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Healthcare for Undocumented Workers in France and The United States

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HEALTHCARE FOR UNDOCUMENTED WORKERS IN FRANCE AND THE
UNITED STATES

A thesis submitted in partial fulfillment of
the requirements for the degree of Masters of Humanities

By

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B.S., Wright State University, 2012

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ABSTRACT

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Healthcare for Undocumented Workers in France and the United States.

The purpose of this thesis is to explore healthcare for undocumented immigrants in France and the US in light of immigration policy, labor needs, and social values. While both countries have historically relied and continue to rely on undocumented labor, they treat irregular migrants differently when it comes to healthcare. While many hospitals in the US deport undocumented patients in a practice termed medical repatriation, the French government has legislated an illness clause that gives residency permits to severely sick *sans-papiers* who need medical care. To explore the reasoning behind these extremely contrasting treatments, the thesis studies the social values that underlie the healthcare systems in both countries. It concludes that in recognition of healthcare as a human right, France has concrete legislation for *sans-papiers*; in contrast, rights language is largely missing from the US healthcare system, resulting in a void of legislation that leads to practices like medical repatriation.

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I. INTRODUCTION

The thesis will explore the healthcare provisions for undocumented immigrants in France and the US in light of immigration policy and the economic needs of both countries. It will study how the labor needs of each country influence immigration policy and consequently influence the presence of undocumented immigrants. With the economic contributions of irregular immigrants in mind, the thesis will summarize the healthcare provisions in place for them. In order to understand the distinctly different treatment of undocumented immigrants in France and the US, the thesis will also explore the development of healthcare policy and underlying social values in both countries.

The United States' economy still demands cheap labor and the United States government does not have a healthcare system for undocumented migrants despite ongoing healthcare reform. Due to the high cost of healthcare and lack of regulation, there have been recorded instances of hospitals shipping undocumented patients to their countries of origin. This extralegal deportation of immigrants is termed medical repatriation. Similar to the US, France, too, employs irregular workers. However, France offers them preventive healthcare. Furthermore, the 1998 French Illness Clause provides legal documentation to severely sick *sans-papiers* who need medical care. This is in stark contrast to the practice of medical repatriation in the US.

In order to study the contrasting treatment of irregular immigrants in the two countries, the thesis explores the relationship between the economies of the receiving countries and undocumented migration. Both France and the US have created policies

that influence undocumented migration. Both countries have also historically benefited from and thus welcomed illegal labor, especially in times of economic prosperity.

Although irregular workers contribute to the economy and pay taxes, they are unable to benefit from many welfare services in host countries. In the realm of healthcare, undocumented immigrants in the US are ineligible for non-emergency Medicaid and Medicare. In France, however, *sans-papiers* can apply for preventive healthcare services and also benefit from the illness clause.

The thesis explores these two disparate healthcare provisions. A look back at the development of the healthcare policies in France and the US sheds light on the underlying values of each nation. While both France and the US value individualism, the French people believe that the government has a responsibility to provide healthcare. The US, on the other hand, has a stronger inclination towards individual responsibility and government abstention from providing healthcare. While in France healthcare is widely recognized as a human right, the issue is much more contentious in the US. The idea of healthcare as a human right is debated; furthermore, that people who are in the US illegally have rights is controversial.

The thesis argues that although the French healthcare system for undocumented immigrants is not perfect, it is rooted in the recognition of healthcare as a human right that is not limited to legal residents whereas the US healthcare system is centered around individual responsibility. Although there is some government regulation of healthcare for legal residents, when it comes to regulating healthcare for undocumented immigrants, the US government is absent. Concrete legislation like the illness clause exists in France because of the strong emphasis on social welfare and government responsibility in

ensuring it, even for *sans-papiers*. The US, on the other hand, where healthcare is still not legislated as a human right and government involvement is often seen as an infringement on individual rights, has a lack of legislation. It is likely that the absence of government legislation makes room for medical repatriation to occur.

IMMIGRATION HISTORY OF FRANCE AND THE US

Throughout the 20th century, France used colonial labor to supplement its own workforce within France. In times of economic prosperity, France allowed undocumented immigrants into the country and gave them legality once they arrived. Immediately after the first oil shock in 1973, however, France expected slow economic growth. In order to protect employment for its citizens and residents, in 1974, France imposed an “official ban on immigration,” thereby significantly reducing competition for immigrants in the French job market (Hargreaves 7-18). Although France created a restrictive immigration policy, undocumented immigration continued (Hargreaves 21). Decades later, France still employs some undocumented workers in agriculture, winemaking, construction, and the garment industry (Fassin, “Humanitarian” 86). The economic opportunities in France, which may be abundant relative to those in developing countries, and the historical reliance on immigrant labor, still act as pull factors for illegal workers.

The United States has also historically depended on undocumented immigrant labor. During WWI and for many decades afterwards, the use of temporary workers was a norm to such an extent that legality did not matter; migrants crossed the borders freely in order to work in the United States (Schain 212). The changing need for undocumented labor has guided immigration policy in the United States. While the US government has repeatedly put legislation in place to curb illegal entry, employer interests have prevented

effective enforcement (Schain 216).

Authors have also pointed out that, to a great extent, the United States influenced undocumented migration through the North American Free Trade Agreement (NAFTA), which was enacted starting in 1994 (Bowden 63). As a result of NAFTA, Mexican peasant farmers now had to compete with American corporations and thus could no longer sustain themselves; this led to their travelling to the US in search of work (Bowden 63). The thesis explores the effect of such changing economic and immigration policies on undocumented migration from foreign countries.

Today in the United States, undocumented labor comprises a significant part of the national economy. Steve Baragona writes that “Of the roughly one million farm workers in the United States, most are immigrants, and an estimated one-quarter to one-half of them are illegal.” Many of the 11.7 million undocumented migrants in the US also work in many other industries such as construction, making it evident that United States still strongly relies on undocumented laborers for its economy (Werner and Sherman).

OVERVIEW OF FRENCH AND US HEALTH SYSTEMS

The French healthcare system was ranked as the best in the world by the most recent World Health Organization report, not in the least due to its notable health outcomes and cost-efficiency (Rodwin 31). Operating within the broader public welfare system, French healthcare is funded through the Statutory Health Insurance system (SHI or NHI) that was legislated in 1945 (Chevreul et al. 17-29). Ninety three percent of the French population is covered under the public-mandated insurance; the majority of the remaining population is covered under voluntary insurance; it is estimated that only about 1% of the population is uninsured (Costich, “France” 565). There also exists the

Couverture Médicale Universelle (CMU), a separate state-run healthcare system for unemployed legal residents (Duguet and Bévière 29).

In contrast, the United States' healthcare system is multilayered, more decentralized, and more variable by state. Instead of operating from a government-run social welfare system, the insurance coverage in the US is mostly through for-profit private companies. The two major social civilian government-sponsored healthcare systems in the US are Medicare and Medicaid. Medicare covers US citizens above the age of 65 who contributed to the social security system as well as people with disabilities. Like the French CMU, Medicaid covers those US citizens living significantly under the poverty line (Gaydos 702-703). Over 15% of US citizens did not have any healthcare coverage in 2012. In addition, 48 million people were uninsured in the United States in 2012 (Pear). Of the twelve million undocumented workers in the US in 2009, it was estimated that 59% had no healthcare coverage (Sanchez et al. 686).

The fragmented structure of the current US healthcare system that is divided between private and public coverage highlights its inherent fragility. It is unlikely that the US would have healthcare provisions in place for undocumented workers when it is unable to consolidate its current mélange of sub-systems in order to provide coverage to the millions of US citizens who are currently uninsured. Although a discussion of the Patient Protection and Affordable Care Act (PPACA or ACA) is beyond the scope of this thesis, it is notable that the ACA does not extend coverage to undocumented migrants. It is also notable that the ACA is expected to cut federal hospital funding specifically set aside to treat undocumented workers in half (Bernstein). Given the controversy surrounding it, the ACA certainly would never have become law if it had stipulated

provisions for undocumented immigrants.

The French health insurance system that was legislated decades ago, on the other hand, is single-payer, more centralized, and geared towards providing the maximum number of people with healthcare, including *sans-papiers*. Since most of the French population is already covered under the state welfare program, it is perhaps easier for the French to expand coverage to undocumented migrants. However, providing virtually every human being healthcare cannot be rationalized in terms of convenience only. The recognition of healthcare as a human right strongly influences the extent of healthcare provided to French citizens and noncitizens whereas in the US, there is debate over whether healthcare is a privilege or a right.

DEVELOPMENT OF FRENCH AND US HEALTH SYSTEMS

The principles underlying healthcare systems, in addition to the specific evolution of these systems, sheds light on what these systems set out to accomplish and why they exist the way they do today. Healthcare provisions are based on different understandings of the role and responsibility of the state to promote public good and are reflective of a society's values especially in regard to the responsibility of the individual versus the community.

For example, T.R. Reid points out that underlying the French system of healthcare is the principle of “*solidarité*” (64). As Béland and Hansen write, “Central to *solidarité*...is this notion of social interdependence, a collective recognition that each individual is dependent upon others” (51). Providing coverage to undocumented workers, who form part of French society, flows naturally from the principle of solidarity. The thesis will explore how strongly the values, such as solidarity, influence healthcare

provisions for *sans-papiers*.

The notion of solidarity is largely missing from the US healthcare system, which considers health a negative right, the kind of right that requires state abstention instead of state activism (Orentlicher 327). In order to ensure a negative right, the state is required to not interfere in individual choice. This creates a reliance on the individual rather than the state to provide healthcare. In fact, the French healthcare system recognizes health care as a human right requiring state activism to guarantee this right (Lomba 360; Record 537). The debate over the passage of programs like Medicaid in the 1960s sheds light on this idea. Medicaid was highly controversial and took decades and significant modifications to pass. The difficulty in legislating the ACA and the repeated efforts to repeal it also show the widespread resistance against universal healthcare in the US.

Critics argue that framing healthcare as a privilege instead of a right or entitlement feeds the notion that health exists only for those who deserve it or can afford it (Orentlicher 328-329). Medicare is more politically acceptable in the US. Those who pay into it are seen as deserving of receiving health benefits when they are no longer able to work (Orentlicher 329). On the other hand, undocumented migrants are often perceived as not contributing to public funds and therefore undeserving of benefiting from them. The thesis will explore this idea of deservedness in providing healthcare to irregular immigrants.

SPECIFIC HEALTH PROVISIONS

“Deservedness” is a constant theme in this thesis. France considers access to emergency, curative, and preventative care for all people as justified by “species membership” (Ticktin, “Medical Humanitarianism” 118), not limited to the citizens of

France but available to all humans within France. In compliance with these ideals, France created *Aide Médicale d'État* (AME) in 1995, a separate system of healthcare for illegal immigrants residing within its borders (Duguet and Bévière 32). This program covers the recipients' hospital and clinic visits, and also prescription costs. Furthermore, AME recipients do not face deportation when they seek care (Duguet and Bévière 33). The thesis will explore the reasons behind the advent of AME.

In addition to creating AME, France also created a special law in 1998 that grants legal status to sick undocumented migrants who are already within its borders if there is fear that deporting them back to countries with poor healthcare systems will further harm their health (Fassin, "Humanitarian" 83). This is often referred to as the illness clause. Ticktin notes that the law was championed by human rights organizations such as *Médecins sans Frontières* and is rooted in humanitarianism ("Casualties of Care" 91).

In comparison to France, there are no formal preventive healthcare measures in place for undocumented migrants residing in the US. Although they are excluded from receiving welfare benefits, undocumented workers can receive emergency care in hospitals that get Medicaid funding under the Emergency Medical Treatment and Labor Act (EMTALA), which was passed in 1986 (Vincent 100-104). While the US does not formally provide healthcare provisions to illegal workers beyond this, there are just over a thousand community health centers around the country that provide limited preventive care to the undocumented. The cost of running these health centers is shared by hospitals and federal and state governments (Bernstein).

Since all of these factors combine with the fact that the cost of healthcare in general is high in the United States, there have been instances of "medical repatriation"

where hospitals autonomously deport unconscious undocumented workers after giving them emergency care because follow-up care would be too costly; although the exact number is unknown, it is estimated that more than six hundred undocumented migrants were deported over the past five years (Pitt). In stark contrast to the use of the illness clause in France, this practice suggests that the US healthcare system is more focused on cost than patient care and it clearly shows that the US understanding of human rights diverges from international norms.

PROBLEMS

However, in some ways, France also falls short in providing necessary care to *sans-papiers*. Despite some attempt to comply with international human right norms, France has separated AME from the larger healthcare system and the CMU. Qualifying for AME is difficult and many *sans-papiers* who are eligible do not receive adequate care. So, even though undocumented migrants are entitled to some health care as human beings, the structural differences within the healthcare system often lead to unequal treatment of healthcare recipients. Some scholars, including Stéphanie Larchanché, have identified substandard treatment of AME recipients. The thesis will analyze the application of AME and whether it falls short of the ideals it is based on.

