From self-interest to solidarity: one path towards delivering refugee health

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From Self-Interest to Solidarity: One Path Towards Delivering Refugee Health

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1. INTRODUCTION

Worldwide, there are approximately 21.3 million refugees, nearly half of whom are children.[1] Refugees are often more vulnerable to deprivations of health than their citizen counterparts in their countries of residence,[2] and typically enjoy

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[1] UNHCR: The UN Refugee Agency. (2016). *Figures at a Glance*. Retrieved September 29, 2016, from: http://www.unhcr.org/figures-at-a-glance.html. [Last Accessed June 12, 2017].

[2] Hebebrand, J. et al. (2016). A First Assessment Of The Needs Of Young Refugees Arriving In Europe: What Mental Health Professionals Need To Know. *European Child & Adolescent Psychiatry*. 25, 1-6; Boise, L. et al. (2013) African Refugee And Immigrant Health Needs: Report From A Community-Based House Meeting Project. *Progress in Community Health Partnerships: Research, Education, and Action*. 7, 369-78.

more limited entitlements to health care.[3] While it has been argued that all people, including refugees, enjoy a moral right to health and/or health care,[4] many wealthy countries have been hesitant to either accommodate refugees and migrants within their borders, or grant them access to the same health care services as citizens.[5]

One reason for this hesitancy is the assumed high financial cost of accommodating refugees and migrants and providing them with health care, and the fear that doing so will result in a reduction in the quality and quantity of care available to citizens - considerations which make granting refuge and entitlements to health care to refugees and migrants politically unpopular (by

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[3] Castañeda, H. (2009). Illegality As Risk Factor: A Survey Of Unauthorized Migrant Patients In A Berlin Clinic. *Social Science Medicine*. 68.

[4] Wolff, J. (2012) *The Human Right to Health.* New York, USA: W.W. Norton & Company, Inc.

[5] Dearden, L. (2016). Refugee Crisis: From Border Controls To Cash Seizures, How Germany Turned Its Back On Refugees. *The Independent*. Retrieved July 20, 2016 from: http://www.independent.co.uk/news/world/europe/refugee-crisis-germany-turning-its-back-on-asylum-seekers-with-border-controls-cash-seizures-and-a6829801.html. [Last Accessed June 13, 2017]; Bennett, A. (2016). Did Britain Really Vote Brexit To Cut Immigration? *The Telegraph*. Retrieved August 30, 2016 from: http://www.telegraph.co.uk/news/2016/06/29/did-britain-really-vote-brexit-to-cut-immigration/. [Last Accessed June 12, 2017].

which I mean that such actions may not be supported by a significant proportion of the electorate, and may thus endanger the political power and longevity of the government which enacted them).[6] In response, it has been argued that providing at least certain kinds of basic health care to resident refugees and migrants is actually in the interests of host nations, and that the benefits of providing such care outweigh associated costs.[7]

This argument from the parochial interests of host nations has been suggested as a valuable discursive strategy for alleviating political concerns about providing health care to refugees and migrants,[8] and encouraging the provision of care to them.

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[6] Kymlicka, W. (2015). Solidarity in Diverse Societies: Beyond Neoliberal Multiculturalism and Welfare Chauvinism. *Comparative Migration Studies 3*(1) p.17.

[7] Illingworth, P. & Parmet, W. E. (2015) The Right to Health: Why It Should Apply to Immigrants. *Public Health Ethics 8*(2), 148–61; Widdows, H. & Marway, H. (2015) A Global Public Goods Approach to the Health of Migrants. *Public Health Ethics 8*(2) 121–29.

[8] In this paper I focus mainly on the health needs of refugees, since they are typically more vulnerable, and enjoy fewer entitlements than voluntary migrants, who in some countries enjoy the same level of access to care as citizens (Rechel, B. et al. (2013). Migration And Health In An Increasingly Diverse Europe. *Lancet*. 381. 1235-45; Hebebrand. et al. *op. cit.* Note 2; Boise. et al. *op. cit.* Note 2.). However, many of the arguments in favour of providing or refusing refugees access to health care apply equally well to the provision (or refusal) of health care to migrants. Therefore, for purposes of brevity, while there are differences between refugees and migrants, I usually discuss the arguments surrounding their access to

However, despite the significant strategic value of such arguments, this approach is limited; it offers little argument for the provision of certain kinds of care which may be especially needed by refugees, and has limited force when applied to the needs of refugees who are not resident in wealthy countries. In response, I suggest that framing the discourse surrounding the provision of health care to refugees and migrants in terms of solidarity, rather than self-interest, can compensate for these limitations.

My goal is to address the shortcomings of self-interested discourses, and expand upon existing pragmatic arguments for the provision of health care[9] to refugees and migrants. I argue that by framing discussions surrounding refugee and migrant entitlements to health care in terms of their similarities with the citizens of wealthy countries, rather than the interests of such citizens, it may be possible to motivate the latter to act in solidarity with the former. In doing so, I suggest that a discourse grounded in solidarity in this way may be one way of motivating

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care together, noting differences in their application to each group where necessary. I am grateful to an anonymous reviewer for reminding me of this important distinction.

[9] I therefore assume, for the purposes of argument, that there are moral reasons for ensuring that refugees and migrants enjoy access to at least basic comprehensive health care, though I do not argue for this claim here.

wealthy countries and their citizens to support the delivery of health care to refugees and migrants which does not rely so heavily on the economic or epidemiological benefits of so doing.

To achieve this goal, I first outline concerns about the financial costs to host countries of granting migrants and refugees access to needed health care. Second, I discuss two criticisms of these concerns, and note their limitations. Having done so, I offer a way of overcoming these limitations, by using the parochial interests of wealthy countries as an epistemological catalyst which can motivate solidarity with refugees and migrants – I argue that health policies based on self-interest implicitly acknowledge the existence of important similarities between the citizens of wealthy countries, and refugees and migrants. By acknowledging and emphasizing these similarities (shared vulnerabilities to certain health threats), health policy can incorporate them into public discourse, increasing citizen knowledge and awareness of their relationships and similarities with refugees and migrants.[10] Following arguments made elsewhere,[11] I suggest that this increased knowledge can function

[10] For this reason it is appropriate to refer to self-interest as an epistemological catalyst in this context, as recognition of it, increases or changes knowledge amongst citizens of their similarities with non-citizens.

[11] Author 2016.

as a starting point for solidarity between members of these seemingly distinct groups.

