

# **The human right to health: exploring disability, migration and health**

## **Abstract**

Across the globe, an estimated 1 billion people are on the move today, of whom 244 million are international migrants. Not only have global horizons expanded in the realm of work and study; global conflict and exploitation have resulted in forced migration. Migration is a political issue, one that raises questions of identity, citizenship, diversity, integration and is utilized to play upon the fear of the stranger, the ‘Other’ and difference in contemporary society. Disabled migrants are a hidden population whose experiences are often overlooked or subsumed within wider debates around disability and ethnicity.

This paper considers the intersection of disability and migration in contemporary society through the lens of healthcare access. Reflecting on the impact of citizenship rights on the realisation of human rights in the context of contemporary migration, using health as an example, the paper considers the implications for disabled migrants, focusing primarily on the EU.

## **Key words**

Human rights; citizenship; migration; health; health care access

## **Introduction**

Migration is a key issue of our times. Across the globe, an estimated 1 billion people are on the move today (World Health Organization 2014). Of this number, 244 million are international migrants (UNDESA, 2015). There are estimated to be around 32 million disabled migrants across the globe (Handicap International, 2014). Yet, little is known about this group (European Union Agency for Fundamental Rights 2016). Individuals are moving for many reasons and in very different circumstances. Not only have global horizons expanded in the realm of work and study; global conflict and exploitation have resulted in forced migration. Further, migration experts have noted the increasing complexity of migration and migration statuses in contemporary society, what Vertovec describes as ‘superdiversity’ (2007). This paper considers writing around the nature of citizenship and human rights in contemporary society in the context of migration and disability.

The paper draws together diverse literatures within the fields of migration studies, disability studies and health inequalities. Engaging with the concepts of cosmopolitan citizenship (Benhabib 2004) and ‘actually existing’ cosmopolitan citizenship (Nash 2009) the paper illustrates the ways in which new forms of citizenship produce inequalities. In so doing the paper attempts to highlight the ways in which the realization of the human right to health is mediated by new forms of citizenship.

In 2010, Ban Ki Moon, UN Secretary General spoke of his concern around what he termed a ‘politics of polarization’ in relation to immigration within the EU (cited in Pace, 2011). Migrants are being denied their basic human rights (United Nations 2010). The health of migrants is of growing concern at the international level (Steele et al 2014; WHO, 2010). Across the EU, access to health care has become a focal point of immigration debate.

Issues of citizenship, identity, belonging and nationalism have been called upon to determine who has access to healthcare. In the UK debates, much has been made of the ‘health tourist’, the vulnerability of the National Health Service (NHS), and the drain on the resources as the national health service becomes the ‘international health service’ (Department of Health 2013). Use of the NHS by migrants have been shown to be less than nationals and while ‘health tourism’ and inappropriate access to healthcare does occur, this is significantly lower than political rhetoric would have us believe (Prederi 2013, Jolly and Bennett 2015, Schulkind, Biggart, and Bowsher 2015). More recently, discourses around NHS have been utilized in the recent EU referendum debate in the UK (Vote Leave Campaign 2016).

These discussions have occurred in a context of the financial crisis of 2008 which quickly engulfed the globe, providing a platform on which neoliberal restructuring of the welfare state could proceed with devastating consequences for populations across Europe (Mason 2015). This has resulted in a reduction in public services in many EU states, with health systems being particularly affected (Karanikolos et al. 2013). For example Ireland faced a 12% cut in its health budget in 2008 (Burke et al. 2014); while in Greece, the Troika (European Commission, International Monetary Fund and European Central bank) has demanded that no more than 6 per cent GDP to be spent on health (Karanikolos et al. 2013, Kentikelenis et al. 2014). In the context of austerity, the reduction in services across Europe has thrown into sharp relief questions of who has entitlement to access services- and issues of human rights are lost in the need to determine who is ‘one of us’, who is ‘deserving’ (Willen 2012, Sargent 2012). Thus, while health is a human right, rights to health and health care are increasingly limited by citizenship rights (Pace, 2011). In the EU, EU citizenship is predicated on member states national citizenship.

Over 500 million people reside in the EU and its population is diverse (Eurostat, 2015). In 2014, the foreign born population equated to 33.5 million of the population of the EU, 6.6% of the total EU population. Non-EU citizens accounted for 19.6 million people equivalent to 3.8% of the population (Eurostat 2015). Migration as a source of population change in the EU is significant, accounting for over 60% of population growth in 2009 (EMN, 2011). Patterns and rates of migration vary considerably throughout the member states. Germany, the UK, Italy, Spain and France account for 76 per cent of non-EU nationals across the EU (Eurostat 2015b, a). The EU is a key provider of asylum for those seeking refugee status, with 1.2 million applications in 2015, double the number of applications received in 2014 (EU 2015) with a third applying to Germany. In the past there have been move towards greater harmonisation of immigration policy in EU member states (1). However, there remains variation between countries due to national laws, policies, interpretations of law, ‘integration’ policies and practices and the EU has no competence to direct national policy on citizenship (Messina 2011) and naturalization (2) rates between countries vary (Eurostat 2015b)(Eurostat, 2015).

