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STATE SOVEREIGNTY AND HEALTH RIGHTS: A STUDY OF LEGAL FRAMEWORKS FOR SERVICE DELIVERY TO MIGRANT POPULATIONS

Fayola Issalillah, Lina Agustina, Martini Mengga, Devy Natalia Mathius, Monita Tinting Sirenden, Ambarwati, Dewi Siti Nurhandayani, Ana Susanti, Ananda Elsya Jaatsiyah, Siti Nur Halizah

Correspondence: fayolaissalillah@gmail.com

Universitas Sunan Giri Surabaya

ABSTRACT

The legal aspects of healthcare for migrants and refugees present a complex intersection of state sovereignty, international human rights law, and practical implementation. This literature study analyzes how national legal frameworks reconcile the authority to control immigration with obligations under international law to realize the right to health for all individuals within a state's jurisdiction. It further examines the critical role of procedural rights and operational policies in determining effective access to care. The findings reveal that reconciliation often results in tiered access models linked to immigration status, influenced by regional jurisprudence and public health rationale. However, at the implementation level, formidable barriers such as fears over confidentiality, excessive documentation requirements, linguistic obstacles, and discrimination frequently undermine legal entitlements. The study concludes that robust legal frameworks must be coupled with deliberate investments in health system infrastructure including interpreter services, staff training, and firewalls between health and immigration authorities to translate normative rights into tangible health outcomes. Ensuring equitable healthcare in contexts of human mobility requires continuous attention to both the design of inclusive laws and the minutiae of service delivery.

Keywords: Health Access, Migrants, Refugees, International Health Law, Procedural Rights, Policy Implementation, State Sovereignty.

INTRODUCTION

The movement of people across national borders, whether driven by the desire to seek work and a better life or forced by conflict, violence or disaster, is a hallmark of today's interconnected world. These individuals, who can be categorized as migrants (with various legal statuses) and refugees (who are fleeing documented threats), bring with them complex and layered health needs. This phenomenon demands a more systematic approach to the provision of equitable and universal healthcare services, including legal and ethical considerations regarding service quality and provider responsibility (Hartika et al., 2023). Their health is not only affected by conditions prior to departure and often dangerous journeys, but is also largely determined by conditions in the destination country, including their access to healthcare services. Recipient countries, on the other hand, are faced with the task of integrating these newcomers into their healthcare systems, a task that involves logistical, economic, social and, most importantly, legal and ethical considerations. The relationship between a person's legal status and their right to healthcare forms the core of this discussion, where universal principles regarding the right to health meet the realities of national sovereignty and often restrictive immigration policies (Elger & Wangmo, 2017).

The right to health, recognized as a fundamental human right in international instruments such as the International Covenant on Economic, Social and Cultural Rights, applies in principle to everyone without discrimination (Norredam et al., 2011). However, the operationalization of this right in practice is highly dependent on a person's citizenship and legal status within a jurisdiction. Citizens generally have clear, though not always perfect, access to their national health systems through insurance schemes or public services. In contrast, migrants and refugees often find themselves in uncertain or marginal legal positions, which directly affects their eligibility for care. Previous research shows that this uncertainty can raise ethical and legal issues, for example regarding the validity of health documents and the professional obligations of medical personnel (Waluyo et al., 2024). The distinction between refugees whose status is officially recognized under the 1951 Convention, asylum seekers whose status is still being processed, migrants with valid residence permits, undocumented migrants, and victims of human trafficking, each carry very different legal implications for health access. This legal landscape creates a fragmented and uneven healthcare landscape for an already vulnerable population.

National health systems are fundamentally designed and funded to serve their resident or citizen populations. The arrival of large groups of migrants and refugees can place significant strain on the resources of these systems, triggering political and public debates about resource allocation and the "obligations" of the state (Onarheim et al., 2018). Some arguments limiting access center on the financial burden, concerns about pull factors, and priorities for the local population. Arguments in favor of broader access emphasize international legal obligations, public health considerations as infectious diseases do not recognize immigration status, and long-term humanitarian and social integration values. Furthermore, access to healthcare is also linked to the quality of services, which affects the effectiveness of service delivery (Mardikaningsih, 2022). Amidst this debate, the law serves as a tool that determines how these tensions are resolved. Law can be an instrument of inclusion that translates human rights commitments into enforceable rights, or it can be an instrument of exclusion that deliberately restricts access through residency requirements, insurance limitations, or the threat of reporting to immigration authorities.