2. COMPETING RIGHTS CLAIMS?[12]

The extent of any legal rights to health care enjoyed by migrants and refugees is the subject of lengthy debate,[13] which has grown more heated as the ongoing European Refugee Crisis has progressed.[14] For example, the costs imposed by migrants and refugees on destination countries were of high prominence during the 2016 British referendum on membership of the European Union.[15] Correlatively, immigration from South America to the United States has long been a contentious issue in the USA, with some States establishing laws which

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[12] Importantly, when discussing "rights to health care" I refer only to legal rights typically associated with citizenship of a given state, rather than a moral right to health care sometimes argued to be associated with the moral status of personhood, the existence of which I do not consider in this paper.

[13] Mladovsky, P. et al. (2012). Responding To Diversity: An Exploratory Study Of Migrant Health Policies In Europe. *Health Policy*. *105*. p.1-9; Dauvrin, M. et al. (2012). Health care for irregular migrants: pragmatism across Europe. A qualitative study. *BMC Research Notes*. *5*. p. 1-9.

[14] Dearden. *op. cit.* Note 5.

[15] Dorling, D. (2016). Brexit: The Decision Of A Divided Country. *British Medical Journal*. *354*. *p*. i3697.

deliberately make it harder for migrants to access health care.[16] Immigration, in particular from Mexico and the Middle East, also featured heavily in the recent U.S. Presidential election, with now-President Donald Trump campaigning on a strongly isolationist and exclusionary platform.[17]

One source of reluctance on the part of destination countries to extend citizen-entitlements to health care to refugees and migrants is that it is feared that doing so will adversely impact the supposedly prior entitlements of their vulnerable citizens. Will Kymlicka describes this concern as the 'progressive's dilemma',[18] and argues that there is a tension between two important commitments of progressive cosmopolitanism; first,

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[16] Chavez, L. (2013). *The Latino Threat: Constructing Immigrants, Citizens, and the Nation* (Stanford, USA: Stanford University Press); White, K. et al., (2014) Impact of Alabama's Immigration Law on Access to Health Care Among Latina Immigrants and Children: Implications for National Reform. *American Journal of Public Health. 104*(3) p.397–405.

[17] Ross, J. (2016). From Mexican Rapists to Bad Hombres, the Trump Campaign in Two Moments. *Washington Post*, Retrieved on October 20, 2016, from https://www.washingtonpost.com/news/the-fix/wp/2016/10/20/from-mexican-rapists-to-bad-hombres-the-trump-campaign-in-two-moments/. [Last Accessed June 24, 2017]; Gallup Incorporated. (2015). One in Five Voters Say Immigration Stance Critical to Vote. *Gallup.com*. Retrieved September 9, 2015, from http://www.gallup.com/poll/185381/one-five-voters-say-immigration-stance-critical-vote.aspx. [Last Accessed June 17, 2017].

[18] Kymlicka. *op cit.* Note 6.

to fulfil the moral rights of migrants and refugees to health care and freedom of movement. Second, to ensure that vulnerable people within destination countries retain their own entitlements to important welfare services. These commitments are possibly in conflict with each other due to the additional strain that may be placed on finite welfare systems by sudden increases in resident populations caused by mass migration or claims of refuge. Here, there is a concern that the health and welfare needs of migrants, refugees, and citizens are engaged in a zero-sum game in which for one to benefit, another must lose out.[19] For example, concerns that allowing migrants to access publicly funded health care systems will lead to excessive costs, or to an influx of 'illegal or unproductive migrants' seeking to take advantage of an 'overgenerous' system has contributed to health care policy making in countries like Australia and the USA.[20]

Based on similar concerns, there is reluctance on the part of countries like the United Kingdom to admit large numbers of

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[19] Widdows & Marway. *op. cit.* Note 7; Dustmann, C. & Preston, I. (2007) Racial and Economic Factors in Attitudes to Immigration. *The BE Journal of Economic Analysis & Policy 7*(1). P.26.

[20] Illingworth & Parmet. *op. cit.* Note 7; Reuters & Palazzo, C. (2016). Australia Sees Abuse In Nauru Migrant Camp As Deterrent, Say Human Rights Groups. *The Telegraph.* Retrieved September 19, 2016, from http://www.telegraph.co.uk/news/2016/08/02/australia-sees-abuse-in-nauru-migrant-camp-as-deterrent-say-huma/.[Last Accessed June 15, 2017].

refugees and migrants, or to grant them automatic, or unconditional rights to the same health care services enjoyed by citizens. For example, certain categories of migrant to the U.K. must pay an additional 'Health Surcharge' in addition to any taxes paid by the migrant, which is intended to 'offset' any additional costs imposed by them on the British National Health Service (NHS).[21] However, there is little evidence that granting refugees and migrants automatic access to health and welfare services actually contributes to migration[22] – 'push factors', such as a conflict and instability in exit countries, and the desire for economic advancement appear to be the primary drivers of migration.[23] Though it should be noted that while generous

[21] H.M. Government of the United Kingdom. (2016). Pay for UK healthcare as part of your immigration application. Retrieved September 15, 2016, from: https://www.gov.uk/healthcare-immigration-application/overview [Last Accessed May 19, 2017].

[22] International Organization for Migration. (2013). *World Migration Report 2013*. Geneva, Switzerland: International Organization for Migration. p.33-34; Illingworth & Parmet, *op. cit*., note 7, p.150; Rechel et al., *op. cit*., note 8.

[23] Pedersen, P. J., Pytlikova, M. & Smith, N. (2008). Selection and Network effects—Migration Flows into OECD Countries 1990–2000. *European Economic Review. 52*(7). p.1180; Handlos, L. N., Kristiansen, M. & Norredam, M. (2015). Wellbeing or Welfare Benefits—What Are The Drivers for Migration?, *Scandinavian Journal of Social Medicine. 44*(2); Squire, V. et al. (2017) *Crossing the Mediterranean Sea By Boat: Mapping and*

public health and welfare may not drive migration *per se*, it is plausible that they may encourage refugees and migrants to seek accommodation in one particular destination country rather than another.[24]

3. TWO POSSIBLE RESPONSES

In response to these concerns, two arguments can be made, each derived from the benefits conferred on destination countries by immigration. First, resident migrants and refugees often confer significant economic benefits on their new countries of residence, and contribute to the delivery of important health care services in those countries.[25] Second, the provision of health care for certain conditions to migrants and refugees contributes to the control of a range of health threats to which citizens are also vulnerable. Consequently, guaranteeing migrants and resident refugees rights to health care (of at least certain kinds) is in the epidemiological interest of their new countries of residence. It has been argued therefore that framing the

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Documenting Migratory Journeys and Experiences Final Project Report. Warwick, UK: The University of Warwick.