Since Ban Ki Moon’s speech, immigration has become a key political issue both nationally and at the European and international level. Migration is often positioned as a *problem* rather than an intrinsic aspect of social transformation in contemporary society (Castles 2010). Across Europe, immigration has been the focal point of elections, with European Union elections seeing an increase in right-wing parties and candidates securing seats. In the UK EU referendum, imagery of refugees were utilized in the ‘leave’ campaign, with the phrase ‘Breaking Point’ (Stewart and Mason 2016). In Austria, Sweden and Denmark, far-right wing parties have been growing in strength. A key issue has been who has access to services and the status of ‘citizen’ in contemporary society. The meaning of citizenship is contested in the

everyday, real world concerns of populations and government. Marshall's notion of citizenship as political rights from which other rights are based forms the basis of citizenship in nation states. Lister has argued that citizenship is predicated on 'exclusionary tendencies' (Lister 2007 50). Inherent to citizenship is inclusion of some through exclusion of others, with 'otherness' key to understanding citizenship (Isin, 2005; Lister, 2007). Debates have considered the relationship between citizenship rights and human rights, with the conflation of these two sets of rights deemed problematic, particularly in the context of the global south (Soldatic and Grech, 2014). More recently, citizenship has been framed in relation to social, political, civil and cultural rights. Questions of exclusion and the 'daily denials' faced by disabled people and their claims to citizenship have been of concern since disability studies formation. Oliver and have others observed the denial of disabled people's political, cultural, civil and social rights (Oliver, 1990, Lister 2007, Young, 1990, Barton 1993).

The summer of 2015 brought EU immigration policy into sharp focus, highlighting the ways in which those fleeing conflict zones-have been 'reclassified' in political and media discourses into 'migrants' seeking economic opportunities. Scenes from Italy and Greece have challenged such discourses, reaffirming the predicament of asylum seekers and refugees, with an estimated million irregular migrants and refugees entering Europe in 2015, the largest number of persons since the Second World War (IOM, 2015). Many asylum seekers and refugees are fleeing conflict zones have acquired impairments during the process of migration (Handicap International and Helpage International, 2014). While this humanitarian crisis has refocused the public imagination around the plight of refugees, it also brings into relief discourses of deservingness of 'types' of migrants (Philo et al 2013; Sargent, 2012).

While we can point to the many ways in which both disabled people and migrants are excluded from civic, political, economic and cultural life; it is the *intersection* of these two identities and experiences which bring issues of human rights and citizenship into sharp relief. Although a language of human rights is utilised for both disabled people and migrants alike across countries, this is contingent upon state interpretation and practices around citizenship (Tyler 2013, United Nations 2006). Both groups face barriers to realising their rights to participate in society, including their ability to access health care (World Health Organization and World Bank 2011, World Health Organization 2010). The combined effects of disability, citizenship status and ethnicity on disabled migrants' experiences is summarised in Trotter's observation '*Being a migrant affects the experience of being disabled but being disabled also alters the experience of migration*' (2012:30). Yet, within the field of migration studies, disability has largely been ignored in the migration experience, with research focusing on issues of gender, class and sexuality (but see Smith-Khan et al 2014). Within disability studies writers have explored the intersections of migration and disability, engaging with wider debates around ethnicity, citizenship and identity with a number considering access to services in social care, education, employment and health care (see Albrecht, 2009; Soldatic and Fiske, 2009, Soldatic et al 2012; Dossa, 2005). There is also now a growing interest and scholarship within disability studies around conflict and forced migration (see Berghs, 2015). Debates within the field of migration studies offer a means by which to explore theoretically the relationship between human and citizenship rights in the context of disability and migration. This paper engages with some of the debates within this field. The paper considers the utility of political philosopher Benhabib's concept 'cosmopolitan citizenship' (2004). Benhabib's approach recognizes the expansion of human rights at the international level as a discourse of the everyday. In the context of disability, Benhabib's work reflects the increasing recognition of disabled people's rights at the local

national, European and international levels. However as many commentators have observed, this assertion of the human rights of disabled people has not necessarily resulted in the enactment or lived experience of these rights. Nash's critical analysis of Benhabib's work offers a way in which to explore the impacts for disabled people. Drawing on Nash's (2009) critique of cosmopolitan citizenship, I consider health as a human right and the implications of varying citizenship status on disabled migrant's entitlement and access to health systems

The next section outlines the invisibility of disabled migrants in policy, practice and research, noting the silences and gaps in our knowledge of this group. In the context of migration and transnational migration, I outline Benhabib's cosmopolitan citizenship and Nash's engagement with this work. The paper considers health as a human right and the ways in which this right is realised or limited in practice for disabled people and migrants. Using Nash's schema, different citizenship statuses are considered for disabled people in relation to health care access. The paper concludes by reflecting on connections with wider debates within disability studies and the application of Nash's schema to other aspects of disabled migrants lives such as education and employment issues.

