University of Mississippi

eGrove

Honors Theses

Honors College (Sally McDonnell Barksdale Honors College)

Summer 12-15-2020

Health Insurance and the Undocumented Immigrant

Anja Diercks

Follow this and additional works at: https://egrove.olemiss.edu/hon_thesis

Part of the Community Health and Preventive Medicine Commons, Health Services Administration Commons, Immigration Law Commons, Insurance Law Commons, International Law Commons, Labor and Employment Law Commons, Other Public Health Commons, Quality Improvement Commons, Social Welfare Law Commons, State and Local Government Law Commons, Taxation-Federal Commons, and the Tax Law Commons

Recommended Citation

Diercks, Anja, "Health Insurance and the Undocumented Immigrant" (2020). *Honors Theses*. 1594.
https://egrove.olemiss.edu/hon_thesis/1594

This Undergraduate Thesis is brought to you for free and open access by the Honors College (Sally McDonnell Barksdale Honors College) at eGrove. It has been accepted for inclusion in Honors Theses by an authorized administrator of eGrove. For more information, please contact egrove@olemiss.edu.

HEALTH INSURANCE AND THE UNDOCUMENTED IMMIGRANT

By

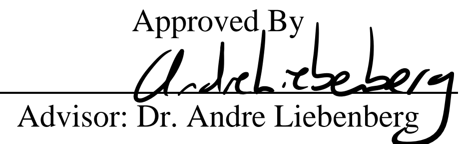
Anja René Diercks

A thesis submitted to the faculty of The University of Mississippi in partial fulfillment of the requirements of the Sally McDonnell Barksdale Honors College.

Oxford, MS

December 2020

Approved By



Advisor: Dr. Andre Liebenberg

Reader: Dr. Stephen Fier

Reader: Dr. John Samonds

© 2020

Anja René Diercks

ALL RIGHTS RESERVED

DEDICATION

This thesis is dedicated to the doctor who showed me that having a heart is always better than having money. And to my grandmothers in heaven now, I kept pushing through this for you.

ACKNOWLEDGEMENTS

First and foremost, I would like to thank Dr. Andre Liebenberg for helping me through this thesis this past year. Without his help and support, I would have never been able to finish this thesis this semester. I will forever be thankful for his kindness and understanding this year. Thank you to Dr. Stephen Fier as well for helping me achieve my goal of finishing this thesis on time this semester. I would lastly like to thank Dr. John Samonds for helping me achieve my goal of presenting this semester, and looking out for the juniors and seniors of the Honors College. I am beyond grateful for the opportunity to have worked with these three professors.

I would also like to thank Dr. Willis Dabbs for inspiring me to pursue this thesis idea in the first place. Your kindness for those who need it most is always inspiring, and I am so thankful to have been able to witness such a wonderful doctor at work.

Thank you to my parents for pushing me through the loss of so much to the end. I would have never gotten back on my feet without their constant encouragement and help. I would like to especially thank my father for offering to help with his own deadlines looming ahead. My mother was a constant supporting voice in this whole endeavor, and I am so glad to have been able to talk to her about this and how it affects her world in the healthcare field.

Finally, I would like to thank Dr. Pedigo for being a wonderful inspiration and an amazing conversationalist these past four years. I would have never made it through undergrad without our long talks about the beauty of art and about how to go about this thesis. I am forever grateful for your guidance and the time you spent helping me so many times during my college career. Thank you.

ABSTRACT

ANJA RENÉ DIERCKS: Health Insurance and the Undocumented Immigrant (Under the direction of Dr. Andre Liebenberg)

The purpose of this thesis is to perform a comparative analysis on how seven different countries (USA, South Africa, Germany, England, Canada, France and Singapore) organize their healthcare system to cope with the issue of undocumented immigrants and whether or not these systems in place were "fair." The thesis will also explore the possible ways the United States could change to be more inclusive and fairer in the world of healthcare and health insurance for the undocumented immigrant. A study on what fairness means both in ethical and economical terms is done to suggest a new basis of a fair system towards undocumented immigrants. A comparative analysis is performed to find the different style of healthcare systems the seven countries listed above have, how they are funded, and what the policy for the undocumented immigrants is for these different countries. In the view of having the fairest healthcare system pertaining to undocumented immigrants, the French outperformed the other six countries. The other countries either did not have a policy for undocumented immigrants or only had limited emergency care and services available.

PREFACE

This thesis paper stemmed from a personal experience with undocumented immigrants and their struggle with healthcare. While shadowing a local doctor at an urgent care clinic in town, families of undocumented immigrants would often come in. They would only be able to pay in cash for illnesses and injuries, as they did not have access to United States health insurance. Medicaid does partially reimburse hospitals to account for these cases in emergency rooms, but not necessarily for walk in urgent cares. Instead of turning the families away, the doctor would end up paying out of his pocket for their care so that they would not have to suffer their illnesses or injuries. The question of “is this fair?” came to mind, and thus the research started.

TABLE OF CONTENTS

LIST OF TABLES VII

LIST OF ABBREVIATIONS VIII

Introduction 1

Chapter 1: A Question of Fairness 6

a) So, What is Fairness? 12
b) What is the Actual Cost of the Undocumented? 15

Chapter 2: An Analysis of other Countries' Healthcare Systems 18

a) Canada 18
b) South Africa 21
c) United Kingdom 24
d) Singapore 27
e) Germany 29
f) France 31

Chapter 3: What would Constitute an Optimal Health System for the United States? 37

a) What are Some General Requirements for an Optimal Health System? 37
b) A Model of an Optimal Health System as it would Affect Undocumented Immigrants 40

References 44

LIST OF TABLES

TABLE 1 A General Overview of the Healthcare Systems Covered in Thesis 34

LIST OF ABBREVIATIONS

ED	Emergency Department
IRS	Internal Revenue Service
ITIN	Individual Taxpayer Identification Number
FFS	Fee For Service
KFF	Henry J. Kaiser Family Foundation
OOP	Out of Pocket
SMI	Supplementary Medical Insurance
HI	Hospital Insurance
VA	Veterans' Affairs
DEERS	Defense Enrollment Eligibility Reporting System
OECD	Organization for economic Co-operation and Development
WHO	World Health Organization
PHC	Primary Health Care
PICUM	Platform for International Cooperation on Undocumented Immigrants
EEA	European Economic Area
NHI	National Health Insurance
GP	General Practitioners
SMA	State Medical Aid
MSL	MediShield Life
MS	MediSave
MF	MediFund
NHS	National Health Service
CDC	Centers for Disease Control and Prevention

Introduction

On a sunny day in September, a family of immigrants comes into the local urgent care. The father has been injured at work, and needs an x-ray to see the extent of his injuries, among other things. The problem? He cannot pay for the treatment, and because he is an undocumented immigrant, he does not have direct access to US health insurance. The doctor on duty has two options –1) provide him with the care he needs, and pay for it out of his own pocket, or 2) turn the family away with the bare minimum of care that they can pay for with cash. At the time, this seemed to happen a lot to the doctors at the local urgent care, and it seemed rather "unfair."

An undocumented immigrant woman enters the ED with her three kids. She is presenting with migraines. She also cannot find the work she needs to provide for her children. Her friend had convinced her to come to the ED due to the constant head pain, and even though she did come, she is extremely worried about getting yet another bill. She does not have health insurance to pay and has no primary care provider, so what happens next? They cannot ethically turn her away, so what happens to her? (Samra, Shamsher, et al.)

This incidence of undocumented immigrants not being able to pay because of inaccessibility to insurance is not isolated to just the local urgent care. It happens across the United States, mainly in EDs. Hospitals experience large amounts of overcrowding.

They are required to give care to anyone needing emergency care, including undocumented immigrants. The Hospital Association of Southern California points out that even though they have a moral responsibility to treat the illegal immigrants as well as anyone else who walks into their emergency rooms, they are only reimbursed for about 5% of the care given to these uninsured patients that cannot pay. So, who pays? The answer to this is, 1) the other patients with insurance, 2) the uninsured patients who do pay, and 3) the hospitals. Specifically, 20% of the $2 billion in unreimbursed medical care is attributed to undocumented immigrants (Focusing on Healthcare Costs of Illegal Immigrants).

The problem with undocumented immigrants using EDs in California has developed to the point that Mexican ambulance companies are allowed to drive uninsured patients to Mexico to receive free medical care so they do not have to get expensive emergency room care in the United States. The Federation for American Immigration Reform has also stated that undocumented immigrants using EDs have caused hospitals to lay off staff, close off maternity wards and trauma centers and cutback on services provided to the public (Ruark, et al.).

A study performed by Rutgers University attempted to observe how often undocumented immigrants used EDs for primary medical care. They found that some reasons for ED use were preventable diseases that resulted from not getting good enough healthcare during initial consultations, or from not being treated at all until the ailment became emergent. Other reasons included having emergent conditions during nights or weekends when other doctors' clinics may not be open, which is a normal use of an ED and not an overuse or misuse (Akincigils, et al). The results for primary care use were inconclusive. The question of why the ED was used for medical care was not asked, so they did not find out for sure whether primary care was a main use. The

nature of the questionnaire did lend itself towards “preference-based visits,” which highlights a different problem: access to care being generally limited.

So, who are these undocumented immigrants? There are two ways to be classified as an undocumented immigrant: those who have entered the United States illegally and can be deported, and those who have entered legally but have overstayed the limits of their original status. If someone overstays, they are then at risk of being deported as well (Artiga, et al.). According to the Department of Homeland Security, the estimated undocumented immigrant (or illegal alien) population was around 12 million as of 2015. Nearly 80 percent have lived in the United States for over a decade and 6 percent have lived in the United States for at least 5 years. As of 2015, 55% of the undocumented immigrant population emigrated from Mexico, followed by Central America (15%), and Asia (14%) (Samra, Shamsher, et al.). This may seem problematic, but 12 million undocumented immigrants only accounted for about 5% of the total U.S. population in 2015. This deceptively large number of undocumented immigrants leads to common misconceptions about their impact on the economy, and they end up being blamed for problems such as increased health insurance rates.