[24] I am grateful to an anonymous reviewer for highlighting this important point.

[25] Simpson, J. M. et al. (2010). Writing Migrants Back into NHS History: Addressing a 'Collective Amnesia' and Its Policy Implications. *Journal of the Royal Society of Medicine 103*(10).

discourse surrounding refugee entitlements to health care in terms of the benefits that doing so provides to their countries of residence, can be an effective strategy for motivating wealthy countries and their citizens to support the provision of health care to refugees and migrants. In this section, I set out these arguments, before exploring their limitations, and suggesting a way to expand their scope further in order to justify extending legal rights to health care to all migrants and refugees.

3.1 The economic benefits of migrants and refugees to destination countries

First, it has been shown that migrants and refugees often confer significant economic benefits on their countries of residence, either through direct tax contributions, or by indirectly stimulating local economies through consumer spending and investment in business. This can be illustrated with three examples; first, in the United States of America, immigrants 'contributed an estimated US$115.2 Billion more to the Medicare Trust Fund than they took out in 2002-09'.[26] Medicare

[26] Zallman, L. et al. (2013) Immigrants Contributed An Estimated $115.2 Billion More To The Medicare Trust Fund Than They Took Out In 2002–09. *Health Affairs*. *32*. p.1153-60. It should be noted that only those migrants with permanent residency or citizenship status (and who are therefore entitled to work in the USA), are entitled to access Medicare services,

is the U.S. federal health insurance programme which provides insurance coverage to people aged 65 and over, and those with certain kinds of disabilities.[27] It is a system which is funded through taxation, and which thus may be seen as vulnerable to incurring additional costs as a result of migration. However, the noted figures demonstrate that migrants in fact contribute more to this system than they take out, thereby benefiting non-migrant enrolees. An example of a more direct contribution made by migrants to the health care systems of their host countries can be found in the United Kingdom; a 2005 study found that in 2003, 29.4% of doctors working in the British NHS, and 43.5% of nurses recruited since 1999 were born overseas.[28]

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meaning that the group of migrants to which this data refers may be smaller than the total number of migrants in the USA overall.

[27] Medicare.Gov. (2016). *What's Medicare?*. Retrieved April 12, 2017, from https://www.medicare.gov/sign-up-change-plans/decide-how-to-get-medicare/whats-medicare/what-is-medicare.html. [Last Accessed June 20, 2017].

[28] Sriskandarajah, D., Cooley, L. & Reed, H. (2005). *Paying Their Way: The Fiscal Contribution of Immigrants in the UK*. London, UK: Institute for Public Policy Research; Johnson, M. R. D. & Mcgee, P. (2005). Globalising Care. *Diversity in Health and Social Care. 2*. p.1.

Second, a recent study on immigration to the United Kingdom found that since 2000, immigrants have had a positive impact on the British economy.[29] This study found that between 2001 and 2011 immigrants to the UK contributed roughly £20 billion more to the British economy than they received from it.[30] In addition, immigration to the UK by highly educated persons effectively saved the UK approximately £18 billion, because the costs of teaching these migrants were borne by their exit countries.[31]

Third, it has also been noted that as a result of demographic shifts, countries like the UK and Germany are increasingly reliant on immigration to maintain their economies in the face of demographic change.[32] The combination of ageing populations[33] with declining birthrates[34] in most wealthy

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[29] Dustmann, C. & Frattini, T. (2014). The Fiscal Effects of Immigration to the UK. *The Economic Journal*. *124*(580). pp. F593-F643, F593

[30] Ibid.

[31] Ibid.

[32] Rechel, et al. *op. cit*., note 8: 1235.

[33] Bijak, J. et al. (2007). Population and Labour Force Projections for 27 European Countries, 2002-052: Impact of International Migration on Population Ageing. *European Journal of Population / Revue Européenne de Démographie 23*(1). p.27; Bloom, D. E., Canning, D. & Fink, G. (2010). Implications of Population Ageing for Economic Growth. *Oxford Review of Economic Policy 26*(4). p.583.

[34] Rechel, et al. *op. cit*., note 8, p.1235.

European countries is predicted to reduce the number of persons able to participate in the work force. This reduction in the working population is also predicted to thereby reduce the amount of tax funding available to pay for the health and welfare needs of an ageing population. Consequently, "Europe needs migrants"[35] if it is to provide for the increasingly expensive welfare needs of its ageing population.

It should be acknowledged there are costs associated with enabling resident refugees to participate in the economies of their host nation which reduce the benefits they can deliver in the short term. However, it has been shown that when destination countries empower refugees to participate in local economies, through the provision of language training and health care for instance, refugees make significant fiscal contributions to the economies of their new destination countries.[36]

Correlatively, a study conducted on the provision of care to refugees in Germany[37] found that denying refugees access to

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[35] Ibid.

[36] Legrain, P. (2016). *Refugees Work: A Humanitarian Investment that Yields Economic Dividends*. New York City, USA: The Tent Foundation. P.7.

[37] It is possible that this outcome is specific to the German context (just as the other examples in this section could be each specific to the countries from which they are taken) and may not be replicated in other wealthy countries. However, these examples were chosen from a range

health care, or strictly limiting which kinds of health care they may access, was more costly than allowing unrestricted access.[38] Additional costs were ascribed to a number of factors, including 'delayed care, focus on treatment of acute conditions instead of prevention and health promotion, reliance on expert opinion of public health officials on decisions whether treatments are "medically indicated"…, and higher administrative costs entailed by the restrictive parallel system with its own funding, purchasing, and re-imbursement schemes'.[39] While these costs

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of countries as they indicate a sample of the ways in which migrants and refugees have contributed to their countries of residence. Further, the range of countries listed indicate that the benefits generated by refugees and migrants are not restricted to one country with unique features. However, it should be noted that poorer countries who receive large numbers of refugees and migrants may not receive the same benefits as wealthier countries, and may rather incur significant costs as a result of immigration and the provision of refuge. As I discuss in section five, poorer countries may lack the resources needed to promote citizen welfare, much less make the initial investment in refugee welfare which may be necessary to enable refugees to participate effectively in local economies, and thus confer benefits on their new countries of residence. Consequently, it is necessary to move beyond mere self-interest as the sole motivation for the provision of health care assistance to refugees, since many refugees live in places where those with the power to help them lack self-interested reasons to do so.

