens. To frame this debate as a battle between UIs and everyone else for scarce resources is an unjustified simplification of our current state of affairs.
1-3. **Prudential Arguments**

I group my assessment of the prudential arguments (Public Health Dependent on UIs, Diminution of Long-Term Societal Burden, and Effects of Denial of Care to UIs on Non-UlIs) into one section because, as the reader might have expected, my evaluation of each of these is essentially the same. I have two primary responses to these types of arguments. First of all, I find these arguments too limited in their scope. Each argument can only justify the level of care necessary to protect other U.S. residents. The public health argument, for example, could only justify treating UIs for communicable diseases, because this is the only treatment that would contribute to the well-being of non-UlIs. I think we need to aim higher than simply providing care that is helpful to citizens and documented immigrants, exploring arguments that justify a more comprehensive level of care.

Lastly, and most importantly, prudential arguments fall short because they advocate for providing care for UIs without any focus on their well-being. It seems that a sufficient argument for providing UIs with care needs to address the needs of UIs, not the needs of non-UlIs. UIs are moral beings deserving of respect and dignity, and to discuss the importance of their health only prudentially ignores their intrinsic moral worth. Healthcare for UIs, if it is important, is important because it aids UIs, not because it aids me or you. I understand the temptation to rely on prudential arguments. In a society that seems to care so little about UIs, it is completely reasonable that UI advocates would try and find instrumental means to justify providing them with healthcare. Although such a strategy may be more politically feasible, it falls short of what we should do. We should do right thing for the right reasons. If UIs should be provided healthcare, it should be because they need it, not because other U.S. residents would benefit.

Prudential arguments do a have role to play in this debate. They can serve to buttress more robust arguments in favor of providing UIs with care, adding additional justification to
supplement already strong arguments. But they are too weak to establish a duty to provide comprehensive healthcare to UIs. If we found some way to protect the welfare of non-UIs without providing care to UIs, these arguments would lose any strength. For example, if we found some fool-proof method of preventing the transmission of tuberculosis, we would lose our justification for treating UIs for tuberculosis. Furthermore, why not follow Pelner Cosman’s advice and increase our rates of deportation or strengthen our border control? The risk to non-UIs would be mitigated and, since these arguments do not hinge upon the well-being of UIs, this should be an appealing strategy. For these reasons, prudential arguments should be used in a secondary role, as they have only limited value in defending the provision of healthcare to UIs.

4. Professionalism and the Obligations of Physicians to Patients

Physicians do have an obligation to take care of patients, an obligation that supersedes the documentation status of a patient. However, I again think that this argument slightly misses the point of the discussion. If we fail to provide UIs with healthcare, is it wrong because physicians are forced to refuse care, or is it wrong because UIs are refused care? Surely a true advocate for UIs would choose to go with the latter, but I think the proponent of this argument will have difficulty making that case. If our intent is to maintain the moral integrity of the medical community, providing UIs with healthcare is again simply a means to a different end. Should we not be arguing for the provision of healthcare to UIs for their own sake? My own distaste for the conclusion, however, does not count as evidence against the argument. One might hope for an argument for UIs that focuses on their well-being, but just because this argument does not provide that does not mean it is incorrect. This argument does, however, suffer from a final problem that is devastating to it.
This final problem concerns the origin of the physician’s professional obligations, something addressed in the Responses section. Do physicians have an obligation to treat all individuals, regardless of documentation status, because of the benefits the physician receives from society? Maybe, but at that point it seems that the physician’s obligations cannot conflict with the will of society. Let us consider the example we presented earlier in the Support section of this argument, where the physician practicing in Los Angeles is required by law to deny UIs healthcare. If our obligation to help the sick is derived from society, and society decides UIs are not part of society and therefore not entitled to our healthcare, does the physician have an obligation not to treat UIs? It seems difficult to avoid such a conclusion. It seems that, if the proponent of this argument is to arrive at the conclusion of her argument, she must locate a better origin for the physician’s obligations.

