
Mandeep Minhas

Thesis adviser: Paul Martin

Submitted in partial fulfillment of the requirements for the degree of Master of Arts

January 2016
Abstract

Since the 1951 Convention relating to the Status of Refugees, there have been vague mentions to the access of emergency relief for asylum seekers under the umbrella of healthcare as a human right. The United States has argued in its reply to the Fourth Periodic Review of the U.S. to the United Nations Committee of Human Rights concerning the International Covenant on Civil and Political Rights that it is promoting access to emergency medical services for asylum seekers through the Emergency Medical Treatment and Active Labor Act (EMTALA). This thesis analyzes the legal framework and definitions of EMTALA in practice and assesses it to prove the policy does not promote a form of human right to healthcare because it does not actually contain both formal and substantive equality. But at the same time, the U.S. has successfully conformed to the international obligations of refugees seeking asylum by codifying the 1951 Convention into the domestic framework. And since 1985 the state has tried to provide emergency medical care to asylum seekers, regardless of their ability to pay, lack of insurance, or immigrant status. Based on this environment, recommendations for the development of international guidelines on emergency medical services and treatment are provided so that a part of healthcare as a human right can be effectively organized and implemented to the state’s domestic framework.
**Tables of Contents**

1. **Introduction** 1
   1.1 The state of asylum seekers: denial of employment and federal benefits 2
   1.2 Contribution of this thesis 10

2. **Overview of the state of medical care for asylum seekers in the U.S.** 12

3. **Defining emergency medical services as a human right** 17
   3.1 Substantive and formal equality in the rights-based approach to healthcare 17
   3.2 How emergency medical care is currently defined by the United Nations 20
   3.3 Breaking down EMTALA policies in practice 23

4. **A brief history of U.S. politics on healthcare policy and why it matters** 32

5. **Conclusion** 35

**Bibliography** 45
I. Introduction

   If discussing healthcare in the broader sense, the United States fails to live up to its obligations to refugees seeking asylum. However in a more narrow definition of healthcare as a human right, the U.S. has argued in its reply to the Fourth Periodic Review of the U.S. to the United Nations Committee of Human Rights concerning the International Covenant on Civil and Political Rights that it is providing emergency medical services for asylum seekers. There are references throughout international documents that directly or indirectly define emergency medical services as a human right to healthcare. And by these international human rights standards, the U.S. is actually promoting a part of healthcare rights for asylum seekers through the Emergency Medical Treatment and Labor Act (EMTALA). But if an asylum seeker arrived to the Emergency Department of a Medicare-affiliated hospital, which are required to provide emergency assessment and treatment regardless of an individual’s inability to pay or immigrant status, with severe back pain and was unable to perform tasks required on a typical day, a qualified physician would have to first diagnose the condition as an “emergency” as defined by the act. However in some situations, the physician would be unable to provide treatment to this condition because it does not meet the legal definition of an emergency, as dictated by the United States Congress. Through this example, and several others that will follow in this thesis, it becomes clear that the international standards for emergency medical services as a human right are not promoting substantive equality. The U.S. has shown its obligation to provide emergency medical treatment for asylum seekers and has also codified the international refugee framework into domestic law. This is why there is reason to believe that the U.S. will wish to continue meeting these international emergency medical treatment standards for refugees seeking asylum if the United Nations issued guidelines to what emergency medical care actually pertains to,
rather than making vague mentions of the right. But before the concept of emergency medical care as a human right can be discussed in practice under EMTALA or what a framework for this right would look like, it is important to detail the laws and policies pertaining to asylum seekers that put them in the position of seeking emergency medical care.

1.1 The state of asylum seekers: denial of employment and federal benefits

In the Caribbean, there is a regrettable expression: *Li mouri bet.* It is Creole for a “stupid death.” When a child dies of a disease for which a vaccine has existed for decades, the people of Haiti say *li mouri bet.* In return, international organizations and institutions reaffirm the right to health care as a human right. But what does the term “health care” actually encompass? Article 25 of the Universal of the Declaration of Human Rights holds that “everyone has the right to a standard of living adequate for…health and well-being of himself and his family, including food, clothing, housing, medical care and the right to a security in the event of…sickness and disability…” Which means health care as a human right encompasses nearly everything – an individual cannot have health care if they are living on the streets, going without food for several days, being restricted by the government to gainful employment and the list goes on. But there are moments in history when migration, sometimes in the masses, to another country is inevitable because the highest attainable standard of health care has never been available or is no longer available. Almost by definition, refugees and asylum seekers often come from conflict areas with poor access to adequate health care. They have experienced trauma and torture in

---

2 UN General Assembly, *Universal Declaration of Human Rights,* 10 December 1948, 217 A (III)
their countries and continue to experience further trauma on their journey to the United States.\textsuperscript{4} These traumatic events are caused by, what mental health advocates call, pre-migration and post-migration stressors.\textsuperscript{5} In the journey to escape terrorism, natural disasters, famine, and war, asylum seekers are often compounded by the loss of kinship or separation of family members.\textsuperscript{6} These pre-migration stressors are later coupled with a difficult journey to the U.S., which can involve witnessing deaths, crossing rivers, and capsizing in rafts.\textsuperscript{7} The mental healthcare community often refers to these stressors as “trauma during transit.”\textsuperscript{8} To show that exposure to trauma indeed does lead to severe mental health problems, a study published in 2010 found that those refugees having arrived from Iraq to the U.S. as "having sustained trauma and environmental stress exposure following the 1991 Gulf War and subsequent invasion were at an increased risk for psychiatric and psychosomatic disorders.”\textsuperscript{9} Given the history of Iraq in 1991, it is difficult to blame the U.S. entirely for causing this environmental stress. There can be an endless debate as to whether the United States is partially responsible for causing pre-migration stressors to occur in certain regions. The state has played an extensive role in policing world affairs and, either directly or indirectly, critics of U.S. foreign policy have traced events leading up to mass migration back to American policies.

\textsuperscript{7} Ibid, Pumariega, 583.
\textsuperscript{9} Ibid, Jamil et al.
However there are post-migration stressors that refugees and asylum seekers experience that the United States government can be definitively held responsible for – such as being barred from gaining legal employment and government housing or not being able to escape the brutal complexity of America’s judiciary system as non-English speakers, and the list goes on. All of these issues are well documented as to having an effect on the health of refugees and asylum seekers.\textsuperscript{10} But many poor and other Americans also experience these deficiencies that can harm health of individuals. For an example, it is not unreasonable to assume that a natural born U.S. citizen or an individual with immigrant status can also be unemployed or lack the resources to afford housing and food. But there are clear legal and policy distinctions between refugees and refugees seeking asylum that do not apply to poor Americans or individuals with immigrant status. According to the United States Immigration and Nationality Act (INA) of 1952, refugee status is granted to individuals who are outside of the U.S., are able to demonstrate they have been persecuted or have a fear that they will be persecuted on the account of race, religion, nationality, and/or membership to a particular social group or political opinion and must also be admissible to the United States.\textsuperscript{11} Refugee status is not attainable to those individuals who have ordered, incited, assisted, or participated in the persecution of any person on account of their race, religion, nationality or membership to a particular social group or political opinion.

Refugee status differs for asylum seekers because only individuals who meet the government definition of a refugee, are already present in the U.S., and seek admission at a port of entry can claim asylum status. It is important to note that those who seek asylum status in the U.S. do not actually possess refugee status; they must only meet the definition of a refugee as defined by immigration law. This definition, as defined by the INA, is based on the United

\textsuperscript{10} Ibid, Silove.
\textsuperscript{11} INA § 101(a)(42)
Nations 1951 Convention and 1967 Protocols relating to the Status of Refugees. But it was not until 1980 that the United States Congress passed the Refugee Act, which actually incorporated the Convention’s definition of a refugee into domestic law. In order to begin the refugee process, an individual must receive a referral to the U.S. Refugee Admissions Program (USRAP) for consideration. Each year, immigration law requires that Executive Branch officials review refugee situations, estimate the possible participation of the U.S. in resettling refugees, and discuss reasons for believing why proposed admission of refugees is justified by humanitarian concerns or national interest. After lengthy discussions between the United States Congress and cabinet representatives, the President establishes in his or her Presidential Determination the overall admissions level and regional allocations of all refugees. During consultations between the Executive Branch members, processing priorities establish criteria to determine which of the world’s refugees are of special concern to the United States. If an individual is able to fulfill the criteria, they are offered an opportunity to interview with an immigration officer. If an individual is approved as a refugee, he or she will receive assistance from the government to formulate travel plans to the U.S., which can include the possibility of a travel loan. Upon arrival, the refugee is eligible for certain government programs that act as a safety net, such as access to medical treatment through health insurance called Refugee Medical Assistance.