This misconception stems from the observation that undocumented immigrants often delay going to get healthcare until it becomes emergent due to their inability to access health insurance. The belief is that they use the emergency rooms for treatable illnesses when they cannot pay for normal care. This then, supposedly, causes the cost of health insurance to increase for others to compensate for these extra expenditures in the emergency rooms. Even though this method of ED use does lead to uncompensated care, it is actually not quite as large a problem it is made out to be by the media. These expenditures account for less than 1% of the Medicaid trust fund and will be discussed more in depth below. Overall, undocumented immigrants make

up roughly 5% of the population but only end up making up about 1.4% of the healthcare spending in the United States, and they normally end up paying out of pocket for their healthcare expenditures, so they are not using taxes as much as people would like to think (Knox). Another paper done by researchers from the International Journal of Health Services shows that undocumented immigrants end up paying more towards medical care than they take out (Flavin, et al).

On another note, to ensure that undocumented immigrants do pay taxes, the IRS has implemented a few benefits. One benefit of making sure they pay taxes is included in a provision in the "Gang of Eight" bill that stipulates "good moral character" and "paying back taxes" as requirements for obtaining legal citizenship. There are undocumented immigrants who are still paid "under the table" and do not worry about taxes, but there are also many others who pay so they can be one-step closer to obtaining citizenship (Hallman). The IRS included provisions to get around the Social Security Number requirement for filing taxes in its enactment of ITINs. These numbers allow undocumented immigrants, lawfully present individuals who are not citizens, and United States resident aliens/nonresident aliens to file federal taxes. The only requirements for obtaining an ITIN are basic information like name, date of birth, address, a filled-in income tax return, and a proof of identity. There is not a requirement to show whether the undocumented immigrant has a work authorization form or whether they are in the United States legally (Internal Revenue Service). Because of this implementation of ITINs, it was proven that undocumented immigrants paid over $9 billion in annual payroll taxes (Internal Revenue Service).

Despite the information shown above, people still believe this system is unfair because the undocumented immigrants do not have to necessarily pay for medical care if it is emergent.

The concept of what is fair or unfair will be discussed and analyzed in this thesis as it pertains to health insurance and healthcare in general for the undocumented immigrant. This will be expanded to include whether and how seven other countries around the world including South Africa, Germany, England, Canada, France and Singapore incorporate this concept of fairness towards undocumented immigrants into their healthcare systems.

Chapter 1: A Question of Fairness

I believe, based on the findings, that the overall idea of fairness in healthcare incorporates a thought process that says people who contribute to society- no matter what their background may be - deserve to be treated the same as everyone else. The important question to be considered is: Is it fair that some people are required to pay for healthcare, such as those that pay out of pocket for emergency room visits or have to pay insurance premiums, while others, such as undocumented immigrants, low-income people and uninsured do not? We will consider three different aspects in this discussion.

a. An Explanation of the United States Healthcare System

The United States' healthcare system is unique when compared to other systems around the world. It is mainly comprised of private markets available to those able to pay for them with some government-funded programs available to other specific groups of citizens. Even for working class people, private health insurance programs can be too expensive, so the U.S. relies on employers to help purchase health insurance for the employees and their dependents (De Lew, et al.). The specific groups the U.S. includes in its public health insurance system include the elderly, the disabled, and the poor. Undocumented immigrants are not allowed access to this public system of health insurance due to them not being citizens or lawful legal residents, so they are forced to use the less extensive public system of clinics and nonprofit hospitals that are controlled by each state. Because of this state control, the regulations and planning of hospitals may range from nothing to extensive depending on the state.

This wide range of planning differences can lead to some areas being underserved by the lack of private hospitals or clinics in areas such as inner cities and remote rural areas. These areas are covered by state or federally funded programs to provide at least some form of primary care to those unable to pay or access the FFS system that is so prevalent in U.S. society. As a result of the government stepping in for the underserved communities, there are private clinics that are provided to the general public in these areas. These clinics are not FFS based and can also be accessed by undocumented immigrants if they need primary care (De Lew, et al.).

The United States healthcare system is divided into three main groups: Private health insurance, Medicare, and Medicaid. Medicare is provided for those who are elderly and disabled. This system is extensive when considering government funded insurance in the U.S. and, according to the KFF, 67.7 million people were enrolled in Medicare in 2020. Medicare is also divided into multiple sections that cover various aspects of life for the elderly and disabled. Care is provided based on the selected plan. Anything not covered by these plans ends up being paid for OOP or through other insurance providers if someone has private insurance as well as Medicare coverage. There are two trust funds that provide the payout for Medicare coverage: The HI Trust Fund and the SMI Trust Fund. The HI Trust Fund is paid for through both payroll taxes paid by most employees, employers, and self-employed individuals and through other sources such as: income taxes on social security benefits, interest earned on the trust fund investments, and Medicare part A premiums from people who are not eligible for premium-free Part A. This trust fund pays for Medicare Part A benefits, and Medicare Program administration costs, which can include the costs for paying benefits, collecting taxes, and fighting fraud and abuse of Medicare. The SMI Trust Fund is funded through Congress authorized funds, premiums from people who are enrolled in Medicare Part B and Part D or other sources, such as the general

interest earned on these trust funds. SMI pays for Part B and Part D benefits and also for the general administration costs as stated above for the HI trust fund (*How Is Medicare Funded*?). Medicare also has a separate trust fund in which it can pay for people who cannot pay for hospital visits, or undocumented immigrants and those that do not fit the criteria for Medicaid. This fund is mainly paid for through taxes, and as observed before, the undocumented immigrants normally pay more into this than they ever end up using.

Medicaid, on the other hand, is different from Medicare and covers those within a certain range of the poverty line instead of the elderly and disabled. Medicaid is one of the "main sources for the states to meet the long-term health needs of their lower-income residents" (Snyder, et al.). This version of public health insurance covers roughly 72.5 million Americans and is the largest source of governmental health coverage in the U.S. (*How Is Medicare Funded*?). To be eligible for Medicaid, children have to be within 133% or below of the federal poverty line. This requirement is mandated by the federal government, but may be expanded to adults depending on which state someone lives in. Most states have chosen this expansion, but there are still some which do not fall under this category. The other requirements for Medicaid that do not fall under financial eligibility include being residents of the state they are applying for Medicaid in, and being either citizens or qualified non-citizens such as lawful permanent residents. In other words, it specifically declines funds towards undocumented immigrants. There are some other limitations to Medicaid including age, pregnancy or parental status even when they fit the other criteria for Medicaid coverage (*Eligibility*). This system also has funds allotted for states to create a "Medically-Needy" program for those who have too much income to qualify for Medicaid, but have medical expenses that are too much to pay for in their income range. Medicaid is paid for through Federal Medical Assistance Match Rates (FMAPs). This is an

arrangement between the federal government and the states that matches funds to states that have "qualifying Medicaid expenditures." FMAP is calculated using a formula that was established in the Social Security Act and is based on the state's average personal income relative to the national average. For example, states with lower annual incomes have higher FMAPs, and as of 2015 in Mississippi, the FMAP was at 67-73%. In other terms, because Mississippi has the lowest per capita income level, it gets about $2.79 in federal funds per $1 spent on Medicaid (Snyder, et al.).

Lastly, the private insurance sector has the responsibility of covering the rest of the population of the U.S., (if this population chooses to purchase insurance) and is the only option available to those that are undocumented. It is rather expensive, but can be provided through employers to their employees, which may be a way for those who are undocumented to gain access to health insurance coverage. The premiums people must pay for this coverage are often too costly, and thus leaves a majority of the U.S. population uninsured. The expensive premiums are caused by the ability to choose between various insurance providers. The tendency of the sicker patients to pick plans that can cover more end up driving up costs overall for others due to the higher risks they pose to these companies. Not only does this discourage undocumented immigrants from trying to purchase private insurance due to the high cost, it also discourages generally healthy citizens from purchasing it because the premiums are so costly (Cutler, et al.). This private sector of insurance can be broken down into two sections: the group market, which is made up of mainly employer-sponsored insurance and the non-group market which is made up of individuals directly purchasing plans from an insurer. According to Rosso, about 178 million Americans (or 55.2% of the population) were covered by the group market and about 43 million Americans (or 13.4%) were covered by the non-group market. The share of total healthcare

expenditures by private healthcare insurance has increased since 1960 by twelve percentage points (having been at around 24% of all healthcare expenditures in 1960). This is largely due to the increases in enrollment in these programs, which corresponds to the general OOP percentage drop associated with the expansions of Medicare and Medicaid (Rosso). This version of healthcare coverage also accounted for a large portion of the overall healthcare expenditures as of 2018 at 35.8% or $1,243 billion worth of healthcare expenditures (Rosso). It is hard to determine which plans are more beneficial overall because the benefits depend on the situations for each person or family. In recent years, individual private plans tended to be cheaper than group plans for individuals without families due to the cost being distributed over millions of people and the opportunity to apply for government subsidies. The subsidies are not available to undocumented immigrants, but the premiums are generally still cheaper to pay for than handling a group insurance plan depending on which tier you get. Individual plans are separated into various tiers that include bronze which covers about 60% of the cost of healthcare, silver which covers about 70%, gold which covers about 80% and platinum which can cover up to 90%. Platinum plans are generally not offered in the individual market, and are more often associated with the small group market (employers with under 50 people). In 2016, annual individual plans cost about $4,632 per person, without any subsidies added, the same plan with subsidies cost around $1,272. Group Insurance (employer-sponsored plans in which the cost is shared between employers and employees) cost individuals around $6,435 per person employed, but it could cover that one person's whole family. To clarify, this cost is split between employer and employee, lowering the cost significantly for the employee (*Employer Health Insurance Vs. Individual Plans*). In 2016, employers paid about 82% of the total cost of group premiums for families. These group premiums, with no employer help, would have been around $18,142, but

because of the employee-employer split of costs, families only ended up paying about a third of this (or $5,277) annually (Norris).