[38] Bozorgmehr, K. & Razum, O. (2015). Effect of Restricting Access to Health Care on Health Expenditures Among Asylum-Seekers and Refugees: A Quasi-Experimental Study in Germany, 1994–2013. *PloS One*. *10*.

[39] Ibid: 19

may be avoided by refusing to accommodate legal refugees, this would also forgo the longer term economic benefits they bring.

3.2 Epidemiological Arguments for the Provision of Health Care to Migrants and Refugees

A second argument based on the interest of destination countries and their citizens for granting migrants and refugees rights to health care can be derived from the public health benefits of ensuring universal access to certain kinds of care. This public health, or 'epidemiological', argument for the provision of health care, at least for infectious diseases, is justified on the grounds that many of the goods, infrastructures, and services needed to promote and protect health, such as public sanitation and sewerage, or herd immunity qualify as 'public' goods.[40] Public goods typically display three main features; first, they are 'non-excludable',[41] meaning that when established no persons within their reach can be prevented from enjoying the benefits associated with the good. Second, they are 'jointly produced',[42] meaning that they are the product of the aggregated

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[40] Widdows & Marway *op. cit*., note 7; Illingworth & Parmet, *op. cit*., note 7.

[41] Waldron, J. (1987). Can Communal Goods be Human Rights? *Archives Europeennes De Sociologie. European Journal of Sociology. Europaisches Archiv Fur Soziologie*. *28.* pp. 296-322, p.304.

[42] Ibid: 304.

actions of all, or most, members of the public in question. Third, public goods are 'non-rivalrous',[43] meaning that one person's use or enjoyment of a given good does not prevent other people from using or enjoying the same good concurrently.

Of the three features of public goods, the most relevant for the epidemiological argument is the jointness of production condition – the feature of public goods which means that they can only be established, delivered and maintained through mass participation by all or most group members.[44] Importantly, where many public goods rely only on the *actions or behaviours* of individual persons – the fact that human persons are both potential 'victims and vectors' of infectious disease means that the effective delivery of environments in which the threat of infectious disease is controlled is also partly dependent on the health states of individual group members.[45] That is, the health of any given person can be affected by the health states of other people – vulnerability to tuberculosis is closely related to the number of one's co-nationals who are already affected by the

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[43] Kaul, I. Grunberg, I. & Stern, M.A. (1999). Defining Global Public Goods. In: I. Kaul, I. Grunberg & M.A. Stern., (Ed.), *Global Public Goods: International Cooperation in the 21st Century*. (*pp.* 2-19: 2). Oxford and New York: Oxford University Press..

[44] AUTHOR 2013.

[45] Battin, M.P. et al. (2009). *The Patient as Victim and Vector: Ethics and Infectious Disease*. New York, USA: Oxford University Press.

disease for example.[46] Each individual's immunity to a vaccine preventable disease for example thus contributes to herd immunity, and the broader good of a "healthful environment".[47]

The impact of individual health states on the health of other persons is therefore the source of at least one reason to provide universal access to certain kinds of health care - the presence in society of large numbers of people who are immune to, and thus not carriers of, infectious diseases reduces the general risk of infection in a given population and contributes to the public good which has been described elsewhere as a "healthful environment".[48] The particular vulnerability of refugees, noted above, therefore provides strong self-interested reasons for host nations to ensure that they have access to at least basic essential services. The relational nature of health, and the public nature of the goods required to protect and preserve it mean that adequate prevention of disease outbreaks within the borders of wealthy countries relies on ensuring that all persons within those

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[46] Farmer, P. (1999). *Infections and Inequalities: The Modern Plagues*. Berkeley, California: University of California Press. pp. 230-231.

[47] Author *op. cit.* Note 11.

[48] For purposes of brevity I shall not provide a detailed definition of a healthful environment here, but it can loosely be described as an environment in which major threats to health are controlled, and which promotes and protects individual health. For a more detailed explanation see (Author, *op. cit.* note 11. p. 1).

borders have access to at least certain kinds of health care services - doing so is necessary to preserve the "healthful environment" which reduces the risk of deprivations of health faced by citizens.[49]

This type of epidemiological argument focuses on risks that people with infectious disease pose to their compatriots,[50] and the need to ensure that all persons within a given community be protected from infectious disease in order to prevent the emergence of 'reservoirs' of infection, from which outbreaks of disease can spread.[51] This kind of argument is typically thought to offer little justification for the provision of health care for non-communicable diseases (NCDs) or injuries.[52] There may be little *epidemiological* argument for providing refugees and

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[49] Widdows & Marway *op. cit*., note 7.

[50] It may be objected that an alternative response would be for destination countries to merely refuse entry to potential migrants and refugees, thus removing the need to include them in public health activities. This position is similar to the problem I discuss in more detail below, of justifying the provision of comprehensive health care to non-resident migrants and refugees, and is a limitation of arguments based entirely on the interests of wealthy countries. For a discussion of the problematic issues of "epidemiological securitisation", national boundaries, and global health see (Flahault, A. et al. (2016). From Global Health Security To Global Health Solidarity, Security And Sustainability. *Bulletin of the World Health Organization, 94*. p. 863)

[51] Battin et al. *op. cit*., note 48. p. 20.

[52] Widdows & Marway *op. cit*., note 7. p. 126.

migrants access to care for psychiatric issues for instance.[53] However, it has been argued that seemingly non-communicable health conditions can in fact have an impact on the health states of other people, and that providing care for such health states should be seen as a way of protecting citizens from such impacts.

Drawing on empirical research by Christakis and Fowler,[54] Illingworth and Parmet note that a wide range of health states which are typically thought to be non-communicable, such as diabetes and obesity, tend to 'cluster' in social demographics.[55] From these findings it is suggested that health states such as obesity and diabetes are argued to have an impact on the health of other persons within a community.[56] Illingworth and Parmet thus argue that it is in the interests of destination countries to grant migrants access to health care even for those health conditions which have not traditionally been viewed as communicable.[57] Doing so, it is argued, will protect citizens from the threat posed by non-communicable disease, in a similar manner as providing vaccination coverage to migrants and

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[53] Hebebrand et al. *op. cit.* Note 2.