Literature shows that the application of the illness clause, too, is imperfect. The illness clause is legislated to help those *sans-papiers* who have life-threatening illnesses. Gatekeepers such as medical professionals and immigration officials determine what is considered “life-threatening.” As such, the granting of legal status can become a subjective process (Ticktin, “Casualties of Care” 90). There is no official list of “life-threatening” diseases. Moreover, doctors considering patients for the illness clause must

assess whether the country of origin has adequate care and whether that care is accessible. This sort of assessment lies outside the expertise of most doctors. However, despite its limitations, the illness clause helps many severely sick patients get much-needed medical care.

In contrast to the illness clause in France, the United States does not provide sick undocumented workers legality but many times US hospitals do the complete opposite and deport undocumented migrants back to their countries of origin (Nessel 61).

Although US hospitals, not the US government, deport patients, the lack of a government-sponsored healthcare system for the undocumented can be linked to this phenomenon. Medical repatriation is not a governmental policy and is performed by hospitals that are under a myriad of limitations, such as a severe lack of resources and growing costs. It is also not performed by every hospital in every state. Because the US healthcare system is not centralized and unified, medical repatriation is not a ubiquitous phenomenon formally rooted in law. Additionally, while immigration policies affect the need and value of the undocumented migrant, anti-immigrant sentiment among doctors and hospitals is not being pointed to as a cause of medical repatriation.

The thesis studies the evolution of the two governments' healthcare provisions for undocumented workers in light of the countries' treatment of undocumented workers today. Chapter 1 provides a link between immigration and the economies of the host countries; it highlights the influence of immigration policy on undocumented migration. Chapter 2 offers a brief analysis of the values that underlie the broad healthcare systems in both countries; it takes into account the development of healthcare provisions since the early-twentieth century. Chapter 3 studies the illness clause in France and the

phenomenon of medical repatriation in the US. The thesis hypothesizes that the recognition of healthcare as a human right in France strongly influences the strong provisions in place for *sans-papiers* whereas the lack of government involvement due to the historical recognition of healthcare as a negative right leads to medical repatriation. The thesis does not study the ethics behind the healthcare provisions; instead, the thesis is a comparative analysis of the interconnection between immigration and healthcare policies.

II. UNDOCUMENTED WORKERS & THE ECONOMY

This chapter of the thesis will present the relationship of undocumented immigrants in France and the United States to the respective countries' economies. Both countries have historically relied on undocumented labor and continue to do so. US and French immigration legislation since WWII has influenced the flow of undocumented laborers in both countries, depending on the economic needs of each country at a particular time. Today, these laborers are an integral form of many industries; their illegality, resulting in low wages and high vulnerability, makes them a desirable form of labor. As such, the economies of both the United States and France benefit from undocumented workers.

Phillip Martin and J. Edward Taylor write that immigration, including undocumented immigration, is established and perpetuated by three factors: demand-pull, supply-push, and networks. Demand-pull includes the incentives that attract a person to the immigrant country, such as higher wages and more job opportunities. Demand-pull is needed for the initial establishment of immigrant flow into the country. It is often also coupled with supply-push, the unfavorable conditions in the emigrant country that drive people to move elsewhere. Once demand-pull and supply-push give rise to immigration, over time immigrants establish networks that span the emigrant and immigrant country, thus making it easier for immigration to continue. Thus, even when demand-pull is lowered or severed, immigration does not necessarily stop (Martin and Taylor 95-118).

As is evident in Martin and Taylor's work, demand-pull strongly depends on the health of the receiving country's economy. Gordon Hanson writes that undocumented immigrants fill essential jobs precisely because they respond directly and quickly to economic changes. Many countries, including the United States and France, often use temporary foreign labor and work out legal guest worker programs. However, since legal travel is often an imbroglio of bureaucracy and processing delays, legal workers are unable to quickly come and fill a country's labor needs in times of growth. Undocumented laborers, on the other hand—who may have already established networks in the immigrant country—bypass legal channels and fill jobs that employers are more than willing to give (Hanson 4-6).

THE UNITED STATES

A nation of immigrants, the United States has used immigration not just presently but historically as a means to benefit the American economy. While they come from a variety of nations, about 56% of undocumented workers in the United States are from Mexico (Chacon et al. 156). During WWI and for many decades afterwards, the use of temporary workers from Mexico was a norm to such an extent that legality did not matter; migrants crossed the borders freely in order to work in the United States (Schain 212). The changing need for undocumented labor has guided immigration policy in the United States. While the US government has repeatedly put legislation in place to curb illegal entry, employer interests have prevented effective enforcement (Schain 216).

HISTORICAL RELIANCE ON UNDOCUMENTED LABOR

During the post-WWII years, the United States went through a period of

economic growth, making the use of undocumented labor necessary. Despite the creation of the Bracero guest worker program, however, undocumented workers continued to enter the United States. Getting labor through legal channels required high fees on part of the employer. US farm owners seeking to not pay costs such as those for transportation allowed undocumented migration to continue. Phillip Martin reports that in 1949, 20,000 farm workers were legal guest workers while a staggering 87,000 were undocumented (“Braceros”).

Even though the Bracero guest worker program existed, employers were often willing to sidestep “cumbersome regulations” and hire undocumented workers (Martin, “Mexican Migration” 121). Throughout the program’s implementation, undocumented workers arrived, began working, were apprehended by law enforcement, taken back to the border, and instead of being deported, were given legality so that they could travel back and resume work. Unsurprisingly, undocumented workers crossed the border illegally expecting legalization once they were employed in the United States. As a result, the outcome of the guest worker program was to, in fact, increase undocumented migration into the United States. As cheap undocumented labor kept flowing into the US, particularly California, the state’s agriculture industry doubled its vegetable output and saw a rise in profitability (Martin, “Mexican Migration” 121-122).

Undocumented migration to the United States continued in the decades after the Bracero program was terminated in 1964 (Chacon et al. 147). In 1978, the Select Commission on Immigration and Refugee Policy (SCIRP) was convened in times of a slowing economy and growing immigration. Created by Congress when immigration was becoming politically unpopular as the economy was becoming stagnant, SCIRP

concluded that undocumented migrants were vulnerable to employer exploitation, but more importantly, their existence led to transgression of US laws such as minimum wage laws, immigration laws, etc. (Schain 250-251). In a period of economic crunch, undocumented workers became undesirable. The commission recommended a two-pronged approach to reducing undocumented migration: employer sanctions were to be enforced while border patrol was to be toughened. In order to deal with the undocumented immigrants already present in the United States, it recommended amnesty (Schain 251).

The Immigration Reform and Control Act (IRCA) was passed in 1986 after the recommendations of the SCIRP and granted amnesty to 3 million undocumented migrants (Schain 252) and increased border patrol (Chacon et al. 203). Although the IRCA called for employer sanctions, they were widely unpopular in Congress and the Reagan administration; taking place during Reagan-era (1981-1989) business deregulation, they were largely left unimplemented (Schain 202). Although successful in legalizing the status of migrants already on US soil, the IRCA failed to curb the flow of undocumented migration (Schain 201-202).

By the time the North American Free Trade Agreement (NAFTA) was signed into law in 1994, the United States had decades of largely failed programs to stop undocumented labor migration behind it. The US economy relied on migrant labor in many sectors, especially agriculture, and NAFTA was created in the hopes of “convert[ing] this migration relationship into a trade and investment relationship” (Martin, “Mexican Migration” 120). The main goal of NAFTA was to erase tariffs on goods traded between Mexico, Canada, and the United States, thus allowing American

and Canadian companies to invest more heavily in the Mexican market (Bacon 25).

While one of the long-term outcomes expected of NAFTA was to reduce undocumented migration by strengthening the Mexican economy, the short-term impact has been different (Martin, "Mexican Migration" 129).

In the short term, NAFTA created more jobs in industry but resulted in fewer jobs for Mexican farmers, thus creating an incentive for them to migrate illegally. NAFTA created both demand-pull and supply-push. Before NAFTA went into effect, the Mexican government provided subsidies to its domestic farmers, many of whom ran small farms (Bacon 25). NAFTA required that the Mexican government remove those subsidies and allow mass-produced, cheaper US corn to be sold in the Mexican market as a way to increase trade between the two countries (Bacon 25). This drove many farmers out of business. Martin reports that many undocumented workers in the United States now pick crops that are then shipped to the workers' countries of origin ("Mexican Migration" 124).

Although the United States has allocated a significant amount of resources for border patrol since the 1970s, attempts at stopping illegal border crossings have been largely futile (Schain 216). In the 1980s, for example, there was a 130% increase in funds for border control (Chacon et al. 203). Over one million apprehensions were made in each year after 1984, an increase from a mere 72,000 in 1956 (Schain 217-219). However, instead of deterring people from crossing the border, the effect was to reroute immigrants to paths that were more dangerous to cross (Chacon et al. 205; Schain 223). Even with increased border patrol, undocumented workers continue to come to the US due to demand-pull and supply-push factors. Analysts write that border enforcement

cannot work in a “borderless economy” (Schain 218); increased border patrol does not change the aforementioned structural factors that drive immigration (Chacon et al. 206).

Schain points out that each time the US government has tried to implement sanctions against employers hiring undocumented immigrants, the attempts wither away in a common pattern (287). Employer sanctions are recognized as potentially the most effective way to stop undocumented migration because they directly diminish one of the main pull factors bringing undocumented laborers into the country. The government has attempted to audit employers and fine them for hiring undocumented laborers. Raids, such as those conducted in agribusiness and meatpacking plants in the 1990s, have resulted in deportation of workers and fining of employers (Schain 220). However, employers have found a way around them. For example, when factories in Iowa and Nebraska were subjected to raids, instead of hiring legal workers and paying them more, they started recruiting undocumented workers from Los Angeles to continue to keep costs low (Bacon 152).

Nevertheless, there are countervailing pressures from the political right. As the US is considering immigration reform, any proposal for granting amnesty to the 11 million undocumented immigrants in the US has been opposed by many in the Tea Party. The party, like some other conservative groups, opposes any path to citizenship because it sees legalization as a way of rewarding those who have broken the nation’s immigration laws. Disregarding the structural and economic factors that bring undocumented immigrants to the US, such as demand for their labor, the Tea Party also calls for more spending on border patrol (Lacey; Nixon; Weisman and Parker).

CURRENT SITUATION

As a result of this push and pull, between the years 1991 and 2001, the number of undocumented immigrants grew from 5 to 12 million in the United States (Hanson 3). Today, the number is not much different, estimated at about 11 million (Davidson). Most of the undocumented workers in the United States are employed in low-paying industries such as agriculture, construction, cleaning services, and food preparation (Hanson 39). That they form an integral part of these industries is evidenced by the percentage of the workforce they comprise: 24% of the labor force in farming, 17% in cleaning, 14% in construction, and 12% in food preparation (Hanson 39).

A significant part of these sectors, undocumented workers are largely underpaid. Bacon reports that in 1994, the average undocumented farm worker in California had a yearly income of just \$8,840 (80). Since then, incomes seem to have dropped. Working with undocumented farmworkers in the 2000's, Holmes reports that most undocumented workers earn about \$3,000 to \$5,000 a year. They are paid approximately \$20 a day for performing an average of 16 hours of physically intensive work. Pay varies by sector but falls far below what documented workers receive. For example, Adam Davidson (2013) profiles an undocumented worker in the construction industry; he earns about \$25,000 a year, which is significantly less than the wage earned by legal construction workers performing the same job.

Undocumented workers are largely underpaid, often less than the legal minimum wage, and are unable to speak out for fair wages and better working conditions. Bacon notes that "IRCA's employer sanctions [partly]...ensured that undocumented workers,

with fewer rights and less access to benefits, remained cheaper for employers, more profitable” (81). Fearing deportation and imprisonment if they request better treatment, undocumented workers are in an especially vulnerable position (Bacon 81). David Bacon and Seth Holmes note repeated physical and emotional abuse faced by undocumented workers at the hands of employers who do not feel obligated to follow workplace laws due to their employees’ illegality (Bacon 81; Holmes 45-110).

Interestingly, undocumented workers perform jobs that are much needed and largely unwanted in the US. In 1960, about 50% of the legal workforce within the United States had little formal schooling and thus qualified for low-end jobs. By contrast in the year 2000, only 12% of the legal workforce filled that demographic. While the number of US citizens who perform low-end jobs has diminished, the labor requirement in the respective sectors is still high. In contrast to the 12% in United States, 74% of working age people in Mexico had little formal schooling (Hanson 14). With few other choices, they fill jobs as the preferred form of labor for US employers who seek the cheapest available labor to retain high profitability (Bacon 105).