Perhaps the justification for a physician’s obligation to the sick derives from the vulnerability and need of the sick and the duty that arises to care for our fellow woman and man. Because of the unique capability of physicians to care for the sick, the obligation falls on their shoulders. Does that sound familiar? It is eerily similar to the argument that UIs have a right to healthcare! This reformulation seems to shift the debate away from the Professionalism argument towards the Right to Healthcare argument. If so, it seems that we should stop dancing around the issue and go directly to our consideration of whether or not UIs have a right to healthcare that our society must recognize.
5. Uls Have a Right to Healthcare

I believe the argument for a right to healthcare ultimately falls short. I agree with this argument that there are certain dimensions of well-being—one of which is health—that are so integral to flourishing that society has at least some obligation to aid its members when these dimensions of well-being are threatened. However, this obligation derives from the magnitude of the need and the extent to which well-being is threatened if no third party intervenes.

Consider the following example that involves one of Faden and Powers’ aforementioned dimensions of well-being—personal security. Society may have a responsibility to maintain a police force, and that police force certainly has a responsibility to respond to situations in which members of society are in danger. If I am being mugged by a man with a gun and a police officer witnesses it, an obligation absolutely exists for the police officer to come to my aid. This is because society has an obligation to protect my personal security and it is the police officer’s job to carry out this obligation. However, there are certainly limits to this. For example, a right to personal security would not extend to the government having an obligation to place officers outside my house 24 hours/day in order to promote my security. This would certainly promote personal security, but it would be above and beyond societal obligations.

Likewise, I think the humanitarian runs into similar trouble with healthcare. Health may be important, but what level of health is society obligated to maintain? Certainly no right exists to any and all healthcare. Do we have a right to be maintained in a vegetative state for 20 years via life-sustaining treatment? It would seem strange to claim that society is failing to fulfill its obligations to us if it fails to do so. It would also seem strange to claim a right to other seemingly unessential interventions, such as laser eye surgery or breast implants.

What then is it the responsibility of society to provide? Emergency care seems to fit the bill best, as it does seem that something morally problematic has occurred when someone is
allowed to die at the foot of the hospital. However, our society provides that already. Beyond that, it seems that it is difficult to justify the claim that an individual’s rights are violated when medical care is not provided. The strength of this argument hinges upon the degree to which health is integral to a decent life, and for much of healthcare, I do not believe such a case can be justifiably made. Are we violating a right when we do not financially cover an annual physical, or a preventive mammogram? Maybe, but it is not clear. I agree that comprehensive medical care might contribute to maximal flourishing, or to an optimal (rather than decent) life, but the strength of the humanitarian argument is founded upon the fundamental nature of the need. I have a strong intuition that we fail to fulfill our humanitarian obligations to the sick when we let them die of an emergency condition, but I think the intuition is less strong and justifiable when it comes to providing comprehensive care. The less severe the need, the weaker the intuition, and the weaker the humanitarian argument. It is not clear when society has done a wrong if it fails to provide some level of healthcare, but the claim loses its force when we move beyond emergency care. It seems that a different approach is needed to justify the provision of healthcare to UIs, and with that, we turn to our final moral argument.

6. Societal Obligation to Promote the Health of UIs

I find this argument ultimately convincing. Rawls’ discussion of the original position and the veil of ignorance remains one of the most staggering achievements in political philosophy. The libertarian society distributes on the basis of a number of different things—the social lottery (socioeconomic status, family values, etc.), the natural lottery (intelligence, good looks, etc.), and documentation status—but we never stop to think just how arbitrary it is that some people are blessed in some areas and not in others. To be born rich, or smart, or in the U.S. are all strong indicators for future success in this world, and over none of these does a person have any
control. They can take no responsibility or credit for the possession of these qualities. I contend that a just society tries to reduce the extent to which randomness determines who has a good life and who does not. Society should try to ensure that everyone, no matter how lucky or unlucky they got in the social and natural lottery, has a chance at pursuing the good life.