[54] Christakis, N.A. & Fowler, J.H. (2009). *Connected: The surprising power of our social networks and how they shape our lives*: London, UK: Little, Brown.

[55] Illingworth & Parmet *op. cit*., note 7: 153.

[56] Ibid: 153.

[57] Ibid: 153-155.

refugees will protect citizens from the threat of infectious disease.

4. THE LIMITATIONS OF SELF-INTEREST

The arguments presented in the previous section provide justifications for the provision of certain kinds of care to some migrant and refugees. However, these arguments retain significant limitations; first, it is unclear that Illingworth and Parmet's argument can offer an epidemiological justification for the provision of certain important health care services to refugees and migrants. To illustrate, psychiatric conditions, such as post-traumatic stress disorder (which are arguably more likely to be experienced by refugees than conditions like obesity) may not be accounted for by this argument.[58] Where obesity is highly socially determined within wealthy countries, and can be addressed by public responses (dietary education, safe areas to exercise etc.), mental health issues often demand a

[58] Goodkind, J. R. et al. (2014). Reducing Refugee Mental Health Disparities: A Community-Based Intervention To Address Postmigration Stressors With African Adults. *Psychological Services.* 11(3). p. 333; Hebebrand et al. *op. cit. Note 2.*

more personalized therapeutic approach, which may not confer health benefits to those beyond targeted populations.[59]

Further, although there is significant stigma surrounding mental illness, and a corresponding fear that people with mental illnesses pose an increased threat to others, data suggest that mental illness is a "weak risk factor" for violence, further undermining the epidemiological argument for the provision of mental health treatment to refugees.[60] Consequently, Illingworth and Parmet's argument may not be as appropriate for some important health deprivations commonly faced by refugees, since they may not pose a risk to citizens and other third parties.[61] However, as discussed above, such provision to at least

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[59] Fazel, M. et al. (2012). Mental Health of Displaced and Refugee Children Resettled in High-Income Countries: Risk and Protective Factors. *The Lancet. 379*(9812). pp.266–82; Betancourt, T. S. et al. (2015). Addressing Health Disparities in the Mental Health of Refugee Children and Adolescents Through Community-Based Participatory Research: A Study in 2 Communities. *American Journal of Public Health. 105*(S3). pp.S475–82.

[60] Rozel, J. S. & Edward P. Mulvey, (2017) "The Link Between Mental Illness and Firearm Violence: Implications for Social Policy and Clinical Practice," *Annual Review of Clinical Psychology* 13(1): 445, https://doi.org/10.1146/annurev-clinpsy-021815-093459; Time to Change, MIND, and Rethink Mental Illness, "Violence & Mental Health," Time To Change, June 11, 2012, https://www.time-to-change.org.uk/media-centre/responsible-reporting/violence-mental-health-problems.

[61] I am grateful to an anonymous reviewer for this point.

some migrants and refugees can be defended on economic grounds, though many others will still be excluded.[62]

Second, arguments from the interests of wealthy nations also implicitly endorse the retention of harmful distinctions between refugees and migrants and the citizens of destination countries – they deliberately emphasise that it is in 'our' interest to provide care to 'them'.[63] While this is done for sound pragmatic reasons, endorsing the distinction between 'them' and 'us',[64] these arguments allow for the retention of barriers which allow 'us' to exclude 'them' from more comprehensive health care services, or even residency, if doing so is in 'our' immediate interests. Emphasising the interests of host nations risks stigmatising refugees and migrants as possible sources of

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[62] Zallman, *op. cit*., note 26; Dustmann & Frattini *op. cit*., note 31: F628-F629. It should be noted that some poorer states may lack the resources to make the initial investment, discussed above, needed for refugees to make such contributions, and may thus require assistance from wealthy countries (Rawlence, B. (2016). *City of Thorns: Nine Lives in the World's Largest Refugee Camp*. Croydon, UK: Portobello Books. Pp. 1-3). I discuss this point in more detail below.

[63] Flahault A. et al., (2016) "From Global Health Security To Global Health Solidarity, Security And Sustainability," *Bulletin of the World Health Organization*, 94: 863, https://doi.org/http://dx.doi.org/10.2471/BLT.16.171488.

[64] Widdows, H. (2015). Global Health Justice and the Right to Health. *Health Care Analysis*. pp.1-10.

infection,[65] because doing so requires that we first show that there are health risks associated with vulnerable and under-treated resident populations in order to show the value of providing them with treatment. This may potentially lead to *more* exclusionary immigration policy, in an attempt to avoid the need to incur the costs and risks associated with providing health care services in the first place.[66]

Correlatively, these arguments are not able to justify the provision of a comprehensive set of health care services to those refugees and migrants who are not resident in nations with the resources to make the required initial investment in their health. What is needed to motivate wealthy countries and their citizens to support the provision of more comprehensive health care to migrants and refugees, is a way to move beyond pure self-interest and remove the psychological barriers which exclude certain persons from our solidary groups.[67]

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[65] Flahault et al. *op. cit.* note 66, p.863

[66] Correlatively, as I discuss below, arguments from the parochial interests of wealthy countries are of only limited force when applied to the health needs of non-resident refugees (Rawlence *op. cit.* note 65).

[67] This idea has been discussed more broadly in terms of global, rather than refugee, health previously (AUTHOR *op. cit*. note 11). Similarly, Christine Straehle has suggested that recognition of vulnerability, and the desire to remove it, is foundational to domestic welfare

In the rest of this paper I explain how, despite the limitations of arguments derived from self-interest, they may be able to provide a valuable foundation for a solidarity based discourse about migrant and refugee health, which could motivate wealthy countries and their citizens[68] to support the extension of legal rights to health care to refugees and migrants.

5. MOVING BEYOND SELF-INTEREST – MOTIVATING SOLIDARITY FOR REFUGEE HEALTH

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state programmes, and that this may be extrapolated to the global stage (Lenard, P. T., Straehle, C. & Lea Ypi, (2010) "Global Solidarity," *Contemporary Political Theory* 9 (1): 118). As discussed in more detail below, a desire to challenge and ameliorate (shared) vulnerabilities is central to my argument for the provision of health care to refugees and migrants. A technical discussion of the psychological foundations of solidarity is beyond the scope of the philosophical claims of this paper. However, for a detailed discussion of cases in which solidarity has transcended national groups, and empirical psychological research into such transcendence, see (Burgoon et al. *op. cit.* Note 39; Vollhardt, J. R., Nair, R., & Tropp, L. R. (2016). Inclusive Victim Consciousness Predicts Minority Group Members' Support for Refugees and Immigrants. *Journal of Applied Social Psychology* 46 (6), pp.354–68).