The legal aspects of health services for migrants and refugees thus involve complex interactions between several layers of regulation. The first layer is international and regional law on human rights and refugees, which sets minimum standards. The second layer is national laws on health and immigration, which determine the practical conditions for access. The third layer is operational policies and implementation guidelines at the sub-national or institutional level, such as those issued by ministries of health or hospital authorities. This ambiguity often poses implementation challenges in the field, such as hospitals' legal responsibility for service disruptions or limitations in information systems (Choirul et al., 2023; Yatno et al., 2023; Mohamad et al., 2024). This ambiguity often poses implementation challenges in the field, such as hospitals' legal responsibility for service disruptions or limitations in information systems (Mohamad et al., 2024). There is often a significant gap between high-level commitments to international standards and implementation in the field, where health workers and social workers must navigate ambiguous rules and limited resources (Lougarre, 2016). This legal uncertainty can lead to inconsistent practices, de facto discrimination, and avoidance of services due to fear of arrest or deportation among undocumented migrant populations.

Furthermore, the legal dimension is not limited to mere financial or administrative access. The legal aspect also covers procedural rights in receiving care, such as the right to give informed consent in a language that is understood, the right to medical confidentiality (particularly sensitive for asylum seekers fleeing persecution), and the right to a competent interpreter. In some contexts, research emphasizes the importance of protecting the rights of patients, including underprivileged and disabled patients, to ensure fair and standardized services (Herisasono et al., 2023; Noor et al., 2023; Subiakso et al., 2023). Legal requirements to report individuals without legal immigration status to the authorities may directly conflict with medical ethics regarding confidentiality and trust, creating a severe moral dilemma for practitioners. Therefore, examining the legal aspects of healthcare for this group requires an approach that views the law not as a static barrier, but as a dynamic arena where public values, national security, human rights, and professional ethics compete and negotiate with each other.

The main problem in this topic stems from a deep dissonance between the normative ideal of universal health rights and legal and policy practices that are often restrictive and discriminatory based on immigration status. Although international declarations affirm the right to health for all, including migrants, these instruments generally lack strong enforcement mechanisms against sovereign states. As a result, the actual scope and quality of access is largely determined by national laws and policies, which can vary greatly from one country to another. These differences create a deeply unequal global health system, in which a person's health and survival can depend solely on the country in which they seek refuge or work. This gap between de jure rights and de facto realities is a source of profound health injustice, where groups already vulnerable due to forced displacement or the search for a better life face additional legal barriers that compromise their physical and mental well-being. Studies on the implementation of services for vulnerable groups in various institutions show varying practices that can be used as a reference for policy improvement (Sukananda et al., 2024). Socio-economic disparities also affect the quality of services and access to healthcare for vulnerable groups (Nalin et al., 2022).

Another more specific problem is the legal uncertainty and bureaucratic complexity faced by migrants and refugees when trying to access services. Even when they theoretically have the right to some form of care, these individuals often face a maze of documentation requirements, such as proof of identity, proof of income, or proof of legal status, which are difficult or impossible for them to meet, especially for those who fled without documents or whose documents were confiscated. Fear of interaction with any authority, including the health system, due to concerns about deportation or detention, further hinders access. This fear is not always unfounded, given that some countries explicitly link the health system to immigration enforcement. This situation creates a dangerous paradox in which urgent health needs are ignored until they become more serious and more costly emergencies to treat, ultimately burdening the system in an inefficient manner. Thus, legal barriers not only violate human rights but can also be irrational from a health economics and public health perspective.

Examining this topic is particularly significant today given the unprecedented scale of global human migration in recent decades. Protracted conflicts, political instability, climate change and wide economic disparities continue to push and pull people to migrate. Destination countries, both in the Global North and South, continue to grapple with the question of how to respond to these influxes in a humane, orderly, and sustainable manner. Health is a central component of long-term social integration and stability. Ensuring equitable access to health is not only a moral imperative, but also an investment in social cohesion and the prevention of broader health crises. A systematic review of existing legal frameworks can identify successful models, dangerous policy gaps, and opportunities for better regulatory harmonization, thereby providing the evidence needed for rights-based and evidence-based reforms.

