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A Moral Perspective on Refugee Healthcare

Tanaya Sparkle and Debanshu Roy

Abstract

There is currently an increasing number of international refugees due to political warfare and natural calamities. Over the recent years, countries are shying away from assisting with the provision of healthcare to this vulnerable population either in their home country through humanitarian aid and services or in the host country by providing free healthcare coverage. World leaders and politicians have attempted to ignore the morality behind these decisions and have put forth a false narrative of scarcity and racism to appeal to the population of developed countries. As this question remains unsolved, we have attempted to look at the question from the perspective of our moral obligations as a species. We have discussed some of the popular moral theories that support providing healthcare services to global refugees and refuted theories that object to the same. We conclude with a brief look at the direction that countries could take without violating established moral code while attempting (without evidence) to prioritize the welfare of their citizens.

Keywords: UNHCR, refugee healthcare, moral theories, lifeboat ethics

1. Introduction

Migration is not going away. A fight for survival and a spirit of curiosity are well-established tendencies of our species. It is hard to put a historical timestamp on when human beings, as we know them, started migrating from their place of birth and settlement to other areas. Some did it in search of better opportunities while others were forced to migrate due to issues such as natural calamities, personal threats, and political warfare. These numbers have only increased with an increase in the world population, climate pattern changes, and individual countries becoming hostile to their own community.

It is no surprise that refugees experience social inequality during their many interactions during displacement and will most likely experience deterioration of their physical, psychological, and social well-being. Poverty and social isolation have adverse health effects in transit and the destination country. The refugees primarily rely on the host community facilities for accessible, acceptable, and reliable healthcare services. While these healthcare services may be partially covered by government health systems and insufficient health insurance, lack of information and language barriers [1] pose significant obstacles to accessing these services effectively. These are particularly significant for undocumented migrants who are often denied access to services for public health or unwilling to use services available to them because of fear of deportation. It is well documented that even migrants with legal rights to healthcare will face numerous obstacles to their use [2]. A systematic

review noted that women with refugee status fared worse with respect to perinatal measures, including mental health, offspring mortality, and preterm birth, compared to women from other migrant groups [1]. The global community faces a crisis, unlike any before. While improved transportation and connectivity have enabled migration and awareness, the steep increase in the number of refugees has led to a lack of consensus when it comes to the matter of refugees and human rights.

One of the primary challenges legislators and healthcare providers face when it comes to providing health security to refugees is a popular ideology that the host country has no responsibility, implying moral and legal, toward providing adequate and safe healthcare to the refugee population due to the argument that responsibility toward its own citizens takes precedence. Support for this argument has been established by the growing number of leaders who have been recently voted for based on their closed border policies [3]. In the light of mounting healthcare costs and challenges related to the provision of healthcare for their population, it is imperative to examine the moral and ethical philosophies proposed toward and against providing health security to the vulnerable world refugee population.

The question of morality here, however, is a complex one due to the contribution of human conscience and sympathy, both of which are subjective and harder to invoke during times of scarcity. Morality also has a temporal, cultural, legal, social, and racial contribution, which makes it harder to examine objectively [4]. Considering this growing human rights crisis, the moral question of the responsibilities of other countries toward resettling and ensuring health security for refugees is an existential one for our species.

2. Methodology

The authors have attempted to synthesize an opinionated albeit comprehensive narrative review on the topic. A broad perspective has been presented including various theories of morality that support the provision of basic healthcare to refugees around the world along with some of the major alternate arguments. Search terms and subject headings were identified for databases including MEDLINE, Google Scholar, and Pubmed. Relevant articles and book chapters were selected. The search used keywords “refugee,” “ethics,” “healthcare,” “morality,” “asylum,” and “aid.” Majority of the articles were obtained using some variation of search string (*ethic* OR morality OR principle**) AND (*refugee* OR asylum**) AND (*healthcare OR aid OR service*). Reference lists of review articles were also searched for any contributory publications. No restrictions were placed on region of origin of publication or on the type of article due to the epistemological nature of the chapter. A google search was also done with the same keywords for news and public opinion articles that were not included in the previously mentioned scientific databases.