It has been noted by economists that undocumented employment results in the decrease of wages for low skilled legal labor (Davidson). However, while it is also true that undocumented workers take away some jobs from low skilled legal workers without a high school education, authors note the opposite with regard to legal skilled workers. Davidson writes that “undocumented workers do not compete with skilled laborers— instead, they complement them.” By performing low skill jobs at very low pay, undocumented workers allow high skilled workers to spend more time on specialized work, thus increasing output and profitability (Davidson).

While US employers benefit from undocumented workers and while undocumented workers are unable to claim rights, they do contribute to social welfare in the US and their home countries. In 1994, undocumented workers in the US paid \$7 billion through taxes. These included income, sales, social security, and property taxes (Bacon 79-80). Not much has changed 20 years later. According to Davidson, undocumented workers pay \$15 billion a year in social security. Because they are ineligible to benefit from most social security and welfare services, undocumented workers only used \$1 billion of the \$15 billion they contributed (Davidson) partly through use of federally funded resources such as emergency rooms in hospitals that take Medicare money (Zallman et al. 2). Given their low wages, impact on consumer prices, and tax contributions, it is no surprise that Hanson writes “by any measure, halting illegal immigration is likely to be a net drain on the US economy” (27).

FRANCE

Like the US, France has strongly relied on immigrant labor in the past century (Schain 39). Through the 1900s, France allowed European workers to migrate and fill labor shortages. Before the onset of the Depression, the need for foreign labor was such that France had a 548% increase in the use of foreign labor in the mining industry alone between 1906 and 1931 (Schain 44). Up until the 1970s, France also used laborers from its former colonies as an integral part of its economy. However, when France found itself no longer in need of foreign, excess labor, it halted immigration in 1974 (Hargreaves 21). However, irregular immigrants have continued to come to France and have gained employment because business interests have circumvented employer sanctions.

HISTORICAL RELIANCE ON UNDOCUMENTED LABOR

In the years following the First World War, France acted on behalf of employers when it enacted immigration policy. In the midst of strong economic growth, it welcomed foreign labor from surrounding European countries and African colonies. However, with the onset of the Depression, France began restricting immigration (Schain 43).

While France had tightened immigration policy during the Depression, the end of WWII brought the country economic growth. Again, France began welcoming foreign labor to fill labor shortages. While it had previously used labor from neighboring European countries like Italy and Spain, those countries also started going through economic growth and decreased their export of labor. At the same time, decolonization created a flow of labor—now considered foreign labor—from countries like Algeria, Tunisia, and Morocco (Schain 47).

Miriam Ticktin highlights the link between France’s colonial history and the prevalence of undocumented workers today. Because of deep colonial ties and the open policy on immigration in the 1960s, workers freely came from North Africa to work in France (Ticktin, “Casualties of Care” 46-47). She writes that although it preferred seemingly more assimilable European migrants to colonial migrants, “France’s ties with its colonies...ensured that an influx of immigrants came from what was coming to be known as the third world” (46).

Since France was going through economic growth during this time—the annual GDP growth in 1964 was 6.5%—it employed undocumented laborers in industry (“Data: France”). Even though policies to discourage undocumented travel existed, the French

state turned a blind eye to illegal border entry because of the economic benefits of using cheap labor (Hargreaves 7). Additionally, despite the presence of legal migrant workers, many French employers used undocumented workers to avoid “lengthy [legal] formalities” (Tapinos). Undocumented workers, reluctant to pass up job opportunities, often took low paying jobs; after they gained employment, however, the French state regularized them by granting them residency and work permits (Hargreaves 21; Tapinos). In other words, even though the French government was officially against illegal immigration, laws “were often circumvented with the more-or-less open connivance of the state” when doing so benefited the French economy (Hargreaves 7).

Alec Hargreaves highlights to what extent this unwritten policy formed part of French immigration practice:

By the late 1960s, the overwhelming majority of new entrants were technically illegal immigrants before being regularized *ex post facto* by ONI [Office National de l'Immigration] after they had found jobs in France. Government ministers acquiesced uncomplainingly in these developments. In 1966, for example, the Minister for Social Affairs, Jean-Marcel Jeanneney, stated: ‘Illegal immigration has its uses, for if we adhered rigidly to the regulations and international agreements we would perhaps be short of labour.’ (178-179)

Unsurprisingly, many undocumented people continued to enter France with the state-perpetuated expectation of regularization at a later time. However, in the 1970s, France foresaw an economic slump.¹ In an effort to ensure employment for its own

¹ In the year 1980, the annual GDP growth rate dropped to 1.6% (“Data: France”)

citizens, France imposed an official ban on immigration in 1974 (Hargreaves 17). With this sudden change in policy, many undocumented laborers who had entered France thinking legalization was only a matter of time now faced an indefinite state of illegality (Hargreaves 21).

In the midst of an economic slump in 1981, however, many undocumented workers were regularized by the newly elected Leftist government (Hargreaves 21) as part of a larger immigration reform. Although the Left posited that the regularization was guided “morally, to repair the ‘wrongs’ caused to immigrants” by previous measures, it was accompanied by increased employer sanctions and deportations to prevent further illegal entry (Schain 52). Furthermore, when it came to regularization, only those undocumented people who held employment could be granted amnesty (Hargreaves 21). They held jobs in construction, catering, domestic service and the clothing industry. After regularization, these workers continued to hold their previous jobs, making evident that they were an integral part of the French economy but were only welcome if they were employed (Hargreaves 51-52).

Even while regularization legislation has been passed in French history, there have been countervailing pressures from right wing parties calling for zero tolerance of irregular immigrants. The National Front, for example, is based on the principle of “restoration” of France to “purer” roots and thus has strong anti-immigrant ideologies. It has gained ground in a time of high unemployment, calling for an even greater number of deportations than the record number performed under Sarkozy’s watch. Promoting an isolationist border policy, the National Front also calls for tighter border patrolling (Diffley; Tidey; Willsher).

CURRENT SITUATION

While the years 1981-2 saw the legalization of many undocumented workers, accompanying attempts at immigration reform did not stem illegal flow. Undocumented workers continued to enter France at the rate of about 30,000 a year (Hargreaves 21). The economic opportunities in France, which may be abundant relative to those in developing countries, and the historical reliance on immigrant labor still act as pull factors for illegal workers. In the year 2005, there were an estimated 60,000-200,000 undocumented workers in France, mostly from the Maghreb, sub-Saharan Africa, and a few Asian countries (Vermeren 3-5). By 2009, this number had increased dramatically; one source estimates that there were anywhere from 200,000 to 500,000 undocumented people living within the country (Moussu). These *sans-papiers* work in industries that face legal labor shortages such as construction, restaurants, cleaning, home care, winemaking, agriculture, textiles, etc. (Prakash; Reed; Moussu; “A New Balance”; Fassin, “Compassion” 372). While the exact number of undocumented workers in each industry is unknown due to the clandestine nature of their work, experts contend that *sans-papiers* are such a necessary part of these economic sectors that many of them would collapse if all undocumented laborers were expelled from the country (Moussu).

The reason that *sans-papiers* have become an integral part of these economies is not just that the country has historically relied on them but also because they cost employers little. During the year 2002, France faced a 9% unemployment rate; despite the high number of French citizens out of jobs, the winemaking and fruit growing industry could not find legal workers (“A New Balance”). These jobs, requiring long hours of backbreaking work at very low pay, were filled by undocumented workers.

While the legal minimum wage in France in 2008 was 1,280 Euros a month, undocumented workers earned only half of that (Prakash). Another source reports that undocumented workers earn wages as little as 400 Euros for every 100 hours of work (Reed). This is well below the poverty line in France.

Many undocumented workers in France work on the black market or do ‘undeclared’ work and are paid under the table (Bohlen; Moussu; Vermeren 15-16). They pay taxes such as consumption taxes and property taxes through rent.² Working under the table, these laborers cost employers less in wages than legal workers whom they would be required by law to pay at least the minimum wage; employers also do not have to make welfare contributions on their behalf. Other undocumented workers use false identity documents to gain employment (Bohlen). Overall, employers benefit from having to make fewer welfare contributions than they would for legal employees (Tapinos; Moussu). While it is often assumed that undocumented workers come to France to take advantage of its generous welfare system, the “welfare magnet” is stronger for the employer than the workers (Tapinos).³

Interestingly, while employers may not need to pay welfare taxes on behalf of their illegal workers, the *sans-papiers* themselves contribute to the French national tax revenue. In 2009, the *sans-papiers* made a combined 2 million Euros in contributions to the government (Moussu). Even while working illegally, many of these workers contribute to social security and retirement schemes, but they are often unable to benefit

² Owners pay property taxes using the rent of tenants.

³ The passage of *Loi Pasqua* in 1994 restricted social welfare services for the undocumented to schooling and emergency healthcare (Schain 21-290).

from them (Vermeren 18).

In addition to low costs, employers have other incentives for hiring undocumented workers, mainly the vulnerability that stems from their illegal situation. Even though *sans-papiers* are paid less than the legal minimum wages, they will not report this discrepancy out of fear of deportation hence giving the employers a *carte-blanche* (Vermeren 15). In addition, as elsewhere, undocumented people face financial instability and are desperate for work, they are often unwilling to risk losing their jobs by speaking up for better pay and/or conditions (Vermeren 15; Tapinos). Since in France the police can perform identity checks based on profiling, most undocumented workers are reluctant to bring attention to themselves out of fear of imprisonment and deportation (Vermeren 15; Ticktin, “Casualties of Care” 36, 45).

Interviews with undocumented workers highlight the desirability of undocumented laborers to employers. Miriam Ticktin writes of her encounter with a legalized man, Ahmed, who used to be undocumented. In talking about the availability of legal work, Ahmed states that “it was so much easier to find work on the black market! I never had trouble. Now that I have papers, I can’t find work” (qtd. in Ticktin, “Casualties of Care” 43). Vermeren’s account supports the preference for undocumented labor; she quotes Sacko when s/he says “In the recruitment agencies...if you come with a real identity card, they won’t hire you because, according to them, ‘undocumented workers are of better use to us, because we pay them as we like without the complaining’” (16). Ahmed’s and Sacko’s testimony reflect how France has a niche market precisely meant for undocumented workers.

To deter irregular migrants from entering, France uses border patrol. As party to the Schengen Agreement, France allows free travel for residents of other member states. While Schengen countries have abolished internal borders, they share a common external border. France subscribes to the border patrolling and asylum rules that are common to all Schengen states. These EU states use the border control agency, Frontex, to monitor the external border. Since the irregular immigrants not caught by Frontex at an external border can travel to France, there has been a call from member countries to revise Schengen policies (“Q&A: Schengen Agreement”).⁴

France has also used employer sanctions to deter undocumented immigration (Schain 66). In 1980, for example, French employers who hired undocumented workers could be fined about \$1,000 per worker. Martin and Miller note, however, that “the detection of illegal alien employment by enforcement personnel did not necessarily lead to punishment of the employer” (7). Vermeren cites “political complicity” as the cause, implying that enforcement authorities became lax in the face of employer interests. She goes on to note that even those employers who were penalized found that firing or not hiring undocumented workers would cost less than paying fines (Vermeren 6). As such, many French employers in the aforementioned industries continue to hire undocumented workers (Reed).

⁴ Border patrolling has become a concerted effort requiring coordination among several EU countries. Even though member states share the same border policy, there have been disputes among them since some countries receive the bulk of illegal immigrants. Italy’s border, for example, is part of the external border. After the 2011 Arab Spring, many asylum-seekers entered Italy. Although Italy had granted temporary residency permits to the immigrants, France did not allow them to enter. This led to a revision of the Schengen Agreement (“Q&A: Schengen Agreement”).

COMPARISON OF US AND FRANCE

A look into French and US history shows a parallel trend in the increased need for undocumented labor in times of economic growth and then the creation of more restrictive policies in times of economic stagnation. During the postwar boom in the 1940s and 1950s, the United States welcomed undocumented labor in order to supplement its workforce. Similarly after WWII and during the 1960s, France opened its doors to immigrants when it needed more labor. Both countries attracted immigrants through demand-pull factors. It does not seem to be a coincidence that both countries used undocumented laborers so avidly that they allowed them to enter without documentation and regularized them afterwards.

In addition to creating an expectation that undocumented people would be legalized instead of penalized after their arrival, states also create other long-term demand-pull factors that attract undocumented labor. The United States created NAFTA, which had the unfavorable short-term effect of decreasing Mexican jobs all the while retaining, if not increasing, employment opportunities in the United States for migrant laborers. While the United States has thus influenced the flow of undocumented migration through economic policy, France's colonial history has had a strong impact on the presence of undocumented laborers within its borders. It has allowed undocumented workers from former colonies—who not only speak French but were also considered French subjects through most of the 20th century—to enter with the expectation of legalization, but changed its policy later when it was no longer in need of foreign labor.

