

# Medical Deportation in the United States as an Extension of State Sovereignty: Immigration Enforcement, State Surveillance and Migrant Health

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## Abstract

Although the right to health is recognized by the World Health Organization as one of the most fundamental rights of every human being, migrants encounter particular barriers in accessing health services and attaining adequate health states. There exists an interconnection between access to healthcare and precarious migrant statuses that put migrants at risk of being deported when seeking medical treatment. Medical deportation—also called medical repatriation—refers to the extralegal practice of forcibly removing immigrant and migrant patients to their country of origin to avoid the burden of costly hospital care. This analytical essay will investigate the logics and mechanisms behind medical deportation in the United States which facilitate the state's production of sovereignty through the control and surveillance of migratory populations. This knowledge will be utilized to understand the barriers faced by irregular im/migrant populations in seeking medical care and the implications of transnational labour migration and medical deportation on migrant health. Not only do irregular im/migrants face the risk of deportation when seeking medical care, shaping their health-seeking behaviours, but they are also commonly positioned in undesirable work situations that heighten their vulnerability to health risks. Moreover, the act of medical deportation neglects to consider an im/migrant's ability to access adequate healthcare within their 'home' country, further placing im/migrants in precarious health circumstances.

**Keywords:** immigration, medical deportation, health policy, migrant health

## Introduction

Quelino Ojeda Jimenez left his small mountain village in Mexico at the age of sixteen to find work in the United States to help support his family. He journeyed to South Carolina and then moved to Georgia where he worked as a roofer. Four years later, he travelled to Chicago to work on a building near Midway Airport (1). While trying to remove a sheet of metal from a roof, he fell backwards twenty feet to the ground below. After being comatose for three days, he awoke at Advocate Christ Medical Centre, nearly quadriplegic and reliant on a ventilator (2).

Quelino Ojeda Jimenez was in the U.S. illegally and after nearly four months of care at Advocate Christ, he was abruptly loaded onto an air ambulance and transported to the city of Oaxaca in Mexico, without his consent and despite his family's contestation. The hospital in which Jimenez was first transported did not have a bed for him and specialized only in emergency care (1). He was then transferred to a smaller hospital that had no rehabilitation services and lacked funding for new filters needed for his ventilator (2).

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Jimenez remained in the hospital in Mexico, four hours away from his family, for one year. He suffered two episodes of cardiac arrest and developed bedsores and a septic infection before dying at the age of twenty-one on January 1, 2012 (2).

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Increased regular and irregular migratory flows globally have led scholars to gain a distinct interest in understanding im/migrants' (a term used to include all immigrants and migrants) access to human rights and basic services within host countries. Regular migration refers to the migration of foreign nationals who comply with immigration laws, whereas irregular migration—also referred to as 'illegal' migration or migrants with 'undocumented' status—refers to the migration of foreign nationals who do not comply with immigration laws (3). Although the right to health is recognized by the World Health Organization (4) as one of the most fundamental rights of every human being, im/migrants encounter particular barriers in accessing health services and attaining adequate health states. In the U.S., irregular im/migrants are not eligible for any federally funded public health insurance programs (5). Although the Patient Protection and Affordable Care Act (ACA) was passed in 2010 with the goal of providing affordable and accessible care to the uninsured population of the U.S., the ACA prevents all undocumented im/migrants from accessing any government-based medical care (5). The only means through which irregular im/migrants can receive healthcare is under the Emergency Medical Treatment and Active Labor Act (EMTALA). This is an (unfunded) federal law that mandates hospitals to treat all patients, regardless of insurance status or ability to pay, in emergency situations (6). In summary, undocumented im/migrants in the U.S. have access to emergency medical care under EMTALA, but there is no framework to ensure long-term access to healthcare and there are few potential reimbursement mechanisms for hospitals treating uninsured undocumented im/migrants.