3. Historical background

After World War I (1914–1918), millions of people fled for their life. Governments of stable countries were forced to respond by assembling and agreeing to guidelines regarding the provision of travel documents for these people. These numbers increased significantly after World War II (1939–1945), as many more were forced to move and settle elsewhere. The United Nations High Commissioner for Refugees (UNHCR) was founded after World War II on December 3, 1949, due to the increasing number of displaced people [5].

The primary goal was to monitor and protect the human rights of the refugees and displaced people. As the numbers continued to increase, global communities were unsure about the appropriate response.

One of the primary goals of the UNHCR was “To provide international protection to refugees and to seek durable solutions for refugees by assisting Governments in facilitating the voluntary repatriation of refugees, or their integration within new national communities” [5].

According to UNHCR, a refugee is someone who has been forced to flee his or her country because of persecution, war, or violence. They do not have much to lose and a lot to gain by securing entry into a country that, despite the legal uncertainties, is safer than their home country. Two-thirds of all refugees worldwide currently come from just five countries: Syria, Afghanistan, South Sudan, Myanmar, and Somalia. Although two-thirds of the world’s refugees come from Syria due to the civil war, the rest are fleeing from other conflicts such as ethnic violence in Myanmar, religious persecution against Muslims in South Sudan, and political warfare in Afghanistan.

According to the 2019 World Health Assembly Update, between 2000 and 2017, the number of international migrants has risen by 49%, a staggering 258 million people. They also noted that most of the refugees are hosted in low- and middle-income countries contrasting the picture painted by political figures. It is valuable to note that the number of internally displaced people has been higher than the number of refugees and asylum seekers confirming that, in most cases, people try to find a safe space within their country due to similarities in culture, religion, language, and food. Estimates by the United Nations Department of Economic and Social Affairs suggest that over 90 million refugees live in the European area of the WHO, accounting for nearly 10%, and nearly one-fifth of the world’s population. According to the estimates of the UNHCR, about 5.2 million refugees and 1.4 million asylum seekers live in the region (including refugees) [6]. In short, the numbers are staggering and only rising by the day.

4. Existing laws and guidelines

An examination of ethics is incomplete without a look at current legal provisions. The existing moral code of the people dramatically influences the laws and policies of the state. The United Nations 1951 convention and 1967 protocol had positive outcomes, with 148 countries attending and agreeing to the framework that was laid out. The global policy structure with ramifications for international health security has been recently defined by the World Health Assembly Resolution (2008), the Executive Committee (2007) and the Guiding Principles on Migrants and Refugees Health (2007), and Resolution 70.15 of the World Health Assembly on 2017 on Refugee and Migrants Health.

Other relevant frameworks and resolutions from the past include [7, 8]:

- The 1951 Convention relating to the status of refugees (ratified by 50 of 53 member states) and the 1967 Protocol relating to the status of refugees. The 1951 convention was initially limited to the people fleeing before January 1, 1951 and within Europe, because of World War II. These limitations were removed in the 1967 protocol, making it more universal.
- The 1990 International Convention on the Protection of the Rights of all Migrant Workers and Members of their Families.

- The 2000 Protocol to Prevent, Suppress and Punish Trafficking in Persons, especially Women And Children (ratified by 52 of the 53 Member States).
- The 2000 Protocol against the Smuggling of Migrants by Land, Sea, and Air (ratified by 48 of the 53 Member States).
- World Health Assembly resolution 62.14 on reducing health inequities through action on the social determinants of health and
- WHO Regional Committee for Europe resolution EUR/RC52/R7 on poverty and health, and related follow-ups, such as efforts to address health inequity linked to migration and ethnicity.

5. Current situation and global trend

Changes in governments over time and change in the attitudes of people have made it hard to ensure enforcement of the international laws and guidelines on the provision of healthcare to refugees. Some of the countries such as Germany and Canada welcomed several refugees and provided asylum to them, while others such as the United States and Austria have taken a more rigid stance against them and have implemented legal and physical barriers against asylum seekers. These governments were elected based on their border policies, and therefore, the decisions are not those of individual people alone but a collective majority. This general trend based on a narrative of fear, racism, and scarcity is, unfortunately, proving to be an excellent political strategy. Chancellor of Germany, Angela Merkel, who strongly supported an open border for refugees making Germany one of the most refugee-friendly countries in Europe, had a decrease in popularity shortly after the most significant intake of refugees. News articles reported that her decisions were not well received in the country.