A just society does not accept an arbitrary distribution of resources that benefits some at the expense of others, that allows some to live full and good lives while it deprives others of ever having a chance. It strives to mitigate the factors that contribute to undeserved disparities in well-being and opportunity. I believe that Rawls, at the very core of his theory, encourages us to approach justice with a little humility. We want to believe that we live in a world in which resources have been distributed justly, that those who have good things deserve those good things and that those who have bad things deserve those bad things. And I do believe that, at least in some part, it is true that we do have control over the lives we lead and that some unequal distribution of goods is morally deserved. But if we are truly honest with ourselves, do we not have to admit that much of what those with better opportunities and a larger share of resources have is due more to dumb luck than moral desert? It is difficult to admit that we are lucky to have what we have, but I think it is the only reasonable conclusion to draw. And if we humbly accept that conclusion, it should spur us to rethink about how we distribute resources and how we arrange opportunities for individuals within a society.

Now, one of the more difficult jumps Rawls makes is in specifying the principles the members of society would agree to at the original position. The difference principle is elegant, but controversial. Perhaps individuals, even if they did not know the distribution of the natural and social lottery, would promote a more free society in which the talented were able to excel even at the expense of the less talented. I do not believe so, but that is the difficult part of the original position: it leaves up to conjecture what those at the original position would decide.
However, the argument for healthcare does not hinge upon the difference principle, but rather the guarantee of fair equality of opportunity. I believe this principle of justice would without a doubt be agreed upon by the members of society at the original position. Whatever the distribution of resources a society would allow, the individuals at the original position would not permit the opportunity to live a good and full life to hinge upon arbitrary characteristics over which we have no control. It would not be acceptable that, just because someone was born into a better family or with a higher level of intelligence, their chance to work hard, live a good life, and provide for themselves and their family, should be compromised. A just society, at the very least, diminishes the extent to which arbitrary factors preclude an individual from even seeking the good life. Some may achieve it and some may fall short, and forcing a certain conception of the good life onto everyone may be unjust. But must we not, at the very least, try to provide an equal opportunity for people to give it a shot?

Absolutely. A just society provides fair equality of opportunity to all of its members, and it is here that we introduce healthcare. Norman Daniels’ extension of Rawls to include healthcare is convincing. Poor health, more than almost anything else, has the unique capability of diminishing opportunity. When we are sick, we are less able to work, enjoy time with our friends and family, provide for ourselves and our loved ones, and other activities integral to the good life. More obviously, if we die due to illness before we have had the chance to live a full life, we are prevented from pursuing the good life. I believe it is beyond dispute that, all things being equal, illness and death have a detrimental effect on the opportunity of individuals to live well and flourish. If that is the case, then it appears that the good and just society would do everything it could to promote the health of its members and consequently their opportunity to live well.
Nozick’s argument for libertarian justice is appealing, as far as it goes. The problem with a libertarian account of justice and the distribution of healthcare is simply that it is too limited. Nozick expects too little of the good and just society. We should not be content ensuring that a society’s transfers go smoothly and call it a day. We have an obligation to address the deprivation of opportunity with which so many in our society must endure. Engelhardt may be right that society is not the cause of the arbitrary distribution of the natural and social lotteries. I do not think, however, that this means no obligations from justice can exist. We do not need to be responsible for an undesirable outcome to have a duty to address it. We are part of a world in which people are arbitrarily prevented from having the opportunity to flourish and live the good life. Such a state of affairs would never be acceptable to a society at the original position, and thus justice requires it not be acceptable to our society now. Our obligation to reduce our society’s arbitrary disparities comes from taking a step back, looking at our social conditions, and realizing we can do better. It is about conceiving of a world in which everyone, regardless of how they fared in the social and natural lottery, has the opportunity to live well.

