AT WHAT COST? THE SOCIAL AND ECONOMIC IMPLICATIONS OF AN UNDOCUMENTED IMMIGRANT’S ACCESS TO HEALTH CARE

A Thesis
submitted to the Faculty of
The School of Continuing Studies
and of
The Graduate School of Arts and sciences
in partial fulfillment of the requirements for the
degree of
Master of Arts in Liberal Studies

By

Stephanie M. Carrion, B.A.

Georgetown University
Washington, D.C.
October 12, 2012
AT WHAT COST? THE SOCIAL AND ECONOMIC IMPLICATIONS OF AN UNDOCUMENTED IMMIGRANT’S ACCESS TO HEALTH CARE

Stephanie M. Carrion, B.A.

MALS Mentor: Kazuko Uchimura, Ph.D.

ABSTRACT

Primary health care services are the cornerstone of a productive society. Therefore, limiting the access of primary care services to any segment of the population will ultimately result in serious negative economic and social consequences for the general public. In the United States, there are an estimated 11.5 million undocumented immigrants who have been unequivocally limited in their access to primary health care services. Federal legislation and state policies have directly targeted noncitizens from receiving public benefits in an effort to control spending and reduce deficits. However, this approach is short sighted. In order to comprehend the broad impact of denying undocumented immigrants access to primary care services this paper explores the economic and social limitations, costs and implications of current health care policy in the United States.

Applying the theory of external diseconomies this paper analyzes how the various social and economic barriers erected by federal and state governments have resulted in a number of unintended consequences. These consequences include: jeopardizing broader public health goals, raising the cost of health care and the cost Medicaid expenditures. These negative outcomes are exacerbated by the fact that the limitations impact much more than just the undocumented immigrants. They carry over to the underinsured, the
uninsured and the indigent who also rely heavily on these public and private benefits. In conclusion, in order to ensure the future prosperity of the United States the federal government will have to consider alternatives to current health care policies if they wish to maintain a healthy and productive workforce in the future.
CONTENTS

ABSTRACT                                                                 ii

INTRODUCTION                                                               1

CHAPTER 1. THE POWER OF THE SOCIAL SAFETY NET AND ITS IMPACT ON THE IMMIGRANT POPULATION  3

CHAPTER 2. A HISTORY OF U.S. IMMIGRATION AND UNDOCUMENTED IMMIGRANTS      18

CHAPTER 3. A HISTORY OF HEALTH POLICY LEGISLATION IN THE UNITED STATES    36

CHAPTER 4. THE ECONOMIC IMPLICATIONS OF LIMITING THE ACCESS OF PRIMARY HEALTH CARE SERVICES TO UNDOCUMENTED IMMIGRANTS  57

CHAPTER 5. THE SOCIAL LIMITATIONS AND THEIR IMPLICATIONS FOR ACCESS TO PRIMARY HEALTH CARE SERVICES FOR UNDOCUMENTED IMMIGRANTS  75

CONCLUSION                                                                 92

BIBLIOGRAPHY                                                              94
INTRODUCTION

There are an estimated 40 million foreign born persons living in the United States. Of those 40 million it is believed that 11.5 million are undocumented, which means that there are over 11 million people living in the United States without adequate access to primary healthcare services. The World Health Organization defines primary health care as “[as] an integral part both of [a] country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.”

Undocumented immigrants are disproportionately affected by the lack of access to essential primary health care services such as: immunizations, pre-natal care and routine health screenings. This situation endangers their health, and puts the health of the larger public at risk. In the past decade, infectious disease-related deaths in the United States have nearly doubled to approximately 170,000 annually. The hurdles that undocumented immigrants face in gaining access to primary health care services create a serious threat by exposing the general public to untreated strains of new and re-emerging infectious diseases.