Similarly, Donald J. Trump, president of the United States of America who won in 2016, has a strong anti-immigrant and closed border policy, which continues to be popular with many people in the United States. These recent global trends have made it harder to enforce policies to ensure health security for refugees. The British voted, by a significant majority, to leave the European Union for similar reasons. They cited “unacceptable strains on housing, welfare, and education” as one of the prime reasons for this decision [9–11].

Governments supporting closed borders and fueling racism have led to increase in the backlash against immigrants or ethnically different groups. Right wing support correlated with hate crimes in Germany according to a survey analysis. Similarly, hate crimes in India had surged by 300% which correlated significantly with the election of the right wing Hindu Nationalistic Party, “BJP” [12]. These changes are concerning as it not only endangers the new vulnerable influx population but also affects the integrated existing immigrants and their future generations. Far right policy changes could leave all refugees, immigrants, and even resident nonimmigrants without basic healthcare.

6. Theories of morality

Moral theories attempt to determine right and wrong conduct. They allow individuals and, in extension, countries to critically evaluate the decisions they make in terms of impact beyond the social and economic implications. Morality has allowed the human species to survive in mutual harmony and to promote maximum welfare.

There are many moral theories. Some of the well-studied ones are utilitarianism, Rawls theory of Justice, Kantianism, virtue theory, four principles approach, and casuistry [13].

6.1 Utilitarianism

Utilitarianism holds that morality must aim to maximize human welfare and happiness as a species. John Stuart Mill, a utilitarian philosopher, claimed that actions are right in the proportion they tend to promote happiness and vice versa, where happiness is intended pleasure and absence of pain.

This moral theory supports many actions in medicine, such as triage and social medicine. However, it fails to take into account the age of the person or our obligations toward specific people such as our children or parents. Another reason why this theory is hard to uphold is the degree of self-sacrifice it demands. It obliges us to sacrifice our interests and the interests of the people close to us for the sake of people that we do not know if that is what will maximize good or utility. For example, it is hard to convince a physician in a developed world to move to a developing country while leaving or endangering their family for “utility.” It is also hard to convince a physician in a developing country to avoid pursuing opportunities in developed countries. If going by utilitarian analysis for providing healthcare for refugees, the sheer number of refugees justifies spending resources to provide healthcare to this vulnerable population. In other words, the burden of cost is not high when compared to the suffering of the large number of refugees [4, 13, 14].

6.2 Rawls theory of justice

Rawls’ Theory of Justice [15, 16] is unique in that it considers the moral, cultural, and experiential differences among us that account for our current value system. Understanding that social systems distort our views and bias our opinions of morality one way or the other, Rawls suggests that in order to construct a system or solution for a problem, it must be done objectively. He suggested that a solution must be made after assuming that one has full control and that once implemented, they would be placed back in the society with random features such as sex, race, socio-economic status, or prior experiences of oppression or wealth. For example, in many countries around the world, students from a university in the United States that is not very competitive are given higher status than a student from one of the top-tier Pakistani universities. Although one might argue that the educational system in the United States third-tier university might be better than the education at a top-tier university from a developing nation, this is also not true as evidenced by standard test scores. If used to make a decision about admission criteria, Rawls’ theory might work out the best possible moral solution to the question. Considering these ambiguities, Rawls holds that an objective stance called “The Original Position” (OP) might be the best way to ensure that lawmakers and politicians, who are responsible for all those who are residing in that area, make decisions that are not influenced by their biases. The OP is meant to be impartial while logically striving to aim for systems that have a high probability of supporting progress and decreasing distress in society. The assumption that the policymaker will have no control over their features when placed back in the system hopes to negate some of the biases while making system decisions that impact many people. The privilege walk activity [17] famously demonstrated how the less privileged must work twice as hard as the privileged. Rawls’ concepts also show how dominant systems, countries and organizations, construct systems that ensure their dominance. Rawls believes that social stability can only be achieved by elevating everyone to equal moral worth. Although

he supported distributing resources from the wealthy to the poor, he also stated that opportunities should be based on just innate qualities and a motivation to excel.