### **Disabled migrants: an invisible population?**

In their editorial overview of a special issue around disability and forced migration, Pisani and Grech observe that '*Migration theory grows without the disabled person, disability studies without the migrant, and practice without the disabled migrant*' (2015: 421). This section provides a brief overview of what we think we know about disabled migrants in the

world today. In part, the silence around disabled migrants reflects two conceptually contested identities – disabled person and migrant, which are both subject to various administrative and bureaucratic and cultural definitions which can simultaneously include and exclude from entitlements and access to a range of rights and protections. Disability is a contested and challenged concept, with biomedical and social barriers approaches to the term providing opposite ends of a spectrum of definitions (Goodley, 2011). Migration categories appear to be fixed but these categories are fluid and complex. Defining ‘who’ is a migrant is difficult, there is no legal definition (Pace 2007). Methods of defining a migrant are dependent on data sources, time and the law in which one is operating (Anderson and Blinder 2015). Further, migration status is not fixed and as individual’s move they experience many ‘categories’ of migrant and importantly, citizenship status. This fluidity presents both risks and opportunities to both state and individuals, as both seek to determine where the individual is located.

The rights of individuals are a key issue in this age of superdiversity. Human rights exist to protect individuals moving between nation states (United Nations, 1951; United Nations, 1990) and a raft of conventions exist to assert these rights including for disabled people, most recently in the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) (2006) Article 18 (United Nations, 2006). However as noted by Benhabib, there is an ‘*outright contradiction between human rights declarations and states sovereign claims to control their borders as well as to monitor the quality and quantity of admittees*’ (2004: 2).

In official data migrant status is often crossed with other characteristics, age, gender, citizenship, nationality. However, data are sparse around the intersection of migration status and disability, with a Fundamental Rights Agency report on multiple discrimination pointing to the lack of reliable data on migrants, ethnic groups and disability (2013 (Mirza 2011)). The

difficulty in accessing data has been recognized at the international level, with lack of formal procedures to identify disabled migrants and refugees a key issue at the national level (Committee on the Protections of the Rights of All Migrant Workers and Members of Their Families and Committee on Rights of Persons with Disabilities 2017, European Union Agency for Fundamental Rights 2016). What little data exist point to the discrimination experienced by displaced disabled people and the additional vulnerabilities they are faced with (Mirza, 2011).

Using the current estimates of the number of international migrants and the WHO estimate of prevalence of disability of 15%, around 32.4 million disabled people may be migrants (WHO 2011). The Women's Refugee Commission estimates that around 6.7 million disabled people are displaced as a result of human rights violations, conflict and persecution equivalent to 15% of the 45.2 million persons displaced globally in 2013 (Women's Refugee Commission 2014, Handicap International and HelpAge International 2014). In recent years, the experiences of forcibly displaced and refugee disabled migrants has been increasingly recognized both within academic writing and international organizations tasked with supporting refugees (see Smith – Khan et al, 2014 ; Pisani and Grech, 2015; Berghs, 2015). Not only are disabled people missing from migration data and debates; migrants are missing from disability data and policy. Andersen and Mannan's analysis of the UNCRPD highlights that displaced persons are not recognized at all and ethnic minorities are least frequently mentioned in comparison with categorisations such as age and gender (2012). The World Report on Disability (World Health Organization and World Bank 2011) refers to migrants only once, as caregivers of disabled people; a point also observed by Pillay (2013).

Until relatively recently, there has been little acknowledgement of the issues facing disabled migrants. Where this has been acknowledged it has focused on particular migrant

groups, with the UNHCR attempting to mainstream disability through its 2011 conclusions on refugees with disabilities, resettlement handbook and the work of the Women's Refugee Commission (2014). The role of the UNHCR differs across countries playing an advocacy role in the global north while adapting a more practice role in the global south (Straimer 2011). The consultation report on the health of migrants (WHO, 2010) makes no reference to disability. The International Office for Migration has no specific policy around disability. Recently the Committee on the Protection of the Rights of Migrant Workers and Members of their Families and the Committee on the Rights of Persons with Disabilities issued a joint statement acknowledging the difficulties in identifying migrants with disabilities and the barriers experienced by this group in accessing services (Committee on the Protections of the Rights of All Migrant Workers and Members of Their Families and Committee on Rights of Persons with Disabilities 2017).