The lack of undocumented immigrants’ access to health care in turn negatively impacts both the social and economic development of the United States. Economists

---

define this situation as “external diseconomy” and explain that the “socially optimal price of a good [in this case health care] causing a diseconomy should be above its marginal cost”. In other words, the up-front cost of providing primary health care services to undocumented immigrants is far less than the future social and economic costs of not doing so. There has not been much scholarly analysis of the economic and social implications of limiting the access of undocumented immigrants to primary health care services. By fully understanding the implications of these limitations Americans may begin to appreciate the critical importance of primary health care services. This is critically important for undocumented immigrants considering they are one, if not they most, disenfranchised social group in the United States. Furthermore, limiting their access to these essential health services will have a resounding negative impact on the nation as a whole.
CHAPTER 1

THE POWER OF THE SOCIAL SAFETY NET AND ITS IMPACT ON THE IMMIGRANT POPULATION

The American Dream is a national ethos of the United States, and it is a belief that spreads far beyond the continental borders of North America. Immigrants from all over the globe envision some measure of achievement, status, and success when they think of coming to America. While, achievement is a central facet of this American dream, bettering ones status, entering a profession, and putting down roots in their new community are all critical.¹ Namely, immigrating to the United States provides a chance to improve their lifestyle, education, and job prospects as they dream of the opportunities that arise from social mobility.

Yet, not all immigrants succeed in achieving this dream. There are substantial barriers that all immigrants, documented or undocumented, must face before they can achieve any measure of success in the United States. So why try? Many scholars claim that the answer lies in the ideals cemented in the Bill of Rights.² However, the motivations for leaving ones home country are often much more complex and multifaceted than some theorists would wish to acknowledge. Furthermore, any attempt to truly define the American Dream entails the difficulty of calculating what part of the dream is spiritual and how much is based on material factors.³

¹ William A.V. Clark, Immigrants and the American Dream: Remaking the Middle Class (New York: The Guilford Press, 2003), xiv.

² Ibid., 2.

³ Clark, Immigrants and the American Dream: Remaking the Middle Class, 4.
Moreover, for all of the immigrants who come to the United States in search of material gains, there are many more who come for a mere chance to subsist. America has become a beacon of hope for those immigrants who are seeking a chance to escape poverty, abysmal living conditions and persecution. However, not all dreams come true and while America may be the “land of opportunity,” constraints are real and opportunities for new comers are not always equal.  

Nonetheless, the existence of these obstacles has done little to deter the steady stream of immigration into the United States. Recent decades have seen increasing numbers of immigrants coming to the United States even as restrictions have become more pervasive. The U.S. Census, American Community Survey (ACS), estimates that are over 31 million foreign-born persons living in the United States who entered between the years of 1980 – 2010. As of 2011, it is estimated that there are 11.5 million undocumented immigrants in the U.S. Despite its large numbers, there has been a slowing down in the rate of undocumented migration since 2007 as indicated among others by low apprehension numbers (in comparison to previous years). The reasons given are the high unemployment rates in the U.S. and enhanced border enforcement. In fact, 55 percent of undocumented immigrants in the United States entered between the years of 1995 and 2004; entrants since 2005 account for only 14 percent of the total. 

---

4 Clark, *Immigrants and the American Dream: Remaking the Middle Class*, 5.

That said, tougher immigration laws have resulted in a higher number of undocumented immigrants due to the simple fact that it is now much more difficult to receive citizenship, asylum, green cards or other visas. The U.S. was at one time very open to immigration, particularly during the 19th century. However, the country has become increasingly closed off since the terrorist attacks on the World Trade Center on September 11, 2001 after which a series of restrictive policies were put in place to stem immigration in the U.S. These include the US PATRIOT ACT (October 2001) and the Enhanced Border Security and Visa Entry Reform Act (EBSVERA) in May 2002. Both pieces of legislation caused a political firestorm. In the aftermath of 9/11 anxieties about terrorism, coupled with the most recent economic recession has reduced the receptivity of immigrants compared to that of the late 19th century. The regulation of immigration since 9/11 has served to maintain its decline.