The process for an asylum seeker differs from the refugee process because the individual is already in the United States. On top of the requirement to meet the definition of a refugee, the asylum seeker must also apply for asylum status within one year of his or her arrival to the United States. This one-year window of opportunity to apply for asylum status is problematic in several ways. It is plausible to assume that because of pre-migration and post-migration

---

stressors, an asylum seeker can meet the definition of a refugee but may be unable to apply for asylum status because his or her mental or physical health conditions prevent them from doing so. This problem is not unique to only asylum seekers in the United States. In 2006, *The British Journal of General Practice* published an email from an organization that assists asylum seekers that highlights why a deadline to file for asylum was problematic for a female in England:

… I have a client who is now 22 weeks pregnant whose appeal for asylum was rejected last year, I understand on grounds of being 2 days overdue in her application. She is very vulnerable, has no partner, speaks little English, has no means of income, and is living in very poor conditions in a ‘flat’ above a derelict factory in Hackney. The premises has no electricity, or hot water, and is not secure from the outside. She ‘shares’ the flat with other families, seemingly of similar status, though many have left since the recent electricity disconnection. I am gravely concerned about her welfare, and that of her unborn baby.  

This is clear evidence that pregnancy can prevent women from meeting deadlines to apply for asylum status. Meaning those asylum seekers who experience physical and mental disabilities or have a difficult time learning English or securing a translator can also experience similar barriers posed by the one-year application deadline. In the United States, according to a study published by the Social Science Research Network by law professors from Georgetown and Temple Universities, shows that ever since the filing deadline went into effect in 1998, almost 21,000 refugees that were likely to have gained asylum status were rejected. The study also found that only 17% of individuals from Iraq that applied past the deadline were rejected but 75% of Guatemalans who filed late were rejected. The disparity of almost being able to predict which refugee will be granted asylum status based on which country he or she is coming from increases

---

15 Ibid, Scrag et al.
the concerns of whether the process is fair and equitable. Another study by Human Rights First found that the filing deadline increased attorney costs and time delays.\textsuperscript{16} Usually judges should be concerned with the merits of the case but seemed to be now also dealing with sorting out arrival timelines. It should be noted that in 2009, when both of these studies first began, the asylum and refugee programs enjoyed bipartisan support in the United States Congress.\textsuperscript{17} (As it will be discussed towards the end of this thesis, this is no longer the case.)

But to make matters more difficult for an asylum seeker, he or she is not allowed to apply for employment authorization at the same time as they apply for asylum status unless 150 days have passed since they have filed their complete application or no decision has been provided on their application. While the intentions behind this 150-day “clock” probably resulted out of bipartisan compromise, the policy itself is hardly favorable to asylum seekers. Asylum seekers usually have to wait an additional 30 days, on top of the 150 days, for this clock to expire because of the time it takes to process the application. However the clock that counts down, from a total of 180 days, can be stopped at any time if the U.S. government determines the applicant has delayed the proceedings. According to the Federal Executive Office of Immigration Review, the clock was stopped at some point for 262,025 (or 92 percent of all pending cases) asylum seekers in 2011.\textsuperscript{18} This means that the majority of asylum seekers will wait until he or she is granted asylum to be able to pursue legal employment and have the option to obtain Employment Authorization Documents for identification purposes. Upon receiving asylum status, the

individual then qualifies for government safety net programs such as Medicaid and housing assistance. This is one of the key differences between an asylum seeker and a refugee or poor American exhibiting similar traumatic or physical injuries. A U.S. Citizen below the poverty line may not be able to work in the country because of a disability, for which they may be eligible to receive some sort of government benefits for, but asylum seekers, regardless of disability, are actually prohibited by policy from legal employment. Therefore it is not atypical for an asylum seeker to be unemployed in the U.S. after having experienced severe trauma in his or her native country. To support themselves, asylum seekers are then forced to find employment without authorization and often become targets for prostitution and organized crime, creating an even more hostile environment.\textsuperscript{19} Remedies to this intensive human rights violation include amendments to the INA to allow refugees seeking asylum to simultaneously seek asylum status and work authorization.

Accordingly this results in a situation where an asylum seeker is not eligible for employer-sponsored healthcare coverage, one of the means to access medical treatment for individuals residing in the U.S. with immigrant status. And because finding legal employment is out of the question, they are unable to earn a living wage to pay for their own medical treatment. According to a Human Rights Watch report, the United States is the only nation amongst developed countries to deny asylum seekers both employment authorization and governmental assistance.\textsuperscript{20} A right to health care has been recognized as many things in international human rights legal and policy agreements. Such as Article 25 of the UDHR, as cited earlier, the International Covenant on Economic, Social and Cultural Rights, the Convention on the

\textsuperscript{20} Ibid, Jacek.}
Elimination of All Forms of Discrimination Against Women, the Convention on the Elimination of All Forms of Racial Discrimination, and the Convention on the Rights of the Child. All of these documents expand the meaning of health care and make the term all the more encompassing by mentioning infant mortality, epidemic control, family planning, counseling services, racial discrimination and the list goes on. But in terms of defining medical treatment as a human right, health policy expert Dr. Maura Ryan explains that it was only recently that “the link between systemic human rights abuses and vulnerability to disease has come to be widely recognized.”

The outcry, *li mouri bet*, of access to certain drugs, and debates over mental healthcare have introduced a sense of urgency to the meaning of “human right to health” that was lacking before. Access to doctors, whether it be for physical or mental care, and medicine, in the form of drugs or equipment, have always been considered a human right inside of health care but it was defined further only in the last decade of the twentieth century and early twenty first century. Examples of the added international urgency include the “3 by 5 Initiative” of the World Health Organization and the Declaration of Commitment by the United Nations General Assembly in 2001. While discussing ways to solve the problems of the 3 by 5 Initiative, the WHO and UNAIDS, in their final report, did not just remark on the end of the program but argued it “was just the beginning of ensuring ARV access for all.” This meant that the response to HIV/AIDS had to be more comprehensive with actual medical treatment. Later in 2006, a UN High-Level Meeting on AIDS used the strongest language to date in regards to actual treatment and care of HIV/AIDS by stating:

---

22 Ibid, Ryan.
We…commit ourselves to pursuing all necessary efforts to scale up nationally driven, sustainable and comprehensive responses to achieve broad multisectoral coverage for prevention, treatment, care and support, with full and active participation of people living with HIV, vulnerable groups, most affected communities, civil society and the private sector, towards the goal of universal access to comprehensive prevention programmes, treatment, care and support by 2010.\textsuperscript{25}

What is unique is that both the 3 by 5 Initiative and Declaration of Commitment were addressed to reach medical treatment for those living with HIV/AIDS but transformed into something larger. The 3 by 5 Initiative failed to reach its 3-million people goal but it increased the number of people on ART by over 700,000.\textsuperscript{26} In this aspect of healthcare as a human right, while the U.S. denies most government assistance programs to asylum seekers pertaining to the broad definition of healthcare there is one program that is available to asylum seekers in terms of medical care: federally funded emergency medical treatment.