More recent history shows that in both the United States and France, not only do

undocumented workers come when they are needed by the immigrant country, they also form a very “flexible” workforce (Hanson 5). They are willing to perform jobs that are physically demanding at low pay without claim to minimum wage, safe working conditions, etc. As such, they cost employers significantly less than legal workers. Not only do they work for little pay, they spend a significant amount of what they earn within the immigrant country, thus also contributing to the economy. Undocumented workers pay taxes and contribute a sizeable amount of their earnings to social security and welfare by using false identity papers, most of which they are not allowed to claim.

Far from being a burden on the economies of the United States and France, undocumented workers form an integral part of the workforce. Not only do both countries currently rely on undocumented workers, they will continue to use them in face of a diminishing workforce. Despite anti-immigrant political rhetoric in both countries, economic projections call for rising labor needs in the upcoming years. Justin Akers Chacon and others write that because of the aging native population in the US and because of an expected 10% decrease in workers between the age of 35 and 44 by the year 2020, it will need more, not fewer, workers to fill low-paying jobs (158). Similarly France already needs approximately 1.7 million additional workers a year to fill necessary jobs due to a dwindling and aging workforce (“A New Balance”). In order to maintain profitability and keep costs low in a competitive global economy, employers in many sectors prefer hiring undocumented workers over legal workers.

While undocumented migrants form a significant part of both American and French labor forces, they are not treated the same way in these countries. The French state, which recognizes health care as a human right, is rare in that it provides *sans-*

papiers access to preventive healthcare. On the other hand, the United States, where there is still a debate over whether healthcare is a right or a privilege, does not have a nationwide healthcare system for undocumented people. The following chapter will consider the existing healthcare infrastructure in the United States and France in order to explore the differences in healthcare offered to undocumented workers in both countries.

III. OVERVIEW OF HEALTHCARE & UNDERLYING VALUES

The goal of this chapter is to summarize aspects of the healthcare systems in the US and France. An understanding of the specific structures of the healthcare systems for legal residents is necessary to understand the healthcare provisions for undocumented immigrants in both countries. Furthermore, the historical development of the two healthcare systems explored in this chapter sheds light on the social welfare values that influence healthcare provisions for undocumented immigrants.

OVERVIEW OF THE US HEALTHCARE SYSTEM

In the United States, most people obtain private insurance coverage through employment. This comprises about 60% of the population. The employer negotiates with the insurance company for specific benefits packages (Luft 18). An additional 9% of the population purchases health insurance directly. About 28% of the remaining population gets insurance through the government. In total, approximately 85% of the people in the United States have some form of healthcare insurance (Memon 48). However, according to the Kaiser Commission on Medicaid and the Uninsured, more than 47 million people in the United States had no healthcare insurance in 2012 (8). After the 2010 healthcare

reform, the Patient Protection and Affordable Care Act (ACA), is fully implemented, analysts estimate that 26 million Americans will remain uninsured (Kliff)⁵.

In the United States, instead of centralized federally-mandated policies, there is a “patchwork system of state regulation of most private coverage” (Luft 19). As a result, the healthcare system is highly decentralized. Although there is no one umbrella system of government-mandated unified healthcare system in the United States, there are two major programs underwritten by the government.⁶ There is Medicare, the government-sponsored social insurance program and Medicaid, a social welfare program (Memon 48). Medicare covers US citizens above the age of 65 as well as people with disabilities. Medicaid covers those US citizens living significantly under the poverty line amounting to about 14.1% of US citizens. Medicare and Medicaid are funded through taxes from individuals and employers (Gaydos 700-703).

According to the Centers for Medicare and Medicaid Services (CMS), the United States spent 17.9 percent of GDP on healthcare. This amounts to a \$2.7 trillion yearly cost, making the United States’ healthcare system the most expensive—but not the most effective—in the world. The annual cost of Medicare was \$554.3 billion and that of Medicaid was \$407.7 billion. The amount spent out-of-pocket was \$304.7 billion (“National Health Expenditures”). An unsustainable rise in healthcare costs over the past decades has made health insurance unaffordable for an increasing number of people.⁷

⁵ At the time of writing, the ACA was just beginning to be implemented and therefore the thesis will not cover the US healthcare system since the passage and implementation of the ACA.

⁶ Other government health insurance programs include Children’s Health Insurance Program, Veterans’ Health Administration, and Workers’ Compensation (Gaydos 700).

⁷ The majority (62%) of personal bankruptcies in the US in 2007 were due to medical bills (Gaydos 706).

Despite having the most expensive healthcare system in the world, the US does not have the best health outcomes. According to the U.S. Department of Health and Human Services (HHS), the United States has 6.15 infant deaths per 1000 live births (2). The estimated life expectancy is 78.7 (in 2010); men live to an average age of 76.2 years while women live to an average age of 81 years. There are 179.1 deaths due to heart disease in a population of 100,000 (“Health, United States” 2-76). Thierry Lang et al. report that in the United States there is a variable use of the Emergency Department among the population; some studies have found as much as 85% of the cases coming into the ER are non-urgent (456). The large number of people in the US who do not have insurance, and therefore cannot afford preventive care, are left to use the ER for non-emergency care.

For people who have health insurance and can access a myriad of preventive and specialized services, the US health system is extremely effective. Although higher socioeconomic classes often receive excellent healthcare, those who cannot afford it or whose employers do not provide it have poorer coverage. As such, the United States healthcare system also has disparities based on socioeconomic class. Not only is the United States healthcare system extremely expensive with high administrative costs, it also does not cover everyone in the population, leading to unequal access (Luft 15, 22).

Despite the astounding amount of money spent on health care costs, the US lacks universal health care. Especially for the millions of people who cannot afford health insurance, there are disparities in access and poor health outcomes. Although programs like Medicaid and Medicare exist, there is no single centralized healthcare system. Instead, the US has a mélange of subsystems that leave many without healthcare. The

specific historical development of health provisions in the US sheds light on the reasons behind the current structure.

HISTORICAL DEVELOPMENT OF US HEALTHCARE

The ideal of individual liberty has been persistent in the United States, especially influenced by the Enlightenment and the US's own eighteenth century revolution. However, individual liberty has often come in conflict with the ideal of social equality (Dutton 3). When it comes to healthcare, the constitution has often been interpreted to promote individual liberty over social responsibility (Koppelman 11-12). Instead of considering healthcare a positive right requiring government intervention, the US constitution leaves it to be interpreted as a negative right requiring state abstention. The framing of health rights as negative rights goes hand in hand with American individualism. Active participation by the government in requiring individuals to pay for healthcare is seen as an infringement on individual liberty. Although this view is not shared by all Americans, it has pervaded past legislation on healthcare (Koppelman 5-8; Orentlicher 327).⁸ William Marshall writes that although American ideals like equal opportunity and social mobility go hand in hand with the idea of national healthcare, there is a constitutional culture of rugged individualism that has prevented its enactment (131-132).

⁸ Andrew Koppelman writes that healthcare can be seen as a "commodity" or as a "shared responsibility," and that the views of Chief Justices Scalia, Kennedy, and Alito on ACA's individual mandate suggest that "the choice between these two models is not appropriately a matter for politics at all, that fundamental fairness is violated by the idea of a right to health care" (8). In other words, government should not interfere in determining healthcare provisions for its citizens. Furthermore, viewing healthcare as a right would be a violation of "fairness," i.e. individuals who are not sick would be paying for those who are. An emphasis on individual responsibility over social responsibility is evident in their views.

Nevertheless, in response to the excesses of the Industrial Revolution, some in the United States in the beginning in 1912 started calling for state involvement in providing healthcare as part of a movement to “safeguard living standards in the face of large-scale industrial capitalism” (Dutton 33). Termed the Progressives, they calling for greater government involvement but believed that a small economic elite had too much control in politics and had compromised laborers’ wellbeing in blind pursuit of profit. Progressives called for “opportunity, equality, and social justice” (Dutton 34). However, even if the idea of equality was in the political rhetoric, it was not widely supported. The American Medical Association (AMA), labor unions, and employers were against the Progressives’ call for universal health insurance. Even though President Franklin D. Roosevelt was a Progressive, he did not openly support health insurance as part of the 1935 Social Security Legislation (Dutton 34; Johnson 334). He was afraid that since the AMA was staunchly against national health insurance and labor unions did not push for it, including it in the bill would sink the entire Social Security Legislation. As a result, the 1935 bill was passed without it (Johnson 334).

The end of World War I brought large scale unionizing in the United States with workers calling for better conditions (Dutton 43). In the US, the American Federation of Labor (AFL) was prominent (48). However, even though the AFL called for worker safety, it vehemently attacked the compulsory health insurance proposals of the Progressives. Instead of working with the Progressives to build a state health insurance system, the AFL insisted on “worker autonomy and voluntarism at all costs” (Dutton 50). Members of the AFL believed that compulsory health insurance would be paternalistic

and would give state too much control over workers (Dutton 48). Labor unions instead called for healthcare benefits through employment (Orentlicher 328).⁹

In addition, there was strong opposition to the creation of national health insurance by the AMA starting in the 1920s. Its members, who were physicians, feared that greater government involvement in medicine would result in a loss of professional autonomy (Starr 247).¹⁰ The strong resistance from the medical establishment was key in stopping the creation of a national healthcare system in the United States. Throughout most of the early twentieth century, the AMA spent vast resources to block healthcare legislation. For example, in 1948 when President Truman and a Democratic Congress called for national healthcare, the AMA spent millions in propaganda against “socialized medicine” (Johnson 334). In its campaign, the organization argued that a government sponsored healthcare system would mean higher taxes and worse quality of care. Up to that point in US history, no other organization had spent that much money in lobbying. Unsurprisingly, the AMA won and no healthcare legislation was passed (Johnson 342).

Even though the AMA continued to fight government involvement in health care during the 1950s and the 1960s, Congress was successful in passing Medicare and

⁹ David Orentlicher writes that “The labor leader Samuel Gompers apparently feared that benefits gained through legislation rather than negotiation would be vulnerable to later repeal or limitation. He probably also felt that benefits won by negotiation would make workers more likely to support unions” (328). In other words, labor unions wanted workers to have more autonomy in their healthcare negotiations without government involvement; additionally, labor unions would be more powerful if they were the ones representing workers in seeking healthcare.
¹⁰ Paul Starr writes that “there were points of tension between the reformers and the physicians, especially where the Progressive search for efficiency conflicted with the doctors’ defense of their income and autonomy. Some reformers saw health insurance as an opportunity to subordinate medical practice to public health...[a change that] the doctors would not accept” (247). In other words, the AMA opposed national health insurance so that doctors would have more control over medicine. Autonomy, therefore, was more important than public health and social welfare.

Medicaid in 1965 because it was not created on its own but added on to the existent social security legislation (Johnson 334-350). In 1964, along with a democratic majority Congress, Lyndon B Johnson, who was instrumental in passing the legislation, was elected president. The administration “recognized that a health insurance plan focused on Social Security beneficiaries would be much easier to sell than a plan for all Americans” because these recipients would be seen as *deserving* and not taking advantage of taxpayer money (Orentlicher 329). Medicare would be for people who had or whose spouses had paid into the Social security system and thus had already paid for the services they would receive (Orentlicher 329). Medicaid would be for children and certain adults, “poor persons who did not seem responsible for their lack of insurance” (Orentlicher 331). In other words, recipients of both Medicare and Medicaid were seen as *deserving* of the healthcare they would receive (Orentlicher 329-331).

It is notable that throughout the call for healthcare in the twentieth century, public opinion polls showed that Americans were in favor of government involvement in healthcare (Johnson 339). However, conservative Democrats and Republicans, and the AMA did not support it (Orentlicher 328-330).¹¹ In 1965, there was support for proposed Medicare legislation from “citizens on the East and West coasts, Democrats, residents of urban areas, and families making less than \$10,000 per year” (Johnson 349). With strong public support and the framing of Medicare as an amendment to social security

¹¹ When President Truman tried to enact national health insurance before President Johnson, he “faced a recalcitrant Congress that at the time was dominated by a conservative coalition of Republicans and southern Democrats” (Orentlicher 328). In other words, both Republicans and more conservative Democrats were against national health insurance; when Republicans presented alternate legislation, they pushed for less government involvement and more reliance on the private sector. It is only because a Democratic majority in Congress during President Johnson’s time supported the legislation that it was able to pass (Orentlicher 330).

legislation instead of a new law on its own, Democrats made compromises to win over Republicans and the AMA to finally pass Medicare in 1966 (Johnson 350-353).

One of the reasons that healthcare legislation has been difficult to pass is the specific structure of the US government. David Wilsford argues that healthcare policy is influenced by the strength of the American state. He writes that the US has a “weak” state marked by interest group domination in policy making. Instead of a strong state that dictates what it sees as in the best interest of the people, the “stateless state” allows policy to be strongly influenced by interest groups such as the AMA (Wilsford 56).