Military-specific health insurance programs, which include VA and TRICARE, provide another alternative source for health insurance. The Department of Veteran Affairs covers veterans of the military who served in the active military, naval or air service for 24 continuous months or the full active-duty period and did not receive a dishonorable discharge (About VA Health Benefits). There are some exceptions to this, which include disabilities and serving before September 7, 1980. Being in the National Guard and on active duty for training purposes does not qualify a soldier for VA benefits. The VA covers a variety of categories but is largely dependent on the individual applying. In general, they help cover the costs of illnesses and injuries, therefore preventing future health problems, improving functioning abilities, and enhancing quality of life. Added care is provided depending on what priority group, advice of VA primary care provider and standards of medical care needed for the individual health conditions of the patient. Overall, the VA generally covers all aspects of healthcare for those who are eligible for VA status. This branch of military health insurance covers about 7 million people or 2.3% of the population as of 2018 (Rosso). The other branch of military health insurance plans is known as TRICARE. TRICARE is available to those entered into a system known as DEERS. This system includes uniformed service members and their families, national guard/reserve members and their families, former spouses, Medal of Honor recipients and their families, and survivors of deceased military members who were covered under TRICARE or the VA (*VA & TRICARE Information*). TRICARE covers all medically necessary and proven treatments for those under its jurisdiction. There are several exclusions and limits, but anything deemed necessary by a healthcare provider is covered under TRICARE (*VA & TRICARE*

Information). As of 2018, nine million people or 2.7% of the U.S. population were covered by TRICARE. When combined, these two providers accounted for around $120 billion or 3.4% of total healthcare expenditures in the United States.

Overall, the United States spent much more per capita on healthcare than any other OECD country at 16.9% of its GDP compared to the average of 8.8%. The closest any of the other countries in this organization comes to this is Switzerland at 12.2% (OECD 2019). Put into other terms, the U.S. spends about $11,172 per person on healthcare. This is a lot of money in general being spent on healthcare, and undocumented immigrants barely make a dent in terms of the overall cost. The system above is relatively unfair in terms of healthcare systems because despite forcing undocumented immigrants to pay taxes, they get nothing in return besides emergency care, access to occasional free clinics (if the state allots money for said free clinic).

a) So, what is fairness?

The concept of fairness can be approached in two ways when considering healthcare. The Actuarial Approach and the Ethical Approach are these two categories. The Actuarial Fairness Approach is a way to look at fairness with an economic lens attached. The Ethical Approach focuses on the ethics of decisions pertaining to health fairness.

Actuarial Fairness can be defined as being:

> "the costs of medical care are a random variable with mean m, the company will charge a premium m, and agree to indemnify the individual for all medical costs. Under these circumstances, the individual will certainly prefer to take out a policy and will have a welfare gain thereby" (Arrow, 21).

In terms of insurance companies, actuarial fairness refers to the premiums charged to customers being equal to the amount that the insurer expects to pay out in claims for that customer (Landes). To explain further, an actuarial fair insurance premium identifies the risk of insuring someone based on various cost-related factors and will often be more costly for someone who needs vision care, hearing aids, mental healthcare, or even AIDS treatment and less costly for those who do not need this extra care. This is based off an actuarial evaluation on how much money someone with these health problems can pay for versus the amount of care they are going to need in the end (Hoffman, Jan). The problem with this in terms of undocumented immigrants, is that they do not have access to government funded insurance plans such as Medicare or Medicaid, so they do not even have a chance to evaluate whether or not they would be able to hold up their side of the actuarially fair deal. Not only that, but they do not have a chance to purchase insurance that could offset the cost of private insurance. Because of this barrier to government funded Marketplace health insurance plans, undocumented immigrants have to resort to applying to private health insurers if they desire insurance. Resorting to the private sector is problematic because premiums are often too high for most undocumented immigrants to afford due to inabilities to purchase subsidies from the government Marketplace (HealthSherpa). This system is complicated when it comes to calling it fair or unfair in these terms. It can be considered actuarially fair in the respect of the cost of insurance premiums being proportionate to the amount of care someone will require. The fact that some people are not allowed to access Marketplace insurance (government-funded insurance) makes it complicated though. It can be seen as unfair not only because some people are not given the chance to purchase insurance to be able to pay for care, but also because some people access EDs and end up not having to pay for them (or they pay out of pocket). Because federal law dictates that

hospitals have to screen and stabilize all emergent cases, undocumented immigrants can access these services whether they can pay or not (Artiga, et al.). Overall, with the emergent case requirement, this system can be seen as unfair in the actuarial perspective because some people pay for insurance premiums or pay out of pocket for care, while others end up not having to pay anything (Artiga, et al.).

The other form of fairness can be viewed through the Ethical Fairness Approach. This version of fairness, according to Normal Daniels of the Harvard School of Public Health, says that if an undocumented immigrant is a contributing member of society, they are entitled to "opportunities protected through protection of health among other things" (Daniels), which follows the "reciprocity principle." Opportunities protected through protection of health among other things, according to the WHO, is in reference to what the WHO has identified as human rights. These rights when considering healthcare include freedoms and entitlements on top of the right to health. These freedoms and entitlements include the right to control one's body and health and be free from interference and the right to a system of health that gives all equal access to the highest quality of health attainable (*Human Rights and Health*).

According to 85% of surveyed economists, undocumented immigrants contribute to the economy in a positive (74%) or neutral (11%) way (*Taxing Undocumented Immigrants: Separate, Unequal and Without Representation*). They contribute to the community through investments, consumption of goods and services, filling essential worker positions, increasing productivity, and contributing to Social Security, Medicare, and unemployment insurance programs (*Taxing Undocumented Immigrants: Separate, Unequal and Without Representation*). Using this definition of ethical fairness, they should theoretically be able to get the same protections and benefits as a legal resident if looked at through the lens of ethical fairness. The

reciprocity principle makes it clear that "reciprocity requires contributors to a shared product to share in benefits produced" (Daniels). To delve deeper into ethics and the general population's view on this, Daniels goes on to explain that if someone was to conduct a survey on whether people believe everyone deserves fair equality of opportunity, depending on how the question is phrased, most people will agree that everyone deserves to be fairly and equally treated when it comes to being free and equal as the U.S. so wishes upon its inhabitants.

Back to the issue of fairness and undocumented immigrants, if these immigrants are contributing members of society, the fair equality of opportunity should be extended to healthcare and the general health of all people, including those that are undocumented. The extension of healthcare to those contributing undocumented is therefore ethical and fair under this approach because they give back to the society everyone believes they are taking so much from. These people deserve to be "reimbursed" and treated equally alongside the documented or general residents of this society. The negative aspect of this train of thought is that this lends to the idea that those who do not contribute to society, do not necessarily deserve to be reimbursed and do not deserve the benefits that should be given to contributing members. It can raise the question of what to do about the elderly who use retirement funds, or children who only have insurance through their parents. How do they contribute to the system to make it ethically fair?

b) What is the actual cost of the undocumented?

Undocumented immigrants and those that cannot afford general healthcare, take cover in what are known as "safety net health systems" which cover the emergency care they are so often associated with. This care consists of a "limited array of private coverage and some state- or locally- funded programs" (Artiga, et al.). The undocumented can also get coverage through their employers and private healthcare packages, but these packages are often too expensive for them

to afford. They have trouble receiving healthcare through employers because they normally do not have a full-time employer, or they work for a small company employer with less than 50 employees. These small employers are not required under the Affordable Care Act to provide health insurance for their employees, thus leading to the problems with access to health insurance under employers (Wallace, et al.).

As was pointed out before, there was estimated to be around 12 million undocumented immigrants in 2015, which made up about 3.7% of the total population. These are a lot of people, maybe not compared to the total population, but in general, it is a high number. Surely these people take up a ton of money using these safety net systems, right? Would having such a large load on the EDs end up using a large amount of the money allotted for such programs, and thus lead to high health insurance premiums? In actuality, "undocumented immigrants had lower expenditures compared to naturalized immigrants and U.S. born citizens and overall contributed a greater amount for Medicare's trust fund than they withdrew" (Flavin, et al). In other words, they spent less money than they ended up paying into our system. Again, they are contributing more to the system than they are taking out of it. They take up 40-50% less than U.S. born citizens. Even though the majority of users of the emergency Medicaid fund are undocumented, this accounts for less than 1% of the total Medicaid budget. There are still uncompensated funds that undocumented immigrants contribute to, but the numbers pertaining to these visits are not large. 13% of undocumented immigrants had at least one uncompensated visit, versus 11% of U.S. born citizens and they were twice as likely to use uncompensated care than U.S. born citizens. This can contribute to the thoughts of undocumented immigrants causing increases in premiums, but the amount they put into the Medicare Health Insurance Trust Fund is actually so

much greater than they take out of it, that this problem ends up being insignificant (Flavin, et al.).

Undocumented immigrants were often more likely to pay out of pocket than citizens. Comparatively, undocumented immigrants paid about 51% more in out-of-pocket medical charges than U.S. born citizens (Flavin, et al.). Blaming undocumented immigrants for increases in healthcare costs is generally not backed up by the data provided. This problem is not really their fault. In fact, they pay $2-3 billion more in taxes towards the Medicare Health Insurance Trust Fund than they withdrew, and they are not even allowed to access these funds or receive the benefits of Medicare outside of occasional emergency room visits (Flavin, et al.). How is it considered fair that they are required to pay for a system that they cannot even access? This is a problem, and according to the definitions of fairness as stated above, it is unfair. So how do other countries handle the problem? Can we fix it?

Chapter 2: An Analysis of other Countries' Healthcare Systems

An analysis of six other countries' healthcare systems was performed. Each of these additional countries was researched to identify what kind of healthcare systems are in use, how each system is funded, and how undocumented immigrants were treated in their specific systems.

These were chosen because they allow for a diverse set of countries to compare. There are several that are similar to each other to show the small variations in systems and a couple that allow for a different approach entirely. This gives a variety of examples for what the United States could incorporate to lean towards a more universal and fair system.

a) Canada

Canada has a single payer system called Medicare that is also known as a "public spending but private delivery system" version of healthcare. This is basically a national health insurance plan that is government run, or universal healthcare. The 1984 Canada Health Act defines the system as it is now. With this act, each provincial health plan is delivered at the provincial level and covers most medically necessary services, which means no out-of-pocket charges for citizens with very few exceptions to this rule (Ridic, et al). The physicians in Canada are paid on a FFS basis and have a large amount of practice autonomy. This system forbids private health insurers from covering services already deemed necessary under the public insurance system.

This is interesting because it keeps a relative equality among the citizens to have the necessary medical coverage and get the same level of care as others in the provinces. There is supplemental health insurance available for uncovered costs such as prescription drugs and dental care, but because of this system, all physicians are required to participate in this plan and again, it allows all residents in the province to be served equally (Henderson). To account for the reimbursement of physicians for their services, the government, or public insurer, repays the provider.

