

Healthcare as Governance Technique: Anti-Immigration Politics Expressed in Access to Health

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Introduction

On October 4, 2019, President Donald J. Trump signed a proclamation requiring individuals to have health insurance or the financial means to cover foreseeable medical expenses to apply for a visa. Although the specific implementation of this requirement was initially vague, it significantly impacted the migration process. The rationale behind this policy was to reduce the financial burden on taxpayers and healthcare providers to treat uninsured individuals, particularly immigrants. A similar initiative was undertaken in Germany during the Asylum Compromise of 1993, with the enactment of the “Asylum Benefits Act.” This law limited healthcare coverage for asylum seekers and individuals with irregular residency status to acute illnesses and emergency care. The underlying objective was to minimize the supposed attraction of healthcare benefits to migrants and alleviate the financial strain on taxpayers. These legal initiatives exemplify two approaches to using healthcare to limit immigration: one, to use healthcare as a condition to enter the country, and, two, to reduce healthcare incentives to decrease the influx of immigrants. Both approaches are based on the rationale that healthcare capacities are limited and can only be provided for citizens but not for aliens.

The examples above demonstrate that healthcare has become a critical area in anti-immigration politics. Access to healthcare serves as a tool of governance to control immigration flows and reinforce national identity. In the United States and Germany, restrictive healthcare policies for immigrants have been justified with claims of reducing financial burdens on taxpayers and preventing the exploitation of public services. According to the prevailing

narrative that is mobilized by advocates for restrictions, nations' social benefits and advanced healthcare systems function as 'pull factors' that attract migrants and result in overburdened public systems.

This essay examines how healthcare policies marginalize immigrant populations and divert attention from systemic healthcare issues in the U.S. and Germany. Laws, policies, and rhetoric are analyzed in terms of their varying perspectives on health. In the context of migration, health policies are presented as either necessary to protect national health, as during the COVID-19 pandemic, or as essential to preventing the exploitation of the welfare and health systems. Since the capacity of hospitals, medication, and doctors can be assessed numerically, healthcare is posited as a limited good that needs to be distributed by political actors according to market logic. Access must be earned or deserved and is reduced to access to medical treatment without acknowledgement of the influence of living circumstances and their effects on health. This perspective leads to a rhetoric of healthcare exploitation in which migrants are beneficiaries and taxpaying citizens, exploited.

In this essay, I contrast a human rights perspective on health with German and U.S. American political realities and name the problems that political actors identify. Arguments about the overburdened healthcare system or migrants' supposed exploitation of the welfare state are critically questioned. Using a human rights framework opens the debate to a more critical engagement with current health and migration discourses. After questioning the logic of constrained health resources that leads to the exclusion of marginalized groups, I propose a human rights framework for how health and healthcare. This framework leads to broadening the spectrum of possible solutions.

To arrive at this perspective, this essay is organized into three parts. First, a post-structural understanding of policymaking is introduced, which contests the assumption that problems exist objectively. Second, the narrative of migration as a pressure point on the health system and the understanding of health as a limited good are elucidated. An underlying zero-sum logic lies behind them, that is, the assumption that a benefit to one group necessarily means a loss to the other. These concepts are then mobilized in the third section, which focuses on German and U.S. discourses on migration and their effects on health and healthcare.

Health and Health Systems: Pressure Due to Migration?

What is a problem, and how can it be solved? From the perspective of post-structural policy analysis, problems do not exist objectively or independently of the actors who present them. Actors' perceptions determine which situation is perceived as a problem, and what kind of problem it represents.¹ Contesting essentialist assumptions about issues and their solutions enables critical reflection on why things are governed as they are. The solutions that are offered depend on the underlying assumptions of the actors making the judgements. For instance, the problem of overburdened hospitals could be solved by making investments to increase capacities or staff. Health issues could be prevented by addressing the causes of illness in society. Patient numbers could be controlled by limiting the number of people entitled to treatment. The predicament of "overburdened hospitals" becomes a different kind of problem that requiring varying types of knowledge and resources, depending on the political actor offering a solution. From such a perspective, we can question political measures and their intentions and ask whether proposed solutions actually target an identified problem or merely address a political actor's specific problematization.²

The concept of health is not universally defined.³ Various approaches to health can be used to set priorities and justify policies. From a curative point of view, the treatment of sickness has the highest priority. Focus lies on the discipline of medicine as the key player in healthcare. Preventive perspectives, like public health, ask, by contrast, how health threats emerge in the workplace, living conditions, and consumption. Normative statements are used to justify the prohibition of health-threatening behaviors or choices. Although these approaches differ drastically in their views on how to promote health, they should not be interpreted as independent of one another.

The codification of the human right to health in Art. 12 para. 1 of the International Covenant of Economic, Social, and Cultural Rights (ICESCR) and

- 1 Carol Bacchi and Susan Goodwin, *Poststructural Policy Analysis: A Guide to Practice* (Berlin: Springer Link 2016), 38–39.
- 2 Ibid.; Renate Mayntz, "Governance Theory als Fortentwickelte Steuerungstheorie?", Econstor, 2004, <https://www.econstor.eu/handle/10419/44296>.
- 3 Peter Franzkowiak and Klaus Hurrelmann, "Gesundheit," in *Leitbegriffe der Gesundheitsförderung und Prävention: Glossar zu Konzepten, Strategien und Methoden*, Bundeszentrale für gesundheitliche Aufklärung, last updated May 19, 2022, <https://leitbegriffe.bzga.de/alphabetisches-verzeichnis/gesundheit/>.

its further definition in the general comment 14 of the CESCR provide a normative guarantee to the right to health, though not to right to be healthy. As the legal text states, everyone is entitled “to the enjoyment of the highest attainable standard of physical and mental health.”⁴ The notion of “highest attainable standard” appears vague at first glance. Yet it defines a clear framework in which states have to operate. It recognizes “individual’s biological and socio-economic preconditions”⁵ and considers structural circumstances and their influence on an individual’s health status.