1.2 Contribution of this thesis

On a timeline the Emergency Medical Treatment and Active Labor Act (EMTALA) was enacted in 1985, well before the international urgency to define medical treatment as a human right, as part of the Consolidated Omnibus Budget Reconciliation. Under EMTALA, asylum seekers in the United States are able to access medical treatment strictly for emergency reasons without healthcare insurance coverage or the ability to pay. Because of this it is informally referred to as the “Patient Anti-Dumping” statute because it was designed to prevent hospitals from being able to refuse patients who have no health insurance or lack immigrant status in the country. It is important to understand that EMTALA does not provide general medical treatment

\textsuperscript{25} Resolution adopted by the United Nations General Assembly. 60/262. Political Declaration on HIV/AIDS. 87th plenary meeting, 2 June 2006.

that refugees receive under federal benefit programs. The state is still in violation of numerous international human rights standards and laws pertaining to the access of healthcare services for asylum seekers. But, as this paper argues, the U.S. manages to meet the standards of emergency medical services for refugees seeking asylum as defined by the 1951 Convention relating to the Status of Refugees and its commentary and other international documents that define emergency medical services as a human right. This means that if the definition of the right to healthcare for asylum seekers was narrowed down to the access of emergency medical care, the U.S. is actually promoting a part of international human rights standards. But why is this a big deal for the United States? For one, the U.S. is the largest country in the world without a single-payer (universal health care) system such as the one in Germany, United Kingdom, Canada, Norway and elsewhere. This leaves millions of Americans without healthcare insurance coverage. Even with the Patient Protection and Affordable Care Act (“Obamacare”), there are obstacles to achieving healthcare coverage for all U.S. citizens through an individual mandate. Which means that EMTALA is an impressive piece of legislation by American standards. It signals that even Americans believe that those who have escaped warzones or repressive government regimes should be allowed medical treatment if they are faced with the possibility of death or permanent disability. But in practice, as this paper will go on to argue, EMTALA is not successful in providing asylum seekers with true emergency conditions with medical treatment because it is a policy made up of formal equality, and that is partially because international human rights standards for emergency medical care/treatment are lacking substantive equality. If the United States’ emergency medical program can be defined as meeting the expectations of what is defined by international human rights law standards and still fail to deliver to the plight of
hundreds of thousands of refugees seeking asylum, it signals that there is a need to revisit these international documents with a renewed promise to deliver human rights based healthcare.

2. Overview of the state of medical care for asylum seekers in the U.S.

Healthcare legislation is usually enacted to eradicate, or at least reduce, inequalities in the system. The key example of this type of legislation is Medicare, a program that provides health insurance to people with lawful immigration status in the United States that are either age 65 and over, permanently disabled, or have end-stage renal disease. Another key example is Medicaid, a program run jointly by the federal and state governments to provide healthcare insurance to the very poor of Americans. These programs are layered with other policies that also focus to reduce inequality, such as the Child Health Insurance Program (CHIP), which expands Medicaid eligibility to children for families that exceed Medicaid eligibility. Asylum seekers are not eligible for federally funded public health insurance programs like Medicare, Medicaid, or CHIP because they require an immigrant status in the country. This would mean that only U.S. citizens, lawful permanent residents, refugees, asylees, battered spouses and children with pending or approved visas, victims of trafficking with the appropriate visas, and Cuban/Haitian entrants are eligible for these federal benefits. And even those who meet the criteria of an immigrant status must meet incomes and family sizes to qualify for certain programs. But to put it bluntly, there is no healthcare insurance coverage or program that provides access to general medical treatment for asylum seekers. There is further no access to Social Security disability, federal or private retirement pension plans, or unemployment insurance. Because federal law

restricts the use of federal funds for the coverage of healthcare for those who do not have an immigrant status, some state and local governments have produced funding to insure asylum seekers through either direct government programs or government-funded nonprofits.  

For an example, the All Kids program in Illinois covers children regardless of immigration status so long as they meet program income requirements. The Healthy Kids program in San Francisco acts similarly.

Permanent Residence Under Color of Law (PRUCOL), an immigration status created by the courts but not recognized by the federal government, is a public benefits eligibility category that refers to individuals who are known to be in the U.S. by immigration services and are not likely to be deported. Before the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 was adopted, asylum seekers meeting PRUCOL eligibility were eligible for Medicaid. But PRWORA eliminated this eligibility, with the exception of Medicaid emergency services.  

There are some exceptions to this, such as in New York, where the State Court of Appeals ruled in Aliessa et al v. Novello that denying access to Medicaid violates the equal protection clause of the federal constitution, as well the State of New York’s constitution requirements that the state provide for the aid, care, and support of the needy. But obviously other states are not bound by the decision of a New York court. What it means is that in some states, without the use of federal funds, some asylum seekers are able to access medical treatment outside of an emergency scope. While states are not bound by the decision in Aliessa,

30 Available at: http://www.allkids.com/hfs8269.html; accessed on October 14, 2015.
31 Available at: http://www.sfhp.org/visitors/programs/healthy_kids/do_i_qualify.aspx; accessed on October 14, 2015.
they can certainly take note of the court’s conclusion as a violation of the U.S. constitution because that is one document that is applicable to all 50 states. Several states other than New York provide benefits to asylum seekers but it is usually limited to the elderly or just children. Needless to say, the patchwork of systems has not proven itself as a reliable solution to the medical care of asylum seekers.

EMTALA differs from the “giants” of federal healthcare programs because the legislation was designed to provide patients with no immigrant status (or those with immigrant status but no healthcare insurance) access to emergency medical care. As it will be discussed later, the U.S. has argued that EMTALA meets the international human rights standards to emergency medical care for asylum seekers. The policy prevents hospitals from ignoring patients in need of critical care because they are unable to pay for their treatment. In theory, any asylum seeker who arrives to the emergency wing of a hospital that participates in the Medicare program “must be given an initial screening, and if found to be in need of emergency treatment (or in active labor), must be treated until stable.” EMTALA defines an emergency medical condition as a “medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in – (i) placing the health of the individual … in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ part.” The federal government requires that hospitals covered by this law, if a hospital receives Medicare funding then EMTALA is applicable to them, to provide patients with an emergency medical condition with “an

35 Examination and treatment for emergency medical conditions and women in labor (EMTALA). 42 U.S. Code § 1395dd
36 Ibid, EMTALA.
appropriate medical screening examination within the capability of the hospital’s emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition (EMC) exists.” Furthermore the medical screening examination must be “conducted by an individual(s) who is determined qualified by hospital bylaws or rules and regulations.” While EMTALA specifically applies itself to the emergency department of a hospital, the guidelines distributed by the federal government have applied EMTALA to all faculties that participate in the Medicare program and offer emergency services. EMTALA requires hospitals to stabilize asylum seekers with emergency medical conditions but it does not require treatment services beyond that.

A part from emergency medical treatment, the patchwork of systems that asylum seekers also rely on in the U.S. as healthcare safety-net providers include health centers for migrants and federally qualified community health centers (FQHCs). But these too are largely location dependent. The federal Health Resources and Services Administration funds FQHCs and health centers for migrants. These not-for-profits provide care regardless of legal status or ability to pay, effectively allowing asylum seekers to receive treatment. The primary difference between a FQHC and health centers for migrants is that the latter is allowed to only treat seasonal farm workers and their families. But because FQHCs and health centers have restrictions to access because of either difficulty of accessibility or qualifiers based on type of employment, they are not adequate solutions to the treatment of asylum seekers as expanding Medicaid to all refugees seeking asylum could be.

37 42 C.F.R 489.24(a)(1)(i)
38 42 C.F.R. § 489.24(a)(1)(i)
The Omnibus Budget Reconciliation Act of 1981 recognizes some hospitals as a “disproportionate share hospital” (DSH). DSH recognition is reached with respect to the percentage of uninsured and low-income patients (which includes asylum seekers) the hospital treats. Because these treatments are classified as uncompensated care, DSHs receive additional payments from Medicaid. The Patient Protect and Affordable Care Act (PPACA; more commonly referred to as ‘Obamacare’) allows refugees seeking asylum to take part in the federal or state health insurance exchange and apply for premium tax credits, which can offset the cost of health insurance, but only if the asylum seeker has been granted work authorization. Section 1312 of the Affordable Care Act states, “If an individual is not, or is not reasonably expected to be for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States, the individual shall not be treated as a qualified individual and may not be covered under a qualified health plan in the individual market that is offered through an Exchange.” This would mean that even without asylum status, an asylum seeker can apply for health insurance through the exchange system but because the federal government is allowed to stop the clock, as discussed in the introduction, rarely does an asylum seeker have the opportunity to participate in the exchange.

However it seems that there is a conflict in practice when both EMTALA and the PPACA are imposed on the domestic healthcare framework of the United States. The PPACA reduces DSH funding by 75%, which is the budget hospitals depend upon to offset the costs of

42 § 1312 (f) (3).
treating asylum seekers through EMTALA. The theory behind the DSH reduction in PPACA was that because individuals are required to purchase health insurance, hospitals would treat fewer documented residents of the United States without health insurance. But Al Aviles, President and CEO of New York City Health and Hospitals Corporation, explains that this calculus does not work for some states like New York because individuals without immigrant status make up a larger percentage of the uninsured population. The number of patients that could be potential asylum seekers will remain roughly the same, if not increase. As a result, the PPACA creates an unfunded mandate because there is no provision that requires hospitals to decrease the treatment required under EMTALA. In return, hospitals may be forced to refuse the treatment of asylum seekers (and undocumented immigrants), pay the penalties for violating EMTALA or possibly face the risk of bankruptcy. As of now, there is not enough data available to indicate that those hospitals, which participate in EMTALA through Medicare, are filing bankruptcy because of the DSH funding reduction. Whether the increase in the number of insured Americans through the individual mandate of the Affordable Care Act will be enough to decrease that groups use of EMTALA also remains to be seen.