This keeps the cost of health services negligible for patients who make use of the care (Ridic, et al). A problem with a system of "free healthcare" is that people tend to take advantage of things called "free." Taking advantage of the system causes an escalation of use of services, and the taxpayers having to compensate for an increase in taxes. For Canada, many of the provinces have curbed what they consider to be "medically necessary" to help solve the problem of healthcare overuse. Another downfall of the Canadian healthcare system is that the waiting lists for healthcare can be long. Canadians end up using the United States' system for the most advanced treatments and elective surgeries like kidney transplants that have these long wait times (Ridic, et al.).

The funding for Canada's healthcare system comes from general revenue raised through federal, provincial, and territorial taxation, which includes both personal and corporate taxes. The other form of funding comes from sales taxes, payroll levies, and other forms of revenue that were unidentifiable (Slaybaugh). Some provinces also charge healthcare premiums on their residents to help to pay for the publicly funded healthcare services, but there is a stipulation with these healthcare premium charges in that someone who does not pay them still gets the same medically necessary healthcare as someone who does pay these premiums (Slaybaugh). Overall,

Canada spends about 11.6% of its GDP on healthcare expenditures (Canadian Institute for Health Information).

Regarding undocumented immigrants, Canada is part of the Universal Declaration of Human Rights United Nations treaty which guarantees healthcare access for all residents. When thinking ethically, physicians have professional responsibilities to give medically necessary healthcare to those who cannot pay, or those who are uninsured or nonresidents. To meet these standards, the government has an obligation to provide the means to pay these physicians back for giving healthcare to those who need it. Because of funding problems, this idea of "giving healthcare" is looked down upon in the government. Despite this, these obligations are often met through opening community healthcare facilities where undocumented workers can go for healthcare. The clinics, though, are often overcrowded and have long wait times, even for basic primary care (Magalhaes, et al). Undocumented immigrants are also often afraid of visiting the clinics because of the reports of immigration officials showing up there (Rousseau, et al). Besides the free community health clinics there are not many other ways for undocumented immigrants to gain access outside of emergency room visits. Oftentimes, they will also avoid these for fear of deportation, causing them to wait until the worst-case scenario before getting healthcare from emergency rooms. There is a risk of getting denied even then, because Canada discourages giving healthcare to undocumented immigrants by occasionally not paying hospitals for the care they give to those who are undocumented to save money (Kuile, et al).

In terms of fairness, Canada's system is rather on the unfair side of the spectrum. Undocumented immigrants do work and do contribute to society in Canada and therefore should receive the same healthcare as citizens who work and pay taxes as well. There are some health systems in place to help undocumented immigrants in the form of free health clinics and

emergency room care, but because of the fear of being deported, these provisions are not often used by these immigrants. Because of the stipulations put in place by the government in the form of not giving payment to hospitals who treat undocumented immigrants, this system can be seen as unfair as it does not provide equal benefits to those who are undocumented as it does the legal citizens despite the contributions undocumented immigrants make to Canadian society.

b) South Africa

The South African healthcare system is a "two-tier system divided along socioeconomic lines" (Health Financing Profile: South Africa) that has both a private and a public sector. This system is not doing well though due to the vast inequalities between the public and private sectors. The public health system is divided into three categories: primary, secondary, and tertiary. Public PHC includes internal medicine, obstetrics and gynecology, pediatrics, general surgery, and general practice medicine. This level of healthcare offers little lab service but does not require a referral to receive it either. The secondary healthcare class includes hospitals with few clinical specialists and small differences in terms of function compared to the primary care facilities. To get secondary healthcare, a referral is required to view whatever ailment the patient has in a more specialized light in a hospital setting. Tertiary level healthcare consists of highly specialized equipment in a much larger hospital setting than the secondary level healthcare. These hospitals have more beds overall, and are made for more specific, higher risk surgeries and procedures.

The only way patients are transferred to the tertiary level care hospitals is if the primary and secondary level physicians and facilities are not suited for the illness or injury of the patient (Young). The public sector is funded through government subsidies which are funded through tax revenue and through venues known as medical schemes. These schemes are not-for-profit

organizations that belong to their respective members. These contributions are pooled together to then pay for possible member healthcare expenses which are listed under each medical schemes' "common risk pool" (Marais, Hogan Lovells-Abrianne, et al). Aside from medical schemes, household spending also contributes a large amount towards healthcare funding which is also due to these medical schemes.

The private sector of South African healthcare is a much higher class, better quality healthcare than the public sector, but it costs more OOP for those who choose to go this route. For the public sector, healthcare is free to those seeking it, but the laws behind who gets this free healthcare are complicated and will be discussed below. The private sector does have fewer facilities available, but people who pay for this are greeted with shorter wait times and better quality of care. Most doctors choose to go with this route of healthcare over joining government funded clinics and hospitals and the proper disease control and prevention are practiced in a much more consistent manner due to the increased availability of resources. Private healthcare is more expensive than the public sector, but is relatively better in terms of people getting the full extent of care they need (Young).

When considering undocumented immigrants, South Africa's laws are very confusing in what is allowed and what is not. The Constitution of South Africa states "everyone has the right to have access to healthcare services, and 'no one' may be refused emergency medical treatment." The National Health Act backs up this statement of emergency care being given to everyone no matter where they come from and says, "...all persons in South Africa can access primary healthcare at clinics and community health centers. All pregnant and breastfeeding women and children under six are entitled to healthcare services at any level." The Refugees Act of South Africa also states that refugees have the same rights to healthcare as full South African

citizens. Note that none of this means these services are free, just that the hospitals cannot turn away these people due to their immigration status. Even for asylum seekers and refugees, anything above the free primary care will subject these people to a means test to see how much they will have to pay for the more advanced secondary and tertiary healthcare South Africa provides; this is, however, the same test that is given to South African citizens when determining how much they will be paying for more advanced healthcare (Migrant and Refugee Access to Public Healthcare in South Africa). The one act that goes somewhat against what the rest of the laws say is called the Immigration Act. This law states that staff at medical centers of primary care facilities must find out the status of immigration for anyone who comes in to use the care, unless the problem is emergent. The thing is, though, this law can only be enacted if the person does not meet the criteria mentioned in the other three acts. If the person there is said to be an undocumented immigrant, they must then be reported to the Director General of Home Affairs (Migrant and Refugee Access to Public Healthcare in South Africa). Overall, undocumented immigrants do get some access to primary healthcare, but are subject to pay all fees and do not have the luxury of it being free like the citizens of South Africa do or have it on a case-by-case basis with a test that determines how much they can pay (Migrant and Refugee Access to Public Healthcare in South Africa).

To address the issue of fairness, according to the OECD, undocumented immigrants work and pay taxes into the system, much like they do in the United States. Using this information, and the fact that they do not receive the same benefits from insurance as legalized immigrants, this system could also be considered unfair in their treatment of undocumented immigrants, because despite paying taxes like the legal citizens, they have to pay for their healthcare all out of pocket (Migrant and Refugee Access to Public Healthcare in South Africa).

c) United Kingdom

The United Kingdom's healthcare system is a version of socialized medicine, also known as Universal Health Coverage, in the form of the NHS and covers everyone (National Health Service Act, 1946). To clarify, socialized medicine and Universal Health Coverage can be synonymous. They both are categorized as medicine that is provided solely by the government, with physicians, specialists, hospitals, and other healthcare necessities all being government run and government funded (i.e. through taxes) (*Universal Health Care).* This system of healthcare covers everything from primary care visits, to specialist consultations when in possession of a referral from a general practitioner, to hospitalization. These are all covered in costs by the NHS, and the citizens do not have to pay anything out of pocket. The only cost people have to pay for are prescription medications which can cost around $8.80 per prescription and the maximum out of pocket payment for these prescriptions cannot exceed $104 a year (Tikkanen, et al.). These costs are only required for when the medical services become outpatient. There are exceptions to these outpatient prescription payments, which include: children 15 and under, full-time students 16-18 years of age, people age 60 and above, low-income people, pregnant women and those women who have given birth within the last 12 months, and people with cancer or other long-term medical conditions or disabilities (Tikkanen, et al.). Additionally, the cost of transportation to and from appointments is covered by the healthcare system for low-income individuals.

A limited private sector exists alongside the public NHS, which is divided into several different branches that cover various aspects of healthcare. Either citizens can opt for the mandatory public healthcare, or they can decide to pay for private services. Most of the time, though, private healthcare is only accessed by employer groups or sometimes the wealthier individuals of society who are trying to access additional benefits and are able to afford the extra

premiums required when accessing healthcare through the private sector (Chang, et al). These 11% get the benefits of having quicker access to healthcare, their choice of specialists, and better amenities especially when considering elective procedures (Tikkanen, et al.). Most of the time though, public healthcare is chosen over private healthcare and only about 15% of overall healthcare expenditures is covered by private healthcare. Government spending covers the other 85% (Chang, et al). The private sector of the United Kingdom's healthcare system is separated into various insurance companies that provide different forms of coverage. These include: BUPA which covers a wide variety of healthcare expenses including dental and heart treatment; AVIVA which is not only a United Kingdom company, (it is available worldwide and allows its patrons access to the best healthcare in the world); AXA, which is actually French, allows various forms of insurance coverage; Medicare International, not to be confused with the United States' form of Medicare, allows full coverage of chronic conditions but also covers general procedures as well; and Freedom Health Insurance which is known as probably the "best healthcare in the UK" and includes coverage for medical, sexual and aesthetic healthcare (Chang, et al.). There are others, but these are the most prominent and most used in the UK.

In general, healthcare in the UK is funded through general taxes, as well as around 18% of the citizens' income in the form of payroll taxes. This payroll tax is split between employers and employees as in Germany. Alongside the tax funding, comes the income from copayments made by patients who use NHS services through private companies (Tikkanen, et al.). Only about 8.9% of the UK's GDP is used for healthcare (Chang, et al.).

