From Privilege to Right: The Debate Over Medical Care for Immigrants

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Abstract

A camel that manages to get its nose inside a tent, an Arabian proverb warns, will eventually attempt to push the rest of his body in as well. Great Society programs have already managed to change the nature of a medical service from a good to a subsidized public benefit. The next question is whether Americans will now allow further encroachment–whether this benefit will become a right for all inhabitants.

The 1996 federal Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), the so-called Welfare Reform Act, attempted to eliminate public benefits, including welfare, medical, and housing services, for certain nonqualified categories. However, the reaction by individual states to the PRWORA highlights where the debate may head in the near future. Thus far, state and federal legislation have maintained that taxpayer-subsidized health care provisions constitute a public benefit, in other words, a privilege for qualified individuals. Certain states and municipalities have since countered with a concept of health care that would have far-reaching implications for states harboring large numbers of immigrants, legal and otherwise.

Literature from the Physicians for a National Health Program unequivocally states, "health care is a right, not a privilege." Led by such groups, supporters of the right to health care hope to replace the current privilege, or public benefit system, of subsidized disbursal of medical care with a system guaranteeing care for all.

Using the societal and economic impact of immigration, as an example, this paper attempts to illuminate the consequences on public policy if Americans pursue a conception of health care as a right, as opposed to a good or even a public benefit.

Introduction

Restrictions on eligibility for taxpayer-subsidized medical care have arisen at the state and national level within the past decade. Proposition 187 in California, passed overwhelmingly by state voters in 1994 but since invalidated by the federal courts, marked the first major victory in halting the entitlement to government-subsidized medical care. On a federal level, the Welfare Reform Act of 1996 (PRWORA) prohibits hospital districts from offering free or discounted nonemergency medical care for noncitizens.

More recently, Texas has become the battleground as hospital districts have been warned of the consequences–ranging from loss of federal funding to possible jail terms for administrators–of providing medical care for undocumented immigrants. The debate in Texas comes at the same time as former Texas governor and current US president George W. Bush engages his Mexican counterpart Vicente Fox in policy discussions that seem to encourage greater immigration in the form of a proposed amnesty plan and formation of a guest worker program.

With immigration levels reaching all-time highs, the debate over the rights of aliens to publicly funded medical care receives greater significance. According to the 2000 census, the proportion of illegal immigration relative to the US foreign-born population is at its highest point ever in history at 28 percent, up from 13 percent in 1994.[1]

Although this paper considers the practical implications of a right to health care using the fight over free care for aliens, the cause of the illegal immigrant is a straw man in this debate. The move to obtain this privilege for immigrants only serves as the most recent publicized move on the part of health rights advocates in the move to secure a right to health care.

The invasion and growth of third-party payers in American medicine signaled the initial departure from the direct recognition of cost by the consumer. But, this recent movement within legislative circles to make rights to health care from former public benefits in health care signals something far worse–the wholesale elimination of the consideration of costs. By making the provision of unfettered access to medical care the paramount principle of legislative policy, supporters of the notion of the right to care effectively remove cost considerations from the equation.

A Look at Texas

Texas has received national attention as the latest arena in the fight to obtain free primary care and preventative health services for illegal immigrants.[2] At the behest of a Harris County Hospital District (Houston) inquiry, in July 2001 Texas Attorney General John Cornyn determined PRWORA's provision failed to allow undocumented aliens eligibility for federally funded nonemergency health services.[3] Despite the preclusion from accessing federally funded programs, immigrants in Texas continue to maintain eligibility for state-funded medical programs. Nonetheless, the Attorney General's determination set off a storm of activity and debate with numerous hospital districts serving large immigrant populations across the state positioned against the state's non-binding dictum.

As a border state, Texas has reason to worry about the implications of actions that attempt to sidestep the PRWORA. Illegal immigrants account for roughly a quarter of the hospital visits in Houston, incurring greater than $100 million in expenditures by the state per year.[1]

To counter, those seeking to attain free medical care for all inhabitants have initiated a two-prong battle through both increased state funding for care and attempts to procure federal funding sources. With assistance from the National Association of Public Hospitals and Health Systems (NAPH), Texas legislators introduced legislation in Washington in July 2001 providing free primary care health services to anyone the hospital district sees fit.

Such attempts to revise the health care-related provisions of the Welfare Reform Act serve notice for the specificity of the proposals. By targeting medical care for omission from the reach of the PRWORA, legislators effectively make health care a sacred cow of welfare public policy, an entitlement on par with basic constitutional guarantees and an issue transcending debate. Such legislation also signals a philosophical shift in policy from one based on consideration of costs and program eligibility to that of a system guaranteeing access to medical care by all inhabitants as a basic statutory right.