In addition to the weakness of the US state when it comes to healthcare policy, there is also an emphasis on individualism and a general skepticism of state interference in public life, as is evident in the constitution’s emphasis on negative rights as opposed to positive rights. Instead of the framing of healthcare as a universal right that the government should implement to ensure social welfare, there is a greater emphasis on the individual to provide healthcare, a commodity, for himself or herself. Government interference in healthcare, then, is seen as an infringement on individual liberty. The difficult passage of Medicare and Medicaid show how these factors have influenced the trajectory of healthcare legislation in the US.

OVERVIEW OF THE FRENCH HEALTHCARE SYSTEM

The French healthcare system is organized to provide universal healthcare coverage. The state-controlled Statutory Health Insurance (SHI), legislated in 1945, covers all people residing legally and illegally within the country. The SHI has several subsections, and the three main components are the “general scheme,” the “agricultural

scheme,” and the “scheme for self-employed people.” The “general scheme” under SHI covers 87% of the French people through employment-based insurance and through a social welfare healthcare program for the unemployed called *Coverture Maladie Universelle* (CMU). The “agricultural scheme” covers 6% of the people, mostly farmers. Lastly, the “scheme for self-employed people” covers 5% of the population comprised of self-employed professionals. Individuals must be enrolled in a scheme and cannot opt out (Chevreul et al. 17-29).

The French healthcare system costs the government approximately 11.14 percent of GDP (Degos et al. 254). According to The World Bank, this is an annual cost of about 290 billion dollars. Healthcare services are funded through taxes paid by employers and workers. While France spends considerably less money than the United States on healthcare, it is the most expensive healthcare system in the European Union (Degos et al. 254-256). The rising cost of healthcare has been and continues to be a concern for the French; however, relative to the US, costs are kept low because prices for health services are set nationally (Chevreul et al. 17-29; Costich, “France” 553).

The Ministry of Health is largely responsible for healthcare delivery and supervision in France. The Ministry decides how money will be rationed to hospitals, mental health centers etc. It is also responsible for setting prices for procedures and medication in conjunction with the National Health Authority (Chevreul et al. 24). In other words, the government sets standardized pricing for the entire nation. All schemes under the SHI are covered through “a national health insurance fund” (Chevreul et al. 29). While there is local control over the administration of care, there is a centralized national insurance fund that streamlines payment of all services.

Overall, France offers high quality care and thus has strong health outcomes. It fares significantly better on factors such as infant mortality and life expectancy than the US. According to the World Health Organization (WHO), France has three infant deaths per 1000 live births. The estimated life expectancy is 82 years; men live to an average age of 78 years while women live up to an average age of 85 years. The Standardized Death Rate (SDR) due to cardiovascular disease was 119 in a population of 100,000 (WHO). In France, it is extrapolated that about 35% of the ER visits are non-urgent; most of the patients utilizing the ER as a form of uncritical care were “unemployed, homeless, born outside of France, and without health insurance” (Lang et al. 456).

France has relatively high patient satisfaction and the majority of French citizens are satisfied with the healthcare system (Dutton 6). Laurent Degos et al. report that “65% of French citizens feel very positive about their health system and only 6% consider it a serious concern” (254). As was noted by the WHO when it ranked the French healthcare system as the best in the world in 2000, there are many criteria that are met exceptionally well in France: “level and distribution of health outcomes, level and distribution of responsiveness, and fairness of financing” (Degos et al. 254). Although there are some health disparities that vary regionally and among socioeconomic groups and although the national health system has a relatively high cost, overall, the French healthcare system has been successful (Costich, “France” 553-573).¹²

¹² Julia Costich writes that despite a universal healthcare system, there are poorer health outcomes among unskilled workers and the employed in France. Although they have access to healthcare, people in this demographic “do not visit physicians (particularly specialists) at rates proportionate to their burden of disease” (“France” 571). Additionally, people in southern France have better health outcomes than those in the northern regions. Costich points to factors such as better diet and environment quality as the reasons for this disparity. In short, the healthcare disparities in France stem less from access to care than from other factors.

Under the SHI, France offers universal health care. Although France is concerned about the relatively high cost of the system, the country has good health outcomes and the majority of people in France are satisfied with it. Among French citizens, there has been and still is strong support for a universal healthcare system. The historical development of the healthcare system sheds light on its underlying values.

HISTORICAL DEVELOPMENT OF THE FRENCH HEALTHCARE SYSTEM

Also based in the Enlightenment, the ideas of individual liberty and social equality were prominent during and after the eighteenth century French Revolution. The French people were disillusioned with the absolute control over the state by the monarchy and aristocrats. These very prominent class divides led to widespread disparities and perhaps thus more strongly fueled the people's desire to take over and control the state for greater social equity. Even though individual liberty is greatly valued in French society, it is accompanied by a strong emphasis on using the state's power to promote social equity (Dutton 9, 20). Michel Roth writes that the French believe "that the role of good governance should be to organize rights and opportunities for its citizens" (330). In other words, it is a French tradition that the government should be *actively* involved in ensuring rights, such as the right to healthcare, for its populace.

These ideals so well highlighted in "*liberté égalité fraternité*" have permeated French health policy. They were especially prominent during the Industrial Revolution when social disparity again came to the forefront. The poor social conditions brought on by industrialization gave rise to a group of people called the *solidaristes* in early twentieth century French politics. They believed that unregulated capitalism was bad for

society because laissez-faire policies led to disparities. So, they called for “commonsense compromises between socialism and unbridled capitalism” (Dutton 34). In particular, they called for compulsory health insurance to guarantee access to health care in France (Dutton 33-34).

Support for compulsory health insurance in France grew after it annexed Alsace-Lorraine in 1918. Since Alsace-Lorraine was formerly under German rule, it had participated in the national health insurance scheme put in place by Chancellor Otto von Bismarck in the 1880s. France feared that Alsace-Lorraine would seek independence if France brought about too many changes in the new territory. However, in order to promote unity, France not only allowed Alsace-Lorraine to keep its health insurance system but started an attempt to institute national health insurance in the rest of France as well. Thus the annexation of Alsace-Lorraine was instrumental in propelling France towards universal healthcare (Dutton 40; Immergut 90).

A push for national healthcare after the annexation of Alsace-Lorraine was also accompanied by the rise in unions and their calls for health care coverage after World War I in France. The call of the *solidaristes* for compulsory health insurance was supported by the *Confédération Générale du Travail* (CGT), the trade union connected to the Socialist Party. The unions were a rising and influential voice in France. Continued workers’ strikes motivated employers to offer health insurance as a way to assuage workers. Thus, two prominent voices—the unions and the *solidaristes*—were calling for social insurance. Although there were voices of opposition and a call from doctors to ensure their autonomy in a NHI scheme, France was successful in creating a bill that satisfied the unions, the *solidaristes*, and doctors; these groups were able to come

together and reach a compromise (Dutton 43-64). Those calling for national healthcare strongly believed not only in the principles of solidarity and social responsibility but also the government's responsibility in ensuring those principles. As a result, in 1928, France passed a law for national health insurance (NHI) that "covered salaried workers in industry and commerce whose wages were under a low ceiling" (Rodwin 32). In 1945, the NHI was expanded to include all residents of France (Chevreul et al. 17-29).

Since there has been emphasis on equal access to healthcare in France, French citizens have called for active involvement of the state in order to reduce healthcare disparities and improve healthcare access. David Jones argues that even though individual liberty is important to the French, they are disposed to give up some individual choice for greater equality. He defines equality as "equal application of the law with the ultimate goal of equal outcomes due to equal provision of services" (221-222). In this drive for equality, French citizens have demanded active state participation in healthcare. This emphasis on using the state's power to provide healthcare has led to greater centralization of services (Jones 217-222).

Historically, France has been what David Wilsford qualifies as a "strong state." It is characterized as and viewed by the French people as "the sole embodiment of the public interest with commensurate powers against political and social manifestations of private interests" (Wilsford 29). In other words, when it comes to creating policy, interest groups have limited power compared to the state. If state governing bodies decide that a certain action is in the best interest of the populace, and if the populace is behind that action, the strong state has more leverage than a weak state to implement policy even if there are interest groups working against it. However, being a strong state does not mean

that France is completely impervious to interest groups but instead that it has more authority over them (Wilsford 34-38). It is illustrative that while there are medical unions in France, there are no medical associations.

COMPARISON OF US AND FRENCH SYSTEMS

The US and French healthcare systems are starkly different in their organization. In the US, there is no unified health insurance system but a decentralized patchwork of private and public systems. The result is that an astounding 47 million people are left without healthcare coverage. In comparison, France has national health insurance system that covers almost everyone within the country's borders. Before the ACA, the US government did not require that all US citizens buy health insurance. In France, however, citizens cannot opt out of the national health insurance scheme.

Because of the thoroughness and inclusiveness of the French healthcare system, people enjoy better health outcomes. France fares significantly better in important measures such as infant mortality rate and life expectancy. Compared to France, the infant mortality rate is more than twice as high and the life expectancy is three years shorter in the US. Additionally, the US spends 17.9% of its GDP on healthcare while France spends 11.14%. The US, despite its significantly higher percentage of GDP, has poor health outcomes and higher disparities among socioeconomic levels.

In France, the centralization of the healthcare system goes hand in hand with tighter government regulations aimed at ensuring equality. The historical development of the system and its roots in French values shed light on why French healthcare is different from that in the United States despite the fact that both are economically successful

Western countries. In France there has been a higher emphasis on active government involvement in providing people healthcare coverage due to the revolutionary ideal of social equality. While change has been revolutionary in France, it has been evolutionary in the US due to the prevalent idea of rugged American individualism. There is a greater emphasis on state abstention in healthcare because state involvement has historically been seen as an infringement on individual liberty. In contrast to the idea of solidarity and a belief that the government is responsible for providing healthcare, there is more emphasis on individualism and the individual's responsibility in providing for himself or herself.

It was in response to the excesses of the Industrial Revolution that citizens of both countries called for government involvement in healthcare. France, however, was successful in passing national health insurance legislation while the US was not. While the annexation of Alsace-Lorraine was instrumental in bringing national healthcare to France, reform was also aided by the support that the *solidaristes* received from unions. In the US, on the other hand, groups like the AMA and workers unions were unable to reach a compromise; the government was, therefore, unable to pass healthcare legislation.

There was a push for national healthcare in both the US and France but in the US, the call for worker autonomy won over the idea of social responsibility. While the *solidaristes* in France and the progressives in the US both called for healthcare, the *solidaristes* were able to reach a compromise with unions. The major union in US, on the other hand, emphasized worker autonomy over state control and rejected the Progressives' healthcare proposal.

The emphasis on individualism in the US and the contrasting emphasis on solidarity in France shed light on social welfare values in both countries; these values can be extrapolated and applied to the healthcare for undocumented immigrants in both countries. While the US lacks formal healthcare provisions for undocumented immigrants, France has created a separate healthcare system for them. France, as part of the European Union, recognizes healthcare as a human right—not merely a citizen right—while the US has considered it an individual responsibility. The debate regarding ACA shows that the country is still divided on the role of government in healthcare. In contrast, there is no debate in France when it comes to healthcare rights.

The US emphasis on individualism has left not just undocumented immigrants but also many US citizens without healthcare. In the US, there has been a reliance on the individual rather than the state to provide healthcare. The strong French state has created a highly regulated and centralized healthcare system that does not leave out undocumented immigrants. The US, on the other hand, has a fragmented system of healthcare that is not centralized and lacks regulation in many key areas. The result, including loopholes in regulation specifically concerning undocumented immigrants, are explored in the following chapter.

IV. HEALTHCARE PROVISIONS FOR THE UNDOCUMENTED

The goal of this section is to outline the healthcare provisions available to undocumented immigrants in the US and France. The US does not have a healthcare system in place for undocumented immigrants while, in contrast, France does. Furthermore, while some irregular immigrants seeking emergency care in the US are extra-legally deported, France gives eligible severely sick undocumented immigrants legalization so they may seek healthcare in France. This chapter details the legislation, practices, and healthcare structures that pertain to the contrasting treatment of undocumented patients in France and the US.

In the United States, undocumented immigrants do not formally receive healthcare coverage for primary care through the government. However, hospitals are required by law to provide emergency healthcare to all people. Once they stabilize patients in need of urgent care, hospitals—not required to provide follow-up care—sometimes send undocumented patients back to their countries of origin to curtail costs. This extralegal deportation often creates health risks for patients (Pitt).

In contrast, the French government provides preventive healthcare to undocumented immigrants free of charge through the *Aide Médicale d'État* (AME) program. Although the AME program is based in humanitarian ideals, it has shortcomings. Not all undocumented immigrants are eligible and not all who are approved have access to care (“Access to Health” 42-43). In addition to the AME, the

French government has also created the illness clause that legalizes severely sick undocumented immigrants so they may receive care in France. Instead of deporting severely sick patients, France gives them an opportunity—albeit a limited one—for gaining legality (Fassin, “Humanitarian” 83-88).