Depending on a state’s particular circumstances and capacities, health has to be secured with an approach based in equity. General Comment 14 further defines clear categories for the design of health services. They must be *available*, and provide sufficient health services; *accessible* in a physical, economic, and non-discriminatory manner; and *acceptable* for different cultural, gender-based, or lifecycle requirements: the requirements of minorities are explicitly mentioned. Further, they must respect medical ethics. Finally, health services must be of good *quality*, and provide scientifically and medically appropriate services, including infrastructure and trained personnel.⁶

This brief overview of different conceptualizations of health helps to make clear the wide variety of measures governments can consider to ease pressure

4 United Nations (General Assembly), “International Covenant on Economic, Social, and Cultural Rights,” in Treaty Series 999 (December 1966), Art. 12 para. 1.

5 UN Economic and Social Council, “General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant),” E/C.12/2000/4, UN Committee on Economic, Social and Cultural Rights (CESCR), August 11, 2000, <https://www.refworld.org/legal/general/cescr/2000/en/36991>, par. 9.

6 Ibid., par. 12. The AAAQ concept is subject of further discussion and a non-exhaustive concept. There is, for instance, the call for implication of *Trust* (Sibel T. Savas et al., “Migrant-sensitive Healthcare in Europe: Advancing Health Equity Through Accessibility, Acceptability, Quality, and Trust,” *The Lancet Regional Health Europe* 41, 2024, art. 100805); *Accountability* (Helen Potts, “Accountability and the Right to the Highest Attainable Standard of Health,” 2007, https://warwick.ac.uk/fac/soc/pais/research/csg/r/csg-events/conferences/2007/hivaids/papers/hrc_accountability_mar08.pdf) ; and *Participation* (Helen Potts, Ford Foundation, and Paul Hunt, “Participation and the Right to the Highest Attainable Standard of Health,” 2008, <https://repository.essex.ac.uk/9714/1/participation-right-highest-attainable-standard-health.pdf>). These additions derive mainly from discussions about health services for irregular migrants, emphasizing the need for further investigation and a required paradigm shift, recognizing non-sedentary lifestyles and realities. Stefano Angeleri, *Irregular Migrants and the Right to Health* (Cambridge: Cambridge University Press, 2023).

on health systems. Most obviously, it is possible to invest large sums of money in national health systems, regardless of profit-oriented facilities' market-driven logic. Another approach is to invest in public health measures that reduce the causes of illness. This can include measures to decrease the spread of communicable diseases and the causes of non-communicable diseases, such as regulating access to sugar-filled and fatty foods and to addictive products and services, including gambling and social media. It can also include promoting traffic safety and safe working conditions, and fostering a healthy and clean environment.

The critical importance of health systems becomes evident during periods of significant stress. The most infamous example is the COVID-19 pandemic. The insecurity caused by missing knowledge and reliable data and the high demand for emergency treatment sensitized societies to the interconnectedness of social environments, human behavior, and infections. This awareness led in Germany, for instance, to prohibiting the sale of fireworks for New Year's Eve to protect the already overwhelmed hospitals against additional stress due to firework related injuries.⁷ The pandemic has shown that overburdening can result in public health issues: the emergence of a new pathogen, inadequate structures to prevent infection and injury, and insufficient capacities in the health system. This contradicts the securitized assumption that health must be protected from "external threats."⁸ However, states tend to respond to major disease outbreaks by imposing travel restrictions and barriers, despite WHO recommendations to the contrary.⁹ Instead of following epidemiological evidence and recommendations that focus on domestic legislation and protecting residents, governments primarily carried out symbolic actions to "make the population feel like it is being protected and provide assurance that the government is doing all that it can, regardless of whether barriers actually prevent disease

7 Bundesregierung, "Verkaufsverbot für Silvesterfeuerwerk," December 28, 2021, <https://www.bundesregierung.de/breg-de/themen/coronavirus/verkaufsverbot-feuerwerk-1993038>.

8 William Aldis, "Health Security as a Public Health Concept: A Critical Analysis," *Health Policy and Planning* 23, no. 6 (2008): 369–375.

9 Catherine Z. Worsnop et al. "The Unintended Consequences of Information Provision: The World Health Organization and Border restrictions during COVID-19," *International Studies Perspectives* 24 (2023): 39–66.

spread.”¹⁰ This led to the false assumption that health threats are imported and that states can protect residents by banning travel.

In Germany, the rhetoric of overburdened healthcare systems has been present since the late 1970s. In 1987, the *Deutsche Gewerkschaftsbund* (DGB) published a health program that acknowledged the relevance of social policy in preventing illnesses.¹¹ The fundamental critique that was expressed in this program was on the emphasis and even the exaggeration of individual behaviors as a cause of health issues and the ignorance of structural influences on health, as expressed in social determinants. Health policy has to be understood as social policy rather than focusing on the efficiency of healthcare systems in processing cases, as reflected in the limited time available for actual treatment. We need to shift the focus on the prevention of illnesses.¹²

From this perspective, blaming and shaming certain groups or individuals for overburdening German hospitals is a misguided endeavor. The rhetoric of limited healthcare capacities and overburdened systems is part and parcel of an epistemic hegemony that favors a medicalized perspective on health. Instead, the various contexts of diseases that lead to an overburdening of the healthcare system during certain periods have to be analyzed in relation to financial issues and work environments.