Undocumented immigrants and visitors to the United Kingdom are generally only entitled to emergency care and treatment for specific infectious diseases (Tikkanen, et al.). The UK had an arrangement initially where they did not have to check residency status or deem

someone “ordinarily resident” before treating people, but now this status is required to be checked before someone is able to be treated. The requirement of being ordinarily resident is complicated, and requires people to meet at least three criteria to be considered as such. These include, 1) someone who is lawfully in the UK, 2) there voluntarily, 3) properly settled for the time being. It also requires that non-EEA nationals who are subject to immigration control have indefinite leave to remain in the United Kingdom (*Guidance on Implementing the Overseas Visitor Charging Regulations*). This last obligation, however, is by itself not good enough to ensure healthcare coverage on its own and as it has to meet the stipulation of being legally in the UK to take effect. This, effectively, makes undocumented immigrants ineligible for the no charge healthcare in the United Kingdom. There are, of course, exceptions for this in that people who do not have permission to be in the UK, but have a relationship to an EEA national are allowed to be in the UK if this EEA national is a resident in the UK. This could include someone who is in the UK illegally, such as an undocumented immigrant, but only if they have relationships with an EEA national resident in the UK (*Guidance on Implementing the Overseas Visitor Charging Regulations*). Overall, though, undocumented immigrants do not have access to more healthcare than simple ED care and whatever access is required to keep infectious diseases from spreading throughout the country.

In terms of fairness, this system is considerably fairer than other countries, but is not the greatest treatment. It still only allows for emergency treatment and the treatment of infectious diseases. Undocumented immigrants in the UK are subject to immediate deportation, or they can “voluntarily return” to their home country. It is not too hard to apply for citizenship to the UK though, and this can greatly help the chances of undocumented immigrants receiving healthcare from their system. This all depends on various circumstances of the individual people though,

and most of the time only pertains to those who were in the country legally originally and are planning to overstay their allotted time (*Your Options If You're in the UK Illegally*).

d) Singapore

The next country's system that will be reviewed is Singapore. Singapore has an interesting system in that it is tiered and set up to where you can choose the type of healthcare you want to receive; based on this choice and how much money you are willing to spend, you get that tier of healthcare. This healthcare system is divided into three different coverage plans that are all covered by setting money aside in a form of a savings account specifically for medical bills. This system is also known as a multipayer, mixed insurance system. It consists of three different programs known as MSL, MS, and MF. These three each cover different aspects or different amounts of healthcare for citizens of Singapore (Tikkanen, et al.).

The MSL tier is the newest addition, or reformation, of this system. MSL coverage is mandatory for all citizens and permanent residents. It covers high-cost emergency hospital bills or other costly outpatient services that would be too expensive otherwise; it also covers general expenses made when making a healthcare visit. This system was made to replace the old MediShield, which was not mandatory and was based off the same idea of covering high-cost hospital stays. The MS system was kept and altered so it helps pay for the new mandatory MSL system and the MF system. MS is now mandatory and is paid for through the same system Germany and France have - payroll taxes split between employers and employees. This scheme pays into the supplementary MSL plans, but also helps to pay for out-of-pocket expenses that may be incurred and are not covered by MSL. It allows families to pay for their family member's health expenses if they do not have an account themselves, such as children. MS is an interest-bearing account that incurs about 4-5% interest over time and cannot be taxed by the government

(Ministry of Health Singapore). MS only covers a portion of the extra charges, and whatever is not covered is expected to come out of pocket from the patient receiving care (Tikkanen, et al.). The last portion is the MF section. This portion of health insurance is mainly the acting safety net for low to mid-income Singaporeans who cannot pay for the extra OOP expenses incurred above what MSL and MS cover. It has the stipulation that these extra costs are deemed clinically required before they are paid for, but once this is established, the low to mid income individuals do not have to worry about excessive extra costs. Hence, this being their safety net for not going into debt over medical expenses (Tikkanen, et al.). What is interesting about these schemes is that the government offers “top-ups” to the various funds to help pay for future retirement, or to help with the cost of having children. On top of this public scheme for health insurance, Singapore has a private sector as well. The private sector covers the supplementary plans that MSL does not cover. They can be paid for through MS, but the majority of these plans are only available to residents or citizens of Singapore. The options that are available to everyone else are the truly for-profit private insurers who cannot be paid through the government systems (Tikkanen, et al.).

When considering undocumented immigrants, there is not much literature or policy pertaining to them, even when considering emergency care. The most Singapore has in terms of undocumented immigrant care would be if the employer provided insurance, or if they paid for private insurance from one of the insurers not part of the government. Emergency care would be given, but it would have to be paid for out of pocket, even if it meant you could not really afford it.

Overall, because of the requirement for employers to supply healthcare coverage for their employees, Singapore could be considered fair in some ways. Another factor that has to be

considered is that each person pays for their own healthcare. They are covered by a government subsidized program that gets interest, but they pay for this out of their taxes and it goes straight to their own funds. When considering this, and the fact that undocumented immigrants would not be funding someone else's system, Singapore could be considered rather fair compared to other countries. That combined with employers having to pay for insurance for their employees contributes to the relative fairness of Singapore's system.

e) Germany

German healthcare is under the socialized medicine category (also known as universal health coverage). Unlike South Africa, the public sector is still good enough to be comparable to the private sector, with few differences between the two health insurance options. However, Germany's healthcare system is a compulsory universal healthcare coverage. If the public sector is not being used, the private must be used in its stead. Those who earn less than $35,000 a year are required to use the public insurance, also known as the sickness funds, where the employee and employer set aside money in each payroll towards insurance (Ridic, et al.)

The German healthcare system is mainly funded through premiums paid for by insured employees and their employers and can receive surplus tax revenue (Ridic, et al.). These payroll contributions are 14.6% of each employee's wages, but this amount is split between both the employee and the employer evenly (International Healthcare Systems: The US Versus the World). This system covers a majority of the healthcare expenses that people can incur when an illness or injury comes up, and the people generally only have to pay a fraction of the cost in the end (Ridic, et al.).

When dealing with undocumented immigrants and refugees, Germany has a seemingly harsh policy. Because there was not a lot of literature on this subject, the latest information on

their undocumented immigrant policy is from 2009. As of 2009, according to the PICUM, all public establishments in Germany are required to report any foreigner without a permit to the migration authorities. This law was updated to prohibit emergency care professionals from having to do this because, legally, everyone is entitled to emergency care regardless of immigration status. For any other healthcare professional in other services, the law of reporting these foreigners still stands. There were other obstacles put in place though to inhibit access to healthcare for undocumented immigrants. These included the risk of hospitals having to bear the full cost of whatever treatment they give to those who are undocumented. This addition of legislation that allows the social welfare society to deny reimbursements to hospitals who treat undocumented immigrants in their emergency rooms has led to hospitals flat out refusing to take in unknown foreigners. They normally either deny them the use of the emergency care, or demand payment OOP before they begin the procedure to ensure that they get reimbursed at least in some form for giving emergency care to someone without insurance (PICUM). Due to these obstacles, it is not very easy for undocumented immigrants to receive the healthcare they may need, even if it is an emergency.

There are ways for undocumented immigrants to get around this issue of being reported to the immigration authorities. Most of the time these are mainly used in consideration of refugees, but because the nature of these aids is anonymous to keep people from getting into trouble with the authorities, undocumented immigrants can use them as well. One of these alternative paths to gaining healthcare is by obtaining an anonymous medical certificate through independent refugee organizations (MacGregor). To obtain this anonymous medical certificate, a medical professional must first evaluate the recipient to determine the extent of the medical care needed. Once this is determined, they then refer the immigrant or refugee to a doctor or hospital

depending on the needs. This is funded through insurance companies, regional, or state authorities (MacGregor). The other option for getting healthcare as an undocumented immigrant, is through the "Medinetz." These are non-government organizations that help people with no papers gain access to the medical care they need as well. This is an anonymous service (like gaining an anonymous health certificate). They also work to provide those without papers with a referral to see a doctor (MacGregor).

With the issue of fairness, Germany has very strict guidelines on what citizens are supposed to do with undocumented immigrants. There is not much information lending itself to how many immigrants are there and whether or not they have jobs. Most likely, if they are living in Germany, they do have jobs and are subject to pay taxes on their paychecks. The problem with this though, is that technically anyone living in Germany is required to get at least some degree of health insurance, whether it be public or private. Even though they cannot legally get non-emergency healthcare, undocumented immigrants may still be paying into the system of public health. Germany does have ways around the system of reporting undocumented immigrants as stated above, and because of these, undocumented immigrants do get access to the same level of free healthcare by citizens. When thinking about it this way, this system could be lending itself towards more fairness than the previous two systems discussed so far.

f) France

The French have a form of Universal Healthcare that offers public hospitals, private hospitals, doctors and other medical service providers, and it provides healthcare for all citizens, no matter wealth, age, or social status. This system is not considered socialized medicine because there is both publically (government) funded medical insurance paid for through taxes and there is also private practice, which is only regulated by the government. Because of the distinction of

having private practices, this system is not necessarily socialized medicine (*Health Care in France - the French Health Service*). This system is a "'solo-based', fee-for-service private practice ambulatory care with public hospitals that are there for acute institutionary healthcare, and is compulsory for everyone to participate" (Rodwin). Acute institutionary care includes secondary healthcare where people have access to short term healthcare for serious injuries, illnesses, or recoveries after surgery (News, A. B. C.). The French have NHI which covers healthcare such as hospital care, outpatient services, prescription drugs, thermal cures in spas, nursing home care, cash benefits, and dental and vision care (some of the time) (Rodwin).

The healthcare system can be split into a few subcategories to explain how it works. The primary care system consists of a multitude of GPs who can be either self-employed or work in group practices with other GPs. The citizens can choose whichever GP they want, and can even visit other GPs, but they have to report a primary GP who signs off on referrals to secondary healthcare. The GPs are virtually all signed with the NHI to provide a consistent rate across the country to charge the citizens who come into the clinics. There is payment upfront of about 25 euros, but the patients are generally reimbursed by the NHI to where they only have to pay 0-6 euros in the end (*Health Care in France - the French Health Service*). Above primary care, there is specialist healthcare, which is accessible throughout all of France in various towns and cities. This section of healthcare does charge a higher fee, but the government agrees upon this fee, and the specialists cannot charge more than the agreed amount. The patient is then also refunded to where they pay a lesser fee that is also agreed upon by the insurance providers (*Health Care in France - the French Health Service*). Depending on how much someone can afford and their occupation, the provider then determines how much of the original payment they can be refunded (Rodwin). Another interesting way the French run their system is by making it possible

for supplementary insurance providers to coexist in the system. There is a way for physicians to charge the patient more for their visit, if given special permission by the French government or if they have earned this right of charging more by becoming specialists in various fields of medicine. To pay for these specialist visits in big cities, people will pay for supplemental insurance that reimburses the people for a bit more on top of what the NHI covers. The various supplementary insurers have different plans where they cover an array of extra costs, but with this flexibility, the French operate both as a universal health coverage country, alongside having a private market (Rodwin). Aside from the details of the French healthcare system, the people in France are more than happy with the set up, and the World Health Organization ranked them as the top healthcare system in the world in 2000 (Tandon, et al).