Disabled migrants in their many forms exist, as groups and NGOs working in communities have identified. For example in the UK, the experiences of disabled refugees and asylum seekers have been overlooked with Amas and Lagnado (2010) describing them as a 'hidden population'. Trotter (2012) identified that the needs of migrants were little understood. Pointing to the fluid nature of migration patterns and processes, this study of BME disabled people highlighted the growing numbers of disabled people within BME groups, the higher numbers of households living in poverty (44%) compared to other households with a disabled person (32%) and the population as a whole. The study, similar to an earlier reports by Ward et al (2008) and Roberts and Harris (2002) and Harris (2003), illustrate the additional complexities and challenges facing disabled asylum seekers and refugees.

Disability studies scholars have engaged with migration for over the past twenty years, reflecting the complexity of intersections of migration status, ethnicity and disability.

This raises important issues around who is defined/ self-defines as disabled. Researchers have been concerned with the issues of access and navigation of services across social and health care fields (see Ward et al 2008; Roberts and Harris, 2002). Within the health realm, what in healthcare services research is defined as ‘cultural competence’ has been a particular research focus. Groce and Zola (1993) point to the need to engage with cultural understandings of disability and illness, migration experiences that may influence migrants’ willingness to access support. Cultural understandings of aspects of disability and mental distress have been explored and the implications for the development services for diverse groups (Quinn, 2014). Whyte and Ingstad (1995) through their edited collection highlighted the need to consider culture in any understanding of disability (Whyte and Ingstad 1995). Pointing to the invisibility of dominant culture within healthcare practice, they point to the need to recognize differences. Multi-culturalism suggests a multiplicity of ways of understanding disability, but as Stienstra (2012) notes, issues of cultural competence can result in the cultural identity aspects of disability being overlooked. Sachs (1995) highlights the ways in which different understandings of health, illness and disability from the point of view of parent and health care practitioner result in a silence around the needs of both child and parent and point to the need for culturally sensitive services at the health care system level.

As the demographics of migration changes; the needs of particular groups surfaced as of relevance. Reflecting the increasing number of asylum seekers and refugees in the UK – and more broadly in Europe, Roberts and Harris’ work highlighted the issues facing disabled refugees and asylum seekers (2002) with lack of understanding by support services to the needs of individuals and lack of co-ordination between services highlighted. Mirza has pointed to the health needs of forcibly displaced disabled migrants in humanitarian camps (Mirza 2011; 2015). The evolution of immigration policy and its disabling and exclusionary

nature has been the focus of a number of papers, focusing on the impact at the individual level in Australia (Soldatic and Fiske 2009, Stevens 2010). The intersection of identities has been similarly recognized in Canada (Dossa 2005) and in Belgium (Albrecht, Devlieger, and Van Hove 2009). What these papers reveal is the complexity of immigration policy, its impact on the everyday lives of migrants and barriers faced by migrants as they attempt to navigate health and social care systems which are ill-equipped to address the needs of this group.

### **Superdiversity and rights: migration, human rights and citizenship**

Vertovec argues that societies are becoming super-diverse. We are now in the age of ‘super-diversity’ (Vertovec 2007) defined by complexity ‘*distinguished by a dynamic interplay of variables among an increased number of new, small, scattered multiple origins, transnationally connected, socio-economically differentiated and legally stratified immigrants*’ (Vertovec, 2007: 1024). Following from Vertovec’s idea of ‘legally stratified immigrants’, an individual can transition from economic migrant with limited rights, to undocumented migrant with little or no rights, to asylum seeker with temporary rights, to refugee.

The rights of individuals are a key issue in this age of superdiversity. Many human rights exist to protect individuals moving between nation states (UN Convention on Rights of Refugees, 1951; Convention on the Protection the Rights of all migrant workers, 1990) and a raft of conventions exist to assert these rights including for disabled people, most recently in

the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) (2006) Article 18. Nonetheless questions have been raised around the realization of these human rights at the level of the nation state and its relationship to citizenship rights. Human rights are increasingly not simply a *moral* position but given legal weight through various mechanisms within international law including its use in positive law which binds states. Human rights are part of the legal landscape in Europe, both citizens and non-citizens can bring cases to the European Court (Nash, 2009).