The False Assumption That Health Is a Limited Good

Health is not a good that can be quantified. Instead, it is a status that individuals and societies aim to have and maintain in order to live in dignity. Medical products and hospital capacities are, of course, limited. However, whether they are overburdened depends not on how many people live in a particular area but on what kind of illnesses or other health problems emerge in these areas and, therefore, how many people will need to rely on medical assistance. The argu-

10 Catherine Z. Worsnop, “Domestic Politics and the WHO’s International Health Regulations: Explaining the use of trade and travel barriers during disease outbreaks,” *The Review of International Organizations* 12 (2017), 365–395.

11 Jost Bauch, “Die Überforderung Des Gesundheitswesens – Anmerkungen Zum DGB-Programm,” *Arbeit Und Sozialpolitik* 41, no. 5 (1987): 146–148.

12 Ibid.

ment of “resource constraints”¹³ that is made to prohibit the realization of the human right to health leads to framing healthcare as a charitable act rather than a right to which individuals are entitled.¹⁴

Using a human rights lens obliges states to follow their legal and moral duty to *respect* this human right by “refraining from denying or limiting equal access for all persons, including ... asylum seekers and illegal immigrants to preventive, curative and palliative health services.”¹⁵ Likewise, states have to *fulfill* the human right to health by “ensur[ing] equal access for all to the underlying determinants of health, such as nutritiously safe good and potable drinking water, basic sanitation and adequate housing and living conditions.”¹⁶ On the basis of the human right to health, rejecting individuals’ access to care due to limited resources is not tenable. Further, the duty to ensure equal access to health by refraining from interference in seeking healthcare contradicts the framing of health as a limited good that can only be provided for particular groups based on their residency status.

Yet enabling more people to benefit from healthcare challenges the status quo of society. Conservative political actors are prone to maintaining the status quo. Social hierarchies and differences are legitimized and the urge for change neglected. Hence, the inclusion of more groups is primarily considered in terms of a potential loss and/or threat to the status quo.¹⁷ In the following, I contest this zero-sum logic by introducing a human rights perspective on health.

The scope of the human rights lens has limitations that are particularly evident in the U.S., which has not ratified the ICESCR and does not recognize health or healthcare as a human right. A legal analysis might stop at this point and refer to the state’s law and sovereignty. However, human rights are not just legal treaties. Rather, they provide a theoretical basis for creating and evaluating policies. A counter-narrative can be found in Amartya Sen’s capability

13 Kayvan Bozorgmehr, Judith Wenner, and Oliver Razum, “Restricted Access to Health Care for Asylum-Seekers: Applying a Human Rights Lens to the Argument of Resource Constraints,” *European Journal of Public Health* 27, no.4 (2017): 592–593.

14 Ibid.

15 General Comment 14, par. 34.

16 Ibid., par. 36.

17 Shai Davidai and Martino Ongis, “The Politics of Zero-Sum Thinking: The Relationship Between Political Ideology and the Belief that Life is a Zero-Sum Game,” *Science Advances* 5, no. 12 (2019): 1–10.

approach,¹⁸ which holds that human rights and health are fundamental for individuals to act as agents and expand on their freedoms. The approach assesses health by evaluating individuals' capabilities to achieve essential functions and pursue meaningful activities. It underscores the importance of expanding freedoms and opportunities to enhance health outcomes beyond economic indicators. However, capabilities have to be promoted on the basis of equity. This entails recognizing various vulnerabilities and the need to consider these vulnerabilities when attempting to create equal opportunities and "eliminating health disparities that are systematically associated with underlying social disadvantage or marginalization."¹⁹ Therefore, transparent and participatory decision-making processes that consider asylum seekers' concerns are necessary, as these individuals are ultimately affected.²⁰ In this context, human rights obligations go far beyond the obligations of legal treaties. They represent the foundation that enables individuals to make free choices. A government that claims to act in accordance with human rights standards cannot, therefore, evade responsibility by claiming the lack of a legal basis for acting on those standards. Thus, the same criteria can be applied to the U.S. and to Germany despite their highly divergent legal frameworks.

A human rights lens requires accepting and prioritizing people as legal subjects. Human rights cannot be denied based on states' capability limits, as this would undermine their universality and inalienability, two characteristics intrinsic to human rights. The expansion and advancement of human rights positively influences individuals and structures in general. It increases individuals' freedoms to live "lives they [individuals] value;"²¹ this, in turn, renders "social arrangements more appropriate and effective"²² by acknowledging individuals' and groups' particular circumstances and needs. Therefore, investing in the social determinants of health and expanding access to health services is worthwhile for governments and society as a whole. Such actions

18 Amartya Sen, *Development as Freedom* (Oxford: Oxford University Press, 2001); Amartya Sen, *Elemente einer Theorie der Menschenrechte* (Ditzingen: Reclam, 2020), 31–33.

19 Paula Braveman and Sofia Gruskin, "Poverty, Equity, Human Rights and Health," *Bulletin of the World Health Organization* 81 (2003): 539–545, 540.

20 Bozorgmehr, Wenner, and Razum, "Restricted Access to Health Care for Asylum-Seekers," 592–593.

21 Sen, "Development as Freedom," 18.

22 *Ibid.*, 31.

recognize “joint interests in realizing the human right to health”²³ rather than following a zero-sum approach.