To fund this extensive healthcare system, the French utilize taxes. The majority of the funds for the healthcare system come from payroll taxes, much like Germany. As of 2000, around 51.1% was covered by employer payroll taxes. There is another form of this income tax which is called a “general social contribution” that contributes about 35% of the funds for healthcare. This is a tax that the government puts on all earnings, including investments. To cover the rest of the costs of this system, there are additional taxes put on various other amenities of society such as tobacco, alcohol, automobiles, etc. (Rodwin).

In consideration of undocumented immigrants, the French actually have a system in place. The system is known as SMA. To be considered for SMA, one must hold residence on national territory for over three months consecutively and have an annual income of less than €8,645; for couples this increases to €12,967. There are also several documents that must be shown to prove this residency and income flow for the immigrant. It does not allow unemployed undocumented immigrants to access the same level of healthcare as citizens. This is due to the

set income level required before SMA access is granted. This measure came into effect at the same time Universal Health Coverage did, but there was another motion that helped undocumented immigrants before SMA. This was simply called “local medical assistance” and consisted of the same amount of coverage, except the person had to be living for three years in a territory rather than only three months. This version of healthcare also did not require residency documents. (André, et al). The SMA is one of the most extensive healthcare coverage programs for undocumented immigrants as long as they meet these requirements for application. SMA covers everything from primary care to childbirth. It has to stay within the limits set by the Social Security. These limits are similar to that of other OECD countries (André, et al.). Emergency rooms cannot turn away cases that are emergent or, if left untreated, could become emergent. These regulations are also for pregnant women and are focused on the elimination of introducing diseases such as tuberculosis into the country. Despite the use of the SMA, this emergency care only accounts for about 12.5% of the money spent by the SMA. Overall, the SMA expenditure totaled about 0.49% of overall social welfare expenditures that were specifically for medical goods and services (Direction de la Recherche).

In France, there is a lot of debate as to whether undocumented immigrants deserve these benefits. The debates were mainly centered on the fear of fraud, the cost of the SMA system, and whether undocumented immigrants really deserve social protections such as healthcare coverage. The concern not already covered above is the thought of fraud. This fear is based upon the belief that some undocumented immigrants may be leaving their country under invalid reasons or may not have the required conditions to enter French territory. The invalid reasons and required conditions were not directly stated in the literature, but may include passport requirements. This is a valid suspicion, and to alleviate this, the government is debating implementing severe

sanctions against those that are deemed guilty of fraud, and the physicians that encourage the individuals guilty of fraud to remain in country and receiving medical assistance. The controversy has also been alleviated a bit due to the income and residency requirements (André, et al.).

In accordance to fairness, this system is the fairest of all of the systems so far. It allows for working, contributing members of society who are not citizens to access healthcare that is more than just for emergent problems. Yes, other countries do have free clinics that are charity and allow undocumented access, but France has a whole system devoted to giving medical help to undocumented immigrants that come into their country. They have a set amount of money that is an allowance to pay for the healthcare of undocumented immigrants, and they have the emergency care system in place as well to account for those who do not meet these minimum requirements. Even though there are people who disapprove of this system in France, under the definitions above, this system can be considered as being fair.

A summary of the above discussed evaluation of fairness of the health care systems in the 7 countries is provided below in Table 1.

Table 1: A General Comparison of 7 Countries' Healthcare Systems and their Undocumented Immigrant Policies

COUNTRY	SYSTEM FORMAT	FUNDING	UNDOCUMENTED POLICY	Fairness Level *
CANADA	Government Run Universal Health Coverage with a single payer system known as Medicare	Federal, provincial, territorial taxation; sales taxes, payroll levies, and other revenues not mentioned in research; some provinces charge premiums	Not much documentation on how undocumented are treated; ED visits allowed but the fear of deportation keeps undocumented immigrants away; there are free clinics as well but they are often plagued with immigration officials ready to deport undocumented immigrants	1
UNITED STATES	Hybrid system with both government funding and private companies	Privately funded through premiums paid out of pocket or through employers. Publicly funded through payroll taxes	Non-existent; they can receive emergency care or go to public primary care clinics. Payment is either out of pocket or nonexistent.	2
SOUTH AFRICA	Two-tier system with both private and public health coverage	Public tier is funded through tax revenue and participation in medical schemes; private is paid for through premiums. Includes out of pocket spending	Emergency care allowed for anyone; must pay for full amount of care received; some laws require healthcare to be given, while others disregard this law and say it will only be given in certain circumstances	3
UNITED KINGDOM	NHS of England which covers everyone; Socialized medicine; no private sector	General taxes and payroll taxes split between employer and employee; copayments from private patients using the NHS	Treatment in EDs and for certain infectious diseases is available and free; other treatment can be denied after a screening of residency status	4
SINGAPORE	Universal Health Coverage through mixed financing in the form of a public statutory insurance program	Funded through savings accounts that are funded through taxes taken out of payroll	If working for a Singaporean employer, they are covered with healthcare to a certain extent; mostly need private insurance or else pay out of pocket for full healthcare charges	5
GERMANY	Socialized medicine; the Universal Health Coverage is compulsory private healthcare system	Premiums paid by insured employees and employers through a percentage of the payroll; also paid for through tax surpluses	Emergency care is given to all, but denial to undocumented is common as well; no insurance means no free healthcare; Medinetz provides referrals needed to get into specialists without asking questions so they don t have to fear deportation; charities provide limited medical care when needed;	6
FRANCE	Universal system with public and private hospitals that cover all residents- NOT socialized medicine	Health contribution levies on salaries; central government funding; users who pay small OOP portions	A system known as State Medical Assistance provides same level of medical care as citizen if proof of residency for three months is shown; Less than three months of residency allows for ED care and prevention of infectious diseases free of charge	7

*Note: Fairness Level,1 being lowest, 7 being highest

Chapter 3: What would constitute an Optimal Health System for the United States?

a) What are some general requirements for an optimal health system?

Optimal health incorporates a few main principles consistent throughout the literature, as highlighted by Solomon Benatar, Nancy De Lew's "A Layman's Guide to the U.S. Health Care System," and the WHO's "Delivering Quality Health Services." These characteristics of an optimal system include access to an "adequate level" of healthcare, the freedom to choose where to get healthcare, a system that promotes innovation and high-quality research, access to healthcare in a timely manner, and, finally, universal and equal access to healthcare for all. One thing to add to an optimal health system's requirements would be to make sure the system was fair to both the undocumented immigrants and the law-abiding citizens of the country. Lastly, a very important aspect to incorporate into the system would be to focus more on preventative care measures to keep EDs open for cases that are genuinely emergent instead of cases that could have been avoided had they been treated sooner. An optimal system would also need to incorporate a way of ensuring fairness, so there would not be a large misuse of the healthcare system.

In general, access to an "adequate level" of healthcare cannot be defined specifically because each country has different access to resources they can provide (Benatar). Despite this, the American Medical Association attempts to define it for the United States. Their definition of an adequate level of care includes the following: transparent care, attempts to include input from all stakeholders including the public, protects the most vulnerable patients and disadvantaged groups, considers the best available scientific data about efficacy and safety towards health care,

improves health outcomes, ensures that there is no discriminatory impact, and has the ability to evolve with the population to continue ensuring broad public support for the basic care threshold (Defining Basic Health Care).

The next requirement for an optimal system would be the continued access of freedom to choose what provider someone goes to. This is a strength the United States' system already has, and what most people are afraid of losing when considering the transition to a universal health coverage system (De Lew, et al.). The freedom to choose providers is important to keep in a healthcare system because, in psychological terms, it is linked to increased patient satisfaction, which later provides for better patient health outcomes. Another thing to consider with the freedom of choice is that the ability to have, express, and have others respect one's choice is important to people's sense of personal worth. Lastly, again with satisfaction, people tend to be more satisfied with goods and services they choose rather than goods and services they were told to use. In the end, the most important part about this aspect is the happiness people feel with getting to choose healthcare providers. It helps them to have better health outcomes because they are more willing to listen to the provider of their choice and adhere to the healthcare plan, which helps prevent later returning to fix an issue that could have been easily solved in the first place had the person felt more inclined to listen (Zolkefli).

People also generally value low wait times in reference to elective surgeries and procedures, but this is a strength the United States already has (De Lew). Elective surgeries do not necessarily mean they are unnecessary, it just means they do not involve a medical emergency and can be scheduled in advance (Johns Hopkins). The importance of keeping timeliness in healthcare is that it helps reduce both morbidity and mortality for chronic conditions like kidney disease. For example, a kidney transplant can be scheduled in advance,

but it is still medically necessary, and without it, someone could die in the end without the new kidney (Smart, et al.). Not only this, but also delaying healthcare and not being timely with it can cause an increase in patient dissatisfaction and complaints. General delays can also cause a reduction in demand for services that should be received in a timelier manner to increase the possibility for better health outcomes (Fleming, et al.).

The promotion of innovation is another important aspect to an optimal system in that finding better care solutions can lead to keeping people healthier. It can also save money for patients in the long run by avoiding long hospital stays and expensive surgeries for potentially preventable ailments (*The Value of Medical Innovation*). Innovation in healthcare helps develop new and improved policies, systems, products, tech, and services and delivery methods that improve the general health of the population. Innovations in these areas can improve the efficiency, effectiveness, safety, quality, and affordability of the healthcare system (World Health Organization Health Innovation Group).

Universal, equal access to healthcare is the main goal of an optimal health system because it allows for all people to obtain the healthcare they need without the risk of financial difficulties from unaffordable OOP expenses (Evans, et al.). This idea lends itself towards Benatar's idea of access to healthcare without excess burdens on the patient. Not only does it allow access to healthcare for everyone no matter their immigration status or financial standing, it lowers overall healthcare costs for the economy as a whole. It forces doctors and hospitals to provide almost the same care at a lower cost. It also eliminates administrative costs by eliminating dealing with private insurers as much and thus lowering overall costs (Amadeo).