3. Defining emergency medical services as a human right

3.1 Substantive and formal equality in the human rights-based approach to healthcare

In the dialogue for access to healthcare for asylum seekers under a human rights framework, especially in the context of emergency medical treatment, it is important to address

the inherent inequalities of the patients. Under the international human rights framework, Dr. Paul Farmer, Chairman of Harvard Medical School’s Department of Global Health and Medicine, notes that “the fight for health as a human right, a fight with real promise, has so far been plagued with failures.”46 That is because, Dr. Farmer argues, ill health is more often a symptom of inequality.47 Do asylum seekers suffer an unequal footing in comparison to refugees? Yes, because of their legal status, or lack thereof, in the country disqualifies them from healthcare insurance coverage. (This can be considered as a post-migration stressor, as well.) But do refugees seeking asylum arrive from similar backgrounds? No, because some have been tortured, some have been potential victims of genocide, some have lost family members to regime violence and the list of differences is endless. (These can be all considered as different types of pre-migration stressors.) In the end, most asylum seekers require different types of medical care. Inequalities are not only related to wealth and income. Healthcare inequalities expand to equality of opportunity and outcome of policies and laws. Thus the human rights approach to health should combat inequality, making it distinctive from other approaches because it is committed to equality and non-discrimination.48 A human rights approach to healthcare should aim to eliminate discrimination in law and policy by requiring both formal and substantive equality. Because these rights are human rights, they are not focused on certain states

---

but on people living within those states, overcoming divisions of developed and developing countries.\textsuperscript{49}

Formal equality, as defined by Jonathan Burns, is when all individuals and health conditions are treated alike.\textsuperscript{50} Burns explains that formal equality is “superficial and [a] deceptive form of equality, however, as there are many social, economic, and political factors at play that obstruct the translation of a law into the real, individual experience of equality.”\textsuperscript{51} During a formal review of social policies pertaining to both men and women in Canada, researchers argued that because men and women are not identically situated in social hierarchy the same application of laws and policies should not be applied to them because they cannot address real social inequality.\textsuperscript{52} This was a rebuttal of policies introducing formal equality because those policies only give an illusion that all is equal. For an example, minimum wage can be defined as formal equality because it does not address the inherent inequalities caused by gender bias. In the United States, where women are noted to make considerably less per dollar than their male counterparts, minimum wage is not truly achieving substantive equality.

Substantive equality is defined as the “equality of opportunity, within the context of structural inequalities present in society.”\textsuperscript{53} Burns argues that there are circumstances that prevent individuals from achieving the desired results of policies set forth by the government because they fail to address structural inequalities present in society. By meeting the definition of

\textsuperscript{49} Ibid, \textit{HLCP Positioning Paper}
\textsuperscript{51} Ibid, Burns 20.
\textsuperscript{53} Ibid, Burns 20.
a refugee, it is already established that asylum seekers come from varied backgrounds. Therefore the barriers, which may or may not be systemic, must be removed if they deny access and empowerment of what is supposed to be advocated by the proposed or enacted policy. In *Andrews v Law Society of British Columbia*, the first Supreme Court of Canada case to deal with section 15 of the Canadian Charter of Rights and Freedoms, the defendant argued that substantive equality does not refer to equality of results. While *Andrews* was a legal argument focused on a barrister unable to qualify for the bar because of his citizenship status, his argument also applies to the access to health care for asylum seekers because achieving equal results of medical treatment is not only impossible but is uncalled for.

3.2 How emergency medical care is currently defined by the United Nations

Where does the right to emergency medical treatment come from? The 1951 Convention relating to the Status of Refugees is a key international legal document that defines who is a refugee and their rights and legal obligations of the state. Originally the scope of the Convention, in response to the Second World War, was limited to within Europe. Later the 1967 Protocol relating to the Status of Refugees removed these geographical and temporal restrictions from the Convention. The U.S. has not ratified the 1951 Convention but it has ratified the 1967 Protocol and Congress pointedly signaled intent of conforming to international legal obligations by adopting the Refugee Act of 1980. In fact the sections 101(a)(42)(A) and 208 of the U.S. Immigration and Nationality Act have significantly close resemblance of text to international human rights law. Even the *Basic Law Manual* used to train Immigration and Naturalization asylum officers also include “extensive discussion both of international refugee law and
international human rights law.” Based on this evidence, the 1951 Convention is also applicable to the United States because the government has shown intent of conforming to the Convention. But in the 1951 Convention there is no explicitly stated right to emergency medical care, let alone healthcare. Only in Article 23, titled Public Relief, does the Convention state, “The Contracting States shall accord to refugees lawfully staying in their territory the same treatment with respect to public relief and assistance as is accorded to their nationals.”

However commentary on the Convention by Professor Grahl-Madsen, Special Consultant in the Office of the High Commissioner for Refugees in 1962-63, provides valuable insights into the work behind the Convention and circumstances that surrounded its creation. These insights, the High Commissioner for Refugees at the UN argues, still prove useful as states are increasingly interpreting the rights of refugees in more restrictive ways. The commentary behind Article 23 reads that during the Ad Hoc Committee, it was stressed, “Public relief encompasses hospital treatment...as well as emergency relief.” It is also taken for granted that the Article continues to cover the cases specified in Article 9 of the League of Nations’ Convention Relating to the International Status of Refugees. (In terms of medical and hospital treatment, a notable difference between the 1933 Convention and the 1951 Convention is that refugees have the right to the highest attainable standard of healthcare rather than the most favorable treatment as according to nationals of a foreign country.) A guide to understanding “public relief and assistance” is referred to the European Convention on Social and Medical Assistance of 1953. Article 2(a)(i) of the Assistance Convention defines medical assistance “in

55 “Convention and Protocol Relating to the Status of Refugees.” UNHCR.
57 E/AC.32/SR. 15, pp. 5-8.
relation to each Contracting Party all assistance granted under the laws and regulations in force in any part of its territory under which persons without sufficient resources are granted means of subsistence and the care necessitated by their condition...”

Finally, Professor Grahl-Madsen notes that the drafters were more interested in the material situation, not procedure—meaning they were not looking for whether the relief and assistance to asylum seekers was provided by federal funds or if by a mixture of non-profits and NGOs. Instead the drafters were more concerned with refugees getting the same benefits as nationals of the state with the “same minimum of delay.”

The 1951 Convention commentary reveals emergency relief as a right for all asylum seekers, and points to the Assistance Convention to further define medical assistance. EMTALA does not satisfy the international human rights obligation to treat all medical conditions but it does satisfy a part of the 1951 Convention by providing emergency relief. Domestic U.S. courts have even strengthened emergency care for asylum seekers through EMTALA. A federal Court of appeals ruling in Hawaii extended EMTALA to all ambulances by qualifying the carriers as a form of an Emergency Department (ED). Meaning even if an asylum seeker is picked up from his or her place of residence, they are officially under EMTALA once the paramedics have made the ED staff aware of the patient’s condition. And obviously, emergency medical treatment can also be found in other international documents. For an example, Article 16, paragraph 1, of the Smuggling of Migrants Protocol reiterates Article 6, paragraph 1, of the International Covenant on Civil and Political Rights: the right to life. It was noted during a Working Group on the Smuggling of Migrants that emergency medical care can also “…be extrapolated from the right

58 “European Convention on Social and Medical Assistance of 11 December 1953.” Council of Europe
59 Cf. E/AC.32/SR.38, p. 5.
60 Arrington v. Wong, No. 98-17135 (9th Cir 2001).
to life, given that in some situations the denial or refusal of such emergency medical care may violate that life.”