[68] It has also been suggested that, initially at least, it may only be necessary to convince a small number of citizens of wealthy countries to recognise solidarity with migrants and refugees. This minority may then act as a "cosmopolitan avant-garde" which seeks to gradually convince a larger and larger proportion of their society to expand national "solidarity's boundaries" (Lenard et al., *op. Cit.* Note 70: 124).

In this section I define the concept of solidarity, and explain how it can be derived from self-interest and used to shape the discourse surrounding refugee and migrant entitlements to health care. I show how such a solidaristic discourse may have significant value in motivating action in response to the health needs of refugees and migrants. Importantly, my goal is not to supplant self-interest as a discursive strategy on this issue, since it has significant utility in certain contexts, but rather to expand upon it. Doing so provides an additional way of motivating action for refugee and migrant health in contexts in which pure self-interest alone is insufficient.

Solidarity has been defined in a wide variety of ways; as a unifying feature of religious, cultural, or national groups,[69] a motivational precondition for the fulfillment of the demands of justice,[70] the act of '"*standing up for", "standing up with",* and *"standing up as*"' other persons,[71] and as the 'enacted commitment to carry "costs" (financial, social, emotional, or

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[69] Rorty, R. (1989). *Contingency, Irony, and Solidarity*. Cambridge, UK: Cambridge University Press: 192.

[70] Krishnamurthy, M. (2013). Political Solidarity, Justice and Public Health. *Public Health Ethics. 6.* pp.129-41: 133; Scholz, S. J. (2008). *Political Solidarity*. Pennsylvania, USA: Pennsylvania State University Press: 78.

[71] Jennings, B. & Dawson, A. (2015). Solidarity in the Moral Imagination of Bioethics. *Hastings Cent Report*. *4*5. pp.31-8: 35.

otherwise) to assist others with whom a person or persons recognise similarity in a relevant respect'.[72] It is this final definition of solidarity upon which I shall base my argument in this paper – that self-interest can ground a solidarity focused discourse which can motivate action for refugee health.[73]

Two prominent features emerge from the various definitions of solidarity; first, it is an active concept, which entails willing engagement with the needs of other persons – it is something we

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[72] Prainsack, B. & Buyx, A. (2017). *Solidarity in Biomedicine and Beyond*. Cambridge, UK: Cambridge University Press. For further discussions of solidarity see also: Dean, J. (1996). *Solidarity of Strangers: Feminism After Identity Politics*. Berkeley, California: University of California Press; Young, I.M. (2002). *Inclusion and Democracy*. New York, USA: Oxford University Press; Gould, C.C. (2014). *Interactive Democracy: The Social Roots of Global Justice*. Cambridge, UK: Cambridge University Press.

[73] Importantly, because what counts as a "relevant similarity" can be very broad, solidarity can be self-interested, or based on expectations of reciprocity. For example, Susan's solidaristic cooperation with Lisa may be based on her recognition of their shared interest in achieving a common objective - Susan recognises that they are similar in their desire for that objective, and she is willing to incur the costs of helping Lisa achieve it as well because doing so will benefit her, and she expects Lisa to incur proportionally similar costs to support their mutual objective. Here, Susan and Lisa's cooperation is self-interested and reciprocal, but is also solidaristic, since they each incur costs to benefit someone with whom they share relevant similarities in pursuit of a shared and otherwise unobtainable objective. In my discussion of antimicrobial resistance below, I elaborate on this point, and distinguish purely self-interested actions from self-interested, yet solidaristic actions.

do, not something we (merely) feel. Second, the willingness to act on behalf of other persons is derived from recognition of similarity with those other persons – one 'stands up as',[74] or 'recognise[s] similarity'[75] with the persons with whom one acts in solidarity. These relevant similarities can be recognised in stable features of persons, such as membership of religious, cultural, or national groups,[76] but can also be found in temporary or transient similarities, such as shared inconvenience as a result of a delayed flight.[77] It is this emphasis on similarity which is most important for my argument in this paper, and which enables the move from the self-interested arguments for the provision of limited health care to certain migrants and refugees, to a broader, solidaristic motivation for providing refugees and migrants with comprehensive health care.

Solidarity is action by an agent for the benefit of another, motivated by recognition of *relevant similarities* between them. Acknowledging that it is in one's interests to provide treatment for a specific disease to distant others (or to resident migrants

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[74] Jennings & Dawson, *op. cit*., note 74: 35.

[75] Prainsack & Buyx, *op. cit*., note 75.

[76] Rorty, *op. cit*., note 72: 192.

[77] Prainsack, B. & Buyx, A. (2011). *Solidarity: Reflections on an Emerging Concept in Bioethics*. Swindon, UK: Nuffield Council on Bioethics: xiv.

or refugees), is to implicitly acknowledge that that disease is also a threat to oneself and one's compatriots, and to thus recognise an important point of similarity between oneself and other persons. It can thus act as an epistemological catalyst for the citizens of wealthy countries to become aware of the ways in which they are similar to vulnerable non-citizens. This awareness can challenge those 'assumptions of distance and difference'[78] which would otherwise encourage residents of wealthy countries to overlook the health needs of distant refugees. Framing public discourse in terms of similarity, rather than self-interest (which is typically exclusionary and distancing) can change the way citizens view refugees and migrants, and thus encourage them to engage in solidarity for the benefit of the vulnerable, as I explain in more detail below.

This emphasis on similarity means that a solidaristic discourse will avoid, or at least minimise, the stigma and distancing problems associated with purely self-interested discourses noted above. Recognising relevant similarities with someone outside of our traditional solidary group reduces, or even removes, one reason to view them as an outsider, and reinforces our reasons for thinking of them as a member of our solidary group.[79] In this

[78] Author, *op. cit.* Note 11. P. 6.