Scientific evidence promotes the advancement of migrant-sensitive healthcare to meet the conditions defined by an evidence- and human rights-based understanding of health. Political discourses, by contrast, paint a picture of healthcare as the privilege of citizens or migrants with legal immigration status (regular migrants). In this way, the overburdening of the healthcare system is framed as resulting out of people seeking treatment. Yet the numbers do not support the accusation of exploitation. Most migrants in irregular residency situations seek fewer health services due to the fear of deportation or other negative consequences.²⁴ These restrictions also lead migrants to seek only emergency care, which could have been avoidable if they were receiving regular care.²⁵

Blaming immigrants reveals a limited conceptualization of the impact of state action and a narrow understanding of health. Positing healthcare as a limited good²⁶ and health as an individual responsibility fails to acknowledge the living circumstances of migrants in emergency shelters or at the border, and it neglects states’ responsibility for dangerous migration routes. Furthermore, the overcrowding of health facilities results out of forcing marginalized people without health insurance into emergency rooms by limiting their access to other facilities.²⁷ In economic terms, state policies increase the demand for general health services by restricting access to specific (emergency) services; these parallel systems are more expensive than the integration of migrants into regular and preventive systems would be.²⁸ The governance of migration

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- 23 Leslie London, “What Is a Human-Rights Based Approach to Health and Does It Matter?” *Health and Human Rights* 10, no. 1 (2008): 65–80.
 - 24 Heide Castañeda, *Migration and Health: Critical Perspectives* (Taylor & Francis, 2022), 50; KFF, “Key Facts on Health Coverage of Immigrants | KFF,” May 8, 2024, <https://www.kff.org/racial-equity-and-health-policy/fact-sheet/key-facts-on-health-coverage-of-immigrants/>.
 - 25 Elisabetta de Vito et al. “Are Undocumented Migrants’ Entitlements and Barriers to Healthcare a Public Health Challenge for the European Union?” *Public Health Reviews* 37 (2016): art. 13, 7.
 - 26 Castañeda, *Migration and Health: Critical Perspectives*, 50.
 - 27 Ibid.; Michael Knipper and Yasar Bilgin, *Migration und Gesundheit* (Berlin: Konrad Adenauer Stiftung, 2009): 65.
 - 28 Kayvan Bozorgmehr, Judith Wenner, and Oliver Razum, “Restricted Access to Health Care for Asylum-Seekers,” 592–593.

routes, accommodations for asylum seekers, and access to the labor market results out of state policies. In these cases, governments create the very health problems to which they also restrict healthcare access.

The narrative of limited resources reappeared in Germany in 2023 in the rhetoric of the Free Democratic Party (FDP) and the Christian Democratic Union (CDU); it was used to describe topics ranging from overburdened healthcare facilities to general social benefits. In September 2023, CDU party leader Friedrich Merz claimed on a talk show that rejected asylum seekers get their teeth cleaned without cost in Germany, thereby taking away regular appointments from German citizens.²⁹ During the same year, Federal Minister of Finance Christian Lindner (FDP) and Federal Minister of Justice Marco Buschmann (FDP) published an article in which they justified harsh restrictions to access to social benefits in the Asylum Seekers Benefits Act (*Asylbewerberleistungsgesetz* – AsylbLG), and demanded the introduction of a payment card (*Bezahlkarte*) to restrict costs for asylum seekers or tolerated persons.³⁰ In the article, they argue that social benefits function as a “pull factor” and that asylum seekers do not need financial resources for cultural activities.³¹ The CDU agreed to these demands in a draft bill,³² and the reform was implemented in February 2024. Thus, the CDU and FDP have created the basis for keeping rejected asylum seekers in a reduced version of the welfare system. Calculating in a zero-sum logic that is bound to national territories, as the politicians named above have done, neglects the capacities that are mobilized through migration and cooperation. Yet the argument that systems are overstretched and exploited serves as a popular justification for ever-stricter

29 Leonhard Landes, “Friedrich Merz über Asylbewerber beim Zahnarzt: CDU-Chef polarisiert mit Satz im WELT Talk,” DIE WELT, September 28, 2023, <https://www.welt.de/politik/deutschland/article247694964/Friedrich-Merz-ueber-Asylbewerber-beim-Zahnarzt-CDU-Chef-polarisiert-mit-Satz-im-WELT-Talk.html>.

30 Christian Lindner and Marco Buschmann, “LINDNER/BUSCHMANN-Gastbeitrag: Eine neue Realpolitik in der Migrationsfrage,” FDP, October 10, 2023, <https://www.fdp.de/pressemitteilung/lindnerbuschmann-gastbeitrag-eine-neue-realpolitik-der-migrationsfrage>.

31 Ibid.

32 Deutscher Bundestag, “Gesetzentwurf der Fraktion CDU/CSU. Entwurf eines Gesetzes zur Weiterentwicklung des Asylbewerberleistungsgesetzes (Asylbewerberleistungsweiterentwicklungsgesetz – AsylbLWG),” Bundestags-Drucksache 20/9309, November 14, 2023, <https://dserver.bundestag.de/btd/20/093/2009309.pdf>.

migration policies, even if similar policies did not led to improvements in the past.