As a result of these gaps in policy, a budgetary burden is placed on hospitals that provide care to irregular im/migrants, blurring the line between healthcare

and immigration enforcement as hospitals resort to medical deportations to avoid the costly responsibility of providing ongoing or long-term care. Medical deportation—also called medical repatriation—refers to the extralegal practice of forcibly removing immigrant and migrant patients to their country of origin in order for the health system and/or government to avoid bearing the cost of hospital care (7). Although most medical repatriations go unreported, hundreds of cases, such as that of Quelino Ojeda Jimenez, have been uncovered and the issue has steadily gained attention in American im/migration literature. However, medical repatriation is not a phenomenon that only affects irregular im/migrants such as Jimenez. Indeed, permanent residents with green cards, temporary visa holders, and at least one U.S. citizen with parents without legal documentation were involuntarily medically deported as a result of being uninsured (7). Therefore, although irregular im/migrants are at a higher risk of medical deportation, uninsured im/migrants also bear the risk of being forcibly removed from the United States when seeking medical care, demonstrating the depth and breadth of the issue. As well as having harmful implications for the lives, health and well-being of migrant and immigrant individuals and their families, the practice of medical deportation can be recognized as a state mechanism of immigration enforcement and surveillance used to regulate and monitor the presence of 'non-citizens' within a country's national boundaries. Through an examination of the academic literature on migration, this essay will investigate the logic and mechanisms behind medical repatriation as a facilitator of the state's production of sovereignty. This knowledge will be utilized to understand the barriers faced by undocumented im/migrant populations in seeking medical care and the implications of transnational labour migration and medical deportation on migrant health. Not only do im/migrants face the risk of deportation when seeking medical care, shaping their health-seeking behaviours, but they are also commonly positioned in undesirable work situations that heighten their vulnerability to health risks such as accidents, injuries and inadequate social determinants of health. Moreover, the act of medical

deportation neglects to consider an im/migrant's ability to access adequate healthcare within their 'home' country and can lead to family fragmentation and economic instability, further placing im/migrants in precarious health circumstances. This essay will first explore the relationship between medical deportation and the state, and then examine the effects of medical deportation on im/migrant health by scrutinizing both the direct and indirect consequences of the practice.

## Medical Deportation and the State

### *i. Access to Healthcare: Membership, Deportability and Deservingness*

In high-income countries, citizens of a particular state and im/migrants residing in that state have access to different degrees of rights based on their membership to the state. As Martin Ruhs (8) explains, the rights prescribed to individuals with citizenship status differ from human rights because they are derived from a relationship with a particular state, rather than from universal notions of human dignity. In other words, although human rights are based on the principles of universality (they apply to everyone everywhere) and inalienability (they cannot be denied to any human being), they are implemented and enforced differently by states based on national interests, creating a category of rights directly tied to citizenship status rather than common humanity (8). However, citizenship status is not automatically provided to im/migrants residing in a particular state and immigration policies tightly limit and regulate their access to citizenship and hence, their access to certain rights. Irregular im/migrants are ineligible for citizenship and have limited access to a number of rights on the premise that they do not belong to the national community and are a threat to national sovereignty (3). Da Lomba (3) argues that states view the right to healthcare as a membership right that they are reluctant to provide to 'outsiders within'. Although at least a degree of membership status is offered to lawful permanent residents, temporary visa holders, and U.S. citizens born to parents without legal status, individuals falling under these categories have experienced involuntary medical deportation as well (7). In this sense, medical deportations can also be

seen to function under Public Charge law which allows the forced removal of migrants and immigrants based on the discretionary determination of an individual's potential to become a public burden (7). As Alonso-Yoder (9) explains, notions of public charge exclusion have developed from colonial histories and are rooted in racially-based fears and discrimination. Therefore, im/migrants of the United States experience restricted access to the right to healthcare as a result of national laws and policies that operate based on the idea that im/migrants are 'outsiders' to the national community, which is inherently rooted in racially- and ethnically-based fears and the idea that im/migrants are a threat to national sovereignty. In fact, evidence suggests that the majority of cases of medical repatriation involve individuals from Latin America (7). Given America's historical and ongoing discrimination against and exclusion of Latinx peoples, this statistic points toward prejudices being played out in hospitals, influencing their tendency to resort to medical deportation.

Not only is Public Charge law rooted in racial discrimination, the idea of deportability—the lived fear of possible deportation—is experienced by im/migrants under this law. Deportability renders im/migrant labour, and undocumented migrant labour in particular, a disposable commodity by creating a vulnerable and flexible labour force that is profoundly profitable and useful in our neoliberal market society (10). In developed countries, the demand for cheap labour is based on labour exploitability which functions under the lived fear of deportation experienced by irregular im/migrants. In other words, the creation of the 'deportable' subject under U.S. immigration law positions undocumented migrants in exploitative work situations at the whims of market capitalistic goals. This simultaneously creates conditions for adverse migrant health and well-being which can be seen through oppressive work situations and the fear of seeking care.