One final difficulty I believe this argument must overcome is to show that it is sufficiently dissimilar to the right to healthcare argument to avoid the objections to which that argument falls victim. If society has an obligation to promote the health and opportunity of its members, what level of healthcare is entailed? What if one’s opportunity to be a terrific actor, something a certain individual might consider to be essential to the good life, is being inhibited because this individual cannot afford plastic surgery? Is it the obligation of society to provide that service? Even Daniels notes that defining the scope of society’s obligation from behind the veil of ignorance is a nearly impossible task.²⁰⁷ Too much healthcare can be tied to opportunity. If we were to provide every member of society with all of it, we would have no resources for

other valuable ends, and the overall opportunity for society’s members to flourish would be diminished. The determination of the just level of healthcare could only be made once the veil of ignorance is lifted and a society is able to see just how much healthcare, when balanced with other just societal goals, would be provided.

This critique, however, can be more easily avoided than the objection to the Right to Healthcare argument. I believe the spirit of Rawls and Daniels, at least as I am interpreting them, has less to do with discerning an appropriate level of healthcare and more to do with the aspirations and goals a just society hopes to achieve. Justice does not require society to recognize a right to a specific level of care, but rather to strive to promote the health and opportunity of its members as far as it can. Under the Right to Healthcare argument, there is a point at which society is failing to respond to the need of its members and a point at which it is not. Under the Societal Obligation to Promote Health argument, as long as healthcare continues to promote one’s opportunity to live well and flourish, our society should continue to strive to provide that care. We have finite resources that may preclude us from providing things like plastic surgery, even if they can be tied to opportunity, but this is an unfortunate reality of living in a nonideal world. Our society should strive to take the resources we have and promote opportunity as much as possible, via not only healthcare but other societal endeavors.

I would encourage us to think less about what level of healthcare to provide, and more about what kind of society we should be trying to build. And that society is one in which all individuals of a society, regardless of their luck in the social and genetic lottery, have the opportunity to live well. We may not always have the ability to achieve it, but the good society strives to approximate it as much as it can. Insofar as healthcare can play a role in fair equality of opportunity, we must strive for it.
That leaves our consideration of whether or not our social ideal to promote health includes UIs. Both of the arguments in favor of this position have something important to contribute. The first argument centers on Joseph Carens’ extension of the original position to the international scale. As I mentioned earlier, I believe the immigration process cannot be completely eliminated, but I do believe the spirit of Rawls’ theory can help us empathize with the plight of the UI. Much is distributed on the arbitrary basis of citizenship because of the massive disparities that exist between wealthy and poor nations. The most important factor in determining these statuses is where one is born, something over which none of us have any control. But there are more ways in which citizenship is arbitrary. Two potential immigrants might have different levels of urgency with which they have to immigrate. One may be relatively comfortable whereas the other might be on the verge of starvation and in need of immigrating immediately. The legal channels are much more open to the former than the latter, even though the factors that led to each individual’s circumstances might have been arbitrary.

We too often conceive of our membership within a more fortunate society as something that we deserve, but I believe this is an incorrect way to look at it. We are fortunate to have been born into an affluent society full of opportunities, and to claim a higher level of moral desert on the basis of something as arbitrary as where one was born seems to be inappropriate. Looking at membership in a society through this lens should allow us to empathize with UIs a little bit more, understanding the wide disparities in the treatment of U.S.-born citizens and UIs in a different light. We may have to maintain the distinction between citizenship and non-citizenship, but to distribute healthcare, and with it opportunity, on such an arbitrary basis is wrong. A just society would do no such thing.

The second account for why we have an obligation to recognize UIs’ right to healthcare is equally compelling. It may be true that UIs are not recognized as legitimate members of
society by our immigration system, and it may also be true that UIs contribute less in the way of taxes than do other residents of the U.S. However, their contributions to our society are considerable. A definition of societal membership that limits itself to legal documentation is far too narrow. As soon as we posit a broader definition of what kind of resident counts as a member of society, it becomes impossible to deny that UIs meet the criteria. As I have mentioned countless times throughout this thesis, UIs are integral components of our society. They work essential jobs that nobody else is willing to work, and they do so eagerly and without complaint. They are our classmates, colleagues, employees, and friends. They are an essential part of our society and, as such, should qualify as members of our society. And, once we count them as members of our society, it becomes our obligation to promote their health.
Conclusion