[79] Widdows, *op. cit.* Note 67.

way, emphasising similarity and solidarity in certain discourse contexts can ameliorate certain problems associated with self-interest as a foundation for action for refugee health, and function as the basis for an effective political discourse surrounding refugee and migrant health

To illustrate, the emergence of anti-microbial resistance (AMR) has exposed the citizens of wealthy countries to vulnerabilities not experienced since the advent of the antibiotic era.[80] In doing so, it has demonstrated an important area of similarity (vulnerability to infectious disease) between citizens of wealthy countries, who had previously enjoyed the security provided by access to antibiotics, and citizens of poor countries, for whom infection was often synonymous with death.[81] Responses to the emergence of AMR have emphasised the need for cooperation between countries, and for wealthy countries to incur costs in order to benefit all persons.[82] Here, solidaristic cooperation emerged as a way to protect the interests of wealthy countries. This is shown by the emphasis in a recent report by the British

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[80] Littmann, J. & Viens, A.M. (2015). The Ethical Significance of Antimicrobial Resistance. *Public Health Ethics*. *8*(3). Pp.209-224.

[81] AUTHOR, *op. cit.*, note 11.

[82] The Review of Antimicrobial Resistance Chaired by Jim O'Neill. *Antimicrobial Resistance: Tackling A Crisis For The Health And Wealth Of Nations.* London, UK: Her Majesty's Government, and The Wellcome Trust; 2014.

government on the shared vulnerability of the citizens of rich and poor countries, and the importance of collaborative efforts between rich and poor countries as the *only* effective way to address the risks of AMR.[83]

This example provides a useful illustration of Ypi's concept of a cosmopolitan avant-garde – a minority group within a political community, whose recognition of, and advocacy for, particular cosmopolitan principles encourages meaningful change within their wider political community.[84] Here, we may describe those responsible for facilitating change within their political communities as being an epidemiological, cosmopolitan avant-garde. Their recognition of the shared vulnerability and risk associated with the threat of AMR, while arguably grounded in self-interest, led to policy recommendations which were characterised by cosmopolitan, rather than nationalist, solidarity.

In this case, the initial motivation for the authors of the report was the promotion of their nation's interests, and the protection of their residents from serious threats to health. However, the

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[83] Ibid. P.16.

[84] Lenard et. Al., *op. Cit.* Note 70; Ypi, L. (2011) "A Cosmopolitan Avant-Garde," in *Global Justice and Avant-Garde Political Agency*. Oxford: Oxford University Press, https://doi.org/10.1093/acprof:oso/9780199593873.003.0008.

recommendations for AMR contained in the O'Neill report, though certainly self-interested, also emphasised an overt willingness to incur costs to meet the needs and interests of persons outside of the group with which wealthy nations were initially concerned, based on recognition of their shared vulnerabilities. Here, engagement with particular hazards for the promotion of national or regional interests provided the catalyst for the commitment to incur costs to benefit those with whom the shared vulnerability was recognised.[85] Self-interest identified a point of relevant similarity between the citizens of rich and poor countries, and motivated a solidaristic policy response.

This example refers to a shift in national policy for global health which extends beyond the particular needs of refugees and migrants. I refer to it here because it demonstrates that solidarity – the active engagement with the needs of other persons, based on the recognition of similarity – can be engendered between the residents of wealthy nations, and vulnerable yet distant persons. It thus provides a blueprint indicating how solidarity can be generated between the citizens of wealthy countries and non-

[85] Author, *op. Cit.* Note 11.

resident refugees, a group to whom arguments from self-interest may have limited applicability.

Many refugees are resident in countries which lack the ability to provide health care to them (or even to citizens). For example, the Dadaab refugee camp in Kenya, which was originally constructed to accommodate 90,000 people, now houses as many as half a million refugees.[86] The absence of large scale health infrastructure, combined with ongoing regional conflict and the limited resources of the Kenyan state mean that refugees living in Dadaab are unlikely to be the beneficiaries of the investment necessary to enable them to contribute more fully to the Kenyan, or global economy, since the Kenyan state may lack the resources to make such an investment.[87]

This problem is compounded by the fact that wealthier countries may also lack significant *epidemiological* incentives to provide care for non-communicable disease to those not within their borders – high rates of cancer amongst marginalized refugees in distant countries do not pose a threat to public health in rich countries for example. Correlatively, while there are some global economic benefits to providing health care to distant

[86] Rawlence, *op. Cit.* Note 65. P.2.

[87] Ibid. Pp.39-40.

refugees,[88] such benefits are less obvious, and thus harder to justify politically, than the provision of care to resident refugees – particularly when fulfilling domestic health care needs will deliver more obvious or immediate economic and health benefits to the electorates of wealthy countries.

However, as discussed above, self-interest can provide the catalyst for solidaristic engagement by wealthy countries with the broader needs of distant, vulnerable refugees who would be excluded under a viewpoint focusing entirely on self-interest. Consequently, while the non-communicable health states of distant refugees may not in themselves motivate wealthy nations to act for distant refugees, concerns about global health more generally provide self-interested reasons to engage with certain narrow health needs of distant persons. This initial engagement can highlight an important point of similarity between the citizens of wealthy nations and distant refugees. Framing public discourse in terms of this similarity enables citizens to recognise their relationships and similarities with vulnerable, distant others, and may thus empower and encourage them to engage in solidarity with those others in a more comprehensive way than a discourse grounded in self-interest alone. Correlatively, it can be argued that through engagement with nearby refugees,

citizens of wealthy countries may acquire increased awareness of the needs of refugees more generally, and their status as individual persons, rather than as abstract or anonymous statistics, which may help them to recognise even distant refugees in a similar fashion, and be more willing to engage in solidarity with them.

This may appear overly optimistic. However, contact between members of distinct social groups, such as citizens and refugees, has been found to lead to more positive attitudes towards, and identification with, members of vulnerable or marginalised groups.[89] For example, it was reported in early 2018 that a senior member of the German far-right (and Islamophobic, anti-immigration) political party *Alternative für Deutschland* (AFD), had converted to Islam and resigned his membership of the party following extensive volunteer work with Muslim refugees in Germany.[90] Correlatively, (though less dramatically) it has been argued that the involvement of migrant workers in the health

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[89] Paluck, E.L., Green, S. & Green, D. P. (2017) "The Contact Hypothesis Reevaluated," SSRN Scholarly Paper. Rochester, NY: Social Science Research Network, https://papers.ssrn.com/abstract=2973474.

