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Lara Middlemiss

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ESSAY

What are the political and ethical challenges that health professionals face in providing care to undocumented migrants? How should they respond to these challenges?

Lara Middlemiss

Medical Student, Cardiff University, Cardiff, Wales

Background

International migrants comprise some 3.5% of the global population (United Nations 2023), and according to the International Organisation for Migration's (IOM) most recent data, between 2020 and 2021 the estimated number of international migrants increased by 13.3%, to 281 million people (IOM n.d.a). Given these numbers, it is no surprise that international migration is at the forefront of the global forum, with the 2030 Agenda for Sustainable Development Goal 10.7 emphasizing global responsibility for facilitating safe migration (United Nations 2023). This essay will focus on undocumented or irregular migrants (UMs), which the IOM defines as the 'movement of persons that takes place outside the laws, regulations, or international agreements governing the entry into or exit from the State of origin, transit or destination' (IOM n.d.b), on a global scale. Whilst UMs are difficult to document, some data are available: for example, in the year ending September 2023 the United Kingdom's Home Office reported that 45,081 people had entered the UK irregularly (UK Government 2023), compared to the 1.2 million people that immigrated regularly into the UK in the year ending June 2023 (Office for National Statistics n.d.).

CONTACT Lara Middlemiss MiddlemissLC@cardiff.ac.uk

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Introduction

It is well established that UMs are a vulnerable population with a challenging disease burden that often differs greatly from that of their destination country's population (Aspinall 2014). This is why health issues have been identified as a high priority for management on arrival in a destination country. However, immigrants, especially UMs, under-utilize health services in their destination country (Winters et al. 2018). There are a number of studies which have investigated the barriers UMs face in accessing healthcare services, however little has been done to identify the challenges that healthcare professionals (HCPs) face when caring for this population. This essay will delve into the political and ethical issues that HCPs worldwide face when providing care for UMs, with a particular focus on professionals working in primary care, with the aim of identifying areas of adaptation to improve the uptake of healthcare services by the vulnerable UM population. It is important to note that there is a large overlap between the challenges HCPs face when treating documented migrants, compared to UMs. Using the four-level model of healthcare system by Ferlie and Shortell (2001), this essay will consider the political and ethical dilemmas HCPs face on an: individual patient level, care team level, organization level, and a societal level. It will then investigate the response strategies that health services across the world could take up, in order to respond to these challenges, arguing that ultimately hostile legislation towards UMs must change to truly overcome the challenges that HCPs face.

Global expectation vs reality in healthcare for undocumented migrants

Goal 3.8 of the UN's 2030 Agenda for Sustainable Development (United Nations 2023) aims for universal health coverage for all. Despite the universality of this goal, and the explicit protection of UM's rights under international law (IOM n.d.b), the global provision of healthcare for UMs is limited. In the UK, despite the first principle of the National Health Service's (NHS) constitution being: 'the NHS provides a comprehensive service, available for all' (UK Government, 2017), underneath the government's 2012 'hostile environment' policy there is an extreme 'migrant health deficit effect' (Berchet and Jusot 2012). While all migrants are entitled to free primary healthcare, emergency treatment, family planning or treatment in secure mental health units, beyond this, temporary workers and foreign students are charged £470-£624 per year as part of their visa for health provision. Other 'overseas visitors', unless exempt (which UMs are not), are charged for medical treatment at a rate of 150% of the cost to the NHS. Unless the treatment required

is urgent, it will be withheld until the person can pay (UK Government, 2014). Most countries provide similar levels of care for UMs, underscoring the global shortfall in achieving the UN's 2030 health coverage targets.

Individual patient level

Disease burden

UMs are a uniquely vulnerable population in terms of health requirements. A study comparing European states illustrated that migrants are more at risk of communicable disease, mental health issues, diseases related to occupation, injuries, diabetes mellitus and maternal/paediatric health problems than the general population (Rechel, Mladovsky, and Devillé 2012). This increased and complex disease burden is a major ethical challenge for HCPs. They must manage these needs, often with difficulties in language and cultural communication, and work within systems which are not configured for such a multifaceted population. These challenges influence HCPs ability to dedicate the same time and quality care to UMs as to the general population, leading to healthcare inequalities.