Furthermore, the COVID-19 pandemic has starkly demonstrated the link between migrant health and the health of the general population. The virus does not discriminate based on citizenship, and barriers to accessing testing, treatment, or vaccination for migrant groups create reservoirs of infection that endanger entire communities. This experience has forced many governments to reconsider health policies for migrants, at least temporarily, and highlights the importance of inclusive public health approaches. This momentum must be seized and transformed into permanent structural change. Furthermore, developments in regional law, such as rulings by European or American human rights courts, continue to articulate and expand states' obligations towards non-citizens in terms of access to healthcare. Following this evolution in jurisprudence is important for understanding the future direction of states' legal obligations and for advocating higher standards of health protection for everyone within a country's territory.

This study aims to critically analyses the legal aspects of healthcare services for migrants and refugees through a literature review approach. Specifically, this study seeks to unravel and evaluate the ways in which various national jurisdictions attempt to reconcile their authority to control immigration with their obligations under international human rights law regarding the right to healthcare. Furthermore, this study seeks to explore how laws and policies are translated into operational practices at the health facility level, with a focus on guaranteeing procedural rights and removing bureaucratic barriers that impede effective access. The theoretical contribution of this research lies in its interdisciplinary synthesis of health law, immigration law, and human rights law, as well as the development of an analytical framework for assessing the inclusiveness of health systems. In practical terms, the results of this study are expected to serve as a reference for policymakers, human rights advocates, and healthcare providers in designing, reforming, or implementing regulations and protocols that are more equitable, effective, and in line with international legal standards.

METHODS

This research is a qualitative literature study that is exploratory, descriptive, and analytical in nature. A qualitative approach was chosen because it is suitable for investigating complex, dynamic, and value-laden research issues that require a deep understanding of legal norms, policies, and practices. As explained by Denzin and Lincoln (2005), qualitative research aims to capture the meaning and interpretation of a social reality, which in this case is the construction of laws and policies surrounding access to health care for migrants and refugees. Researchers play a key role in collecting, selecting, interpreting, and synthesizing textual data from various written sources. This process involves content analysis of legal and policy documents, as well as thematic analysis of academic discourse, to identify patterns, tensions, and gaps in the existing normative framework.

The stages of this study follow a systematic literature review method that has been modified for the needs of normative-conceptual research. The first stage begins with the formulation of clear and specific research questions. The second stage involves a broad and structured literature search through academic databases. The third stage is the selection and critical evaluation of the collected material based on relevance, source authority, and contribution to understanding the research problem. The fourth stage is data extraction and synthesis, using the thematic analysis method proposed by Braun and Clarke (2006). Themes such as "sovereignty versus international obligations", "legal fragmentation", "bureaucratic barriers", and "procedural rights" were identified, grouped, and analyzed in relation to each other to construct a coherent answer to the research question.

RESULTS AND DISCUSSION

Reconciling State Sovereignty and International Obligations in Health Law for Migrants

The intersection between state sovereignty and international obligations in the provision of health services to migrants and refugees creates a complex and often tense legal landscape. The principle of state sovereignty gives a state exclusive authority to control who enters and resides in its territory, as well as to organize and finance its own health system. This authority forms the basis for states to differentiate between citizens and non-citizens in the provision of social benefits, including healthcare. On the other hand, the international legal regime, particularly human rights law, imposes an obligation on states that have ratified treaties to respect, protect and fulfil the right to health for everyone within their jurisdiction, without discrimination based on race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status (Raposo & Violante, 2021). Immigration status, although not always explicitly mentioned, is broadly interpreted as falling within the category of "other status" that is prohibited as a basis for discrimination. Implementational challenges often arise due to differences in fiscal capacity, health service readiness, and diverse domestic regulations (Harianto et al., 2024). The fundamental tension lies in the extent to which states can use their sovereign power over immigration to restrict the right to health for those who are not their citizens.

Reconciliation between these two seemingly conflicting principles is rarely absolute; rather, it emerges through the interpretation, negotiation, and application of various mediating principles in international and national law. The principle of non-refoulement in refugee law, which prohibits returning a person to a territory where their life or freedom would be threatened, has important implications for health. Courts and treaty bodies have increasingly interpreted that the forced return of a refugee or asylum seeker in need of health care that is unavailable in their country of origin may violate this principle, particularly if their health condition would deteriorate drastically (Khorramabadi et al., 2023). Thus, the non-refoulement obligation may limit a state's sovereignty to expel a person and indirectly require the provision of certain healthcare as a prerequisite for remaining. Furthermore, research shows that national regulations and policies must take into account the readiness of facilities, accountability, and quality of services in order for migrants' health rights to be effectively realized (Wahyusetiawan et al., 2024; Essa & Mardikaningsih, 2022). This represents one of the most concrete points of convergence where international obligations directly limit national immigration policies related to health.