[90] Williams, J. (January 24, 2018) "A Prominent Member of Germany's Far-Right Anti-Islam Party Just Converted to Islam," Vox, https://www.vox.com/2018/1/24/16927978/germany-far-right-party-afd-islam-convert-arthur-wagner. [Last accessed 25 February 2018].

care systems of their new countries of residence can function as an additional basis for solidarity. That is, their professional involvement in the health services of their countries of residence provides their co-workers with opportunities to meet, interact with, and thus develop relationships with migrants who might initially be excluded from membership of nationally defined solidarity groups.[91] Such participation has contributed to the emergence of intra-group solidarity between immigrants, refugees, and citizens within trade unions, as professional collaboration was found to provide opportunities for the latter to develop personal and professional links with new arrivals which trumped existing national solidarities.[92]

The importance and impact of recognising refugees as individuals with whom important similarities may be shared, rather than as abstract, anonymous, and distant "others" can also be demonstrated with recent events in the ongoing European Refugee Crisis. In 2015, approximately 4000 people drowned

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[91] Burgoon, B. et al. (2010). Immigration and the Transformation of American Unionism. *The International Migration Review. 44*(4). pp. 935, 968; Eckenwiler, L. Straehle, C. & Chung, R. (2012) "Global Solidarity, Migration And Global Health Inequity," *Bioethics* 26(7). P.387.

[92] Eckenwiler, Straehle & Chung. *Op. cit.* note 94. P.387. I am grateful to an anonymous reviewer for this point.

while trying to cross the Mediterranean into Europe.[93] While these deaths were not ignored, responses to them were largely muted at the international level. However, shocking images of the dead body of Alan Kurdi, a three year old boy fleeing the Syrian civil war with his family, drew increased attention to the plight of refugees in the Mediterranean,[94] and led to significant increase of both donations to organisations working to provide aid to refugees, and criticism of national failures to adequately respond to the crisis.[95]

In part, this increase in support for refugees can arguably be attributed to an increased awareness amongst the residents of wealthy countries, that the European Refugee Crisis involved identifiable, and identified, *people* with whom the citizens of

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[93] BBC News. (2016). *Migrant crisis: Migration to Europe explained in seven charts* BBC News. Retrieved September 15, 2016 from: http://www.bbc.com/news/world-europe-34131911. [Last accessed May 29, 2016].

[94] Regencia, T. & Chughtai, A. (2016). Alan Kurdi: What Has Changed Since His Death? *Al-Jazeera*. Retrieved September 25, 2016 from: http://www.aljazeera.com/indepth/interactive/2016/08/alan-kurdi-changed-death-160831173922096.html. [Last accessed 30 Sep 2016].

[95] Henley, J. et al. (2015). Britons rally to help people fleeing war and terror in Middle East. *The Guardian*. Retrieved September 25, 2016 from: https://www.theguardian.com/uk-news/2015/sep/03/britons-rally-to-help-people-fleeing-war-and-terror-in-middle-east. [Last accessed 30 Sep 2016].

European countries could identify solidaristically, rather than abstract statistics.[96] However, it must be noted that one year after the death of Alan Kurdi, as media and public attention has moved to other concerns, the factors which expose refugees to serious risk of harm remain largely unaddressed.[97] The point remains however that when awareness of the suffering of distant persons is forced into the public consciousness, in terms of the suffering of identifiable persons with whom we share important similarities rather than as abstract statistics, those in position to

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[96] For a further illustration of the impact of individual recognition of refugees see (Boseley, S. (2017) Efi Latsoudi: In Solidarity with Refugees. *The Lancet 389*(10074), 1093). The subject of this piece emphasises the importance of solidarity with refugees, and is presented as feeling solidarity with them as a result of her family experience of fleeing persecution – a similarity she shares with those she helps. See also (Benhabib, S. (1986) The Generalized and the Concrete Other: The Kohlberg-Gilligan Controversy and Feminist Theory. *Praxis International 5(*4), 402–24; Chinchilla, N. S., Hamilton, N. & Loucky, J. (2009) The Sanctuary Movement and Central American Activism in Los Angeles. *Latin American Perspectives 36*(6), 101–26). Correlatively, recent studies have shown widespread support for granting refugees residency in many wealthy countries (Maltz, G. & Malknecht, A. (2017, May 22). Some Good News About Public Attitudes to Refugees. *News Deeply: Refugees Deeply.* Retrieved June 30, 2017 from: https://www.newsdeeply.com/refugees/community/2017/05/22/some-good-news-about-public-attitudes-to-refugees. [Last Accessed June 30, 2017]).

[97] Regencia & Chughtai, *op. cit*., note 97.

help often (though not always) respond in solidarity with those persons.

6. CONCLUSION

My aim in this paper has been twofold; first, to show in general terms how solidarity between migrants and refugees, and the citizens of wealthy countries could be derived from the parochial interests of wealthy countries and their citizens. Second, to explain how this solidarity can shape an effective discourse to motivate action to promote and protect refugee and migrant health. To achieve this goal, I outlined two arguments for the provision of certain kinds of health care to resident refugees and migrants, each derived from a focus on the interests of destination countries and their citizens. Having done so, I noted that while self-interested justifications for the provision of health care to resident migrants and refugees had significant force in certain contexts, they are limited in scope, and risk being interpreted as providing a justification to deny refugees and migrants residency and access to care in wealthy countries. Further, reliance on self-interest risks stigmatising vulnerable people, and tacitly accepting that wealthy countries should exclude refugees and migrants if doing so would generate greater benefits.

Despite these limitations I suggested that the argument from the interests of wealthy countries and their citizens can provide the basis for a discourse based on solidarity which addresses these weaknesses. I argued that the self-interest upon which these arguments are based, exposes and draws attention to the similarities that exist between the citizens of wealthy countries, and migrants and refugees. This recognition of similarity can, if incorporated into public discourse surrounding refugee entitlements to health care, act as an epistemological catalyst which raises awareness of the connections that exist between refugees and migrants, and the citizens of wealthy countries. This can engender solidarity for public and individual health, and motivate the citizens of wealthy countries to engage in solidarity with those they may previously have ignored (as in the AMR and Alan Kurdi examples).

In this way, a discourse based on solidarity, the cooperative, egalitarian precursor to justice,[98] can emerge from arguments based on self interest, and motivate action for migrant and refugee health through emphasising recognition of the common vulnerabilities and interests that the citizens of destination countries share with those they may previously have ignored.

[98] Krishnamurthy, *op. cit.*, note 73: 133; Scholz, *op. cit.*, note 73: 78.

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