Lack of medical records

In addition, UMs rarely have up-to-date medical records (Lindenmeyer et al. 2016), the lack of records is a barrier to continuity of pre-migration treatment for the UM population. For some, especially those from war-torn countries, there is an increased chance of conditions being undiagnosed. HCPs identified that undiagnosed psychiatric issues amongst the UM population were a particular 'drain' of time and resources. Politically, HCPs may find it difficult to justify the increased use of a nation's resource to care for non-tax paying UMs. However, looking through the ethical lens of beneficence, it is difficult to justify not providing the same level of care to UMs as to the general population. This conflict between legality and politics against the professional ethics of the healthcare profession is a theme that will continue to be illustrated in this essay, as a major challenge for HCPs when caring for the UM population.

Language challenges

A further dilemma for HCPs is the issue of language and use of translation services. While many patients attend with relatives for translation and comfort purposes, it is difficult ethically to use relatives over professional services due to the risk of inaccurate history taking (Suphanchaimat et al. 2015). However, interpretation services are not always available, expensive and

often time-consuming with issues such as the patient and interpreter speaking different dialects of the same language. Furthermore, while professional interpreting services can overcome the language barrier, it does not necessarily make communication easier, with interpreters rarely being trained in a culturally sensitive manner to serve such a diverse population.

Difference in culture and expectations

Differences in UM culture and expectations of healthcare systems are a frequent source of frustration on the side of HCPs and can lead to a reluctance on the part of UMs to access health care in their destination country. A study focusing on sub-Saharan migrants in Morocco found that UMs often take offence to a holistic approach to history taking due to their prior 'patriarchal' experiences of healthcare, so psychiatric problems and sexual assault are less easy to identify and manage (Van Den Ameele et al. 2013). An ethical dilemma that HCPs may face when treating UMs is how much, if at all, they should adapt their style of healthcare practice to the patient's culture, or whether the patient should be expected to adapt. Differing expectations of healthcare is a further challenge; for most UMs, preventative medicine is a foreign concept, so patient involvement in their own care can be a huge obstacle to HCPs (Jessen 2010). Health seeking behaviour is heavily influenced by culture; a study in the Netherlands found that UMs tended to seek health advice through friends, religious leaders, religious groups and lastly through the formal healthcare system (Teunissen et al. 2014). Research shows (Riggs et al. 2012) that building trusting relationships with UM patients requires more time and continuity of care than the general population, and that lack of trust led to UMs being less likely to engage with healthcare services fully. This delayed presentation may lead to ethical and practical challenges for HCPs; some issues may be harder to treat as thoroughly, competently and safely as the HCP may wish.

Care team level

Professional ethics

HCPs must manage contradictory opinions within the profession about providing care for the UM patient group: a Canadian study (Vanthuyne et al. 2013) found that HCP attitudes towards UMs ranged from 'professional fraudsters' to vulnerable members of society in need of collective aid. This dichotomy of thought means HCPs may end up using their own moral compass and ethical values when determining whether or not to treat this vulnerable patient group.

Knowledge gaps

Knowledge gaps in adapting healthcare to the UM population are a further challenge. A majority of London-based HCP's 'majorly expressed' uncertainty in their abilities in history taking of trauma and torture and requested training on different aspects of migrant health (Lawton et al. 2017). Again, ethically, this is a challenge for doctors who feel that they are not practicing within their competency levels when treating UM patients.

Organization level

Lack of resources

European research into the challenges faced managing UMs with mental health issues (Straßmayr et al. 2012) found that the largest barriers were the lack of competencies and resources, including the deficit of professionals with the skills specific to the management of migrants, and the general shortage of resources in healthcare systems. This is a challenge that HCPs face on a political front, as funding of resources is not within their remit but massively affects ethical decisions they must face daily about the distribution of resources.

Rigidity of healthcare systems

The rigidity of healthcare systems has been highlighted as a major barrier to HCPs when caring for UMs (Kavukcu and Hakan Altıntaş 2019), who require a flexible health system due to their unique requirements. UM patients tend to have a larger disease burden but the exact same time slot as the general population, meaning there is rarely sufficient time to build trust with the patient as well as cover UM specific physical, psychological and socioeconomic issues. In short, HCPs are very constrained in what they can provide in terms of complete care for this patient group, many HCPs have resorted to finding 'loopholes' through which they can provide full care to UMs in accordance with their usual professional standards (Priebe, Bogić, et al. 2011). These loopholes might include ordering laboratory samples in the HCP's name, actively choosing not to check identification, or referring patients to charities. Again, HCPs appear to be faced with the ethical dilemma of choosing between providing the care to UMs, as they would the general population, but through dishonest means or not to their usual standards.