The notions of deservingness and 'selective inclusion' are other important concepts for understanding irregular im/migrants' access to health and medical services. These concepts are based on neoliberal ideas of individual

responsibility and self-sustainability that only grant im/migrants access to the health safety net when they are presumed to have made vital contributions to society, they are viewed as having a legitimate need for health care, or they are seen as being innocent (5). As Viladrich (5) argues, the right to healthcare for undocumented im/migrants, as is framed in U.S. news coverage, functions within a merit paradigm that grants only those among the undocumented deemed 'deserving' eligibility to healthcare and social benefits. Not only do perceptions of deservingness function within capitalistic notions of productivity, "scholars have also noted that, particularly in the developed world, deservingness categories are shaped by fear and anxiety toward the foreign born, with the public commonly considering as deserving those groups they identify with the most" (5 p1449). Therefore, racially-based fears of im/migrants are represented in immigration and public health laws and policies, creating conditions for migrant exploitation and ill health. In addition to this, widespread public discourses on the right to healthcare also function within discriminatory ideas of deservingness based on perceived productivity and relatability.

## ***ii. Establishing Sovereignty: Immigration Enforcement and Surveillance***

Nation-states view irregular migration as a threat to the internal and external dimensions of national sovereignty, such as its power to control its borders and the national community's right to self-determination (3). Moreover, foreign-born individuals have been framed by the government and the media as criminals and 'freeloaders' who threaten public health and the American public in general (5). The United States' ambivalent approach to enforcing the rights of migrants is shaped by the 'state consent supernorm,' which refers to the state's primary role in the creation, implementation and enforcement of international law, as well as its national sovereignty (3). Therefore, the restriction of migrant rights, such as the right to healthcare, can be construed as an affirmation of state power and hence, immigration policy becomes grounds for the renegotiation and reassertion of state sovereignty (3,11).

While medical deportations are recognized as an extralegal practice that functions outside of the U.S. immigration system, hospitals engaging in the practice of medical deportation supplant the state by engaging in removal in cases that the state has overlooked (7). Medical deportation has become a unique method of U.S. immigration enforcement that is produced through restrictive healthcare laws and policies that bar irregular im/migrants from accessing long-term healthcare coverage. Furthermore, it extends de Genova's (10) concept of the 'border spectacle' into the internal health service market. As de Genova explains (10), the elusiveness of the law and its relative invisibility requires the spectacle of enforcement in order to make it visible and produce racialized im/migrant 'illegality'. By increasing enforcement and maximizing arrests at the border, the 'spectacle of enforcement' is staged to enhance the impression that the U.S. has control over their border and thus, control over their sovereign territory. While de Genova (10) situates this performance at the U.S.-Mexico border, we can perceive the hospital as a second stage for the 'spectacle of enforcement' through medical deportations. Additionally, hospitals become a space for the state's surveillance of 'non-citizens' whereby health providers are required to screen individuals for citizenship status (7). Therefore, by complying with the state's healthcare and immigration laws and policies, hospitals become a state mechanism that makes im/migrant 'illegality' visible through status screening and engages in immigration enforcement through medical deportation, which together re-establishes state sovereignty.

## **Medical Deportation and Migrant Health**

While the fear of medical deportation is a clear barrier facing im/migrants seeking care, there are numerous other factors that interact with one another to create conditions for the ill health and well-being of im/migrant populations. In fact, "[mis]representations grounded in empirically unfounded assertions, flawed culturalist assumptions, and racializing stereotypes interact with other tangible and intangible barriers to exacerbate psychosocial stress and constrain immigrants' ability to

attend to their health needs" (12 p808). In other words, although medical deportation negatively impacts the health and well-being of im/migrants in countless direct and indirect ways, im/migrants in general, and irregular im/migrants in particular, tend to be at an increased risk of injury, illness and violence. They also have an increased likelihood of confronting both tangible and intangible barriers to accessing healthcare (12). This can be witnessed through their tendency to occupy the most dangerous, dirty and demeaning jobs characterized by exploitation and precarity (5,12). Scholars have shown that irregular im/migrants are often discriminated against, not paid for their labour, overworked, underpaid or mistreated at work (13). Moreover, the embodiment of 'illegalization' and the frequent criminalization of im/migrants have important health effects. Anxieties surrounding 'illegality' can become embodied as allostatic load, which is the cumulative burden on the body due to chronic stress and life events. It can also interact with other forms of social exclusion, such as those grounded in racial-ethnic background and socioeconomic status, to further impede the attainment of adequate health statuses through the social determinants of health and access to care (12). Such ideologies about 'illegality', alongside notions of deservingness, can further affect migrant health through its internalization by health providers (5). Therefore, discourses of undeservingness can become silently embodied as allostatic load, visibly embodied through a delayed seeking of care that may appear as improperly healed fractures, late-stage cancers or festering wounds, and silently internalized by health providers, which can lead to inferior treatment (12).