Traditionally (liberal) citizenship is a legal status based on nationality which provides rights and responsibilities, it enables political participation and it is about identity (Marshall, 1950; Nash 2009; Lister, 2007). As noted by Lister, citizenship offers inclusion through exclusion (see 2007). In thinking through the relationship between human rights and citizenship rights, Nash critically engages with Benhabib's notion of cosmopolitan citizenship (2004). Building from Kant's notion of hospitality and Arendt's discussion of 'the right to have rights' Benhabib reclaims cosmopolitanism (2004); arguing that the movement of human rights from a moral principle to a positive international law, is changing the way states govern. Importantly this includes those who, in liberal terms, would be regarded as non-citizens, such as migrants. While human rights laws work at the supranational level, these laws are realised through '*democratic iterations*' at the national and local level. Democratic iterations refer to '*complex processes of public argument, deliberation and exchange through which universalist claims and rights are contested invoked and revoked, posited and positioned*' (Benhabib, 2004:179). Such iterations take place in a variety of spaces including the legislature, government and civil society. Benhabib argues that through democratic iterations, local practices can bring nation states into line with human rights law. While Benhabib's concept of cosmopolitan citizenship offers a positive vision of rights being created through

the engagement of citizens and non-citizens through human rights, Nash questions the limits of Benhabib's position, arguing that her theory works at a level of abstraction that enables Benhabib to assume that these iterations *are* democratic (2009: 1069). Rather, Nash argues that the question is one of the *impact* of human rights on citizens and non-citizens in practice. Drawing on David Lockwood's argument around axes of inequality - that the presence or absence of legal/bureaucratic rights and moral and material resources can limit the enjoyment of rights by an individual- Nash asserts that the enjoyment of rights and the securing of rights *'also depends on social structures through which power, material resources and meanings are created and circulated'* (2009: 1069). In Benhabib's world, cosmopolitan law results in the abolition of distinction between citizens and non-citizens in terms of rights, resulting in greater equality in access to rights. Nash argues that can in fact lead to greater *inequality* arguing that *'securing human rights may even put people in positions in which they find themselves subjected to further violations of their fundamental human rights'* (2009:1070). Thus, far from levelling the rights of citizens and non-citizens, we are seeing a proliferation of stratified groups of 'actually existing' cosmopolitan citizens who are differentiated through entitlement to formal and substantive rights dependent upon their status as 'non/citizens' and the resulting resources -moral, legal and material- which flow from this status. Although cosmopolitan law is intended to abolish the distinctions between citizens and non-citizens, Nash asserts that such laws can in fact result in new forms of inequality. As Nash argues, axes of inequality and discrimination have profound implications for the ability of individuals to both *have* citizenship rights and *exercise* those rights. *' "Actually existing" cosmopolitanism involves the multiplication of differences which are also inequalities...[ In practice there are quite different sets of rights for different person of different status.'* (2009: 1079-1080). The having and exercising of citizenship rights has long been a key concern of disability studies, whereby the exclusion of disabled people from social, economic, political

and cultural life has been identified by researchers and disability activists, most recently in the era of austerity (Briant et al, 2013; Goodley et al 2014; Grover and Soldatic, 2014; (Mladenov 2015) ). Both disabled people and migrants face structural and systemic barriers to realising their rights to participate in society, including their ability to access health care. (World Health Organization and World Bank 2011, World Health Organization 2010). The next section considers Nash's arguments around the axes of inequality in relation to healthcare through a discussion of the human right to health and the barriers to the realization of this right.

### **Health, migration and disability: entitlements and access to services and systems**

Health has been deemed a human right and one which is available to all, regardless of nationality or migrant status (Pace 2009, 2007). A raft of international and EU instruments uphold the rights of all to health. The International Covenant of Economic and Social Rights article 12 1 '*recognise[s] the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*'. A legally binding interpretation of the human right to health, General Comment 14 takes an inclusive definition of health, supporting the right to health care and other factors which support health. In Europe a range of charters protect the right to health including the European Social Charter Article 11. Significantly, Article 13 of the Charter recognises the right to access health for all regardless of resources. The UNCRPD reasserts the right of disabled people to health (Article 25). The only convention which specifically acknowledges that irregular migrants have a right to health care, - not including preventive health care- is the International Convention on the Protection of the Rights of All

Migrant workers and Members of their Families (1990). To date, this convention has not been ratified by any EU countries.

Yet, while the right to health is not the ‘sole privilege of citizens’ in practice it appears to be so (Pace 2007:11). Many groups are denied the human right to health and both disabled people and migrants face health inequity (WHO, 2010; WHO 2011; Emerson et al, 2012, Ingleby et al, 2012). The ways in which health systems are constructed, the mode of entitlement, contribution through tax, insurance and citizenship all define who has entitlement to health care. Further where individuals may have entitlement, a number of barriers exist to accessing healthcare with resulting health inequalities.

Disabled people experience poor health (WHO, 2011). While disabled people may have health conditions arising from their impairment, this does not explain the health inequities experienced by disabled people as a group. The relationship between health and disability has been a source of continued debate as researchers and activists have pointed to the disablist and disabling practices and environments which those with impairments encounter every day, the health issues which many disabled people experience, and health inequities which they face as a result of this disabling society (Emerson et al, 2011; Heslop, 2014). Greater exposure to social determinants of health increases the risk of both health conditions or impairments associated with disability and poor health (Emerson et al 2012:255). Disabled people’s health can be compromised by disablist practices and resulting barriers to healthcare access for disabled people and poorer health outcomes (WHO, 2011).