Germany: A Maze of Insecurity

The German law on providing healthcare to irregular migrants is complex due to the principle of subsidiarity, which leads to differences between the federal states (*Bundesländer*). In 1993, in response to the heavily violent attacks on accommodations housing immigrants in Rostock-Lichtenhagen, Hoyerswerda, and Solingen, the then governing coalition of the CDU and the FDP passed the so-called asylum compromise (*Asylkompromiss*), with the AsylbLG as one of its core components.³³ These policies aimed to reduce immigration incentives such as welfare and healthcare provisions and were intended to lower the influx of asylum seekers, thereby appeasing the aggressive and racist sentiments that had fueled the violent attacks against immigrants.³⁴ This legislation covers not only asylum seekers but also tolerated persons (*Geduldete*), that is, persons to whom asylum has been denied but who cannot be deported due to unsafe situations in their countries of origin or illness or missing documents. The law remained in effect, with several amendments, and was further restricted in 2023 by extending its period of applicability from eighteen to thirty-six months and by implementing the payment card.³⁵ People subject to this law are guaranteed living standards lower than the minimum subsistence level provided for citizens, regular immigrants, and refugees whose status has been recognized.³⁶

The scope of health services and illnesses considered worthy of treatment is limited to the most basic emergency care. § 4 of the AsylbLG specifies that medical treatment is granted only in cases of acute illness or pain. Other services are provided only if deemed essential and at the discretion of the com-

33 Hannah Franke and Frederik von Harbou, "Das Asylbewerberleistungsgesetz und die Menschenrechte: Argumentationspraxis aus 30 Jahren Gesetzgebung und Rechtsprechung," *Zeitschrift für Ausländerrecht und Ausländerpolitik* (ZAR), no. 11–12 (2023): 412.

34 Constanze Janda, "Existenzminimum, Gleichbehandlung, Menschenwürde: Rechtliche Anforderungen an die Gesundheitsversorgung von Asylsuchenden," *Z'Flucht. Zeitschrift für Flucht- und Flüchtlingsforschung* (2021): 29–50, 33.

35 Franke and von Harbou, "Das Asylbewerberleistungsgesetz und die Menschenrechte," 411.

36 *Ibid.*, 412.

petent authority (§ 6 AsylbLG).³⁷ In this context, “acute” refers to illnesses that break out unexpectedly, thus excluding chronic diseases.³⁸ The assessment of whether an illness is acute is determined by members of the social administration staff in the social welfare model (*Sozialamtsmodell*). In this case, migrants have to obtain a treatment certificate (*Behandlungsschein*) before they can see a physician. This certificate is issued only if Social Welfare Office officials consider the illness or injury to be acute.³⁹ However, these public officials lack medical training. This is particularly problematic in cases involving mental trauma as well as when symptoms occur that could indicate an emerging acute and life-threatening disease.⁴⁰ From a medical perspective, the distinction between “acute” and “chronic” is highly problematic; the former can easily lead to the latter, and the lack of treatment of a chronic disease often leads to acute emergencies, thus creating care situations that violate medical ethics.⁴¹

The situation for migrants without residency status is even more severe. Although physicians are bound to confidentiality, the Social Welfare Office and hospital billing offices are required to report to immigration authorities under § 87 of the Residency Act (*Aufenthaltsgesetz* – AufenthG). This poses the serious threat of deportation to those seeking care.⁴² In extreme cases, physicians can be charged with aiding and abetting illegal residence (§ 96 AufenthG), which, although rarely prosecuted, serves as a significant deterrent.⁴³ When migrants do access the healthcare system, they may encounter differential treatment and barriers due to a lack of culturally sensitive communication, language barriers,⁴⁴ or polypragmasia – the increased prescription of medications or ther-

37 Ibid.

38 Janda, “Existenzminimum, Gleichbehandlung, Menschenwürde,” 34; Kajo Kramp et al. “Wann wird das Asylbewerberleistungsgesetz erwachsen?“, Völkerrechtsblog, November 30, 2023, <https://voelkerrechtsblog.org/de/wann-wird-das-asylbewerberleistungsgesetz-erwachsen/>; Anja Blümlein, “Die Gesundheitsversorgung älterer Geflüchteter in Deutschland – Die unterschiedliche Versorgung von Asylbewerber*innen und geflüchteten Ukrainer*innen,” *Z’Flucht. Zeitschrift für Flucht- und Flüchtlingsforschung* 7, no. 2 (2023): 391–404, 401.

39 Janda, “Existenzminimum, Gleichbehandlung, Menschenwürde,” 34.

40 Blümlein, “Die Gesundheitsversorgung älterer Geflüchteter,” 394.

41 Knipper and Bilgin, *Migration und Gesundheit*, 8; 69.

42 Ibid., 69.

43 Ibid., 70.

44 Ibid.; Blümlein, “Die Gesundheitsversorgung älterer Geflüchteter,” 399.

apies without a clear diagnosis.⁴⁵ All of these barriers result in the underutilization of healthcare by migrants,⁴⁶ leading to delayed diagnoses with potentially life-threatening consequences. Nonetheless, to demand more restrictive policies for access to welfare and healthcare, politicians uphold the unfounded claim that migrants, and especially asylum seekers, are taking advantage of the social system.⁴⁷

Since its inception, the AsylbLG has been particularly criticized because of its alleged violation of the human right to health. However, this violation is compounded by the AsylbLG's severe neglect of the social determinants to health from a medical perspective.⁴⁸ The Act creates insecurity for migrants and healthcare providers alike. The former do not know which services they are entitled to, and the latter are forced to act in an unclear legal territory. Regulating access to health and providing social determinants of health is inconsistent with the criteria for implementing the human right to health.

