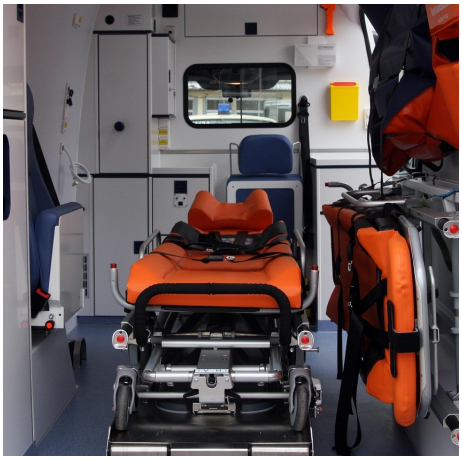
The Takeaway
Policy Briefs from the Mosbacher Institute for Trade, Economics, and Public Policy

Migration, Health, and Security:

Emergency Care Provision at the U.S.-Mexico Border



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TRAUMA AND MIGRATION IN THE BORDERLANDS

"You guys have to do a body retrieval." These were the words immediately following an apology from the Emergency Medical Services (EMS) captain about interrupting an interview to pull our participant back into service. The individual we had been interviewing was needed to retrieve the body of a migrant from the Rio Grande River at the request of Border Patrol. The participant's head dropped, a clear display of displeasure, and commented on how they did not enjoy this part of the job. When we inquired about this later that day, the EMS captain informed us that this event was relatively common because Border Patrol relied on their department for almost all migrant body retrievals from the river. He explained that this was just one of many duties that the city's EMS service provides in support of the federal law enforcement agency.

Border security has been an increasingly prominent U.S. domestic policy topic. Beginning with Operation Hold-the-Line

WHAT'S THE TAKEAWAY?

Most Americans think that migrants should receive emergency care even if they enter the country illegally.

Migrant-related calls strain an already overburdened and underfunded EMS system in U.S.-Mexico border communities.

The humanitarian aspect of migration has significant mental health impacts for EMS clinicians.

EMS agencies in the U.S.-Mexico border region need more support to meet their mandate.

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(1994), investment in border security personnel and infrastructure has grown exponentially. The FY26 Congressional funding request for U.S. Customs and Border Protection is $18.93 billion and aims to provide sustained funding for 22,000 Border Patrol agents.[1] Importantly, the security focus at the U.S. southern border is based heavily on the strategy of deterrence. This strategy plays out in the miles of new border fence,[2] policies that increased the height of the new and existing border fences,[3] and an increase in Border Patrol presence in specified locations. The policies push migrants to cross the border in increasingly dangerous locations.[4] Notably, the federal government acknowledges that deterrence strategies have not reduced the number of crossings, but they have increased the number of migrant deaths.[5]

More miles of border fence, combined with a 2017 Executive Order that increased border fence height to 30 feet,[6] contributed to an increase in the number of crossing-related traumas and deaths.[7] In the San Diego area, for example, hospitals experienced a 10-fold increase in the number of border wall-related traumas between 2016-2021.[8] Additionally, migrant deaths increased 162% between 2020-2022.[9]

IMPACTS OF MIGRATION ON FIRE-BASED EMS

While these traumas and deaths are tragedies for the individuals and families that experience them, they also have a negative impact on the EMS agencies and clinicians tasked with responding. Notably, migration and the medical and humanitarian emergencies that often accompany it can lead EMS clinicians to experience multiple, consecutive "standing 24s."[10] These shifts are 24 hours shifts in which EMS clinicians on the ambulance are running so many calls that they do not get time to eat, sleep, or rest between calls.[10] In times when there are higher numbers of migrants crossing the U.S. southern border, EMS clinicians also face mass casualty-like incidents in which they have dozens, sometimes hundreds, of patients needing care at the same time.[10-12] Just like any other mass casualty incident, clinicians are forced to decide who needs care the most and which patients can wait longer before receiving care.[10] Unlike most mass casualty incidents, however, EMS clinicians in the border region can experience these events every shift for months in a row.[10]