There is a wide array of opinions concerning the level of healthcare to which UIs are entitled. Many on both sides are persuasive, many are not. In Chapter 4 I have attempted to take what I can from each argument, and discard the portions that are untenable. What I believe we are left with is a duty to provide UIs with healthcare. Rawls’ theory may not be perfect, but I believe certain tenets of his arguments are beyond contention. We live in a world in which opportunity is unfairly distributed, arbitrarily giving some a better shot at a good life than others. We cannot be content with a Nozickian account of justice whereby justice is met in full when individuals are free to acquire and transfer holdings as they please. Justice is a grander ideal than that. Justice requires that we seek to mitigate the unfair distribution of opportunity that the social and natural lotteries yield, striving for a society in which all are provided a fair equality of opportunity to achieve human flourishing.

Healthcare is unique in its ability to promote fair equality of opportunity. If we are uninhibited by morbidity and mortality, we have a greater opportunity to pursue good and fulfilling lives. Because of this inextricable connection between health and living well, the just society promotes the health of its members as far as it can.

The future of healthcare for UIs in the U.S. is bleak. The ultimate shape of the post-Affordable Care Act landscape may be indeterminate and difficult to predict for most Americans, but it is far more certain for our 11.2 million UIs. They are likely to continue to be excluded from accessing the much needed healthcare that our society should strive to provide everyone. UIs were, for the most part, born into societies without the kind of opportunities those fortunate enough to be born in the U.S. take for granted. They come to our society hoping for a better life, comprising an invaluable part of the fabric of our society. We are in a unique position to
help them, and we cannot forget them. Our future must include a plan to address the unmet healthcare needs of UIs. Justice requires it of us.
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Curriculum Vitae

1. Education

a. Pepperdine University: Bachelor of Arts in Philosophy
   i. Graduate summa cum laude
   ii. Completed the Pre-Medicine curriculum
b. Wake Forest University: Candidate for a Master of Arts in Bioethics

2. Publications


3. Research Experience

a. Research assistant to Dr. Caleb Clanton
   i. Studied the philosophy of Alexander Campbell
   ii. May 2011 to August 2011
b. Research assistant to Dr. Jay Brewster
   i. Studied Endoplasmic Reticulum stress signaling
   ii. May 2009 to July 2009
c. Research assistant to Dr. Laurie Nelson
i. Conducted statistical analyses of the effects of high school and undergraduate performance on MCAT scores

ii. August 2010 to May 2012

d. Research Assistant to Professor Nancy King
   i. Assist her with the course material for a graduate level Research Ethics course
   ii. September 2012 to present

e. Research Assistant to Professor Mark Hall
   i. Assist him with the 8th edition of his book, *Health Care Law and Ethics*
   ii. December 2012 to March 2013

f. Research Assistant to Professor Nancy King and Dr. Ana Iltis
   i. Assist them in researching the ethical issues related to spermatogonial stem cell allotransplantation
   ii. February 2013 to July 2013

4. Service Experience

   a. Clinic Assistant at the Venice Family Clinic
      i. September 2008 to December 2011

   b. Medical Mission Trip in Fiji
      i. May 2010

   c. Service Learning Program in Uganda and Rwanda
      i. July 2010

5. Awards and Recognition

   a. Regents Scholar at Pepperdine University
      i. August 2008 to April 2012
b. Humanities Division Academic Scholarship at Pepperdine University
   i. July 2009

c. Seaver Dean’s Honor Roll at Pepperdine University
   i. 2008 to 2012

d. Phi Sigma Tau Honor Society at Pepperdine University
   i. January 2009 to May 2012

e. Outstanding Senior Graduate in Philosophy at Pepperdine University
   i. April 2012

f. Research Assistantship Scholarship at Wake Forest University
   i. August 2012 to Present

g. Bioethics Fellowship at Wake Forest University
   i. January 2014 to May 2014

6. Leadership Positions

a. Secretary of Pepperdine’s Chapter of the Phi Sigma Tau Honor Society
   i. September 2011 to April 2012

b. Founder of the Pepperdine Bioethics Club
   i. October 2011 to April 2012