Another layer of reconciliation occurs through human rights doctrine, which allows for certain restrictions on these rights. Human rights instruments recognize that rights may be restricted to achieve legitimate aims, such as public order, national security, or the protection of public health, provided that the restrictions are prescribed by law, necessary in a democratic society, and proportionate. Many states use this justification to restrict undocumented migrants' access to non-emergency healthcare, citing resource constraints and the need to regulate migration flows. However, the standards of "proportionality" and "necessity" are the subject of legal debate. A policy that systematically denies access to basic preventive care, such as vaccinations or prenatal care, is difficult to consider proportional, as it can lead to more severe and costly health emergencies in the future, ultimately burdening the same system (Dagron, 2019). In practice, monitoring the implementation of these rights requires clear legal mechanisms, including enforcement against medical malpractice or substandard services (Safitri et al., 2023). Thus, international law does not prohibit all restrictions, but imposes the burden of proof on states to demonstrate that such restrictions are legitimate and not arbitrary.

At the national level, this reconciliation is often manifested through tiered healthcare access schemes, which explicitly link the right to care with immigration status. This model openly recognizes the sovereignty of states to make classifications, but also seeks to meet minimum international obligations by providing some level of protection. For example, a country may grant full access to the national health system to recognized refugees, limited access to emergency care and treatment for communicable diseases to asylum seekers, and only emergency care that is truly life-threatening to undocumented migrants. Each of these levels represents a different political and legal compromise between the principles of inclusion and exclusion. Research by Harianto et al. (2024) shows that the design of a tiered service scheme must also consider the management of specific diseases and the availability of facilities in certain areas in order to be effective. The existence of a tiered scheme itself is an acknowledgement that the state has certain obligations that extend beyond its citizens, but it also affirms it’s right to differentiate treatment based on legal status. An important legal and ethical question is whether the established tiers meet the core minimum standards of the right to health and comply with the principle of non-discrimination.

The influence of regional jurisprudence on this reconciliation is significant. Courts such as the European Court of Human Rights (ECtHR) and the Inter-American Court of Human Rights (IACtHR) have repeatedly been called upon to decide cases where migrants' claims to health access collide with national immigration policy. These decisions collectively form a body of law articulating state obligations. For example, the ECtHR has ruled that denying healthcare to individuals detained under a state's jurisdiction, regardless of their immigration status, may violate the prohibition of inhuman or degrading treatment (Article 3 of the European Convention on Human Rights). By placing health access within the framework of non-derivable rights, regional courts place strong limits on state sovereignty (Hall & Perrin, 2015). Such decisions compel states to adjust their national laws, thereby creating a top-down process of reconciliation driven by law enforcement.

The principle of public health also serves as an important bridge between sovereignty and international obligations (Lougarre, 2016). The public health argument asserts that protecting the health of the entire population, including migrants, ultimately benefits the receiving country by preventing disease outbreaks, reducing long-term emergency care costs, and promoting social stability. Therefore, providing access to basic prevention and treatment services is not only a matter of human rights, but also a prudent national interest. Many countries incorporate these considerations into their policies, for example by providing free vaccinations to all children regardless of immigration status or by offering tuberculosis screening and treatment to migrant populations. In these cases, state sovereignty is exercised in a manner consistent with, rather than contrary to, international obligations, as the state acts to protect the welfare of the entire community within its territory. This instrumental approach is often a more politically acceptable entry point for expanding health coverage.

However, the reconciliation remains fragile and highly dependent on political will and domestic legal interpretation. States can and do ratify human rights treaties while making reservations or interpretative declarations that limit their application to non-citizens. More commonly, states may fail to translate their international obligations into effective domestic law and budgets, creating implementation gaps. This problem is also evident in the management of terminal patients, where health facilities face complex accountability and legal implementation challenges (Wahyusetiawan et al., 2024). Domestic courts may be reluctant to challenge immigration policies, which are a highly privileged domain of the executive (Onarheim et al., 2018). Thus, reconciliation is often partial and incomplete, resulting in a patchwork legal landscape where migrants' rights vary greatly. The absence of an international court with mandatory jurisdiction over violations of economic, social, and cultural rights further weakens enforcement mechanisms, leaving political pressure, monitoring, and name and shame as the primary tools for ensuring compliance.