Health Care as a Privilege

The notion of health care as a privilege involves two separate definitions. The first vision of privilege predates the modern

state–suggesting privileged availability by virtue of affordability of the care. The second interpretation comes closer to the modern version of privilege within the environment of socialized medicine–a notion of privilege as a public benefit conferred by the state–for those meeting eligibility for Medicare, Medicaid, or other health programs.

Privilege, as considered in this paper, focuses on the latter interpretation; moreover, the terms "public benefits," and "privileges" are used interchangeably below.

Health Care as a Right

The movement to formalize a legal right to health care is a modern development. With the 1948 Universal Declaration of Human Rights, the United Nations' rights manifesto marked a significant departure in the conception of rights. Heretofore, rights in the Western tradition existed largely as provisions of independence and noninterference from governing entities.[4] Moreover, not only did the UN Declaration expand the scope of rights to include the provision of goods and services, but it also revised the conception of the right to health care from a national to a universal right.

Devoid of legal force, the UN Declaration serves notice not for the practical effect on American policy, but for the similarities states have sought in the decades hence.

In its broadest interpretation, a right to medical care proffers unlimited free access to health-related services. And, at its narrowest, proponents suggest a sufficient minimal level of medical care for all inhabitants. However, by means of a series of decisions involving abortion rights (e.g., Harris v. McRae and Maher v. Roe)[5], the federal courts have disputed the existence of a legal right to health care. The reluctance of the court to force the state to subsidize the medical procedure hinged on the obligations implicit in such a right.

In Maher, the Court noted, "Constitutional concerns are greatest when the State attempts to impose its will by force of law; the State's power to encourage actions deemed to be in the public interest is necessarily far broader."[5]

While the courts have failed to recognize such a right, increasingly states have moved to confirm such a right to health care by statute. Similar to UN Declaration provisions suggesting universal rights to care, recent legislation attempts exempt PRWORA restrictions on medical care, thereby allowing for subsidized health care access for all.[6]

The Shift from "Privileges" to "Rights"

As noted thus far, within public policy medical care has been relegated to the status of a privilege, insofar as legislative bodies have placed restrictions on taxpayer-subsidized access to care to privileged elements within society, such as the poor and the elderly in regards to Medicaid and Medicare, respectively. Analysis of health care, or any issue for that matter, from the standpoint of a privilege involves an analysis from a financial construct measuring costs. For example, the courts have held that states may impose restrictions on these public benefits as long states presented a rational basis for this exclusion, such as to maintain the fiscal integrity of the program.[7]

While eligibility for the privilege of accessing federal health programs involves some semblance of revision subject to cost-benefit analysis, determinations of rights transcend analysis of the financial data. Once an idea, good, or service attains the status of a right, consideration of the costs entailed to meet that obligation becomes a non-issue. Rights, as ingrained in the American constitutional fabric, involve a series of negative obligations and noninterferences. Thus, the costs to society of these rights are expressed in conceptual terms. For example, the costs to society for providing a right to free exercise of religion are measured by the practical implications of letting religious expression go unchecked–not involving financial costs per se.

However, development of a positive in rem obligation–that is, against society as a whole–to provide medical care imposes a direct cost burden, which typically fails to receive consideration in discussions of rights. Therein lies the fundamental problem with such a shift to creating this new "right." Once the health care debate is framed as a moral obligation of society and is classified as a basic human right, it will not remain amenable to the consideration of costs.

Conclusion

Supporters of unfettered health care access suggest compassion and equality are the driving factors of the movement for unlimited care for undocumented immigrants.[8] However, invocation of the plight of the immigrant is merely a diversion of the debate on rights to health care.

Since the inception of Great Society, policies enhancing the role of government in medicine, medical provisions have remained a privilege, or a public benefit, guaranteed to those meeting eligibility requirements. By including undocumented immigrants as eligible recipients of state-funded care, the government effectively increases the patient pool to include virtually all inhabitants of the state.

The Welfare Reform Act was legislated with the intention of placing a higher burden on the ready acquisition of free health services and other goods. But, by sidestepping existing regulations and developing state remedies, individual states succumb to the notion that health care warrants status as the paramount entitlement worthy of creating a new-found societal duty of provision of care, while ignoring costs.

Moreover, further removal of the recognition of medical costs by the taxpayer can have a disastrous effect on public policy with states willing to spend unlimited sums of taxpayer money to fulfill the obligation. Taxpayers in border and immigration hub states will immediately recognize the increased financial burden of providing for a larger population. States such as Texas and Florida may have to alter existing tax structures and accept a state income tax, while other states accept even higher rates of local taxation.

If the pursuit of a universal right to health care is simply an outgrowth of American noblesse oblige, a basic right transcending costs, as proponents of the right claim, the purported exercise in humanity may be better served by building the health facilities and providing physicians on the other side of the US border. As noted in the filed demarche that spurred the Attorney General's action in Texas, it would just save immigrants the trip.

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