Rawls' Law of Peoples adds to the Theory of Justice to provide insight into global ethics and a definition of justice without directly addressing immigration. He relaxed his assumption of society as a closed system or nation-state. He suggested that a decent liberal regime must be enjoyed by all people and expanded on principles of noninterference, respect for human rights, and assistance for countries lacking the conditions for a just regime to arise.

Criticism of Rawls mainly involves practical aspects of implementing a true OP. Also, strict equality principles are rarely favored in the world as there is no easy way of distinguishing between the passive, the corrupt, and the underprivileged. Either way, this has been looked upon as an excellent moral guideline when it comes to making decisions about international health policies and global refugee health security.

6.3 Moral subjectivism

Moral subjectivism [4] holds that right and wrong are determined by the subject and that there are no objective moral properties. All ethical judgments, according to moral subjectivism, are not absolute truths but an attitude or opinion of the subject. In contrast, moral realism states that ethical principles are independent of the personal attitude. A subjectivist, by reasoning, cannot object to anyone's behavior as all behaviors have been approved by the subject in question.

A few objections have been raised about the theory. A subjectivist making a statement about an ethical issue is only communicating a belief and not facts, although the statement might be confusing. For example, when stated by a moral subjectivist, "He is a liar" cannot be an objective statement announcing what one considers an immoral act but can only be a subjective opinion.

There are different types of moral subjectivism:

1. *Simple subjectivism*. The view that all ethical thoughts are not objective truths but personal feelings and attitudes.
2. *Individualist subjectivism*. Protagoras suggested that every human had a distinct moral compass and that his self interest is the goal.
3. *Moral relativism*. Relativism is an extension of moral subjectivism to the society. This view holds that in order to be right, it needs to be approved by the society as well.
4. *Ideal observer theory*. This idea was introduced to account for the biases and irrational ideas in the minds of the people. A hypothetical ideal observer would make the decisions, if there were too many clashes [18].

6.4 Theistic morality

This theory pertains to the belief that morality is linked to religious prescriptions. A person subscribing to theistic voluntarism hold that our morality is governed by "moral obligations" as designed by God. The belief is that God's command and/or God's will (what he desires for us) are the backbone of our moral obligations [12]. Religious philosophers believe that all human beings have been created by God in his image. God's commands are a guide toward fulfilling God's will. Actions are morally required, morally wrong, or morally optional according to this theory. Christian

Miller simplified the theory by delving into scope (Who is expected to live up to a specific desire of God?), objectivity (the inherent morality of certain acts due to the creation of morality by an all-loving knowledgeable being), learning (from religious texts, leaders, revelations, reasoning), and nontheist morality (atheists are also created in the image of God and therefore with a properly functioning reasoning can grasp some of the reasons that inform God's desires related to moral obligations). This theory has been refuted both by debating the presence of a supreme being as well as arguments for "moral constructivism" and "independent moral realism" [12].

Irrespective of the religion, an obligation toward caring for the sick and helpless is prescribed as a moral obligation by the religious texts of major world religions including Judaism, Christianity, Hinduism, and Islam. In extension, healthcare policies that do not include refugees or a subset of refugees violate the code of theistic morality.

6.5 Kantian ethics

Kantian ethics [19] proposes that the morality of an act is decided by the intended consequence of the particular action. Kant said that the "maxim" or intended reason behind our action is vital for determining its rightness. For example, according to this theory, physicians are expected to prescribe what they believe to be the best course of treatment for the patient. A negative outcome due to the prescription would not be considered morally wrong. Whereas, if another physician prescribed a drug to maximize his income, the act of prescribing the drug becomes morally wrong. Kant holds that only goodwill can be morally right.

One of the criticisms is that a country's political system would have a responsibility of individual goodwill under Kantian morality, and this moral obligation would trump a question of utility. For example, according to Kantian morality, impeding the provision of healthcare to refugees would be morally wrong just by the nature of the act and its consequences on the people that the act is intended toward. It would ignore any potential negative consequences on the country's citizens and legal residents. Kant also fails to propose a hierarchy of moral obligations. For example, can one risk the death of a refugee to prevent the death of a legal resident? Can one lie to prevent the murder of their family? Although Kant proposes a moral principle, he also fails to successfully define a strong logical reason to follow his principles.