The evolution of the concept of "extraterritorial obligations" in human rights law adds a new dimension to this discussion. There is a growing argument that developed countries, through their trade, aid, or climate policies that contribute to instability and displacement elsewhere, have an obligation to ensure the right to health not only for those within their borders, but also for those affected by their policies abroad (Lougarre, 2016). Although controversial and underdeveloped, this line of thinking challenges the traditional concept of sovereignty by stating that a state's obligations can extend beyond its geographical territory. If it gains traction, this could fundamentally change the debate about who is responsible for the health of migrants and refugees, highlighting the role of countries of origin and destination in creating the conditions that lead to migration and the accompanying health needs.

Reconciling state sovereignty and international obligations is not a process that produces a neat and singular synthesis (Lougarre, 2016). Instead, it produces a continuum of legal approaches ranging from full assimilation (treating migrants like citizens in terms of health access) to near-total exclusion, with various graded and conditional models in between. In practice, continuity of service and quality management are important factors in assessing the success of this legal reconciliation (Essa & Mardikaningsih, 2022; Harianto et al., 2024). A country's position on this continuum is determined by the interaction between international legal pressures, domestic political considerations, fiscal capacity, and prevailing social values. Law serves as the language and framework within which these compromises are formulated, debated, and sometimes challenged. The most successful reconciliation processes tend to occur when the domestic legal framework explicitly internalizes international human rights standards, when courts are active in interpreting these rights progressively, and when public health policy is used as a rational basis for inclusion, thereby aligning national interests with global obligations. Without these elements, state sovereignty often becomes a pretext for denying rights without regard for legitimate international legal obligations.

Health Policy Implementation: Procedural Rights and Effective Access for Refugees and Migrants

Following the discussion on the normative framework, the analysis shifts to the implementation level, where abstract laws and policies meet the daily realities in clinics, hospitals, and administrative offices. It is at this level that the right to health becomes either effective access or merely an empty promise. A large number of procedural and administrative barriers can undermine even seemingly inclusive legal schemes, creating a wide gap between de jure rights and de facto access (Knipper, 2016). These barriers are often insidious and interrelated, forming a maze that must be navigated by individuals who are already in situations of stress and uncertainty. An examination of the level of implementation reveals that procedural rights guarantee such as information, confidentiality, consent, and non-discrimination are not technical complements, but fundamental prerequisites for the realization of meaningful health rights. Several studies state that service quality, facility accountability, and administrative procedures are important factors that influence patient access to health services (Darmawan et al., 2022; Arum et al., 2023).

The right to understandable information is the first foundation that is often shaky. Migrants and refugees, especially those who have recently arrived, may have limited understanding of the local language, the health system, and their rights. The absence of information materials in appropriate languages and access to qualified medical interpreters constitutes a serious violation of procedural rights. Without clear information about how to register, what services are available, what costs may be incurred, and complaint procedures, individuals become heavily dependent on the goodwill of frontline staff. This dependence places them in a vulnerable position to misinformation, denial of services they are entitled to, or unnecessary fear. Many healthcare systems fail to allocate adequate resources for professional interpretation services, relying instead on linguistically talented staff or patients' families, which can compromise accuracy and confidentiality (Suess et al., 2014). Research on service quality shows that responsive systems and trained staff can improve patient satisfaction and service effectiveness in public health facilities (Khayru & Issalillah, 2022). This systemic failure transforms the right to information into an insurmountable first barrier for many people (Abdullah et al., 2023).

The confidentiality of medical data emerges as another critical issue with direct implications for access. For undocumented migrants or asylum seekers, the greatest fear is that interaction with the health system will lead to reporting to immigration authorities and result in detention or deportation. This fear is not always unfounded. In some jurisdictions, there are explicit legal requirements or informal practices for healthcare providers to report individuals whose immigration status is unlawful. In other jurisdictions, health databases may be linked to or accessible by immigration enforcement agencies. Even uncertainty about reporting policies can have a profoundly chilling effect. When confidentiality is not guaranteed, individuals will delay or avoid care altogether, seeking help only in life-threatening emergencies (Raposo & Violante, 2021). The legal and ethical aspects of medical record management are key to ensuring patient confidentiality, while also supporting effective procedural rights (Mubarak et al., 2023). Therefore, strong confidentiality guarantees that are clearly communicated are not only a matter of privacy, but a public health prerequisite for ensuring that this population seeks care in the early stages of illness.