Being a migrant can have an adverse impact on health both through the process of migration and the status of being a migrant (Gushulak et al, 2010). Migrants are recognised to face additional barriers in accessing safe and effective health care, so much so that in 2008 the World Health Assembly adopted resolution 61.17 in which it called for states to ‘*devise*

*mechanisms for improving the health of all populations, including immigrants in particularly through identifying and filling gaps in health service delivery*' (World Health Assembly 2008). Health inequalities experienced by migrants' has been an issue for a long time, which now is reflected in concern around ethnic minorities health inequalities and inequities, although this has not translated into equitable access (Ingleby et al. 2012 , Rechel et al. 2011, Salway et al. 2010 , Salway et al. 2014 , World Health Organization Regional Office for Europe 2010, Gil-González et al. 2015). Despite the race equality directive being in place for 14 years and Europe having established migrant communities for several decades, across health and social care systems, ethnic minorities face structural and institutional barriers to access healthcare systems (WHO 2010, Gil- Gonzalez et al, 2015).

The discussion above has shown that while the human right to health exists, entitlement is mediated by citizenship rights. As I discuss below, for some migrants, this may result in the formal legal denial of entitlement to health care (European Union Agency for Fundamental Rights 2011, Gil-González et al. 2015). Where there is legal formal entitlement, inequities exist in health and barriers to healthcare arising from greater exposure to the social determinants of ill-health in a society which through racist and disablist practices block access to health care.

### ***'Actually existing' citizens and health***

Using Nash's 'actually existing' categories, this section considers the impact of citizenship on access to healthcare in relation to the intersection of disability and migrant status. Taking this as one vantage point, we can consider the implications of current shifts in social and health care systems from a disability studies perspective and to look at the impact on migrants who are disabled. Through examples, I illustrate the ways in which the intersection

of citizenship rights and axes of inequality in relation to this particular group is potentially causing greater harm to disabled migrants.

*Supercitizens* have the rights of all citizens, are not tied to states, they are in possession of secure employment or skills which enable them to be mobile across borders. In relation to healthcare systems, they will have full rights through their contribution to insurance/ tax system. While disabled people have the right to move under Article 18 of the UNCRPD, gaining access to a number of countries can be denied on the grounds of health.

In immigration policy, the links between disability and health exhibit a biomedical approach, whereby disability is viewed as a burden, a vulnerability and ultimately a cost to the state in which the disabled person and their family wishes to reside. Thus while disability may be framed as a human rights issue through the UNCRPD; as discrimination faced by those with impairments, through equality legislation such as the 2010 Equality Act, policy and practice in the realm of immigration slips into a view of disability which is more akin to the biomedical discourse and related discussions around 'burden' to the healthcare system.

In the EU, the UK has a reservation upon Article 18 enabling refusal of entry on medical grounds which has been challenged by the Equality and Human Rights Commission (2011). Similarly, Canada and Australia have immigration policies which exclude those deemed a potential drain on society's resources, regardless of qualifications or skills (Emery 2015, Collins 2015, Civil Society 2012). Thus, disabled people may be excluded from this group. Similarly, association with a disabled person can result in families making hard decisions around whether to leave a member behind (Jennings et al. 2014 ).

*Marginal citizens* have full citizenship rights and as such are entitled to full access to health care systems either by dint of citizenship, insurance contributions through employment or through social protection systems. However, as a result of socio-economic inequality and experiences of racism and disablism manifesting in health care systems which have little or no recognition of the needs of diverse communities, access to healthcare is denied. A lack of cultural humility, cultural understandings of health and illness all play a role in denying access to health care. Lack of effective communication between health professionals and patients can result in safety issues, misdiagnosis and potentially harmful treatment.

Entitlement and access to health care is not only of concern for non EEA migrants. While EU citizens have a right to move and reside freely across Europe- something which many disabled people are denied (see ANED report on Citizenship and Participation, Dec 2013), Directive 2004/38/EC states that in order to stay longer than three months, EU citizens must have sufficient health insurance and resources 'to ensure they do not become a burden to the host member during their stay'. In practice, many EU migrants are required to pay upfront for health costs- a known financial barrier to accessing health (Chauvin P 2013).