LACK OF PROVISIONS IN THE US

Currently, there is no formal healthcare system in place for undocumented immigrants in the United States. Of the 46.3 million total people in the United States without any healthcare insurance, undocumented migrants count for about 7 million (Irshad 800-801). They are unlikely to have private insurance because most undocumented workers are not employed in jobs where employers provide health insurance; additionally, buying private insurance on their own is likely unaffordable for many undocumented migrants, who earn less than the minimum wage (Irshad 801).

Up until the mid-1990’s, many undocumented immigrants were, in fact, eligible for Medicaid coverage (Chesler 259). There existed the PRUCOL (“permanently residing under the color of law”) doctrine, a vaguely worded provision that stated any person “permanently residing under the color of law” could not be denied Medicaid benefits (Sheridan 744). In other words, undocumented aliens could receive healthcare coverage and other government benefits as long as the INS was not actively looking to deport them (Costich, “Legislating” 1047).¹³

However, Julia Costich writes that even though “the majority of undocumented immigrants could not benefit from the PRUCOL doctrine because their lack of legal

¹³ Unfortunately, there is very little literature on this topic.

status was clear, a broad category of immigrants had access to publicly-funded health care because of their uncertain legal position” (“Legislating” 1047). In other words, undocumented immigrants who were not being sought by the INS could receive government-funded healthcare. She goes on to note that many healthcare providers still “provided necessary health services” to aliens irrespective of their legality (“Legislating” 1048).

One reason for this practice was that the Supreme Court had mandated in *Plyler vs. Doe* in 1982 that states allow undocumented people to receive basic public benefits (1048). According to the court, “in some circumstances persons generally, and children in particular, may have little control over or responsibility for such things as their ill health” and therefore undocumented immigrants should not be denied access to healthcare as a form of punishment for being illegally resident in the US (*Plyler*). Because of this Supreme Court ruling, healthcare providers did not have to check immigration status to determine federal aid eligibility. Before 1996, federal regulation was lax enough that many undocumented people benefited from publically funded health services (Irshad 804).

However, in 1996, Congress passed the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) in order to cut spending, specifically on social services (Costich, “Legislating” 1049). In the face of rising healthcare costs, Congress limited healthcare access for undocumented immigrants (Cutler and Gruber 1). It made undocumented workers ineligible to receive federal and state benefits, including non-emergency Medicaid; they could still receive emergency care (Irshad 804). This, in effect, disqualified PRUCOL. Although the PRUCOL doctrine was ambiguous at best

and did not clearly allow undocumented people to receive government sponsored healthcare, the PRWORA outright prohibited it (Costich, “Legislating” 1047-1049).

According to PRWORA, undocumented immigrants are ineligible for “any retirement, welfare, health, disability . . . or any other similar benefit for which payments or assistance are provided to an individual, household, or family eligibility unit by an agency of a State or local government or by appropriated funds of a State or local government” (qtd. in Irshad 805). In other words, undocumented immigrants cannot qualify for Medicaid or Medicare. They are not eligible to receive government-funded preventive care but can still receive emergency care.

However, there are safety net provisions throughout the United States, though they are often inadequate. People with irregular status may go to public healthcare providers such as the 1,200 to 3,000 community health centers in the United States that receive federal dollars (Celone 135; Bernstein). These centers, however, do not have nearly enough resources to provide all undocumented immigrants with necessary care (Bernstein).

In his study of undocumented Triqui workers, Seth Holmes identifies substandard treatment of those seeking care at free clinics¹⁴. Some healthcare professionals do not recognize the structural factors that contribute to illness. They are apt to view individual behavior and assumed cultural differences as the main cause of illness or reason for its persistence. They do not take into account, for example, the extreme toll agricultural work takes on a body and the severe limitations of undocumented patients’

¹⁴ The Triqui are an indigenous people from Oaxaca, Mexico

underprivileged place in society. Such misunderstandings are perpetuated by language barriers. Holmes gives the example of an undocumented worker who sought care for migraines at a free clinic¹⁵. The stress of his life as an agricultural worker and the hopelessness he felt in the face of perpetual discrimination and verbal abuse at the hands of his employers made him fear that he might lash out at his family. When he related this to a doctor at the free clinic, she simply told him to go to therapy. She discharged him without making sure that he understood what therapy was. Holmes explained to him what was expected of him, and the patient realized that he could not afford \$15 sessions. When Holmes later interviewed the doctor about the patient, she explained that in her experience migraine medications were ineffective and that people expected to be violent should be imprisoned (Holmes 111-154).

Although the above example shows an especially dismissive doctor, there are many healthcare professionals who do want to help undocumented workers; however, free clinics and community health centers are not sufficient. They are not located everywhere that they are needed; as such, they are often inaccessible for many undocumented workers who live in remote locations (Celone 135). The result of this inaccessibility of preventive healthcare is that many undocumented workers—like many of those without healthcare insurance in the US—wait until their illness has progressed to such a point that they need emergency care (Celone 135).

Although the PRWORA made public benefits inaccessible to undocumented immigrants, it did not supersede the Emergency Medical Treatment and Active Labor Act

¹⁵ Holmes worked alongside the Triqui people as an agricultural laborer as part of his study.

(EMTALA) (Irshad 806). Enacted in 1986, EMTALA banned hospitals receiving Medicaid funding from rejecting uninsured patients seeking emergency care. As such, hospitals could not practice patient-dumping, at least not within the United States (Irshad 806). Emergency rooms are thus required by law to stabilize any person who requires emergency care, no matter the immigration status (Celone 135-6). Thus, while undocumented immigrants are ineligible for non-emergency Medicaid, they are eligible for emergency Medicaid (Agraharkar 577-8).

The use of emergency services by undocumented workers who are largely denied preventive care has many adverse consequences. Because they do not receive preventive healthcare, they are forced to use emergency rooms, thus not only letting their health deteriorate but also creating a larger cost for health care providers and even US taxpayers. Preventive care costs significantly less than emergency care: according to estimates, emergency care is four to ten times more costly than preventive care (Celone 139, 143).

In addition, while hospitals are required to provide emergency care to patients, they do not always receive full reimbursement from Medicare for providing emergency care (Irshad 819). During the years 2005-2008, the government allocated \$250 million a year for emergency healthcare for undocumented workers (Agraharkar 578). The yearly cost sustained by hospitals for treating undocumented people, however, is an astounding \$2 billion (Celone 138). This uncompensated care translates into higher costs of care overall (Irshad 810-812). Thus, the EMTALA requirement that hospitals provide emergency care to undocumented people, coupled with the lack of preventive care

measures perpetuated by legislation like PROWRA, leads to higher medical costs for consumers throughout the healthcare system.

Due to the high cost of healthcare, hospitals are unlikely to provide follow-up care to undocumented patients after they have been stabilized. While EMTALA requires hospitals to treat emergency conditions, it does not require hospitals to provide care after stabilization. However, the Department of Health and Human Services (HHS) requires that if a patient who needs follow-up care is discharged after receiving emergency care, he or she can only be discharged to “appropriate” facilities (Agraharkar 573). These “appropriate” facilities are those “that can meet the patient’s assessed needs on a post-discharge basis and that comply with Federal and State health and safety standards” (qtd. in Agraharkar 576). The legislation, therefore, does not cover international facilities, thus leaving them in a legal no-man’s land.

MEDICAL REPATRIATION

Due to this gap in health care legislation, numerous hospitals have, in effect, privately deported stabilized patients to their countries of origin in order to curtail costs. The exact number of medical repatriations is unknown since ambiguity in legislation allows them to go unreported—there is no governmental body that oversees these occurrences (Sontag, “Immigrants”). However, it is estimated that more than six hundred undocumented migrants were deported over the past five years from hospitals across the country. It is likely that the actual number is much higher (Pitt).

Hospitals usually carry out these extralegal deportations through private ambulances, private plane, or commercial planes without going through immigration

authorities. There even exists a private company, MexCare, that hospitals contract to carry out medical repatriations for them (Sontag, “Immigrants”). The cost of transportation is paid for by the hospitals since offloading patients is cheaper than paying for follow-up care.

The process of medical repatriation risks the health of patients. The actual vehicle used for transportation is not always suitably equipped or staffed to provide medical care. If complications arise en route, the patient may not receive the necessary care to prevent further deterioration (Agraharkar 571). Once patients arrive at the destination facility, it is unlikely that they receive adequate care (Irshad 809). Even when hospitals claim that the patient is being transferred to an “appropriate” facility, there US standards dictating what constitutes an “appropriate” facility do not apply to foreign locations (Agraharkar 584-5). International law, too, is fickle in this case since the US has ratified the relevant international conventions with reservations that allow medical repatriation (Agraharkar 584).

Moreover, hospitals do not always gain consent from patients before repatriating them. According to US law, patients—or in certain cases their guardian(s)—must be notified of post-discharge procedures and their choices must be taken into consideration (Agraharkar 570-576). However, hospitals have sometimes repatriated patients while they are still unconscious or comatose. There have certainly been cases where patients’ or guardians’ wishes have been disregarded (Pitt).

When it comes to immigration and healthcare laws, medical repatriation, if not strictly illegal, at least lies in a legal grey area. Michael Celone writes that “immigration

courts have generally suspended removal based on an individual's health" but only if the undocumented individual meets rigid and limiting criteria (137). Even though EMTALA is not violated because the patient is moved after stabilization, this form of "international patient dumping" occurs extra-legally (Agraharkar 584; Sontag, "Immigrants"). Undoubtedly, the standard of due process is violated when patients are deported outside of legal channels (Agraharkar 589).

Very few cases involving medical repatriation have been challenged in court. Their impact has been minimal (Agraharkar 580). Writing in 2010, Vishal Agraharkar states that there has only been one medical repatriation case that has gone to the courts. In the case of Luis Alberto Jimenez, the court decision ultimately did not prevent his repatriation. An undocumented person from Guatemala, he was hospitalized after a car accident and subsequently remained in a vegetative state for a year at Martin Memorial Hospital in Stuart, Florida (Sontag, "Jury Rules"). When Martin Memorial sought to relocate Mr. Jimenez to a Guatemalan rehab center, Mr. Jimenez's guardian challenged the decision in court (Procaccini 476-480). The hospital won; it argued that since Martin Memorial could not find a facility in the US willing to take Mr. Jimenez and since the hospital itself could not provide the necessary services, it was in the best interest of the patient to be taken to Guatemala where an "appropriate" facility had been found. An appellate court overturned the lower court's ruling in part because it found the rehab facility to not fit the guidelines for an "appropriate" facility. However, the hospital transported Mr. Jimenez before the ruling was overturned. Mr. Jimenez stayed in the rehab center for a short amount of time and was then sent to his mother's village in a medically underserved area (Agraharkar 580-1).

As can be seen in Mr. Jimenez's case, medical repatriation results from discordant government requirements and the financial incentives of hospitals. Since the government does not provide healthcare coverage for undocumented immigrants but does require that they be provided emergency healthcare, hospitals have to bear the brunt of the costs. After a patient is stabilized, it is unlikely that medical facilities will accept an insured undocumented patient for follow-up care. Whereas EMTALA prevents domestic patient dumping, there is no clear-cut legislature to prevent international patient dumping. The result is medical repatriation, an extralegal deportation of patients that not only circumvents United States' laws but also has the potential to harm the patient.

HEALTHCARE PROVISIONS IN FRANCE

In contrast to the restrictive and ambiguous legislation in the US, France has created clear-cut laws pertaining to healthcare for "irregular" immigrants. France provides a system of healthcare to some illegal immigrants residing within its borders called *Aide Médicale d'État* (AME) that was legislated in 1994 ("Access to Health" 42). The AME exists separately from the social healthcare system for legally employed people in France and from the *Couverture Médicale Universelle* (CMU), the state-run healthcare system for unemployed legal residents (Duguet and Bévière 29). Under AME, eligible undocumented aliens can receive publically funded preventive healthcare services without fear of deportation. If an applicant is approved for AME, he or she receives a certificate that serves as documentation of coverage ("Access to Health" 42-43). The AME recipient shows this certificate to providers who get reimbursed by the government for providing care (Gray and Ginneken 4-6).

The application for AME can be submitted through hospitals, NGO's, and health and social service centers (Gray and Ginneken 4). The application has three main requirements: proof of identification that can be in the form of a passport, birth certificate, etc.; proof of three-month uninterrupted residence in France to be demonstrated through documentation such as utility bills; and proof that the household income of the applicant is less than 634 Euros per month ("Migrants" 17; "Access to Health" 42-43). While AME coverage used to be free, a yearly 30 Euro fee was initiated circa 2011 ("Migrants" 17). Of the 400,000 undocumented people estimated to be in France, 180,000 receive AME coverage (Gray and Ginneken 4).