Excessive and rigid documentation requirements are the most common and crippling administrative barriers. To register for health insurance schemes or to prove eligibility for free or subsidized care, agencies often request documents such as passports, visas, proof of address, or proof of income. For refugees who fled without documents, or migrants whose documents were confiscated by traffickers or authorities, meeting these requirements is impossible. Even for those who do have documents, the verification process can be lengthy and complicated, causing dangerous delays in care. This document-cent red approach fails to recognize the realities of forced displacement and legal marginalization. More progressive systems adopt the principle of "barrier removal" by accepting alternative evidence or using self-declaration processes, recognizing that inflexible documentation requirements are essentially a form of denial of access (Vito et al., 2016).

Discrimination and prejudice in service provision are hidden but pervasive procedural barriers. This discrimination can be overt, such as outright refusal to serve based on origin or appearance, but more often it is subtle. It can take the form of differences in the quality of care, impatience or condescension on the part of staff, assignment to less desirable clinics or doctors, or unfounded assumptions that migrant patients are feigning illness to gain benefits (Brandenberger et al., 2019). Such discrimination violates the principle of non-discrimination, which is at the core of human rights law and medical ethics. However, it is difficult to prove and report, especially for those who do not understand the complaint mechanism or fear retaliation. Creating a discrimination-free service environment requires ongoing staff training on cultural competence, data monitoring for health outcome disparities, and reporting mechanisms that are accessible and safe for patients.

Mechanisms for obtaining truly informed consent are also compromised by the context of migration. The psychological stress of displacement, trauma, fear, and uncertainty can impair a person's decision-making capacity. In addition, there is a significant power imbalance between healthcare providers representing the state and migrant patients who are in a vulnerable position. In such situations, consent may be given out of obedience or resignation, rather than autonomous understanding. Ensuring valid consent requires extra patience, the use of independent interpreters (not family members), and recognition that the consultation process may need to be conducted over several sessions (Norredam et al., 2006). A paternalistic approach that assumes "the doctor knows best" is particularly risky in this context and can lead to medical decisions that are not in line with the patient's values or preferences, thereby violating their autonomy.

Access to mental and psychosocial healthcare illustrates a particular failure of implementation. Migrants and refugees have a high prevalence of conditions such as depression, anxiety, and post-traumatic stress disorder due to their experiences before, during, and after displacement. However, mental health services are often the least accessible in tiered access schemes (Suphanchaimat et al., 2015). The barriers are multiple: stigma against mental illness in certain cultural communities, a lack of providers trained in culturally sensitive and trauma-informed therapy, and a failure to recognize that mental health is an integral component of the right to health. Even when services are theoretically available, the need for interpreters skilled in psychological vocabulary and therapeutic relationships that take time is often unmet. This neglect of mental health not only causes great human suffering but also hinders social integration and recovery.

The role of frontline staff, such as administrative workers, community nurses, and social workers, is crucial in mediating access. These staff members are often the first point of contact and gatekeepers of the system. Their knowledge, attitudes, and discretion can determine whether a person successfully accesses care or is denied. However, they also often work with ambiguous guidelines, significant time pressures, and little specific training on migrants' rights. The moral and administrative burden placed on them is enormous. Without clear support and direction from higher levels of policy, inconsistency and arbitrary decisions are common. Therefore, investment in training, clear standard operating procedures, and decision-making support for frontline staff is not an administrative cost, but an essential investment in equitable access.

Coordination between different sectors of public institutions is another major implementation challenge. The health of a refugee or migrant may require the involvement of the housing, social welfare, education and legal systems. Lack of coordination between the health ministry, the home affairs ministry (immigration) and local authorities can lead to conflicting information, shifting of responsibility and patients falling between service gaps. For example, a refugee child may be eligible for vaccination through a community health clinic but be denied enrolment in school due to a lack of documentation, or a trauma survivor may require medical care but be detained in an immigration detention center with inadequate medical facilities. An integrated, "one-stop shop" approach is essential but rarely implemented effectively.