Societal level

The lack of harmony between the politics and legality of managing UMs, and HCPs professional ethics, is a significant challenge on a societal level. HCPs are

hindered by legislative policies towards UMs, meaning that the law may not permit them to treat this patient group to the same standards as they would the general population. Ethically, this is a huge dilemma faced by HCPs around the world, as they are trapped between the moral dilemma of following the law or doing what is 'right' for the UM patient group. Weighing up the ethical principle of 'justice' is difficult in this context. Is treating UMs by using loopholes to give them access to secondary care 'treating all patients equally' or is it an unfair distribution of resources?

Research into the experiences of volunteer nurses caring for UM in Sweden found that the volunteers experienced 'moral anxiety' when working at the clinic (Sandblom and Mangrio 2016), feeling that they had to do something to help this vulnerable population but were unable to do more than provide 'just healthcare'. This highlights a further ethical challenge that HCPs face when treating UMs and that due to the limits of the healthcare system and legislation of the countries they work in, they are unable to provide UMs with complete care.

Response strategies

The Migrant Friendly Hospital project (The European Commission 2004) was launched in 2002 with the aim of finding solutions to the health disparities experienced by migrants in Europe, and the challenges faced by HCPs when managing them. Solutions suggested for HCPs included: building staff's capacity for cross-cultural communication and diversity-related skills, tailoring clinical practice, public health practice and health promotion services to diverse populations, taking the health literacy of different populations into account, and adapting practice to these patient groups, heightening awareness of the potential of psychiatric issues in UMs. Other solutions suggested in the literature (Priebe, Sandhu, et al. 2011) for HCPs include engaging with cultural competency training for themselves and interpreters, offering lengthened time slots for vulnerable patient groups, engaging with migrant community leaders to create a cultural 'bridge' to improve understanding of health and healthcare and engaging with training on how to treat patients affected by trauma and torture, all within the constraints of their respective healthcare systems.

While it is possible for HCPs to adapt their practices as set out above, ultimately national laws can still present political and ethical challenges to HCPs providing care to UMs. If universal healthcare was truly realized, attitudes and healthcare policies/legislation were changed away from penalizing those who leave their countries, and focus was shifted towards solving the root reasons behind mass migration, such as conflict and climate change, and more funds and resources were released to specifically care for the migrant

patient group, then the moral anxiety that HCPs are currently experiencing when managing such populations would be significantly alleviated.

The two countries which have realized universal health coverage for UMs are Thailand and Spain. Since 2002, Thailand has used the Health Insurance Card Scheme (HICS); a voluntary non-profit health insurance with an affordable annual premium of 1600 Baht (USD $49), which is accessible to UMs (Health Insurance Group 2013). Research has (Pudpong et al. 2019) found that HICS increased access to healthcare services for UMs, reduced financial load for healthcare services, improved referral pathways for migrants, secured health services for migrant school children and increased understanding of migrant health needs amongst HCPs. In 2018, Spain re-established universal health coverage for UMs (Gimeno-Feliú et al. 2021). This is provided through the Spanish national health system, which is nearly fully funded by taxes, meaning that UMs pay for 40% of the cost of treatment, the lowest co-pay rate in Spain. Perhaps one option that could help HCPs to tackle the crisis of treating UMs would be to lobby for insurance card systems, as in Thailand, or access to healthcare through national health systems, as in Spain, for UMs within their respective national systems.

Conclusion

HCPs face considerable political, ethical and practical challenges when providing healthcare services to UMs. Developing short-term solutions such as, increasing cultural competency and migrant-specific training, offering lengthened time slots for vulnerable groups, and engaging with communities to overcome differing expectations of healthcare systems, for UMs living in countries with hostile legislation may temporarily alleviate some challenges. However, the moral dilemmas for HCPs in balancing professional ethics against unfriendly healthcare policy and legislation are very real. As this essay has demonstrated, it is vital that progress is made towards universal health coverage, perhaps through a Thai or Spanish model, so that HCPs are no longer forced to treat this vulnerable group as second-class patients.

Disclosure statement

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Notes on contributor

Lara Middlemiss is a 3rd year medical student at Cardiff University with a strong interest in global health, particularly managing health inequities, refugee health, and conflict response.

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