*Subcitizens* Nash argues that subcitizens are created through international human rights law. Pointing to the situation of asylum seekers, Nash notes that asylum seekers are locked out of work and welfare systems as the asylum system processes claims. The increasing use of detention centres and the lack of access to care has been identified across Europe (Tyler, 2013). Concerns have been raised within the UK around conditions within Yarlswood detention centre (Taylor 2015) and in Greece, a recent report on detention centres pointed to the health threatening conditions in which detainees were subjected (Kotsioni 2014). Despite disabled people being viewed as a 'vulnerable' group with special conditions sets for asylum (Straimer 2011), it is clear that such conditions are not always being met (Kotsioni,

2014)(European Union Agency for Fundamental Rights 2016). Lack of formal procedures to identify disabled people, the use of health screenings, a reliance on self-identification and lack of training for staff have resulted in poor identification of people who require support. Restrictive interpretation of legal provision has resulted in disabled people being denied access to assistive technology and devices in reception detention centres (European Union Agency for Fundamental Rights 2016). This group will have endured suffering, including the need to flee conflict which in of itself results in impairment and mental distress. Help Age international and Handicap International report on Syrian refugees in Jordan and Lebanon pointing to 20% of refugees having physical, sensory or intellectual impairment (2014). The crisis faced by Greece, Turkey and Italy throughout the summer of 2015 and the position taken by some EU states points to the hostility toward these groups.

*Un-citizens* Many migrants may be denied access either through their undocumented status or a lack of coverage from employers. A FRA report highlighted the lack of access to mainstream healthcare for undocumented migrants aside from emergency medical treatment (European Union Agency for Fundamental Rights 2011). The inability to access services leaves individuals in a situation whereby they may require intense treatment, leading to long-term health conditions and impairment (see Björngren Cuadra, 2011) .

Undocumented migrants are in the most precarious position. Often utilised as a source of informal labour, they are rarely registered within systems of social and health protection. Spain has since retracted this as a result of austerity, leading to many healthcare professionals protesting against such a policy retraction. This group may be especially subject to health threats, with greater exposure to dangerous work practices which can maim and impair (Kim, 2011).

What these examples highlight is that the intersection of migration process and migrant status plus health and /or disability status restriction/ denial of entitlement and access to healthcare systems in Europe have several implications for our understanding of disability and migration, which I reflect upon in the next section.

## **Discussion**

Over the years, disability studies captured a diversity of experiences, recognising the ways in which lived experience is shaped by the multiple identities and intersection of discrimination faced by disabled people in society, focusing on gender, ethnicity and sexuality (Morris, 1991; Ghai (Ghai 2002); Shakespeare, 2000). Benhabib's and Nash's works offer a way to consider another aspect of identity, that of migrant and enables us to think through where aspects of identity intersect and resulting experiences of disabled migrants as they navigate health care.

While extolling the virtues of human rights, governments undermine citizenship rights through the politics of austerity and neoliberalism (Grover). In the everyday, disabled people and migrants encounter racist and disablist practices which 'Other' (Hughes 2013), and deny their humanity and citizenship (Oliver 1990). Across Europe, health and social protection spending has been slashed, raising questions over who has access to welfare systems (Karanikolos et al. 2013, McKee et al. 2012, Phillimore 2011). In the current climate of austerity migrants, like disabled people, are often positioned as 'abject' subjects who rely upon the state and are deemed a risk to public funds (Tyler, 2013), reflecting values of moral worth tied to, for example, work (Grover and Soldatic, 2014); while many migrants and disabled people are denied the opportunity or right to work through legal or informal barriers.

Benhabib's and Nash's work offers a way to consider where aspects of identity intersect. The exploration of the intersection of identities: of gender, ethnicity, class, disability, migrant status offer a means through which to identify multiple discrimination and its realisation in the mundane and everyday, such as seeking healthcare, echoing Lister's observation of an understanding of lived citizenship, exploring the inclusion and exclusions experienced by disabled people in their everyday lives (see Walby et al, 2012 and Crenshaw, 1991). In the field of health research, intersectionality has been usefully applied to explore seemingly intractable issues that defy simple interpretation, offering the possibility of more nuanced interpretations of health beliefs and behaviours of both health professionals and patients as they navigate health systems (see Hankivsky, 2010; Bowleg, 2012). Multiple discrimination faced by particular groups in health systems has been recognised within policy and academic literature, with calls for an intersectional approach to understanding the health inequities experienced by individuals and communities (European Union Agency for Fundamental Rights 2013, (Hill 2015, 2016) Hill 2016, Bowleg 2012). Earlier, I noted that Nash pointed to the power, social and material resources which mediate rights and entitlements. Inequalities in health extend beyond class and disability (Bowleg, 2012; Hill, 2016). Exploring access to health systems through Nash's schema enables us to think about the right to health for groups and across groups, to explore the power structures which shape entitlement and access to health and disadvantage particular groups in our society (Hill, 2016). While Nash is skeptical of democratic iterations capacity to challenge state definitions of 'us' and 'them'; Benhabib's democratic iterations offer a space whereby disability activists can and do engage in challenging exclusion. It also offers the promise of a 'politics of solidarity in difference' (Lister, 2003:91). Nash is correct to alert us to the inequalities in power which shape the ability to assert rights; there are nonetheless many instances where groups of people have challenged state definitions of 'citizenship'. For example the collective the Sans-Papiers,

formed by irregular migrants in France, challenged state interpretations of political belonging (McNevin 2006, Tyler 2013). It can also be seen in the everyday struggles and activism of disabled people in the UK at present (Tyler 2013). The disabled people's movement resulted in a redefinition of disability a recognition of disabled identity and a reassertion of disabled people fundamental human rights through the UNCRPD.