6.6. Four principle theory of morality

Justice, autonomy, beneficence, and non-maleficence provide another framework for critically evaluating the morality of decisions in Medicine. Justice implies that healthcare resources must be distributed in a fair and just manner. Autonomy allows for individual decisions regarding healthcare. Beneficence is the moral obligation that healthcare workers have to act in order to benefit the patient. Non-maleficence aims to avoid harming patients. This framework, although simplistic, is not all-encompassing, and critical large-scale decisions need to be evaluated using other moral standards.

6.7 Arguments against providing healthcare to refugees

Currently, there is no consensus regarding the matter of refugees, and in extension, the provision of healthcare services for this population. While some countries have upheld the laws that were established to protect their human rights, others

have stayed passive or voiced their lack of support. Many politicians and philosophers have argued against the provision of healthcare services, aid, food supplies, or refuge in case of war, famine, or other international crises. Some of the major claims are listed below along with a look into the validity and significance of the claim.

6.7.1 Limited resources claim

One of the most common arguments put forth against providing aid and services to refugees is the proposition that resources are limited and that wealthy countries have limited capacity when it comes to resources and capacity. The 2016 British referendum shed light on the costs imposed by refugees and migrants [20]. Garrett Hardin, an American philosopher, has elaborated on this argument in his controversial article, “Lifeboat Ethics: The Case Against Helping the Poor” [21].

He compares a developed nation to a lifeboat. He creates a metaphor by assuming that a developed nation is a lifeboat with a capacity for 60 people with it currently holding 50 with room for 10 more. He then asks the readers to imagine that if the people in the lifeboat saw 100 swimming outside begging for admission, the options that the people inside have are limited.

- Admitting all of them, which would ultimately swamp the boat and drown it.
- Admitting 10 people, which poses further questions such as which ones to deny admission, or if it is a smart decision to load the boat to capacity in the first place.

He states that although it seems “morally abhorrent to many people,” not admitting more people to the lifeboat might be the only way to ensure the survival of the people in the lifeboat by preventing resource shortages and allowing for a safety margin of 10 people” for growth. He supports his argument with the potential effects on the food supplies, fishing supply, and environmental destruction that a few additional millions would have on a “wealthy nation.” He strongly supports a closed border and unflinchingly argues that a developed nation must focus on the protection, welfare, and survival of its own people and that considering the earth’s dwindling resources, the “lucky” nations need to protect what they have instead of giving it away by accepting refugees from other countries.

As to the matter of providing aid and services to war-torn and impoverished nations, Hardin argued that death is a mechanism to prevent overpopulation from destroying the limited resources on earth, which relieves another human being of the moral duty to actively prevent this. In his subsection on “Population Control the Crude Way,” he stated that if other nations did not assist these countries, the rate of population growth in the world would be checked by famine and death. Hardin and other philosophers have suggested that saving refugee lives, by provision of humanitarian aid, poses a potential risk to the chance of survival of human beings due to the limited resources that the earth has.

Most philosophers and world leaders who support the above view are unhappy about the economic costs of providing healthcare and other resources to protect the human rights of refugees due to the costs falling on a few affluent nations. The commitment of the United States to provide \$419 million in humanitarian aid to assist Syrian refugees and the countries holding them was not well received by these philosophers and was used as an argument against the whole approach. They used the standard argument against socialism to argue that nations would be enabled to

draw from aid and to multiply in number instead of attempting to find solutions themselves, eventually bringing ruin upon the world.

The American President Donald Trump, along with other nationalist leaders around the world, believes that refugee presence is costly, dangerous, burdensome, and a drain on the country's resources and has based his political campaign on this policy [22]. Greg Ip [23] stated that people were apprehensive about refugees and immigrants, in general, more due to the value they place on cultural identity than the economy. It is evident that leaders who believe in discouraging refugees from coming into their countries resonate with many people, as evidenced by the overall support separatist leaders have received in recent political times. The return of support for nationalism among the people of developed nations and their pushback against providing refuge for individuals whose governments or people are violating their human rights increases the importance of assessing the ethics behind providing healthcare security to refugees. Although most leaders, if pressed, would agree that fundamental human rights are a requirement for the existence of the human society and species, which must transcend geographic and cultural barriers, their policies say otherwise.