U.S.A.: Health Status and Borders

Restrictions on access to healthcare in the United States are rooted in a historical tradition similar to that in Germany. Similar to § 87 of the AufenthG, Proposition 187, a 1994 ballot initiative in California prohibited undocumented immigrants from accessing non-emergency healthcare, public education, and other social services. However, it was overturned by the U.S. federal court in 1999.⁴⁹ The general notion of exploitation and the need to protect welfare systems was powerfully mobilized during the Reagan administration, as is evident in the

45 There is evidence for higher prescription of sleeping pills and sedatives without medical justification for migrants. Knipper and Bilgin, "Migration und Gesundheit," 67, with reference to Anders Hjern, "High Use of Sedatives and Hypnotics in Ethnic Minorities in Sweden," *Ethnicity & Health* 6, no. 1 (February 1, 2001): 5–11.

46 The drastic effects of migrants' reluctance to use the healthcare system are well illustrated in the campaign Ärzte der Welt e.V., "GleichBehandeln," n.d., <https://gleichbehandeln.de>.

47 Christian Lindner and Marco Buschmann, "LINDNER/BUSCHMANN-Gastbeitrag."

48 PRO ASYL, "APPELL: Es gibt nur eine Menschenwürde – Asylbewerberleistungsgesetz abschaffen!," January 11, 2024, <https://www.proasyl.de/asylbewerberleistungsgesetz/>.

49 Encyclopaedia Britannica, "California Proposition 187 | Summary, Effects, 1994, & Facts," August 20, 2021, <https://www.britannica.com/topic/California-Proposition-187>

widely used racializing term “welfare queen.” The term was used to create a “public identity,”⁵⁰ to attribute “stereotypes and moral judgements,”⁵¹ and to “justify class based sexist and racist assumptions about the presumed behavior and moral failures of welfare mothers.”⁵² Identifying single mothers in Black communities as ‘lazy beneficiaries’ of the welfare system who were having children for the sole purpose of receiving welfare benefits led to high birth rates being perceived as a group behavior that had to be controlled⁵³ rather than as a reproductive healthcare issue. Access to welfare was moralized and tied to prescribed behavioral changes for certain demographic groups. Following demographic changes, groups, such as regular and irregular immigrants become the targets of constructed public identities.⁵⁴

During the campaign and administration of former President Donald J. Trump, immigration became a central political issue. The narrative promoted by the Trump administration was of immigrants being criminal and dangerous. It culminated in the demand to build a physical wall on the border with Mexico. Meanwhile, restrictions to immigration and immigrants were increased. The “public charge” policy – the obligatory test of whether an immigrant might have to rely on public services – was expanded under the Trump administration in 2018. Since then, medical conditions and use of the public health insurance program Medicaid have become reasons to deny Green Cards or visas. Although this policy was relaxed in 2022 under the Biden administration, it created a “chilling effect” that led immigrants to avoid using public programs for fear of negative consequences to their residency status, even when they were legally entitled.⁵⁵

Additionally, the 2019 Presidential Proclamation 9945 (“Suspension of Entry of Immigrants Who Will Financially Burden the United States Healthcare

50 Anne Marie Hancock, *The Politics of Disgust: The Public Identity of the Welfare Queen* (New York: New York University Press. 2004).

51 Ibid., 15.

52 Carly Hayden Foster, “The Welfare Queen: Race, Gender, Class and Public Opinion,” *Race, Gender & Class* 15, no. 3 (2008): 162–179, 164.

53 Ibid., 166.

54 Ibid.

55 Jennifer M. Haley et al. “One in Five Adults in Immigrant Families With Children Reported Chilling Effects on Public Benefit Receipt in 2019,” Urban Institute, June, 2020, https://www.urban.org/sites/default/files/publication/102406/one-in-five-adults-in-immigrant-families-with-children-reported-chilling-effects-on-public-benefit-receipt-in-2019_1.pdf.

System in Order To Protect the Availability of Healthcare Benefits for Americans”) required immigrants to have health insurance or to demonstrate sufficient financial resources to be able to pay for “reasonably foreseeable medical expenses.”⁵⁶ The very name of the Proclamation indicates the logic of constrained resources and creates a binary between U.S. Americans and others. Individuals’ financial resources to cover medical costs do not increase the capacity of healthcare or health services. Rather, these factors are instrumentalized in order to reject and exclude individuals.

The COVID-19 pandemic fostered a narrative of importing diseases. Despite recommendations by the World Health Organization⁵⁷ and the Centers for Disease Control and Prevention, the Trump administration imposed harsh restrictions on the entry of migrants regardless of their status,⁵⁸ even if they were trained healthcare workers.⁵⁹ In his Agenda47 speech, Trump directly refers to the alleged “pull effect” of the U.S. American welfare system, including “free healthcare,” and contrasts the situation of so-called “illegal aliens” with veterans who do not receive any benefits.⁶⁰ The alleged burden of migration on hospitals has been further reinforced by the “Secure Borders and Reclaim

56 The original proclamation is not available anymore. I refer to the summary by the National Immigration Law Center (NILC): National Immigration Law Center, “President’s Proclamation Requiring Immigrants to Have Health Insurance,” October 10, 2019, <https://www.nilc.org/wp-content/uploads/2019/10/proclamation-health-insurance-2019.pdf>. This Proclamation was revoked in May 2021. White House, “A Proclamation on Revoking Proclamation 9945,” May 14, 2021, <https://www.whitehouse.gov/briefing-room/presidential-actions/2021/05/14/a-proclamation-on-revoking-proclamation-9945/>.

57 Travel restrictions were a common global phenomenon during this period. Catherine Z. Worsnop et al. “The Unintended Consequences of Information Provision: The World Health Organization and Border Restrictions During COVID-19,” *International Studies Perspectives* 24 (2023): 39–66; Anne G. Beckett et al. “Misusing Public Health as a Pretext to End Asylum – Title 42,” *The New England Journal of Medicine* 386, no. 16 (April 21, 2022): e41.