In terms of fairness, an optimal system would ideally have some basic requirements like proof of income or residency such as the French have. This would allow there to be a level of

fairness that would ensure undocumented immigrants contributed to the society in a way that supports them having healthcare. This would go slightly against the idea of universal healthcare, but would ensure that people do not take too much of an advantage of an "adequate level" of care.

The suggestion of focusing more on preventive care is also beneficial to both the economy and the patient in various ways. The CDC recommends preventive care because it reduces the risk of chronic disease and later the burden of dealing with a chronic disease. The patients benefit from not having to pay for treating a chronic disease that will affect them for the rest of their lives (Levine). The Trust for America's Health shows the economic advantages of preventive healthcare. Disease prevention as a whole was shown to reduce significant amounts of US healthcare costs- over $16 billion annually. On average for all states, for every dollar spent on prevention, there is a $5.60 return on costs. To break it down further, Medicare would save over $5 billion, Medicaid over $1.9 billion, and private payers would save over $9 billion annually. In Mississippi specifically, if the focus were more on preventive care, it would save over $150 million a year with a return on costs at around $5.20 for every dollar spent on preventive care (Prevention for a Healthier America).

b) A Model of an Optimal Health System as it would Affect Undocumented Immigrants

When considering what an optimal health system would look like for the United States and how various other countries treat undocumented immigrants, the French Healthcare system stood out the greatest in terms of the above requirements. Their level of care allotted towards undocumented immigrants and people in general stood out above the rest because not only did they have emergency rooms available at all times without fear of deportation, they also had access to an "adequate level" of care offered. The State Medical Assistance Program allows

access to the same level of healthcare offered to citizens after a residency of three months. This is fair to these immigrants because they are working and contributing to the economy, and get the same care that the citizens get for the same work put in. The United States has its strengths in itself in terms of timeliness, choice of providers, and innovation of care, but definitely needs to work on equal access to at least an adequate level without fear of excess financial burdens. Another aspect about the French healthcare system that is important towards undocumented immigrants is that if they are there less than three months, they still do not have to pay for preventive healthcare or emergency department visits. The United States does account for some uncompensated visits in its Medicaid plan, but the hospitals are often not going to give care for the very low incidence of them being paid back for these uncompensated visits. The French also still have freedom of choice in their system which was a requirement highlighted above as well.

The fear of deportation was a large problem in various countries, and in terms of undocumented immigrants and the rights of all humans having healthcare of an adequate level, is not sustainable for an optimal health system. This fear acts as a barrier, and in places like Germany, Canada, and the UK, this barrier interferes with the possibility of immigrants getting the healthcare they need. The fear of deportation is not the only barrier though to undocumented immigrants getting health, the other barrier was the fear of not being able to afford ED healthcare when an emergency arises. This acts as a barrier in that immigrants may not even go to the emergency room when they need it in places like South Africa, the UK, Singapore, and Germany at times. Not only is this a barrier on the undocumented immigrants, it’s a barrier to hospitals wanting to provide healthcare as well. The fear of not being compensated causes these hospitals to deny care to undocumented immigrants, which in turn, denies them a basic human right to healthcare as defined by the World Health Organization. Singapore does not have a system that

allows emergency care to undocumented immigrants free of charge, so it does not have to worry about compensating hospitals for giving free healthcare. The barrier here simply lies in whether the undocumented immigrants can afford the healthcare at all, at full cost. This being said, an optimal system should not have barriers set up to where undocumented immigrants fear excess financial burdens or the fear of deportation when considering the healthcare they need.

This leads into preventive healthcare being something to incorporate. Preventive care being provided lessens the risks of EDs being used and therefore lessens the risk of not having the funds to pay for uncompensated visits. The UK and the French had a system of providing care to avoid spreading of infectious disease to the general population at no cost to the patient whether undocumented or not. Even though preventive care extends past just avoiding spread of infectious disease, this is a step in the right direction for an optimal healthcare system. Ideally, it would also extend to clinics that allow for care such as yearly checkups or physicals that can help prevent chronic diseases or catch illnesses before they get to an untreatable, unaffordable condition, thus saving everyone money in the long run.

In terms of funding, part of the private insurance system is already paid for through payroll deductions on employee paychecks, so shifting that to a public system would account for some of the funding like it does in Germany, France, and Singapore. Singapore has an interesting funding solution as well that could be integrated, but it does not account for undocumented immigrants. Germany does not have the system to where it accounts for undocumented immigrants either, but payroll taxes helps to fund the healthcare they do have. The undocumented immigrants who work would then also be paying for their healthcare through the payroll taxes, and therefore contributing to a system they can also benefit from. Integrating this

would ensure that all undocumented immigrants who work have healthcare insurance through their employers.

To incorporate fairness, an optimal system would ideally have the requirements of a set time of residency in the country and a proof of income. This income would also have to prove that the immigrant is paying into the tax system as well to prove they are not being paid "under the table." The United States had an interesting idea in this, and it allows both undocumented immigrants and citizens to pay taxes while also distinguishing between citizens and non-citizens. The idea of having a separate "social security number" for those who are not citizens was useful in that it still ensured taxes were being paid and allowed for this income to be tracked in terms of how much has been paid into the system. It also helps to distinguish who should and should not receive the same level of healthcare as contributing members of society. Again, this does go against the idea of everyone receiving equal healthcare in a universal system, but there could be a support system for those who do not fit the above requirements such as the "local medical assistance" in the French system. This way disease spread is prevented, pregnant women still get the care they need, and emergency care is still accounted for.

An optimal system could come about in various ways, and incorporating ideas from other systems that already have these aspects figured out can help the United States to venture closer to a Universal Health Coverage system. It does not necessarily have to be socialized medicine in that the government funds everything, there could be a private sector or private practices that are simply government regulated alongside government-mandated insurance, but the overall idea is that it would need to support even undocumented immigrants. This system would not only help the undocumented immigrants, but the millions of uninsured in general in the United States, therefore saving money overall and providing the basic human right of healthcare to everyone.

References

"About VA Health Benefits." *Veterans Affairs*, 30 Apr. 2020, https://www.va.gov//health-care/about-va-health-benefits.

Akincigil, Ayse, et al. "Emergency Room Use by Undocumented Mexican Immigrants." *Journal of Sociology*, p. 19.

Amadeo, Kimberly. "Why America Is the Only Rich Country Without Universal Health Care." *The Balance*, https://www.thebalance.com/universal-health-care-4156211. Accessed 2 Dec. 2020.

André, Jean-Marie, and Fabienne Azzedine. "Access to Healthcare for Undocumented Migrants in France: A Critical Examination of State Medical Assistance." *Public Health Reviews*, vol. 37, no. 1, Aug. 2016, p. 5. *BioMed Central*, doi:10.1186/s40985-016-0017-4.

Arrow, Kenneth J. "Uncertainty and the Welfare Economics of Medical Care." *The American Economic Review*, vol. 53, no. 5, American Economic Association, 1963, pp. 941–73.

Artiga, Samantha, and Maria Diaz. "Health Coverage and Care of Undocumented Immigrants." *KFF*, 15 July 2019, https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-coverage-and-care-of-undocumented-immigrants/.

Ataguba, J. E., and D. McIntyre. "Paying for and Receiving Benefits from Health Services in South Africa: Is the Health System Equitable?" *Health Policy and Planning*, vol. 27, no. suppl 1, Mar. 2012, pp. i35–45. *DOI.org (Crossref)*, doi:10.1093/heapol/czs005.

Chang, Josh, et al. *The UK Health Care System*. http://assets.ce.columbia.edu/pdf/actu/actu-uk.pdf. Accessed 2 Dec. 2020.

Cutler, David M., and Richard J. Zeckhauser. "Chapter 11 - The Anatomy of Health Insurance* *We Are Grateful to Dan Altman for Research Assistance, to Jon Gruber, Tom McGuire, Joe Newhouse, and Alexandra Sidorenko for Helpful Comments, and to the National Institutes on Aging for Research Support." *Handbook of Health Economics*, edited by Anthony J. Culyer and Joseph P. Newhouse, vol. 1, Elsevier, 2000, pp. 563–643. *ScienceDirect*, doi:10.1016/S1574-0064(00)80170-5.

Daniels, Norman. *Unauthorized Immigrants and Health Care Coverage*. p. 15.

"Defining Basic Health Care." *American Medical Association*, https://www.ama-assn.org/delivering-care/ethics/definingbasic-health-care. Accessed 2 Dec. 2020.

De Lew, Nancy, et al. *A Layman's Guide to the U.S. Health Care System*. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4193322/. Accessed 2 Dec. 2020.

Elements of Access to Health Care: Timeliness | Agency for Healthcare Research and Quality. https://www.ahrq.gov/research/findings/nhqrdr/chartbooks/access/elements3.html. Accessed 2 Dec. 2020.

Eligibility | Medicaid. https://www.medicaid.gov/medicaid/eligibility/index.html. Accessed 2 Dec. 2020.

Employer Health Insurance Vs. Individual Plans | Medical Mutual. https://www.medmutual.com/For-Individuals-and-Families/Health-Insurance-Education/Health-Insurance-Basics/Employer-vs-Individual-Health-Insurance.aspx. Accessed 2 Dec. 2020.

Evans, David B., et al. "Universal Health Coverage and Universal Access." *Bulletin of the World Health Organization*, vol. 91, no. 8, Aug. 2013, pp. 546-546A. *DOI.org (Crossref)*, doi:10.2471/BLT.13.125450.

Financial Management | Medicaid. https://www.medicaid.gov/medicaid/financial-management/index.html. Accessed 2 Dec. 2020.

Flavin, Lila, et al. "Medical Expenditures on and by Immigrant Populations in the United States: A Systematic Review." *International Journal of Health Services*, vol. 48, no. 4, SAGE Publications Inc, Oct. 2018, pp. 601–21. *SAGE Journals*, doi:10.1177/0020731418791963.

Fleming, Neil S., et al. "Patient-Centeredness and Timeliness in a Primary Care Network: Baseline Analysis and Power Assessment for Detection of the Effects of an Electronic Health Record." *Proceedings (Baylor University. Medical Center)*, vol. 19, no. 4, Oct. 2006, pp. 314–19.

"Focusing on Healthcare Costs of Illegal Immigrants Draws Attention Away from the Real Problem." *Hospital Association of Southern California*, https://www.hasc.org/blog-entry/focusing-healthcare-costs-illegal-immigrants-draws-attention-away-real-problem. Accessed 2 Dec. 2020.