But has the United States observed and acknowledged emergency medical treatment as a human right? During the fourth periodical report of the United States in relation to the International Covenant on Civil and Political Rights, the UN asked the U.S. to provide information on obstacles to the access of undocumented immigrants health services and the solutions the state was providing. In response, the U.S. promoted EMTALA and noted that there was existing policy guidance issued by the Department of Health and Human Services (HHS) and U.S. Department of Agriculture (USDA) that makes clear that Medicaid coverage of emergency medical services are available to asylum seekers. This marked the first time that the U.S. acknowledged that the right to healthcare also encompasses access to medical emergency treatment and they were a promoter of it.

3.3 Breaking down EMTALA policies in practice

In practice, EMTALA hinges upon vaguely defined words. Meaning, as examples below will demonstrate, EMTALA does not actually promote substantive equality that covers all asylum seekers seeking emergency relief, which raises the question of how effective EMTALA can really be and whether international human rights standards are truly promoting values of non-discrimination and equality. EMTALA statute states that any individual that comes to the ED must be provided with the appropriate medical screening examination, within the hospital’s

---

62 UN Human Rights Committee (HRC), Concluding observations on the fourth periodic report of the United States of America, 12 September 2013, CCPR/C/USA/CO/4
63 UN Human Rights Committee (HRC), Replies of the United States of America to the list of issues, 23 April 2014, CCPR/C/USA/Q/4/Add.1
capability, to determine whether or not an emergency medical condition exists. Subsection (e)(1) goes onto define an “emergency medical condition” (EMC) as:

(A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in— (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part; or (B) with respect to a pregnant woman who is having contractions — (i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or (ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.

This means that merely the medical history of an asylum seeker cannot qualify as an EMC. An asylum seeker that walks into an ED must go through a medical screening examination (MSE) to determine if an EMC exists. The courts have not defined or given guidance on what an appropriate MSE pertains to – it seems as if it is more of an ongoing process that ends if the physician decides no EMC exists or once the patient has been stabilized through treatment.

Returning to the definition of an EMC – pain in general is obviously considered a medical condition but the MSE requires there to be a diagnosis of “severe pain.” But unless treatment of the pain will prevent serious jeopardy of the asylum seeker, impairment to their bodily functions, or serious dysfunction of any of their bodily organs or parts, severe pain does not alone warrant an EMC. A common example of a pre-migration stressor for asylum seekers is PTSD, which is a credible occurrence amongst people who have been exposed to “torture, isolation, collapsed social support, violence, and other forms of psychological stress.” An asylum seeker has more likely than not been exposed to these factors by meeting the definition of

---

64 Ibid, EMTALA.
65 Ibid, EMTALA.
a refugee. PTSD is a chronic mental health condition that can disable an asylum seeker from their ability to function on a day-to-day basis, lead to depression, and make them more vulnerable to suicide.\textsuperscript{67} (PTSD is also one of the illnesses, as research cited earlier, that can disable them from the ability to actually file for asylum within the one-year window rule.)

But can a mental health condition such as PTSD be translated as “severe pain” by the EMC definition? Another way the medical community describes mental health is as behavioral health – the two terms are often used interchangeably. The hospital in question must have a dedicated emergency department that is a Medicare-participating hospital with a behavioral facility to accept the asylum seeker with PTSD or they have an EMTALA-mandated responsibility to transfer and transport the asylum seeker to a facility that can treat the condition. A doctor can diagnose the patient with severe pain and meet the definition of an EMC because of the relationship between PTSD and committing suicide, which would obviously place the patient’s life in jeopardy. But the issue with this is that diagnosing PTSD is incredibly difficult. It is not always an obvious diagnosis. Just because the asylum seeker has escaped a war zone six months ago and does not show any signs of distress at the ED, it does not mean he or she has not developed PTSD. It is scientifically documented that traumatic events do not surface immediately and sometimes tend to come and go.\textsuperscript{68} A flashback to a traumatic event can educe PTSD symptoms but they may only last seconds. In some cases, PTSD may be masked by a social obsessive-compulsive disorder. Not only is it difficult to diagnose obsessive-compulsive disorder as “extreme pain” but also it is sometimes impossible for it to be seen as placing the

\textsuperscript{67} PTSD Overview, Dep't of Veterans Affairs, Nat'l Ctr. for PTSD, http://www.ptsd.va.gov/public/pages/fslist-ptsd-overview.asp
individual in serious jeopardy or risking the dysfunction of his or her bodily organs. Once a physician has determined that no EMC exists, all other hospital obligations mandated by EMTALA also cease to exist for the asylum seeker.

But it is not only mental health conditions that are impossible to diagnose as an EMC by the EMTALA definition. Dr. Robert Bitterman, a physician-attorney consultant specializing in emergency medicine risk management, explains that a “chronic back pain patient with ‘severe pain’ … does not have an emergency condition if he does not need immediate medical attention for an aortic aneurysm that’s ruptured, an epidural abscess, a herniated disc that’s producing serious neurological loss, or some other true emergency condition.” If an asylum seeker is unable to properly walk, sit, stand, or sleep and unable to perform simple tasks required of an asylum seeker, like traveling a short-distance to meet with his or her attorney, because of chronic back pain, EMTALA will not provide emergency relief. The pain can be diagnosed as a fifteen out of a possible ten but EMTALA will not apply to the asylum seeker if he or she is not diagnosed with an EMC. In fact, even if the asylum seeker leaves with worse pain than it initially was upon arrival to the ED, the asylum seeker will still not be covered under EMTALA unless the physician has reached the conclusion that they are experiencing an EMC. Because of the complexity of mental and physical health issues and the restrictive definition of what EMCs may pertain to, EMTALA is unable to produce policy of substantive equality even though it meets the standards of emergency medical care for refugees and asylum seekers as implied in international human rights documents.

But there are possible instances of where an asylum seeker may be properly diagnosed with an EMC and only then has the hospital met the conditional obligation to stabilize the patient. The statute breaks down two definitions pertinent to the actual treatment:

(3)(A) The term “to stabilize” means, with respect to an emergency medical condition described in paragraph (1)(A), to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), to deliver (including the placenta).

(B) The term “stabilized” means, with respect to an emergency medical condition described in paragraph (1)(A), that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), that the woman has delivered (including the placenta).

Bringing back our asylum seeker with PTSD, who this time went through an MSE and was diagnosed with an actual EMC – meaning, he or she has earned the hospital’s obligation for treatment. Under EMTALA a hospital must provide stabilizing treatment within the capabilities of their staff and facilities or the hospital must transfer the patient to another medical facility that can meet the requirements of their condition. It is important to note that capability does not only refer to the ED but to all of the facilities of the hospital. Does the hospital have a psychiatric staff or facility to stabilize the asylum seeker with PTSD but outside of the ED? If so, they are required to provide services available on what are routinely provided. This obviously means that hospitals with larger psychiatric facilities will be available to provide a higher standard of healthcare than one with a smaller facility. But this is more of an issue of the inequality of the United States healthcare system than the intent behind the 1951 Convention. The 1951

70 Ibid, EMTALA.
Convention, in improvement to the 1933 Convention, requires emergency relief not in accordance to the most favorable treatment for nationals of a foreign country but to the same favorable treatment that U.S. citizens receive. This means citizens of the U.S. that visit the lesser hospital also receive the same level of treatment. But the 1951 Convention can also be considered as a document of formal equality in this aspect because it does not acknowledge healthcare facilities from one city to another in states may have different capacities (however General Comment No. 14 does observe this phenomenon in some ways, as it will be later discussed). At the end of the day, if a hospital is able to stabilize the patient, when is a psychiatric treatment supposed to be deemed “stabilized”? Given the nature of psychological and mental health problems, as noted earlier, these problems come and go. Once the asylum seeker has received treatment, a full treatment may traditionally require multiple follow-up visits. Unfortunately, EMTALA does not include follow-up care responsibilities. If the asylum seeker were to return to the hospital after being stabilized but found themselves in another medical emergency, he or she would have to be diagnosed with an EMC all over again and hope the system works in their favor again.