Evidently, the everyday health and well-being of im/migrants is significantly influenced by many tangible and intangible factors, separate from medical deportation. However, it is essential that we also recognize the direct and indirect impacts of medical deportation on the lives, health and well-being of im/migrants and their family members. While medical deportation can certainly exacerbate the health-related factors discussed above, such as health-seeking behaviours, it can also introduce new and different health consequences to those experiencing it. General anxieties associated

with coming into contact with official authorities and structures may deter im/migrants from seeking care and can become intensified when combined with fears of medical deportation, leading to the delay or foregoing of treatment. Patients being medically repatriated may also experience worse treatment outcomes in their country of origin due to inappropriate or inadequate facilities or a disregard for the patient's social and spiritual well-being, contrary to what medical transport companies may claim. This can be seen in the case of Quelino Ojeda Jimenez, where the rehabilitative care necessary for his recovery and the filters needed for his ventilator were not available in the hospital he was transferred to in Mexico (1). Moreover, the transfers themselves can be risky and may lead to the deterioration of a patient's health or even death (2).

In addition to affecting the health of the individuals experiencing medical deportation, the individuals' families can be severely affected. Deportations separate families, which can lead to economic instability and loss of support. Moreover, the repatriation of an individual to a hospital in their country of origin may place them far from any family. For Quelino Ojeda Jimenez, his wife and children lived four hours away from the hospital in which he was staying and spent little time with him because of their inability to afford transportation or accommodation (1). It is clear that countless interconnected factors in the everyday life of im/migrants lead to adverse health outcomes, which are compounded and magnified in the presence of the possibility of medical deportation. Health risks can be perceived in the type of positions irregular im/migrants tend to work, their health-seeking behaviours and the embodiment of 'illegalization' and deportability, as well as in their ability to access care after deportation and family separation.

## Conclusion

While there exist no formal mechanisms for reporting medical deportations, based on current evidence, it is clear that the United States is engaging in this practice with alarming frequency (2). The United States' implementation and enforcement of international law restricts access to basic rights for irregular im/

migrants as a tactic that enforces state sovereignty (3). Through current public health and immigration policies, the U.S. engages in immigration enforcement and surveillance which regulates and monitors the presence of 'non-citizens' within its national boundaries and thus, establishes and re-exerts its national sovereignty at the consequence of the lives, health and well-being of im/migrant populations. Not only do these laws and policies directly prompt medical repatriations, but they directly and indirectly produce adverse health circumstances and outcomes for all im/migrants, with irregular im/migrants, in particular, being affected. In understanding the logic and mechanisms behind im/migrants' access to health care in the United States and medical deportation as a phenomenon, we are able to understand how 'illegality,' deportability, and undeservingness are systemically produced and how they, in turn, shape access to adequate social determinants of health and medical care for im/migrants. This knowledge demonstrates the implications of transnational labour migration and medical deportation on im/migrant health in the United States and establishes a clear need to address the overarching issues and their root causes. As was seen through the case of Quelino Ojeda Jimenez, medical deportations are a harmful phenomenon that is sure to continue as long as irregular im/migrants are ineligible for comprehensive medical coverage (14). The explicit inclusion of long-term medical care in EMTALA, and ensuring this care is entirely or majorly funded by the government, would relieve the financial burden placed on hospitals and reduce the incidence of medical repatriation. However, medical repatriation affects more than only irregular im/migrants. Permanent residents with green cards, temporary visa holders, and U.S. citizens with parents without legal documents are also at risk of being involuntarily medically deported (7). Therefore, in addition to inclusive comprehensive health coverage, there is a need for changes in widespread ideological perceptions and representations of im/migrants in U.S. society, as well as tangible and enforced laws and policies to protect their rights and freedoms.

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