France | Commonwealth Fund. https://www.commonwealthfund.org/international-health-policy-center/countries/france. Accessed 2 Dec. 2020.

"Germany: Sick without Papers." *InfoMigrants*, 11 Nov. 2019, https://www.infomigrants.net/en/post/20743/germany-sick-without-papers.

Guidance on Implementing the Overseas Visitor Charging Regulations. p. 129.

Hallman, Hunter. *How Do Undocumented Immigrants Pay Federal Taxes? An Explainer | Bipartisan Policy Center*. https://bipartisanpolicy.org/blog/how-do-undocumented-immigrants-pay-federal-taxes-an-explainer/. Accessed 4 Dec. 2020.

Health at a Glance. https://www.oecd-ilibrary.org/social-issues-migration-health/health-at-a-glance_19991312. Accessed 2 Dec. 2020.

Health Care in France - the French Health Service. https://about-france.com/health-care.htm. Accessed 2 Dec. 2020.

Hoffman, Jan. "What Would Giving Health Care to Undocumented Immigrants Mean? (Published 2019)." *The New York Times*, 3 July 2019. *NYTimes.com*, https://www.nytimes.com/2019/07/03/health/undocumented-immigrants-health-care.html.

"How Does Singapore's Healthcare System Work | Pacific Prime Singapore." *Pacific Prime Singapore's Blog*, 11 June 2020, https://www.pacificprime.sg/blog/singapores-healthcare-system/.

How Is Medicare Funded? | Medicare. https://www.medicare.gov/about-us/how-is-medicare-funded. Accessed 2 Dec. 2020.

"How Obamacare Changed Group Health Insurance." *Healthinsurance.Org*, 28 Nov. 2016, https://www.healthinsurance.org/group-health-insurance/.

Human Rights and Health. https://www.who.int/news-room/fact-sheets/detail/human-rights-and-health. Accessed 2 Dec. 2020.

"Individual Health Insurance under Obamacare." *Healthinsurance.Org*, 26 Oct. 2020, https://www.healthinsurance.org/obamacare/individual-health-insurance/.

Information, National Center for Biotechnology, et al. "Health Care in Germany: The German Health Care System." *InformedHealth.Org [Internet]*, Institute for Quality and Efficiency in Health Care (IQWiG), 2018. *www.ncbi.nlm.nih.gov*, https://www.ncbi.nlm.nih.gov/books/NBK298834/.

Internal Revenue Service. *Immigration and Taxation*. https://www.irs.gov/pub/irs-utl/20-Immigration%20and%20Taxation.pdf. Accessed 4 Dec. 2020.

International Healthcare Systems: The US Versus the World. https://axenehp.com/international-healthcare-systems-us-versus-world/.

Johns Hopkins University, Types of Surgery, https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/types-of-surgery

Knox, Richard. *Are Immigrants Health Care "Moochers"? On The Contrary, Boston Researchers Say*. https://www.wbur.org/commonhealth/2018/08/08/immigrants-health-care-cost. Accessed 2 Dec. 2020.

Kuile, Sonia, et al. "The Universality of the Canadian Health Care System in Question: Barriers to Services for Immigrants and Refugees." *International Journal of Migration, Health and Social Care*, vol. 3, July 2007, pp. 15–26. *ResearchGate*, doi:10.1108/17479894200700003.

Landes, Xavier. "How Fair Is Actuarial Fairness?" *Journal of Business Ethics*, vol. 128, no. 3, May 2015, pp. 519–33. *Springer Link*, doi:10.1007/s10551-014-2120-0.

Levine, Susan. "Health Care Industry Insights: Why the Use of Preventive Services Is Still Low." *Preventing Chronic Disease*, vol. 16, 2019. *www.cdc.gov*, doi:10.5888/pcd16.180625.

Magalhaes, Lilian, et al. "Undocumented Migrants in Canada: A Scope Literature Review on Health, Access to Services, and Working Conditions." *Journal of Immigrant and Minority Health*, vol. 12, no. 1, Feb. 2010, pp. 132–51. *PubMed Central*, doi:10.1007/s10903-009-9280-5.

"Migrant and Refugee Access to Public Healthcare in South Africa." *Scalabrini*, 25 Sept. 2019, https://www.scalabrini.org.za/news/migrant-and-refugee-access-to-public-healthcare-in-south-africa/.

MOH | What Is MediShield Life. https://www.moh.gov.sg/home/our-healthcare-system/medishield-life/what-is-medishield-life/medishield-life. Accessed 2 Dec. 2020.

"New NHS Rule Requiring Patients to Prove Residency Has Implications for Undocumented Immigrants." *Marketplace*, 21 May 2018, https://www.marketplace.org/2018/05/21/new-rule-nhs-means-patients-without-uk-residency-have-pay-care/.

News, A. B. C. "News You Can Use: Health Care Glossary." *ABC News*, https://abcnews.go.com/Health/story?id=2558661&page=1. Accessed 2 Dec. 2020.

Norris, Louise. "Individual Health Insurance under Obamacare." *Healthinsurance.Org*, 26 Oct. 2020, https://www.healthinsurance.org/obamacare/individual-health-insurance/.

OECD (2019), Health at a Glance 2019: OECD Indicators, OECD Publishing, Paris, https://doi.org/10.1787/4dd50c09-en.

Population Estimates Illegal Alien Population Residing in the United States: January 2015. 2015, p. 13.

"Prevention for a Healthier America." *Tfah*, https://www.tfah.org/report-details/prevention-for-a-healthier-america/. Accessed 2 Dec. 2020.

Ridic, Goran, et al. "Comparisons of Health Care Systems in the United States, Germany and Canada." *Materia Socio Medica*, vol. 24, no. 2, 2012, p. 112. *DOI.org (Crossref)*, doi:10.5455/msm.2012.24.112-120.

Rodwin, Victor G. “The Health Care System Under French National Health Insurance: Lessons for Health Reform in the United States.” *American Journal of Public Health*, vol. 93, no. 1, Jan. 2003, pp. 31–37. *DOI.org (Crossref)*, doi:10.2105/AJPH.93.1.31.

Rousseau, Cécile, et al. “Health Care Access for Refugees and Immigrants with Precarious Status.” *Canadian Journal of Public Health = Revue Canadienne de Santé Publique*, vol. 99, no. 4, July 2008, pp. 290–92. *PubMed Central*, doi:10.1007/BF03403757.

Rosso, Ryan J. *U.S. Health Care Coverage and Spending*. p. 3.

Ruark, Eric. *Out of the Shadows*. https://www.fairus.org/sites/default/files/2017-08/JobsReport_7-3-13.pdf. Accessed 2 Dec. 2020.

Samra, Shamsher, et al. “Undocumented Patients in the Emergency Department: Challenges and Opportunities.” *Western Journal of Emergency Medicine*, vol. 20, no. 5, Sept. 2019, pp. 791–98. *PubMed Central*, doi:10.5811/westjem.2019.7.41489.

“Singapore: Health Expenditure as a Share of GDP 2017.” *Statista*, https://www.statista.com/statistics/780864/health-expenditure-share-of-gdp-singapore/. Accessed 2 Dec. 2020.

Slaybaugh, Chris. *International Healthcare Systems: The US Versus the World*. https://axenehp.com/international-healthcare-systems-us-versus-world/.

Smart, Neil A., and Thomas T. Titus. “Outcomes of Early versus Late Nephrology Referral in Chronic Kidney Disease: A Systematic Review.” *The American Journal of Medicine*, vol. 124, no. 11, Nov. 2011, pp. 1073-1080.e2. *ScienceDirect*, doi:10.1016/j.amjmed.2011.04.026.

Snyder, Laura, and 2015. “Medicaid Financing: How Does It Work and What Are the Implications?” *KFF*, 20 May 2015, https://www.kff.org/medicaid/issue-brief/medicaid-financing-how-does-it-work-and-what-are-the-implications/.

Tandon, Ajay, et al. *Measuring Overall Health System Performance for 191 Countries*. p. 23.

The Health Care System Under French National Health Insurance: Lessons for Health Reform in the United States | AJPH | Vol. 93 Issue 1. https://ajph.aphapublications.org/doi/full/10.2105/AJPH.93.1.31. Accessed 2 Dec. 2020.

“The Importance of Preventative Care.” *Barrow Group Insurance*, 3 July 2014, https://www.barrowgroup.com/blog/importance-preventative-care/.

The Role of Medical Schemes Once the NHI Is Implemented. https://www.discovery.co.za/corporate/health-nhi-the-role-of-medical-schemes. Accessed 2 Dec. 2020.

The Value of Medical Innovation: Saving Lives, Saving Money – HINJ. https://hinj.org/the-value-of-medical-innovation-saving-lives-saving-money/. Accessed 2 Dec. 2020.

Types of Surgery. https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/types-of-surgery. Accessed 2 Dec. 2020.

Tikkanen, Roosa, et al. *Commonwealth Fund*.https://www.commonwealthfund.org/international-health-policy-center/countries/singapore. Accessed 2 Dec. 2020.

Unauthorized Immigrants and Health Care Coverage. p. 15.

Universal Health Care. https://www.healthpaconline.net/universal-health-care.htm. Accessed 4 Dec. 2020.

VA & TRICARE Information - VA/DoD Health Affairs. https://www.va.gov/VADODHEALTH/TRICARE.asp. Accessed 2 Dec. 2020.

Wallace, Jacob, and Benjamin D. Sommers. "Effect of Dependent Coverage Expansion of the Affordable Care Act on Health and Access to Care for Young Adults." JAMA Pediatrics, vol. 169, no. 5, May 2015, p. 495. DOI.org (Crossref), doi:10.1001/jamapediatrics.2014.3574.

WHO Health Innovation Group; https://www.who.int/phi/1-health_innovation-brochure.pdf

Young, Montgomery. *Western Michigan University*. Private vs. Public Healthcare in South Africa. p. 21.

Your Options If You're in the UK Illegally. http://www.citizensadvice.org.uk/immigration/living-in-the-uk-illegally/your-options-if-youre-in-the-uk-illegally/. Accessed 2 Dec. 2020.

Zolkefli, Yusrita. "Evaluating the Concept of Choice in Healthcare." *The Malaysian Journal of Medical Sciences : MJMS*, vol. 24, no. 6, Dec. 2017, pp. 92–96. *PubMed Central*, doi:10.21315/mjms2017.24.6.11.