Beyond the commentary behind the 1951 Convention, the single most important document to expand the meaning of the “right to health” is the non-legal binding General Comment No. 14, which was issued by the UN Committee on Economic, Social and Cultural Rights upon complications stemming from the implementation of the ICESCR’s Article 12, “the right to the highest attainable standard of health.” The ICESCR has not been ratified by the United States, even though President Jimmy Carter signed the treaty in 1979. But the U.S., as

according to the Vienna Convention on the Law of Treaties, is “obliged to refrain from acts which would defeat the object and purpose of a treaty when it has signed the treaty…” While it is not likely that domestic courts will take this into consideration if an asylum seeker filed suit because of the unavailability of services beyond emergency care, the U.S. still has intent of obligation to the ICESCR. But the ICESCR does not mention emergency relief or hospital treatment, as the commentary related to the 1951 Convention does. However it does cite the right to the highest attainable standard of healthcare and then expands on the right in Article 12(2)(d) by stating the state’s responsibility to “The creation of conditions which would assure to all medical service and medical attention in the event of sickness.” The mention of “all medical service” arguably includes emergency medical care/treatment for asylum seekers. But even with the ICESCR’s expansive definition of healthcare, clarity is needed so there is a possibility for states to turn the stated human rights into operational policy. This is where General Comment No. 14, issued in 2000, provides significant direction for states attempting to incorporate the ICESCR into their domestic frameworks.

Paragraph 18 of the General Comment stresses that even if a state does not have the resources to provide complete medical care, the state can still advance the right to healthcare if programs are designed to eliminate discrimination by providing timely information and abrogation of legislation. The human right to emergency care would not have a legitimate place in human rights if it only advocated formal equality – such as stating “the right to the highest attainable standard of health” and leaving it at that. Because of the 1951 Convention and General

---

75 Ibid, *General Comment No. 14*. 
Comment, not only is the United States responsible to provide emergency medical services to asylum seekers but the state is also responsible for providing information to asylum seekers on the availability of EMTALA. This is an example of health policy promoting formal equality and substantive equality, of which both are necessary to promote human rights to healthcare. The major advantage of General Comment No. 14 is that substantive equality does not have to rely on the interpretation of courts dependent on each state. It introduces some degree of certainty to the right to healthcare that cannot always be found in court rulings.

How does General Comment 14 interact with EMTALA’s definition of an emergency medical condition if an asylum seeker with PTSD walks in to the ED? Does it stand to strengthen the access to emergency medical services as a human right for asylum seekers by forcing EMTALA to make the definition of an EMC more encompassing? The Comment contains four “interrelated and essential elements” which would encompass emergency care. Health goods, services by the hospital, and facilities must be available in sufficient quantity, accessible without discrimination, acceptable (culturally and ethically but with a focus that can be interpreted as modern medical privacy laws), and of good quality.76 The Comment then offers three principles: equality and nondiscrimination (this alludes to the inherent substantial equality of healthcare as a human right, there should be no discrimination to accessing emergency services), participation (the public must be engaged with health policy), and accountability (government is responsible to implementation).

EMTALA meets the availability criteria because General Comment 14 only would require the ED to be equipped with “safe and potable drinking water and adequate sanitation…trained medical and professional personnel receiving domestically competitive

76 Ibid, General Comment No. 14
salaries, and essential drugs, as defined by the WHO Action Programme on Essential Drugs.” All facilities that receive Medicare must act as EMTALA facilities and the standards of Medicare funded hospitals usually always meet those set by the Comment. Accessibility is defined in terms of non-discrimination, physical accessibility, economic accessibility and information accessibility. Non-discrimination is explained in Paragraph 18 and 19 as no entitlements can be “denied on the grounds of race, color, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation and civil, political, social or other status.” Because EMTALA is the only federal program that does not deny asylum seekers emergency medical attention based on their immigrant status, there is no clear-cut discrimination. Does EMTALA’s definition of what encompasses an EMC act as discrimination to some length, especially to those with mental health problems? This is one of the instances where EMTALA works with General Comment 14 in some cases but fails to work with it in other cases. Some asylum seekers with PTSD can be diagnosed with an EMC but, as reasons cited earlier, may not be. Maybe not in practice, but the text of EMTALA still holds by the standards of the Comment. But can it be argued that EMTALA’s obligation on hospitals to define an EMC before providing care is an act of discrimination? This would be difficult to prove because EMTALA in itself is primarily a nondiscrimination statute of the United States government and there has to be some level of discrimination of patients to contrast what is an emergency and what is not.

77 Ibid, General Comment No. 14
78 “Frequently Asked Questions about Accrediting Hospitals in Accordance with Their CMS’ Certification Number (CCN).” http://www.jointcommission.org/faqs_ccn/
79 State Operations Manual Appendix V - Interpretive Guidelines - Responsibilities of Medicare Participating Hospitals in Emergency Cases. Centers for Medicare & Medicaid Services. (Rev. 60, 07-16-10)
EMTALA also meets the requirements of *quality*, where health facilities, goods and services at a Medicare participating hospitals are culturally acceptable and are scientifically and medically appropriate of good quality. And the policy meets the requirements of *acceptability*, where good and services are provided in accordance with medical ethics and culturally appropriate guidelines. These requirements are usually met by achieving the accreditation process by the Joint Commission, which issues hospitals with their Centers for Medicare and Medicaid Services Certification Number.  

4. A brief history of U.S. politics on healthcare policy and why it matters

To a degree General Comment No. 14 makes some positive ground in promoting substantive equality, instead of just formal equality that the 1951 Convention and its related commentary produces. But it still does not go far enough to strengthen the United States’ emergency medical program that asylum seekers utilize. The fact that a policy like EMTALA can be defined as international human rights legislation but still fail to deliver effective medical treatment means that international human rights standards on emergency medical services have failed asylum seekers. A solution would be to strengthen the language surrounding emergency medical care under healthcare as a human right. But why is it important to surround the U.S. with stricter international guidance around emergency medical treatment when the international framework has already given guidance to building frameworks for healthcare for everyone, regardless of immigrant status, residing in the country?

To answer this, a brief history of U.S. politics related to healthcare policy and immigration law is necessary. Since the Great War and the anti-Germany fever surrounding the

---

80 “Frequently Asked Questions about Accrediting Hospitals in Accordance with Their CMS’ Certification Number (CCN).” http://www.jointcommission.org/faqs_ccn/
decade, government-commissioned ads or elected politicians have denounced health insurance for all as “socialist” or a “Prussian menace” that is not align with American values. Even when compulsory health insurance finally came onto the national stage with the full support of President Harry Truman in the mid-1940s, the Cold War allowed opponents of national health insurance to acquire strength and again make a case about “socialized medicine” as being a form of communism. The opposition against national health insurance programs was strong enough for even the media and the American Medical Association to be against any form of government-sponsored healthcare. Discouraged by defeat over and over, advocates of healthcare decided to take an initiative to promote healthcare insurance for just the elderly – which arguably marked the beginning of Medicare, the program that EMTALA is practiced through since 1985.

Subsequent plans for some form of mandatory or optional government healthcare insurance for all came and largely failed under many more U.S. presidents to come. It was not until the election of President Barack Obama in 2008 that a call for universal health care was renewed. Before President Obama however, President George W. Bush iterated a now infamous remark regarding EMTALA and how he thought a healthcare system should act and it shows to highlight the differences in policy agenda between party lines: “The immediate goal is to make sure there are more people on private insurance plans. I mean - people have access to health care in America. After all, you just go to an emergency room.” Ignoring the calls from President Obama for universal care out of fiscal concerns, the United States Congress finally passed into law the Patient Protection and Affordable Care Act (PPACA) in 2010. But just over two years

later, the Supreme Court of the United States gutted the PPACA that left its intent less impactful. The Court decided to uphold the individual mandate as a form of a tax in King v. Burwell but also allowed states to opt-out of Medicaid Expansion. Arguably the Medicaid Expansion provision of the PPACA is one the biggest milestones in health care reform. It expands Medicaid coverage to the nation’s poorest and, at the time, could have covered nearly half of the uninsured American population. Effectively the Court allowed states led by opponents of health care reform to reject the expansion and leave millions without coverage. As of early 2016, 32 states have adopted Medicaid Expansion but 16 states have not. The individual mandate was a necessary win for the Obama administration because without it, the act would have simply fallen apart because the uninsured population would have continued to raise healthcare costs by utilizing the emergency room. The majority of the act has survived two high profile Supreme Court cases but faces constant attempts of repeal in the United States Congress and it is more than likely that the Court will have another opportunity to rule in a way that can further damage the intent and purpose of health care reform.