The stress and pressure of working as an EMS clinician in the border region has implications for the physical well-being of individuals, but it also creates higher levels of stress. Calls involving children that become sick or injured during the journey or those who have lost their parents increase distress for EMS clinicians. Additionally, the intersection of medical care and humanitarian provision that frequently collides in the border region pushes EMS clinicians beyond their normal duties as medical providers and forces them to serve in the capacity of humanitarians, providing food, water, and blankets.[11] This uniquely challenging environment takes a substantial toll on EMS clinicians in the border region.

AMERICAN UNDERSTANDING OF EMERGENCY CARE

We recently found that most Americans believe that migrants should receive emergency care if they are sick or injured when crossing into the United States illegally (CC Blackburn, unpublished data, 2025). Importantly, however, most Americans have no idea about how this care is provided or who provides it. We found that 41% of Americans thought that U.S. Customs and Border Patrol (CBP) were primarily responsible for providing emergency care for sick or injured migrants at the U.S. border (CC

Blackburn, unpublished data, 2025). In reality, local EMS agencies hold this responsibility, and in some localities like the Arizona communities we interviewed, those local EMS agencies are the only ones legally allowed to transport patients from the scene of injury or illness to a healthcare facility.

The lack of understanding regarding emergency medical care at the U.S. southern border has potentially significant policy implications. High levels of federal financial and resource support, specifically through defense and border security allocations, are provided to CBP and local law enforcement as part of U.S. immigration policy. Local fire departments and EMS agencies, however, receive little attention or acknowledgment of the role that they play in the complex environment that mixes national security with health. In many border states (similar to states throughout the country), primary funding for EMS comes from state general funds with additional funds coming through EMS professional licensing fees or traffic tickets and motor vehicle-related fees.[13] State funds are allocated based on the local population being served by EMS agencies. Partly because of this, border region EMS agencies are serving their local population and a migrant population in need of emergency care with insufficient funds and resources. Additionally, individual states or localities become financially responsible for bearing much of the costs for migrant emergency care. Acknowledgement of the critical role that local fire departments, EMS agencies, and EMS clinicians play in the border region is the first step in providing them with the support that they need to do their job efficiently and safely.

IMPLICATIONS

Previous research suggests that migration has a substantial health and financial impact on border region EMS clinicians and agencies. Additionally, evidence suggests that deterrence policies tend to exacerbate the effects on EMS clinicians.[10-11] With regard to the mental health implications of the current environment, continuing without policy change is likely to lead to increased burnout and reduced retention among EMS clinicians. Studies show that EMS clinicians face higher levels of burnout when they have constant exposure to trauma and high-stakes decision making, two elements often present in the border region.[14-16]

Another relevant implication is that, without additional resources and financial support, some border region EMS agencies struggle to meet the needs of both the local community and individuals coming through and between the ports of entry. This lack of resources could reduce emergency health access for all populations. Additionally, deterrence-based policies, such as increasing the height of the border wall have increased the demand on EMS clinicians rather than lessened it, because such policies have increased the number of traumatic injuries and rescue operations.[7] For example, one study conducted in the San Diego Sector found that the number of hospital admissions due to falls from the border wall increased 5-fold after the height of the border wall was increased to 30ft, even with CBP apprehensions normalized.[7]

The same study demonstrated that the injury severity score for patients brought in for border wall falls has increased, as well as the inflation-adjusted cost per patient.[7] While no study has been done to quantify the impacts on EMS, increased injury severity and the number of necessary hospitalizations due to border wall falls is likely to affect the EMS clinicians who respond and transport those individuals. By acknowledging the complexity of the border region and the unique emergency care needs

that accompany migration, state and federal governments can develop programs and resources that adequately support EMS clinicians and lessen the impact on both the individuals providing the care and those receiving it.

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Notes:

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