There are many problems with Hardin's comparison of developed nations to lifeboats. Hardin's definition of capacity is far from the real-world capacity of most developed nations and often appeals to a scarcity mentality harbored by many politicians either as a political strategy or as a false personal belief.

Overpopulation seems to be what Hardin is concerned about in the "Lifeboat." Anne Roback Morse and Steven M Mosher defined overpopulation "as a situation where the *number of people* exhausts the resources in a *closed environment* such that it can no longer support that population" [24]. Research has shown that many developed countries are still capable of hosting many refugees before coming remotely close to their "full capacity." Forty-eight percent of people around the world live in countries that have below-replacement fertility rates. Therefore, the initial assumption of Hardin seems to be false even before the presentation of moral arguments [24].

Assuming the assumption of scarcity was true for most countries of the world, Morse and Mosher compared this situation to an office that had too many people. They suggested that, if the environment was closed, resources like water and food would be used up. However, they refuted that most environments are not closed, which is why none of the countries have launched sterilization campaigns or started killing older people, both of which would be morally wrong.

They also extended the argument by comparing the same office to an artificially closed environment, such as a country where governments prevented food and healthcare from being sent to or prevented people from leaving. The burden of morality is not on the "overpopulation of the closed environment" but the tyrannical governments locking people in without providing them with resources when they are available in abundance elsewhere.

Currently, according to research, there is food being produced for more people than people in the world. Resources like food and water are not limited. By large, matter and energy have remained relatively constant. However, they have been mismanaged and contaminated. Scientists have highlighted that currently, every human being could have 5 acres of land and half an acre of arable land. We have survived despite the bleak predictions of the past. Human beings have put their minds together to find solutions for the growing needs and dwindling resources.

By extrapolation, hunger is not a phenomenon due to low supply, but due to political failures and human flaws. Human beings have defied all predictions of doomsday using their minds and technology. There is no absolute reason to believe that they will not continue to do so.

6.7.2 Negative consequences argument

Another argument against providing aid and healthcare services to the countries is a question about the consequence of helping countries in crisis. Hardin states that helping these countries and their governments that do not plan ahead and save for a rainy day, and bailing the population of these challenged countries with aid each time will only allow them to “continue their ways” without planning for a more permanent solution. Considering the higher reproductive rate of underdeveloped countries in crisis, it further contributes toward overpopulation. Hardin believes that the overall stamp of “charity” that most measures to uplift underprivileged communities have harbors a sense of inequality that defeats the whole purpose of integration. The other “negative” consequence and concern of allowing refugees and allowing access to the public health system is the potential increase in illegal immigrants seeking to take advantage of the system. In contrast, there is sufficient evidence that when appropriately integrated, migrants contribute to the economic development of the host country. As per the 2003 stats, 29.4% physicians and 43.5% of nurses in the British National Health service were migrants [25]. According to the analysis of the government expenditure data from 2004 edition of Public Expenditure Statistical Analyses and the public finances section of the Financial Statement and Budget Report, Sriskandarajah et al. reported that the relative net contribution of immigrants was higher than that of the United Kingdom born. They used the ratio of immigrants’ contributions to their consumption of public expenditure, which represented the net annual fiscal contribution (NAFI). The NAFI of migrants has remained higher than that of the UK born since 1999, with a steady relative increase in the contribution from migrants. The NAFI was calculated after apportioning the cost of administering the asylum system to the immigrants alone. To summarize, the migrant NAFI/UK-born NAFI has increased from 1.03 to 1.09 even if the growing asylum costs were divided and included in the immigrant expenditure for calculation [25].

There is little evidence that healthcare is a driver for migration. The major “push factors” noted include conflict in home country and desire for economic progress [26, 27]. Resident migrants and refugees often contribute to the delivery of healthcare and contribute to economic growth of the host country [28].