Those undocumented workers who can demonstrate that they have been living in France for over three years can receive another form of healthcare. This coverage is not as comprehensive as AME but allows them to see primary care doctors free of charge. However, proving uninterrupted residence for three years is challenging for most undocumented residents and many eligible undocumented people go without coverage (Gray and Ginneken 6).

Those undocumented immigrants who do not have any form of healthcare coverage can still receive some other forms of medical care. Emergency care is offered through any type of hospital with ER's. Other services such as "treatment of contagious diseases (necessary to eliminate a risk for public health), all types of healthcare for children, [and] maternity care and abortion for medical reasons" are theoretically accessible through public hospitals ("Access to Health" 43). Although treatment of chronic illnesses in adults is not offered, pre- and post-natal care for women is ("Migrants" 24; Gray and Ginneken 6).

The aforementioned list of services is provided through healthcare centers termed *Permanences d'Accès aux Soins de Santé* (PASS). Public French hospitals are required by law to run PASS centers, which receive reimbursements for treatment through a state emergency healthcare fund (“Access to Health” 43). Accessing PASS services does not require health insurance or documentation; usually, care is offered at little or no cost. In addition to PASS, there are other forms of healthcare venues for undocumented people. Paris, for example, has free clinics that provide preventive healthcare and chronic illness treatment to indigent populations, including undocumented workers. Nonprofit clinics run by organizations such as *Médecins du Monde* also provide some services (“Migrants” 30-35).

Although many forms of healthcare provisions exist in France, not all undocumented people who are eligible for coverage receive health care. Speaking specifically of AME, thousands of eligible undocumented people find barriers to access. Bradford Gray and Ewout van Ginneken write that even though AME is applicable nationwide, there is “uneven interpretation and implementation of the law across agencies and cities” (“Access to Health” 55). The result is that “only 11% of foreign nationals covered under the AME system are able to access their rights on demand” (“Access to Health” 55). While theoretically AME is supposed to offer the same coverage to undocumented people as it does to people enrolled in the national insurance system and CMU, the range of services offered to AME recipients varies regionally within France (Gray and Ginneken 4-6).

Some providers simply turn away AME certificate holders even though doing so is unlawful (“Migrants” 43; Gray and Ginneken 6). This is due to the lengthy and

convoluted AME reimbursement process through the state. In 2005, *Médecins du Monde* led a study of health care providers in 10 different cities in France to find that an astounding “37% of the health professionals [observed] refused to treat *l’Aide Médicale d’Etat* (AME) recipients” (“Migrants” 42). Thus, even if a significant number of undocumented immigrants are officially covered through AME, many are denied services in practice.

While providers that deny AME recipients often want to evade lengthy administrative processes required to get reimbursed, many are often unaware of or misunderstand AME. There is “a lack of knowledge of the law on the part of public services and benefits agencies” (“Access to Health” 55). There have been cases where staff has asked AME recipients to pay when they are not required to do so (“Migrants” 44). This problem is exacerbated since many undocumented immigrants themselves are not knowledgeable about AME (“Access to Health” 55).

Even though safety net healthcare venues like PASS centers and clinics exist, they too are problematic. Many PASS centers deny coverage to those seeking care (“Access to Health” 55). Although public hospitals are required to create PASS centers, many do not because there is a general lack of resources to fully fund them (“Migrants” 35, 38). When it comes to nonprofit clinics like those operated by *Médecins du Monde*, there is again a lack of resources to offer treatment to every undocumented person in need (“Migrants” 30).

The requirements one must meet to be approved for AME are also limiting in two ways. One, undocumented people are required to provide proof of residence for three

months; this can be challenging for people who are generally living in precarious situations (“Migrants” 19). Two, the economic threshold set for AME is very low; in order to qualify for AME, the undocumented worker must earn extremely low wages. In fact, the economic threshold is even lower than the poverty line in France. In other words, if undocumented immigrants earn at the poverty line, they earn too much to qualify for AME (“Access to Health” 55).

Additionally, some scholars, including Stéphanie Larchanché, have identified substandard treatment of AME recipients. She writes that illegal immigrants who seek out AME are often faced with significant mistrust and disdain from the AME offices (858). Many applicants are “harassed” to such an extent that they either face significant delays in their application process or they give up AME altogether (Larchanché 860). The case of a Malian woman applying for AME serves as an example. Although her application was approved, it is illustrative of the discrimination applicants sometimes face. Larchanché relates the woman’s account:

So I told her I earned 400 euros a month...And she looks at me frowning, as if I’m a liar...I feel like I’m begging to this woman, and she thinks I’m a liar...I told her sometimes, when I braid on the side, I make a little more. And she screamed at me, repeatedly, ‘so how much is it you are earning???’ I was frozen. I wanted to scream back at her. I never responded. (861)

As the patient’s experience highlights, irregular immigrants face many barriers to access. Despite the existence of AME, PASS centers, and health clinics, not all undocumented immigrants seeking care receive it. Although France has many healthcare provisions in

place for irregular patients, they do not always work seamlessly in practice. Nevertheless, AME is unique, even among European countries, and it grants access to health care for some undocumented immigrants.

THE ILLNESS CLAUSE

In addition to creating AME, France also created a special law in 1998 that grants legal status to sick undocumented migrants who are already within its borders if there is fear that deporting them back to countries with poor healthcare systems will further harm their health (Fassin, “Humanitarian” 83). This is often referred to as the illness clause. Undocumented people who are approved under the illness clause receive a residency permit and often times also a work permit. Miriam Ticktin notes that the law was championed by human rights organizations such as *Médecins sans Frontières* and is rooted in humanitarianism (“Casualties of Care” 91).

Didier Fassin calls the illness clause “a humanitarian exception” because it was created at a time of restrictive immigration policies in the face of decreased economic need for undocumented labor. Advocated by NGOs and healthcare professionals who worked closely with undocumented immigrants within France, the illness clause had wide support at the time of its advent. Instead of economic need, it was grounded in humanitarianism (Fassin, “Humanitarian” 83-88). A group of thirty five NGOs called on the government to not deport sick patients if doing so could result in their death (Ticktin, “Casualties of Care” 91). Not only humanitarian organizations but also official public health institutions actively opposed the deportation of severely sick patients. The National AIDS Council, for example, criticized the French government for expelling

AIDS patients to countries where adequate care would be hard to access (Fassin, “Humanitarian” 88).

The law had widespread political support. Although a few right-wing voices were against it and went even so far as to propose that hospitals report sick undocumented people seeking care to immigration authorities, they were a fringe group. Most lawmakers agreed that previous legislation pertaining to sick undocumented immigrants was problematic and needed to be augmented. In fact, the same conservative majority that called for more restrictive immigration policies passed the ban on deporting sick foreigners (Fassin, “Humanitarian” 88-9).

Before the illness clause was put into law as part of the Chevènement Act in 1998, many prefects had already started to issue residence permits to sick undocumented people in the 1990s.¹⁶ The prefects evaluated each case on an individual basis. The cases came to them from doctors in the Directorate of Health and Social Welfare (DDASS) who had evaluated a patient and recommended him or her for residency permit that would last three months. Although the patient received legal residence for a brief amount of time, he or she was not able to work. Then in 1997, the Debré Act was passed. Although it mandated that the government not deport undocumented individuals who were severely sick, it did not create provisions for granting them legal status. This created a category of individuals who were illegally resident in France and could neither be deported nor be granted legality. To fix this law that left many in limbo, in 1998, the Chevènement Act was passed. It allowed severely sick undocumented immigrants to receive residency

¹⁶ Prefects are regional governmental offices.

permits and even work permits if their doctors so recommended to the immigration offices (Fassin, “Humanitarian” 88-91).¹⁷

In order to be eligible for the illness clause, the applicant must satisfy three requirements. One, he or she must be “habitually resident in France,” preferably for longer than a year (Fassin, “Humanitarian” 98). Second, the applicant should have a “life-threatening” illness (Ticktin, “Casualties of Care” 90). Third, there should be sufficient reason to conclude that deportation of the undocumented immigrant would result in adverse health. In determining the last requirement, doctors must consider the both the availability and accessibility of healthcare in the country of deportation (Fassin, “Humanitarian” 96-103).

If an undocumented immigrant is declared sick enough to require continued treatment in France, the doctor’s office collaborates with immigration officials to provide the immigrant legality i.e. residency and/or work permits; sometimes, the immigrant is also given a work permit (Ticktin, “Casualties of Care” 104-111). The law is meant to allow access to care when an illness is “life-threatening” (Ticktin, “Casualties of Care” 90).

Undocumented workers who are severely ill can apply for legality through this process: a doctor would give eligible patients an “official medical certificate” stating that the migrant was recommended for residency papers; this official document would then be presented to immigration officials (leaving out the disease or illness that the patient experienced); the official would then decide whether the undocumented worker received

¹⁷ France is a party to the European Convention on Human Rights (ECHR), which guarantees rights for all individuals residing within the borders of the state. The move to grant work and residency permits is likely rooted in part in the ECHR.

papers. The patient might also be referred to see another doctor—one in the state medical office—who may influence the decision of the immigration office (Ticktin, “Casualties of Care” 90-111).

However, gatekeepers such as medical professionals and immigration officials determine what is considered “life-threatening.” As such, the granting of legal status can become a subjective process (Ticktin, “Casualties of Care” 90). There is no official list of “life-threatening” diseases. Most patients with AIDS or cancer who request illness permits are granted the permits at almost all prefects. However, when it comes to chronic conditions like diabetes or heart disease, the approval rate for illness permits varies from prefect to prefect. In a given year, Fassin notes that the approval rate of diabetes cases varied anywhere from 28% to 84% and the approval rate of heart cases varied anywhere from 24% to 92% from prefect to prefect (Fassin, “Humanitarian” 100).

Additionally, doctors considering patients for the illness clause must assess whether the country of origin has adequate care and whether that care is accessible. This sort of assessment lies outside the expertise of most doctors. In the years immediately following the passing of the illness clause, most doctors based their recommendation for the illness clause for a patient on the seriousness of the diagnosis and not on the availability of care in the country of origin. However, in 2002, the French government created a list of countries and the availability of treatment for specific diseases in those countries. The intent was to objectify the permit-granting process and consequently reduce the number of approvals. However, the list did not have the intended effect, especially because it did not take into account the geographical and monetary accessibility of care for the specific patient (Fassin, “Humanitarian” 103-105).

Because of this ambiguity in access to care in countries of origin and what constitutes a life-threatening illness, the doctor's or other healthcare worker's subjectivity influences the decision to recommend the patient for an illness permit. While many health care professionals recommend patients with arguably non-life-threatening chronic illnesses like hypertension, there are also some who do not recommend patients with serious illnesses. Ticktin writes of a doctor who refused to recommend an HIV positive patient simply because he did not want more HIV positive patients within French borders ("Casualties of Care" 102). Even though the illness clause is inclusive in theory, it allows anti-immigrant sentiment and other personal views to affect its implementation.

COMPARISON OF US AND FRENCH HEALTHCARE PROVISIONS

Despite the problems in the implementation of the illness clause, France is unique in allowing some eligible undocumented patients to stay in France and receive necessary care. While France often provides residency permits and even work permits to severely sick undocumented people, many US hospitals deport injured undocumented patients to their countries of origin, often aggravating their condition in the process. The Illness Clause came after AME, the French healthcare system for undocumented immigrants. It was championed by humanitarian organizations and passed by popular vote. Rooted in humanitarianism, these healthcare provisions in France stand in stark contrast to the lack of healthcare provisions for undocumented immigrants in the US for-profit healthcare system.

Another difference between the two is that while France has AME, there is no formal healthcare system in place for undocumented immigrants in the US. PRUCOL

was in place until 1996. Although PRUCOL did not prevent undocumented immigrants from receiving Medicaid dollars for preventive care and although there was a Supreme Court mandate that undocumented workers could receive preventive healthcare, there was no distinct national healthcare program for undocumented people rooted in law like the French AME and Illness Clause. These policies reflect two very different concerns. While the US passed PRWORA in 1996 to curtail costs in a for-profit healthcare system, France passed AME legislation in 1994 to provide health care access to undocumented immigrants in recognition of their human rights.

By introducing PRWORA, Congress sought to lower costs. However, limiting access does not limit need. As undocumented immigrants continue to come to the US, they will continue to need health care. Restrictive policies like PRWORA can have many adverse effects, even if viewed just in an economic sense. Because undocumented immigrants cannot access preventive care but can access much more expensive emergency care, they end up costing the government a significant amount of dollars and endanger the immigrants' health.

The safety net provisions such as free clinics in the US are inadequate. They are not always accessible and often lack resources to sufficiently help the seven million undocumented immigrants without healthcare in the United States. In this respect, however, the US is similar to France. The free clinics and PASS centers in France cannot provide care to all the undocumented population either. Not enough of them exist and many do not have sufficient resources.