58 Associated Press, “Pence Ordered Borders Closed After CDC Experts Refused – Los Angeles Times,” *Los Angeles Times*, January 28, 2021, <https://www.latimes.com/world-nation/story/2020-10-05/mike-pence-close-borders-cdc-experts-refused>.

59 Miriam Jordan and Annie Correal, “Foreign Doctors Could Help Fight Coronavirus. But U.S. Blocks Many,” *The New York Times*, April 13, 2020, <https://www.nytimes.com/2020/04/13/us/coronavirus-foreign-doctors-nurses-visas.html?searchResultPosition=5>.

60 Donald Trump, “Agenda47,” *donaldjtrump*, n.d., <https://www.donaldjtrump.com/agenda47>.

National Sovereignty”⁶¹ policy point in Trump’s 2024 political agenda, which blames immigrants for the domestic burden on hospitals.

Heide Castañeda’s 2023 *Migration and Health: Critical Perspectives* is insightful and describes the problems involved in maneuvering different entitlements and restrictions on healthcare for a mixed-status family. The family’s health is regulated by three healthcare policies due to its members varying residency statuses: the parents are undocumented, two children were born in Mexico, and three in the U.S. Castañeda illustrates the complexity of maneuvering different types of medical entitlements, resulting in a high investment of time and resources to organize medical treatment for everyone because they are obliged to use different facilities. Such examples show why families are hesitant to use governmental programs, because the effort to seek medical assistance is too high. Castañeda concludes that “[t]here is little doubt that the rise in anti-immigrant policymaking has fostered an unhealthy environment for immigrants and their families.”⁶² The unhealthy environment results from the complexity of a health system that grants or excludes access based on residency status regardless of medical necessity. The logic behind this can be found in the discourse of sovereignty and immigration.

Historical and ongoing restrictions on healthcare access for immigrants in the United States reflect a pattern of exclusion rooted in economic protectionism and racialized narratives. From Reagan-era policies to Trump administration measures, immigrants are portrayed as the exploiters of the welfare system. This portrayal is used to justify severe limitations on immigrants’ access to healthcare and other social services. These policies have created significant barriers for immigrants, exacerbated health disparities, and fostered an environment of fear and avoidance of essential public health programs. The COVID-19 pandemic further intensified these issues. The cumulative impact of these policies has created a profoundly unhealthy and unjust environment for immigrant families, undermining their well-being and integration into society.

61 Donald Trump, “Secure Borders and Reclaim National Sovereignty,” donaldjtrump, n.d., <https://www.donaldjtrump.com/issues>.

62 Castañeda, “Migration and Health: Critical Perspectives,” 47.

Policy Effects: (Un)intended Health Threats

In both Germany and the U.S., immigration policies increasingly reflect a security-centric approach that focuses on restrictive measures meant to protect citizens against the abstract threat of immigrants. This approach aims to curtail immigration, particularly through irregular channels. In Germany, paradoxical policy trends are in place. On the one hand, the government is tightening general immigration controls. On the other hand, it is simultaneously seeking to attract skilled migrants to alleviate local workforce shortages. Conversely, in the U.S., stringent requirements, such as proving financial means for health-care, inadvertently lead to an increase in people with irregular residency status. This occurs because individuals become “illegalized” by the system. This policy approach in the U.S. demonstrates that people are not inherently “illegal” but are made so by state practices and regulations.⁶³

In Germany, the focus is shifting towards delegitimizing migrants who seek social benefits by narrowly interpreting and enforcing immigration laws that exclude individuals from essential services. Contradicting the universal human right to health, these restrictive policies have profound implications not only for the health of migrants but also for public health systems. The health consequences of such policies necessitate a reevaluation of immigration laws, first, to ensure that they align more closely with public health priorities and human rights commitments, and, second, to foster an environment that supports the well-being of migrants as well as the health of the broader community.

Under the Trump Administration, individual health conditions and coverage were made subject to scrutiny by immigration authorities. Even though this is not the case in Germany, both countries locate the relationship between the state and migrants in the domestic territory without acknowledging the extraterritorial effects of policies. Germany is surrounded by so-called safe third countries that belong to the Schengen Border Codex. Therefore, there is little opportunity for asylum seekers to enter the country officially, forcing them to take irregular and unsafe routes. Additionally, the German government supports further EU restrictions on immigration, such as the Common European Asylum System (CEAS) reform, which is expected to result in prison-like border camps with limited infrastructure and questionable health conditions. The standard of accommodations, especially in emergency shelters, is inconsistent

63 Ibid., 15.

and difficult especially for people with mental health issues. Sharing rooms with strangers, often with less than three-square meters of private space, can exacerbate conditions for traumatized individuals.⁶⁴

During the COVID-19 pandemic, such shelters failed to apply adequate quarantine facilities or infection prevention measures. After the pandemic, conditions in these shelters led to several outbreaks of scabies among the residents, resulting in further quarantines.⁶⁵ Strict European border regimes, which often result in illegal returns, and the lack of regular passageways force migrants to take dangerous routes, sometimes traveling for months without access to food or health services. A similar situation can be observed in the U.S., where the border regulations adopted by the Biden administration in 2024 allow for only a limited quota of 2,500 people per day to cross the border. This could lead to a bottleneck in which those who want to cross the border will have to wait in degrading circumstances.