6.7.3 Competing needs claim

There is a reluctance of most governments to provide refugees with the same healthcare services extended to their citizens. This is due to a concern that by doing so, the vulnerable populations (citizens) of the country might be negatively impacted. Although most policy makers agree upon the universal morality of providing equitable healthcare to all populations, this is sidelined in the name of an already overburdened healthcare system and the potential to encourage illegal immigration by provision of welfare services to all [29]. “Health-related deservingness” [30] has therefore been used to justify excluding refugees and asylum seekers from public healthcare systems. This deservingness has been defined individually by each country based on race, religion, national belonging, and perceived contribution to the society and used to discriminate against refugees. Further studies highlighting the contribution of these immigrants economically and socially might help to attend to the misconception that forms the main basis of this argument.

Besides the strain on the healthcare services, there is a concern that for one group to benefit, the other has to lose out [31]. Due to the motivation of “national economic interest” and the current citizens of the country, policies favoring

equitable healthcare access for refugees and asylum seekers are rejected. There is sufficient evidence from multiple countries around the world showing the economic benefits of migrant influx. It has also been shown that restricting the access of refugees to healthcare could increase the cost more [32, 33].

6.7.4 Cultural and national identity claim

Recently, the importance of national identity and cultural differences as a reason for intolerant attitudes toward refugees has come into light. This has been found to be the primary reason for the support for exclusionary healthcare policies by the host population [34]. A deeper look into this claim is essential considering its growing importance in the political climate of today's developed world.

Refugees from sociocentric cultures find it harder to integrate as compared to egocentric individualistic cultures [35, 36]. Higher social barriers and limited opportunities for new refugees also leads to a higher probability of turning to "their own kind" and forming diaspora communities [37]. This leads to a heightened awareness of their own cultural identity and encouragement of parochial altruism (and potentially outgroup hostility) [38]. All of these factors have been shown to lead to a social distrust, thereby indicating that for a country with a large immigrant population or a country open to welcoming refugees, multiculturalism, albeit controversially, is not the best situation. Unfortunately, mistrust and social exclusion of refugees leads to "collectivistic communities" and "looking inward," which only worsens the problem of social exclusion. In sufficient numbers and in smaller countries, these communities might pose a greater threat to cultural and national identity than if they were welcomed and allowed to integrate successfully with the host country.

Sniderman et al. showed that national identity trumped economic considerations as a reason for opposition to immigrant minorities in western Europe [39]. Tsukamoto and Fiske, across three studies, showed that immigrant groups were thought to be untrustworthy and perceived to threaten American civic values (political ideology, etc.), but not ethnic values (shared cultures, customs, etc.) [40]. The British Social Attitudes Survey indicated that the perceived threat to limited resources, shared traditions of the British society, and, to a lesser extent, the potential for increased crime were the main reasons for an opposition to immigration and, in extension, provision of any services that might encourage immigration [41].

Recent literature has also attempted to tease out some of the factors that lead to a host society fearing loss of national identity and thereby opposing provision of healthcare to refugees, which is thought to encourage immigration. Grajzl et al. proposed and demonstrated that the longevity of national identity had a robustly negative effect on the preference of the host population for cultural assimilation of refugees and immigrants [42]. The modern acculturation theory refers to cultural assimilation as "melting pot" and accommodation of cultural diversity as "multiculturalism." "Ultra-Tolerance" has been described as hypocrisy by some thinkers as in many parts of the world, "tolerance" has started leading to discrimination by the separation of the "tolerant" from the "backward and intolerant" [43].

Irrespective of personal beliefs regarding the claim, the ethics of providing healthcare to refugees is not altered. Fear of loss of cultural identity (religious) might cause psychological distress and hardship to the host population. However, the difference in cost makes it impossible to morally justify the withholding of basic life-preserving and welfare-preserving services to refugees. The question of whether the cost of losing national identity is enough to warrant not permitting refugees to enter is a different one and out of the scope of this discussion.

7. Conclusion

It is easy to understand the moral obligation of helping a man who is bleeding or a woman in labor on the street. The moral obligation is no different when we do not see them directly. Most of the major moral theories, if used to solve the question of providing healthcare coverage to refugees and internationally displaced population, allow us to conclude that in order to be on the right side of morality, it is essential that we do everything we can to provide basic healthcare coverage to all people. Each country does have the liberty to decide what the “minimal acceptable health coverage” needs to be. In the long run, providing healthcare services to all people residing in a country will ensure the welfare of the whole population: citizens, temporary residents, and asylum seekers.

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Conflict of interest

The authors declare no conflict of interest.

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