Effective grievance and redress mechanisms are a crucial component of procedural rights that are often absent. When access is unlawfully denied or poor care is provided, individuals must have a way to challenge the decision without fear of repercussions. However, complaints processes can be intimidating, linguistically inaccessible, and lengthy. For those with unstable immigration status, involving official authorities in disputes may be considered an unacceptable risk. Therefore, alternative mechanisms such as community health mediators, independent ombudsmen, or hotlines managed by non-governmental organizations may be more effective. The existence and promotion of these accessible and trusted channels is a true test of the system's commitment to procedural rights.

Systematic monitoring and evaluation of health access and outcomes based on migration status is essential to inform and improve policy. Without disaggregated data, it is impossible to identify disparities, measure the impact of specific barriers, or assess the effectiveness of interventions. Many countries deliberately do not collect data on immigration status in health records for privacy or policy reasons, but this renders injustices invisible and unaddressed. Developing ethical methodologies for data collection that protect individual privacy while revealing systemic patterns is an important task for public health research and policy. This data should then be used to periodically review and revise policies and procedures, creating feedback that reinforces a cycle of continuous improvement.

The implementation phase revealed that effective access is highly dependent on procedural details and institutional culture. Good legal policies at the national level can be defeated by bureaucratic barriers, fear of reporting, discrimination at the facility level, and lack of inter-agency coordination. Advancing the right to health for migrants and refugees thus requires a dual strategy: continuously strengthening the normative legal framework while simultaneously and diligently addressing operational barriers at the service delivery level. This requires a commitment to procedural rights not as mere formalities, but as operational principles that shape how systems are designed and how staff interact with each patient. Without serious attention to implementation, the promise of the right to health remains an unattainable legal abstraction for those who need protection the most.

CONCLUSION

This literature review concludes that the legal aspects of healthcare services for migrants and refugees are characterized by complex and dynamic tensions between state sovereignty and international obligations, as well as between normative rights and the realities of implementation. The analysis shows that reconciliation between state sovereignty and human rights obligations rarely results in a perfect synthesis, but rather manifests itself in various models of tiered access that link care rights to legal status. Regional jurisprudence and public health principles serve as important bridges in limiting the state's room for man oeuvre and shaping more concrete legal obligations. On the other hand, the implementation phase reveals that effective access is highly dependent on respect for procedural rights and the removal of operational barriers. Medical confidentiality, accessible information, flexible documentation requirements, and a discrimination-free environment are fundamental prerequisites without which the right to health becomes meaningless. Thus, an inclusive legal framework must be designed in parallel with supportive operational infrastructure, ensuring that legal promises are translated into tangible services at the point of care.

The findings of this study have important implications for various stakeholders. For law and policy makers at the national and regional levels, the implications encourage the design of a legal framework that explicitly internalizes international human rights standards, reducing reliance on overly complex and tiered access schemes. Furthermore, legislation is needed that explicitly separates health services from immigration enforcement to guarantee confidentiality and build trust. For health system administrators and facility managers, the implications demand investment in operational capacity, including staff training on cultural competence, provision of professional interpretation services, simplification of registration procedures, and establishment of safe and accessible complaint mechanisms. For frontline health workers, these findings underscore their ethical and professional responsibility to ensure non-discriminatory care and respect the procedural rights of every patient, regardless of their immigration status. For civil society organizations and advocates, the implications provide an evidence-based foundation for monitoring implementation, pursuing strategic litigation, and advocating for policy reforms cent red on the rights and needs of migrants and refugees.

Based on the conclusions and implications, several suggestions for future research and action are proposed. First, in-depth comparative policy research is needed to identify and analyses legislative models and inter-agency coordination mechanisms that have successfully minimized the gap between law and implementation in different contexts. Second, it is important to develop and validate measurement tools and monitoring systems that can capture effective access and health outcomes disaggregated by migration status, while maintaining strict data privacy ethics standards. Such tools will be essential for accountability and evidence-based policy improvement. Third, the curriculum for health professions (medicine, nursing, public health) needs to systematically include modules on global health law, migrants' rights, and clinical skills in the context of cultural diversity and situations of vulnerability. This education will equip future health workers with the knowledge and attitudes necessary to provide fair and ethical care in an increasingly mobile society.

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