Migration is not simply a one way flow, there are many subtleties to migration processes. Engagement with migration provides one means to challenge discourses of exclusion, raising fundamental questions about the role of rights in the 21<sup>st</sup> century in a context of rising inequalities and inequities. This may be one way to foster a transnational disability studies (Soldatic and Grech, 2014) as we consider the ways in which the processes of migration; and the treatment of migrants when they arrive on other shores can result in the production of impairment. It also offers an opportunity to reflect on the work of migrants in society, and the role migrants play in social care systems in caring for disabled people (WHO and World Bank 2011).

Citizenship is about identity (Nash, 2009 and Isin, 2005) and the means through which states construct identities has real world implications for individuals and communities. This can be seen most clearly in the relationship between health and disability in the context of migration policy, which highlights the disjuncture between human and citizenship rights. Recalling Benhabib, countries '*monitor the quality and quantity of admittees*' (2004: 2). The elision of health and disability means that health status can be used to exclude migrants from entering sovereign space, whereby disability and ill-health are viewed as burden, and ultimately a cost to the state in which the disabled person and their family wishes to reside. As stated

earlier, the UK has a reservation upon Article 18 enabling refusal of entry on medical grounds (Equality and Human Rights Commission, 2011). Third country nationals may be denied access on public health grounds (see European Commission Directive 2003/86/ EC), playing upon the notion of the migrant as a disease vector. Smith-Khan et al (2015) point to the differences in figures of disabled refugees produced using definitions based on a medical understanding of disability and those which are tied to the UNCRPD definition, using the ICF classification system. Disabled people's redefinition of disability poses a challenge to the use of a biomedical understanding of disability within immigration policy.

Both Benhabib and Nash offer new ways to consider the experiences of disabled people across the globe. Benhabib offers a reassertion of disabled people's rights by dint of common humanity and to be judged as human through opinions and action rather than through citizenship of a sovereign state alone. Benhabib's democratic iterations recognize the ways in which different groups can challenge and shape meaning. The redefinition of disability from a predominantly biomedical understanding to a human rights issue is an exemplar of this. However, this is tempered by Nash's explicit engagement with inequalities that groups including disabled migrants face at the state and local levels which undermine the humanity of those deemed 'Other'. Nash's approach provides a means by which to explore and situate the lived experiences of disabled migrants, taking into account the complexity of cosmopolitan citizenship and its potential consequences in producing inequalities.

## **Conclusion**

This paper has brought together the somewhat disparate fields of disability studies, migration studies and health inequalities to consider the situation of disabled migrants in

contemporary society. Using health as an example, this paper has explored the ways in which ‘actually existing’ citizenship status interacts and intersects with local, national and supranational policies and structures to impact on the experiences of disabled migrants both in their entitlement and access to health care. The construction of health both within migration policies and rights to healthcare, and its relationship to disability— through entitlement and access to health care - intersect both to produce impairment and result in disablement amongst migrants in healthcare systems across the globe. The utility of Benhabib’s cosmopolitan citizenship and Nash’s ‘actually existing’ cosmopolitan citizenship has been considered in the context of disability. Both Benhabib and Nash offer us another lens through which to consider the rights of disabled people and their struggle for inclusive citizenship (Lister 2007). There is scope for both Benhabib’s and Nash’s frameworks to be used as a basis for exploring the lives of disabled migrants in the context of rights asserted in the UNCRPD and access to areas such as education, housing, social care and work.

In recent times there has been an increasing recognition of the difficulties facing disabled migrants at the European and international level (European Union Fundamental Rights Agency 2016, Committee on Protection of Rights of All Migrant Workers and Members of Their Families and Committee on the Rights of Persons with Disabilities 2017). This increasing recognition of disabled people as migrants at the international level offer opportunities for the disciplines of migration studies and citizenship studies to understand the complexities of migrant status on disabled people’s lives. A disability studies approach to migration, as highlighted in the literature reviewed earlier, provides a means for migration studies to critically engage with disability, providing a critical analysis of the ways in which disability is conceptualised in immigration law and policy at the local, national and supranational levels.

## Notes

1. For example the Common European Asylum System; the EC Common Immigration Pact, Schengen Border Treaty and FRONTEX
2. Naturalisation rate is defined as the ratio of persons acquiring citizenship and total stock of non-nationals.

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