Nevertheless the conversation has shifted from “government healthcare is socialism” (although some prominent opponents of PPACA still refer to the act as socialism) to “who deserves healthcare insurance.” The conversation of which individuals the government should fund healthcare insurance for revolves around those with immigrant status, with primary focus on the rights of U.S. citizens. The conversation leaves out the undocumented and those seeking asylum. To make matters worse, the national conversation around immigration law can be

described almost as toxic as it was during the Great War, with some conservative leaders calling for mass deportation of undocumented immigrants and a halt to the intake of refugees. The bipartisan support which the asylum program enjoyed in the U.S. Congress in 2005 is no longer evident in the face of the Syrian refugee crisis.

With this in perspective, it makes it all the more likely that Congress will not be passing a single-payer health system act (universal healthcare) anytime in the near future and that further eliminates the possibility of all of Medicare being expanded to asylum seekers. But at the same time, the state has shown that it also believes those with “medical emergency” situations should be able to receive some form of treatment. EMTALA is not a form of healthcare insurance but it still offers asylum seekers with medical emergencies the right to treatment and without any cost. As mentioned earlier, the U.S, in response to the fourth periodical review by the UNCCPR, has argued that EMTALA lives up to certain expectations of healthcare as a human right. This is the case for why the United Nations and other international institutions and organizations should collectively release further guidance on emergency medical treatment for refugees seeking asylum. Policies and legal cases related to EMTALA should serve as an example of what formal and substantive equalities are needed to promote emergency medical treatment as a human right under healthcare.

5. Conclusion

Médecins Sans Frontières, or Doctors Without Borders, is an international NGO known for its humanitarian aid work in developing countries. Their work in the United States is clearly limited. But the NGO offers an interesting philosophy on the human right to healthcare; they emphasize strict medical treatment as a means of promoting health rather than the traditional call
for health as a human right.86 The intent behind this is to promote health rather than political advocacy, as “health is a human right” has become affiliated with. A bit of this philosophy was seen during the campaign for the eradication of HIV/AIDS – which eventually turned the international attention to actual medical supplies, doctors and treatment. Apart from offering substantive and formal equality, what should an emergency medical services guidelines look like under healthcare as a human rights framework? Given that the U.S. does not fall under the Doctors Without Borders definition of a “developing country,” the philosophy is not entirely applicable to the state. Asylum seekers arrive with a host of conditions, some which may require emergency relief or some that may require periodical follow-ups. International standards to human rights cannot ignore the need of housing and food, of which are both under definitions of health care, for asylum seekers and thus cannot limit the definition altogether. But a guideline to emergency medical services can take care to acknowledge the United States’ political atmosphere like the philosophy of Doctors Without Borders does so in politically unstable countries. This is why a potential guideline on emergency medical services should focus on finding ways to cooperate with Americans of all political beliefs by emphasizing medical treatment.

However this strategy does seem to have a possible downside. In the case of female genital cutting (FGC), human right advocates managed to frame FGCs as a strict health and sanitary issue in Egypt.87 Instead of taking the traditional way to “cutting,” Egyptians were more likely to perform the procedure through actual physicians in hospitals. This reduced the likelihood that women and girls will experience infections and other health consequences but it

87 Ibid, DeLact 216.
did little to advance human rights norms because FGCs continued to threaten the bodily integrity of females. But at the same time, success in medical treatment has to be pragmatic. In the case of FGCs, before the traditional way was replaced with a procedure at an actual hospital, there was no medical assistance and no promotion of healthcare rights. But by applying a stricter definition of healthcare, there were less chances of a female to experience a life threatening infection caused by an unsanitary procedure and thus there was a small promotion of healthcare as a human right. It was not an all ends meet solution but it was a step forward in the right direction for the public health community. There may be complications similar to this if the guidelines to emergency medical services promote strict treatment over an all-encompassing definition of healthcare. But because documents like the ICESCR and ICCPR and their related commentaries will remain to affirm the right to healthcare in all aspects, the guidelines to emergency care can take this approach with less risk of decentralizing other rights.

This brings into question of the role of public health advocates in the development of emergency medical services guidelines for the United States. Clearly, the United States Congress did not initially consult with experts on public health and the conditions at which asylum seekers arrive to the country with, otherwise the federal government would not have had to issue further regulations and guidelines on EMTALA many years later that included public health expert testimonies. Public health experts, like Dr. Paul Farmer of Partners In Health, has acknowledged that public health efforts are more fruitful with a human rights framework:

Imagine, for a minute, that you don't want to take a human rights perspective and that you're not at all interested in solidarity or service to your neighbor. Instead, you want simply to make a Hobbesian cost-effectiveness argument. Well, one woman had four kids, and she was dying from AIDS. A month later, after starting antiretroviral therapy in a public clinic near the border of the Dominican Republic, she looked like a completely different person. Would it have been more

---

cost-effective to relegate her four children to orphan hood? My colleagues at Partners In Health and I believe that our model—community-based AIDS treatment and prevention offered in the context of primary health—can be successfully exported to other settings beleaguered by poverty and disease. The human rights approach—quite simply, that health care is a right, not a commodity—is the most satisfying approach to medicine than I can imagine.89

In the same way the public health community has found ways to incorporate human rights into public health, human rights frameworks on healthcare must continue to consult with public health experts to realize and understand the complexity of emergency medicine. A human rights based approach to healthcare is the idea that without human rights, even the most effective health system will not reach the most vulnerable.90 But only with consulting public health experts can guidelines for emergency medical treatment ensure that governments are maximizing the availability of health facilities, ensuring the accessibility of these services, establishing acceptability, and providing the highest quality.91 These are the principles found in General Comment No. 14 in response to the confusion created by the ICESCR. They are valuable elements that can be interpreted to make EMTALA stronger but are still left too vague for nations to actually turn into operational policy.

The potential guidelines obviously have to tackle and define elements that make up what the human right to emergency medical services should consist of. The framework of EMTALA gives us those elements: 1) what is an Emergency Department, 2) what is an emergency, and 3) what is treatment until stabilization? EMTALA was unable to offer an asylum seeker with PTSD the right to emergency treatment because either the definition of an “emergency” was too strict,

---
91 Ibid, Unnithan.
or the “treatment” did not require a follow-up. As stated earlier, it is important to define what an emergency consists of because it is the only way to discriminate between an emergency and a non-emergency. In 1996, the federal government realized that the definition of an emergency under EMTALA was problematic. An EMTALA Task Force was formed to clarify the definition and regulations were published later in 1998. While some of these federal regulations do not carry any legal weight that the actual text of EMTALA does, hospitals under Medicaid have shown to take them into consideration for the most part. But the definition is still unpractical because of the numerous possibilities of medical illnesses. On top of that, federal and state courts have significantly tried to either limit or broaden the scope of EMTALA interpretation. It is easy to assume that hospitals are then forced to spend a hefty amount on legal fees to figure out whether they are in compliance or not with the various interpretations offered. This does not mean that the general rules of EMTALA were changed by the new federal guidelines. At its core, hospitals must continue to provide MSEs and stabilizing treatment without discriminating their economic means or immigrant status.

In respect to defining what an Emergency Department can be, the Centers for Medicare and Medicaid Services (CMS) published regulations that govern services under EMTALA that became effective in 2003. CMS outlined four scenarios that could apply to asylum seekers, depending on which “door” they present to: the “dedicated emergency department,” hospital property other than the dedicated ED, hospital-owned/operated ambulances, or hospital-owned off-campus facilities. The regulations noted that each of these locations have their own regulatory distinctions that have to be considered when determining how the scope of EMTALA is applied. This is the regulatory issue that international guidelines to the framework of

---

emergency medical care have to address. How can there still be an environment appropriate of emergency medical care but still have limitations that prevent medical treatment to be encompassing of all non-emergency treatments? EMTALA regulations defines the “door” the asylum seeker chooses as a dedicated emergency departments if it meets at least one of the requirements: it is licensed by the State as an emergency room/department, it is held out to the public (by advertising, signs, and other means) as a place that requires treatment for emergency medical conditions without prescheduling appointments, or if during the calendar year preceding the calendar year in which a determination is being made, the entity has provided at least one-third of all outpatient visits treatment of emergency medical conditions on an urgent basis. These regulations actually eliminate the application of EMTALA on the previously discussed off-campus facilities of hospitals that do not offer emergency services regardless of its Medicare affiliation. Studies to show that this negatively affects asylum seekers are nonexistent but it is easy to hypothesize that a possible refugee-seeking asylum in the suburbs of a small state may only have access to off-campus facilities of a larger hospital. But it can be argued that the regulation was not placed in order to hurt those seeking emergency care but to rather promote the quality of emergency care by having off-campus clinics make references to the closest emergency facility. The intent of this regulation can be argued as being advocating the well being of asylum seekers but if there is no legal requirement for off-campus clinics affiliated with federal Medicaid funding to actually transport those outpatients to dedicated EDs, the result will not always uphold human rights. It is not enough to trust that a good-natured hospital administrator will take care to transfer the asylum seeker to another hospital.