AME provisions, too, are limited in practice. The stringent application requirements for AME preclude many undocumented immigrants from getting healthcare. Some immigrants are unable to provide the necessary documentation because of the precariousness and unpredictability of living with irregular status. As a result, nearly half of all irregular immigrants are not covered by AME and must turn to free public clinics for care. Furthermore, even those who are approved for AME find barriers to access. But despite these limitations, France has at least created the opportunity to receive healthcare for some undocumented people. For those who qualify, France offers preventive care. Furthermore, patients who need care for serious illness also have the opportunity to seek care and obtain legal status in France.

In contrast, patients with serious, life-threatening illnesses may face medical repatriation in the US. Repatriation results in large part from ambiguous legislation. While EMTALA requires that hospitals provide emergency care, there is no law in place to address follow-up care. Undocumented people cannot access Medicaid funds, often do not receive healthcare through employment, and cannot afford to buy health insurance. Particularly for vulnerable people, the US healthcare system is profit-centered to such an extent that patient care can be secondary to profits (Holmes 143). Therefore, when some for-profit US hospitals have stabilized patients but have no way of getting paid for follow-up care, they deport them to an “appropriate” facility. The ambiguity of what constitutes an “appropriate” facility in the country of origin is also problematic. It allows hospitals to send undocumented patients to places where they might not be able to receive the care they need. The patient becomes subject to the hospital’s interpretation of what is appropriate. This is troublesome especially when hospitals are driven by profits.

Undocumented patients in France, too, can be subject to healthcare professionals' interpretation of slightly ambiguous legislation. The illness clause requires that healthcare professionals determine the severity of the illness and whether it can be adequately treated in the patient's country of origin. Patients are thus subject to the professionals' interpretation of what constitutes a severe illness. As illustrated in the earlier example, a doctor can refuse to recommend a patient with an arguable life-threatening illness like HIV/AIDS based on his or her own political views.

Many patients with HIV and other serious illnesses like cancer receive temporary legality through the illness clause. At least in theory, France recognizes the humanity of undocumented immigrants and not just the cost their health needs pose on the nation. This approach that prioritizes patient care over profits is missing in the US healthcare system. Although undocumented immigrants face discrimination in access to health care in both the US and France, they have a much better chance of receiving treatment in France. Their access to healthcare is tentative and limited in France, but many irregular immigrants whose applications are approved are able to receive not only emergency but also preventive care. Although the cost of healthcare services is a growing concern in France, since healthcare is recognized as a human right, it is unlikely that healthcare provisions for *sans-papiers* will be repealed.

V. CONCLUSION

Even though they make a significant part of the workforce in both France and the US, irregular laborers do not have reasonable access to healthcare services in the US and many have limited access in France. That undocumented immigrants not only lack sound healthcare provisions but also experience medical repatriation in the US likely stems from the understanding of healthcare as an individual responsibility. On the other hand, the French believe more strongly that the government is responsible for providing healthcare to all people within its borders, whether they are legal residents or not. Since healthcare is recognized as a human right, there exist the AME and the illness clause. Although both these provisions have shortcomings, they do give healthcare access to those who qualify. Based on the imperfect yet existent healthcare provisions in France and their lack in the US, the thesis concludes that the contrasting treatment of undocumented immigrants results from the contrasting underlying social values in both countries.

Even though France and the US treat their undocumented immigrants differently when it comes to healthcare, both countries have historically relied on them as laborers. During periods of economic prosperity in France and the US, irregular migration was tolerated to a great extent (Schain 43, 212). Even when the US implemented the Bracero guest worker program starting in the 1940s, often employers hired undocumented immigrants because it was easier than hiring legal labor. Throughout the program's

implementation, undocumented workers arrived, began working, were apprehended by law enforcement, taken back to the border, and instead of being deported, were given legality so that they could travel back and resume work (Martin, “Mexican Migration” 121-122). Similarly in France in the 1960s, there was a need for foreign labor. Despite the presence of legal migrant workers, many French employers used undocumented workers to avoid “lengthy [legal] formalities” (Tapinos). Even though policies to discourage undocumented travel existed, the French state turned a blind eye to illegal border entry because of the economic benefits of using cheap labor (Hargreaves 7).

The two countries also had policies that directly encouraged undocumented labor. NAFTA resulted in a loss of jobs for Mexican farmers, creating a push factor for undocumented migration to the US. Ironically because of NAFTA, many undocumented workers now harvest crops in the US that get shipped back to their countries of origin (Martin, “Mexican Migration” 124). Similarly, France influenced undocumented migration by using labor from its former colonies. It created the expectation of regularizing undocumented immigrants but left them in the lurch when the economy stagnated (Hargreaves 7-21).

Both countries continue to use and benefit from undocumented labor. The US relies heavily on irregular immigrants in many industries. Nearly a quarter of the entire labor force in farming is undocumented. In addition, irregular workers form a significant part of cleaning, construction, and food preparation industries (Hanson 39). France, too, has a reliance on irregular immigrants. The *sans-papiers* in France work in industries that face legal labor shortages such as construction, restaurants, cleaning, home care, winemaking, agriculture, textile, etc. (Prakash; Reed; Moussu; “A New Balance”; Fassin,

“Compassion” 372). Experts contend that *sans-papiers* are a necessary part of these economic sectors (Moussu).

Not only do irregular immigrants contribute to the economies of France and the US by working, they also make welfare contributions. However, they often do not benefit from them. In the US, irregular workers pay income, sales, social security, and property taxes (Bacon 79-80). In France many irregular immigrants contribute to social security and retirement schemes (Vermeren 18). While *sans-papiers* in France are unable to benefit from retirement schemes, they can, however, access preventive healthcare services through programs like the AME. That is not the case in US. Undocumented immigrants in the US cannot receive many services funded through taxes, such as Medicaid.

Undocumented workers are largely underpaid, often less than the legal minimum wage, and are unable to speak out for fair wages and better working conditions. As irregular immigrants face financial instability and are desperate for work, they are often unwilling to risk losing their jobs by speaking up (Vermeren 15; Tapinos). Since the police can perform identity checks based on profiling, most undocumented workers are reluctant to bring attention to themselves out of fear of imprisonment and deportation (Vermeren 15; Tickin, “Casualties of Care” 36, 45).

Therefore, irregular immigrants make up a vulnerable demographic, especially because they are unable to claim many rights. Despite their contribution to the societies they live and work in, their illegality prevents them from claiming the rights enjoyed by citizens. Although both the US and France have healthcare provisions in place for

undocumented migrants, they fall short. However, France is significantly closer in realizing that right than the US. US hospitals are barred from rejecting patients who need urgent care but are not required to provide costly preventative care to people who are unable to pay. While the US essentially does not have a healthcare system in place for irregular immigrants, France does. In addition to emergency care, France offers preventive care coverage to qualified *sans-papiers* (“Access to Health” 42).

What is most remarkable, however, is the stark contrast between the instances of medical repatriation in the US and the illness clause in France. While hospitals in the US sometimes ship sick undocumented patients who have been stabilized after emergency care to their countries of origin to curtail costs, the government in France has legislated the illness clause to offer legalization and even work permits to severely sick undocumented people (Sontag “Immigrants”; Fassin “Humanitarian” 83). The reasoning behind these two contrasting practices is perhaps reflected in the development of the broader healthcare systems in the two countries.

In the United States, instead of centralized federally-mandated policies, there is a “patchwork system of state regulation of most private coverage” for legal residents (Luft 19). There has been no overarching national health insurance system. Even government legislated programs like Medicare and Medicaid were only passed in the face of strong opposition and after several failed attempts (Johnson 334-353). The lack of centralization and the prevalence of private over public insurance is perhaps rooted in the fear that government intervention in healthcare will not ensure rights but instead infringe upon individual liberty.

In contrast to the US, France has a centralized and tightly regulated national healthcare system. It covers almost all of the population living within France. Ensuring equal access and inclusivity were strong rationales behind French healthcare legislation. The centralization of the system—going hand in hand with government control over it—is perhaps rooted in the belief that the government is responsible for ensuring the right to healthcare; in order to ensure equitable access to that right, the French are willing to give up some individual choice (Jones 217-222).

In contrast, rights language is largely missing from US healthcare legislation (Orentlicher 327). When the recognition of healthcare as a human right is not prevalent even in rhetoric pertaining to US citizens, it is far from being realized for undocumented immigrants. As is evident from the historical trajectory of US legislation, healthcare is more of a commodity than a right. Even though there have been repeated calls from many groups, such as progressives, to consider healthcare a right, they have been drowned out.¹⁸ An emphasis on individualism and personal responsibility rather than communitarianism and social welfare has been prevalent.

In contrast, the French have been more willing to prioritize social welfare. The healthcare model in France is not based on profits the way the US healthcare system is; instead, it functions with the recognition of healthcare as a human right where the end-

¹⁸ Analysts conclude that even the Patient Protection and Affordable Care Act (PPACA), legislation that comes closest to offering universal healthcare, is not rooted in human rights. Jean Connolly Carmalt, Sarah Zaidi, and Alicia Ely Yamin write that the entailing “reforms are structured as an expansion of a market-based model that leaves fundamental questions unanswered about justice and equity” (154). The healthcare system in the US still remains profit-based; critics argue that the end-goal largely remains financial gain for the private sector instead of equal access to affordable care for patients (Carmalt, Zaidi, and Yamin 170). This was, however, the most that advocates for healthcare reform could get—and even it is highly contested.

goal is patient care. This includes not just citizens but all who live in France.

Additionally, a different understanding of human rights, including economic and social rights, and an emphasis on the overarching principle of solidarity rather than an emphasis on cost control and profit maximization brings healthcare for *sans-papiers* into the fold. Because the healthcare system in France relies heavily on public insurance and less so on private insurance, the result is very different.

In the US, there is a heavier reliance on the private market. The ensuing problems are exacerbated by the absence of government regulation. Jean Connolly Carmalt, Sarah Zaidi, and Alicia Ely Yamin write that “from a rights-based perspective, the problem with US healthcare is not the mixture of public and private funding per se, but rather the failure of the government to step in and level the playing field in the face of obvious inequities in the system” (160). In other words, the absence of government in ensuring healthcare provisions for people in the US strongly contributes to unequal access. This applies to undocumented immigrants, especially in cases of medical repatriation. Because the US government does not have legislation to cover follow-up care for irregular patients and does not have a system in place for preventive care, hospitals have been able to perform international patient dumping (Agraharkar 584).

In analyzing the US healthcare system, Paul Dutton writes that “one would have to return to the France of the 1960s to find the same levels of the uninsured and the shamefully poor access to healthcare” (6). But when it comes to healthcare for undocumented immigrants even today, France does not have a perfect system. Qualifying for AME is difficult and many *sans-papiers* who are eligible do not receive adequate care (Gray and Ginneken 6). The illness clause, although unique and generous, also allows

room for subjectivity (Ticktin, “Casualties of Care” 90). However, despite their imperfections, France does have AME and the illness clause in place. Both are rooted in the recognition of healthcare as a human right. Both were created through active government legislation.

This is not the case in the US: healthcare is not widely regarded as a human right and the approach to immigrants in this nation of immigrants is less than inclusive. Slowly, the US is moving towards universal healthcare coverage and perhaps learning from the French model. However, when it comes to regulating healthcare for undocumented immigrants, the US government is absent. Healthcare provisions are based on different understandings of the role and responsibility of the state to promote public good and are reflective of a society’s values especially in regard to the responsibility of the individual versus the community. Concrete legislation like the illness clause exists in France because of the strong emphasis on social welfare and government responsibility in ensuring it, even for *sans-papiers*. The US, on the other hand, where healthcare is still not legislated as a human right and government involvement is often seen as an infringement on individual rights, has a void of legislation. This leaves immigrants in the richest country of the world experiencing practices, like medical repatriation, that violate the right to human dignity.

The study of the treatment of undocumented immigrants exposed several areas in the field that require more research. There is a lack of data on the number of medical repatriation cases in the US. Since there is no formal agency to oversee medical repatriation, the extent and severity of this practice remains largely unexplored. Additionally, the implementation of the PPACA will also influence the treatment of

undocumented immigrants in the US and will open up a new area of study. While there is literature on the relationship of the PPACA to human rights, there are not many sources that directly link social values or human rights to healthcare provisions for undocumented immigrants in the US. This is also partially true for France: while human rights language is strongly cited in literature when it comes to healthcare for *sans-papiers*, it is surprisingly difficult to find authors relating their arguments to a discussion of French social values. A deeper understanding of these values and their link to the current treatment of undocumented immigrants will bring attention to the largely concealed experiences of an especially vulnerable demographic in both of these wealthy Western countries. An extensive study on the social values that are held most deeply in the US and French societies will likely show a discrepancy between what these values are in theory and what they are in practice. It will, hopefully, lead to an acknowledgement of the contributions of and the deservedness of people who remain largely in the shadows due to their so-called illegality.

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