Another striking contrast is the perception of whether someone deserves the same health treatments as regular migrants or citizens. According to the individualistic view, ill health is a personal failure due to behaviors or actions brought against better knowledge. Such a view sees ill health as divorced from national structural problems that make people ill. Death, trauma, or injury are often blamed on migrants themselves, because they decided to risk taking dangerous and illegalized routes of migration against better knowledge. The structure of conditions leading to immigration that render it necessary to accept the sometimes fatal consequences of flight, are rarely addressed by the state.

Economic arguments in favor of restrictive migration policies that promise to reduce the burden on healthcare systems and create vast savings in public spending cannot be substantiated. In the case of asylum seekers, living under stressful conditions in sometimes overcrowded emergency accommodations

64 The initiative “9m² Hamburg” demands higher standards for such accommodations, directly referring to the health infringements produced through the current situations. Kathrin Ganz, “9qm Initiative,” 9qm, <https://9qm.hamburg/>. The situation leads to consequences for asylum seekers’ duty to cooperate. The general conditions of constant artificial and bright illumination, noise, and confinement can lead to deterioration of mental health issues and trauma. Tobias Bachmann, “Traumatherapie für Geflüchtete: Alleingelassen in der Wartehalle,” TAZ, March 8, 2024, <https://taz.de/Traumatherapie-fuer-Gefluechtete/!5993666/>.

65 MDR Thüringen, “Lage bleibt angespannt: Thüringer Flüchtlingsunterkünfte wieder überbelegt,” MDR, November 16, 2023, <https://www.mdr.de/nachrichten/thueringen/fluechtlinge-unterkunft-innenministerium-100.html>.

has an adverse impact on health and may lead to the spread of communicable diseases. The AsylbLG insistence on maintaining inferior care, leads to further disadvantages and delays in preventive and early treatment. Emergency treatment is often more expensive and can have lasting effects on health.⁶⁶ Cuts in budgets and services for asylum seekers and refugees have an inverted impact, leading to higher costs.⁶⁷ Instead, improving the social determinants of health such as education, basic income, and housing conditions would positively affect migrants' ability to become self-sufficient. Protecting taxpayers and the health system requires the very opposite of what current political discourse demands. What is needed is more inclusive care without discrimination.⁶⁸

Conclusion

Restrictive healthcare policies targeting immigrants in both the United States and Germany serve as tools of governance that reinforce national identity and control immigration flows under the guise of economic and social protection. While these policies claim to alleviate financial burdens and prevent the exploitation of public services, they actually marginalize immigrant populations and mask systemic healthcare issues. The rhetoric of healthcare exploitation is deeply rooted in historical, racialized narratives that perpetuate a misleading image of immigrants as burdens on the system. Empirical evidence contradicts these tropes, showing that immigrants are less likely to use healthcare systems and more likely to suffer from inadequate access to medical services.

The AsylbLG and the Trump administration's healthcare restrictions reveal a pattern of using healthcare as a gatekeeping mechanism to deter immigration. Attendant narratives, patterns, and policies not only undermine the human right to health, but also exacerbate health inequalities and public health

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- 66 Aldo Rosano et al. "The Relationship Between Avoidable Hospitalization and Accessibility to Primary Care: A Systematic Review," *European Journal of Public Health* 23, no. 3 (2012): 356–60.
 - 67 Kayvan Bozorgmehr and Oliver Razum, "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, no. 7 (2015): e0131483.
 - 68 Louise Biddle, "Extended Restrictions to Health Care Entitlements for Refugees: Negative Health Consequences without the Anticipated Savings," DIW Weekly Report, December 2024, https://www.diw.de/documents/publikationen/73/diw_01.c.897801.de/dwr-24-12-1.pdf.

risks. By framing health as a privilege rather than a universal human right, these policies contribute to immigrants' precarious existence, forcing many to avoid seeking necessary medical care for fear of deportation or legal consequences.

Ultimately, the politicization of healthcare in the context of immigration reveals deeper issues within Germany and the U.S.A.'s healthcare systems and governance structures. Instead of addressing the root causes of healthcare system overload and financial strain, these countries' policies divert attention to a vulnerable population and foster xenophobia and social division. A shift towards more inclusive and equity-based healthcare policies, which would acknowledge the social determinants of health and uphold health as a human right, is essential for creating a fair and just society that does not marginalize individuals based on their immigration status. While current restrictive healthcare policies toward immigrants in Germany and the U.S. intend to protect national resources, they ultimately harm immigrants and society as a whole.

Looking towards the future, there is an urgent need to reframe discourse on immigration and healthcare in society and politics. Policymakers must recognize that immigrants' health is inextricably linked to the population's health overall. Inclusive health policies that provide equitable access to medical care, regardless of immigration status, are central parts of just and effective healthcare systems. Such policies need to emphasize the social determinants of health and address factors like living conditions, employment, education, and access to nutritious food that significantly influence health outcomes.

Finally, international cooperation and an adherence to human rights frameworks are vital to ensuring that the needs of migrants are met. Countries must uphold their obligations and commitments under international agreements such as the International Covenant on Economic, Social, and Cultural Rights (ICESCR), which mandates the right to the highest attainable standard of health for all individuals. Investing in public health infrastructure and services can alleviate many of the pressures on the healthcare systems regularly attributed to immigration. By improving the capacity and resilience of healthcare systems, governments can better respond to the needs of all residents, including migrants. This includes training healthcare providers in intercultural competence, improving language services, and ensuring non-discriminatory practices of healthcare delivery. Employing a human rights framework provides the foundation for a necessary paradigm shift. This shift

will provide an exit from a zero-sum logic about healthcare and create the basis for policies that target everyone's health.