---

In the same manner, the definition of an “emergency” is important to develop under a human rights framework. This is where public health and medical experts will need to play a strong role in. There are thousands of diseases and illnesses that the medical community is aware of and new advances for treatment are made more rapidly than ever before. The guidelines have to allow a degree of flexibility in the definition of an emergency. An earlier example provided to show that “chronic back pain patient with ‘severe pain’ … does not have an emergency condition if he does not need immediate medical attention for an aortic aneurysm that’s ruptured, an epidural abscess, a herniated disc that’s producing serious neurological loss, or some other true emergency condition.” ⁹⁴ Again, if the asylum seeker is unable to walk or perform day to day activities that are required for his or her ability to maintain their livelihood in an environment where state support is so weak, is the individual’s back pain not an emergency condition? The definition of an “emergency” has to flexible in the sense that it has to take in account of the environment that the asylum seeker is coming from, as well. As implied in the introduction, asylum seekers are not like other individuals without healthcare in America. The closest group that can be compared with is undocumented immigrants but they are not all able to meet the definition of a refugee.

The legal definition of an EMC leaves much to be desired. The determination the physician is making is not a legal one but one based on medicine. A framework for emergency medical care cannot define an emergency as so open ended that it defeats the point of an “emergency”, and provokes the political sentiments of Americans, but has to show some degree of compromise. If a physician sees someone who is unable to properly walk because of his spinal condition but is also unable to legally diagnose it as an emergency, the physician should be

⁹⁴ Ibid, Bitterman.
allowed to overrule the legal definition for a more medically informed definition of an emergency. In respect to EMTALA, the statute already mandates the physician diagnose an EMC. This is a strong element of the law. But in diagnosing an EMC, EMTALA should also allow the physician to use his or her better medical judgment (and medical ethics) to treat and stabilize. The downside of this law is that it would leave some asylum seekers’ treatment to the judgment of the physician, who may be less experienced and unable to diagnose an EMC, but it at least offers a mode of flexibility that EMTALA currently prohibits.

The third element is to define what treatment until stabilization may mean. In the case of the asylum seeker experiencing possible PTSD, he or she is currently unable to return to the hospital for a follow up under current EMTALA guidelines. It is no secret that some diseases or illnesses, especially if mental, can be apparent one day but difficult to diagnose the following week. That is, again, the complexity of psychiatric science. But in some cases the regulations issued by the federal government allow follow-up appointments under EMTALA. Take for example if an asylum seeker arrives to the ED, is diagnosed with an EMC, and requires abdominal surgery. The treatment of the asylum seeker cannot be medically complete, or stabilized, until he or she has had their surgery examined. He or she may require physical therapy, x-rays to verify the surgery was a success, and a host of other possible medical procedures. This is a case where EMTALA works. Therefore the guidelines to emergency medical care/treatment as a human right have to include a strong clause on follow-up obligations of the hospital for all patients treated. Even if a patient was not diagnosed with an EMC, the hospital should not be allowed to turn away the patient for a follow up because the EMC was unapparent the first time.
A subcategory of treatment until stabilization also involves the process of transferring a patient, as mandated by EMTALA, if the ED is unable to provide treatment. There are two components that must be met for a proper transfer to occur: the patient seeking medical attention should require the specialized capabilities of the receiving hospital and the receiving hospital must also have the ability to treat the patient. A physician must also certify in writing the benefits of transferring a patient outweigh the risks of the actual transfer. Possible complications that arise from this can concern an asylum seeker who is pregnant. The nature of pregnancy can make a transfer to a better-equipped hospital as a case where benefits outweigh the risks but the situation can be completely different in between hospitals. There is very little that international guidelines on emergency medical treatment can do to prevent this. It is the responsibility of the physician to take caution before signing off on a transfer and EMTALA has taken this into consideration.

It is difficult to produce guidelines on emergency medical treatment that can be legally binding. Neither General Comment No. 14 nor the commentary behind the 1951 Convention is legally binding. EMTALA enforcement is unique because it is largely complaint driven. Patients and receiving hospitals are able to file complaints to the Centers for Medicare and Medicaid Services or the State Survey Agency if they suspect EMTALA violations have occurred. EMTALA also provides whistleblower protections for hospital staff that report EMTALA violations of their own hospital. This is important because there is protection for a hospital employee to report violations without the fear of losing his or her job. Based on the likelihood that international guidelines on emergency medical treatment will not be legally binding, there is reason to take EMTALA’s enforcement mechanisms into consideration for the guidelines. The problem, however, is how do these guidelines come into practice in the U.S. if they are not
legally binding? How can EMTALA be modified under these guidelines to promote emergency medical care for asylum seekers? The U.S. has acknowledged that EMTALA meets some aspect of human rights because it provides emergency healthcare services for those without immigrant status. In an incentive to not completely fall behind healthcare rights for asylum seekers, there is reason to believe that the state will modify the regulations surrounding EMTALA, which do not require action by the U.S. Congress.

These are the three basic frameworks as defined by the U.S. Congress in EMTALA that can serve as a starting point for international human rights guidelines on the access to emergency medical treatment. There will be new discoveries in medicine that will shatter barriers and it is the obligation of the international human rights community to ensure these guidelines are kept up to date so that the healthcare rights of refugees seeking asylum will be consistent. In a broader sense, the U.S. is not the only country that will benefit from an international framework on emergency medical care. There will be other countries in the world that are unable to find political compromise for the access to healthcare for all those within their borders and a framework that is politically sensitive can serve to provide the most vulnerable with actual medical treatment. EMTALA should also not be the only program that is referenced to developing a human rights framework for the international guidelines on emergency medical care but it can still serve as a strong starting point.

95 UN Human Rights Committee (HRC), Replies of the United States of America to the list of issues, 23 April 2014, CCPR/C/USA/Q/4/Add.1
Bibliography

Arrington v. Wong, No. 98-17135 (9th Cir 2001).
Bolton, Elisa. PTSD in Refugees, Dep't of Veterans Affairs, Nat'l Ctr. for PTSD (Dec. 20, 2011), http://www.ptsd.va.gov/professional/pages/ptsd-refugees.asp
Cf. E/AC.32/SR.38, p. 5.
“Convention and Protocol Relating to the Status of Refugees.” UNHCR.
E/AC.32/SR. 15, pp. 5-8.
Examination and treatment for emergency medical conditions and women in labor (EMTALA). 42 U.S. Code § 1395dd

“Frequently Asked Questions about Accrediting Hospitals in Accordance with Their CMS’ Certification Number (CCN).” http://www.jointcommission.org/faqs_ccn/


“Global Issues at the United Nations.”


INA § 101(a)(42)


https://www.oyez.org/cases/2014/14-114

http://www.law.cornell.edu/cfr/text/45/152.2


http://www.nyshealthfoundation.org/section/aviles_and_gianelli_event


PTSD Overview, Dep't of Veterans Affairs, Nat'l Ctr. for PTSD,


Resolution adopted by the United Nations General Assembly. 60/262. Political Declaration on HIV/AIDS. 87th plenary meeting, 2 June 2006.
State Operations Manual Appendix V - Interpretive Guidelines - Responsibilities of Medicare Participating Hospitals in Emergency Cases. *Centers for Medicare & Medicaid Services.* (Rev. 60, 07-16-10)
“The United States Refugee Admissions Program (USRAP) Consultation & Worldwide Processing Priorities.” *USCIS.*
UN General Assembly, *Universal Declaration of Human Rights*, 10 December 1948, 217 A (III)
UN Human Rights Committee (HRC), *Concluding observations on the fourth periodic report of the United States of America*, 12 September 2013, CCPR/C/USA/CO/4
UN Human Rights Committee (HRC), *Replies of the United States of America to the list of issues*, 23 April 2014, CCPR/C/USA/Q/4/Add.1
42 U.S.C. § 1395dd
42 C.F.R 489.24(a)(1)(i)
42 C.F.R. § 489.24(a)(1)(i)
§ 1312 (f) (3).