Editorials

Access to health care for illegal migrants:

ethical implications of a new health policy in the UK

Access to health care for migrants is of immediate relevance in the UK following the Department of Health's (DH) recent introduction of a new charging regulation for 'overseas visitors'.[1] In a stated attempt to maintain a high-quality, efficient, and progressive health system that is free to all British residents, the new policy demands payments even from those who cannot afford it: undocumented migrants and failed asylum seekers.

In *Making a Fair Contribution*, the DH argues that, for the NHS to be sustainable, regular residents and those who have paid into the common pool must be prioritised.[2] However, the notion of an equal input alone fails to guarantee a just and equitable allocation of resources in a decent society.[3]

Health, whether conceptualised as a 'good' or a 'right', requires a doctrine for its distribution. There are usually two dominant responses to migrants' access to health care:

- services for migrants should be the same as those given to citizens; or
- migrants should only be provided with what is minimally sufficient.

At its core, we are faced with a delicate question of *'Who is obliged, to whom, to do what?'*[4] These questions also highlight the important role human relationships play in our moral and legal ethics. In particular, this relational paradigm takes on special significance with regard to the duties and rights that play out between migrants, the government of a sovereign state, and the medical community.

Framing the issue of migrant health in terms of our relational obligations highlights how vulnerability and the Rule of Rescue principle (RoR) create special duties within the area of migrant health. We also see why the professional identity of doctors is incompatible with the new migrant health policy.

VULNERABILITY AND THE RULE OF RESCUE

The interplay between the vulnerability of migrants and the RoR imposes special obligations on the state and its institutions. Although the NHS's charging regulations seems to be guided by utilitarian principles of increasing efficiency and cost-effectiveness, the vulnerability of some migrants puts special duties on the state. Indeed, the DH reassures the public that the welfare of the vulnerable is being safeguarded.[2] Examining this exception more carefully reveals the RoR as its philosophical foundation.

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The RoR, first coined by the philosopher Albert Jonsen, requires a *'... moral response to the imminence of death'*.[5] However, although Cookson *et al*[6] oppose the rule, arguing that 'imminent peril' is meaningless because we are all mortal, Mark Sheehan considers the RoR to be founded in an agent-relative relation rather than 'imminent peril'.[7] Sheehan argues that references to identifiability and special circumstances, such as risk to life, support the existence of a strong relation to an agent. Relationships inherently create obligation between agents, such as our friends and family — or even someone who is merely in our proximity. Furthermore, he notes that policy decisions should remain within the bounds of this principle because policy is not only about maximising a good, but also about protecting and promoting a sense of justice.[7]

Robert Goodin addresses the interplay between vulnerabilities and corresponding duties in his book *Protecting the Vulnerable*. He asserts:

'What is crucial ... is that others are depending upon us. They are particularly vulnerable to our actions and choices.'

Ultimately, Goodin tells us that both moral and legal omissions of our special duties to the vulnerable are serious wrongdoings and conclusively indefensible.[8]

Both vulnerability and the RoR take on fundamental importance within the migrant–host country dynamic. Proximity and suffering are also significant factors that render migrants identifiable to an agent. Even a libertarian like David Miller agrees that illegal immigrants' proximity to the state and the government's sovereignty over its territory render the state responsible for those within its borders. This is because a migrant depends on their host society for physical safety and wellbeing, while also enduring governmental authority and power. Hence, such a genuine and profound condition of vulnerability creates special duties for the state and its institutions.[9]

MEDICAL COMMUNITY — PROFESSIONAL IDENTITY

The duty of doctors working in the tax-funded NHS is to the public and the state. A disparate treatment of patients resulting from the recent NHS policy may be morally inconsistent with what 'doctoring' means.[10]

Paragraph 56 and 25b of the General Medical Council's (GMC) code of good medical practice demands that doctors care for patients based on their medical needs and take action if concerned that a patient's wellbeing is undermined by deficient resources or practices. The GMC's codes reflect the principles of virtue ethics: respect for patients, honesty, and integrity. In *Virtue Ethics and Professional Roles*, Oakley and Cocking argue that virtue ethics lays the stress on the ends of a profession.[10] The proper conduct in a profession is invariably linked to the purpose of that profession and the human benefit it is dealing with; for medicine, health is the benefit whereas providing health care is the goal. Guidelines for effective medical practice are crucial to identify malpractice and clarifying what amounts to a 'good doctor'. Looking at the nucleus of medicine helps differentiate the fringe from what is at its foundation.[10]

A profession's purpose is also strongly linked to professional identity. The professional identity of doctors is built around that conduct and those practices which are committed to delivering health care. If a doctor's actions are divorced from the fundamental goal of medicine, then that practice cannot be called 'doctoring' any more. Similarly, there can be demands made of medical professionals that are

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irreconcilable with being a doctor. Oakley and Cocking conclude:

'Were efficiency — or some other value external to medicine — to become an overriding guiding ideal for a doctor in the way he used his skills, there would be a real question about whether this doctor had now ceased to "practise medicine".'[10]

AN ETHICAL RESPONSE

Allocating services based on citizenship essentially renders illegal migrants ineligible for NHS care. Such a policy compounds the vulnerability of a group that we know lacks the means to self-fund access to health care. Therefore, the new NHS charging regulations are morally questionable at the intersection of the following factors: the capabilities of a wealthy UK, the seriousness of the need (health), the vulnerability (for example, suffering, poverty, and isolation) of the illegal migrant, and the responsibility of the very profession that has been deemed the main provider of a special good, that of health and caring — factors that in combination potentially result in grave harms to the health of illegal migrants.[10]

Taking an agent-relative perspective, I suggest that the specific relation between undocumented migrants and other agents is defined by the very vulnerability of the former group. Such a perspective obliges the state under the RoR and also acknowledges the professional identity of doctors whose duty is to prioritise patients' welfare.

A recent *BMJ* editorial addresses the ethical concerns that a migrant-hostile environment and disparate health care raises for US and UK professionals alike. In the US, some health facilities distinguish themselves as *'places of sanctuary'* where people *'seek care without fear'*.[11] In the same *BMJ* issue, another article, discussing innovation in general practice, reminds us of the unique relationship between patients and GPs, between GPs and their colleagues in the medical community, and between the medical community and society at large.[12] This special relationship is the privilege of general practice and also places special obligations on it. Hence, our governing bodies must challenge policies that undermine the delivery and coordination of health care in our communities. What is more, we all must advocate for policies that are attentive to a doctor's professional identity.

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