Today, the U.S. – Mexico border is one of the most heavily guarded in the world. Given the current political and economic tensions it is without question that immigrants, those here legally and otherwise, are becoming more limited in their access to basic needs. Basic needs refer to access to primary health care services, food, schooling, and shelter, all of which comprise a part of the ever-evolving structure of the U.S. social safety net. The social safety net is defined as a set of “social programs that are primarily focused on the less-advantaged. Designed to serve people with little money, inadequate

---


education, poor health, physical or mental disabilities or those in living situations where they risk abuse or neglect.⁷ The anxieties that stem from the recent economic recession have further limited the access and distribution of public benefits of both citizens and noncitizens. However, these limitations disproportionately impact recent and undocumented immigrants overall.

Despite these obstacles immigrants still hold steadfast to the belief that they can achieve the American dream with a little determination and hard work. In fact, the belief that a better future is built by one’s own work ethic was the foundation of the American Dream. Nevertheless, the erosion of the American dream has been brought about by the notion that this dream is a birthright.⁸ No government, social agenda or person can guarantee a better future, and every individual must work for one. With a little luck and a lot of work a immigrant can get ahead, but the government cannot and will not provide everyone with the resources for success. Somehow, the American Dream has become synonymous with entitlement, which was simply not the original understanding of the term, nor the intent of the social safety net. Undeniably, the government plays an important role in providing a safety net for its citizens but the social “safety net are [the] necessary minimums; the American Dream was [meant] to aspire for maximums and work to attain them.”⁹

---


⁹ Ibid.
The modern U.S. safety net began in the 1930’s with President Franklin D. Roosevelt’s New Deal legislation that created a number of economic relief programs in response to the Great Depression (1929 – 1941). The recognition of widespread poverty, and the belief that it was hurting the nation’s wellbeing carried over to the 1960s to what the U.S. would come to know as President Lyndon B. Johnson’s “War on Poverty” and the “Great Society.” Along with other programs, the New Deal legislation established Aid to Families with Dependent Children (AFDC) in 1935 and housing assistance in 1937. These programs were not conceived of as “poor relief.” Instead historians referred to them as the “3Rs”, relief, recovery, and reform, and were meant to prevent a repeat of the conditions experienced during the depression. The programs were considered preventative measures that would ensure the U.S. to keep afloat in the case of another recession. The early programs were designed to provide temporary relief to persons during an era when husbands were expected to work and women were expected to stay at home and raise children. For example, AFDC was intended to provide assistance to women whose husbands were deceased or had abandoned them. While housing assistance was originally intended to make housing and mortgages more affordable, this soon developed into public housing.

The social safety net continued to expand exponentially throughout the 1960’s and 1970’s. President Lyndon B. Johnson declared his “War on Poverty” as part of the “Great Society,” which he described in 1964 when delivering his State of the Union.

---

Address before Congress. During his address President Johnson highlighted the chief areas of concern for the United States:

Our chief weapons in a more pinpointed attack will be better schools, and better health, and better homes, and better training, and better job opportunities to help more Americans, especially young Americans, escape from squalor and misery and unemployment rolls where other citizens help to carry them.¹¹

These reforms became increasingly essential in 1964, as the poverty rate skyrocketed to an astounding 19 percent.¹² In theory, these programs were meant to lighten the burden of poverty. Instead programs such as the AFDC left many recipients in the same precarious conditions they were before. The AFDC program was a federal-state matching grant program, which meant that each state could set their own eligibility standards, and the federal government would match state payments.¹³ This approach led to a huge discrepancy in benefits among states. Except for a few of the more generous states, benefits did not come close to the federal poverty line leaving many families just as poor as they were before.¹⁴ The federal poverty line is the minimum dollar amount that the federal government believes families’ need for food, shelter, and other necessities.¹⁵


¹⁴ Ibid., 14.

¹⁵ Ibid., 15.
Considering the lack of any substantial assistance, it is no wonder that the AFDC did not succeed as part of the “War on Poverty.”

Healthcare was another critical component of the birth of the social safety net. The year 1965 saw the creation of Medicare and Medicaid, two major components of President Johnson’s “Great Society”. These programs were the first of its kind to provide some form of universal access to healthcare for the elderly (those over 65 years of age), the disadvantaged, women and children. Medicaid is a public health insurance program that provides coverage to poor women and children, the disabled and some elderly.\(^\text{16}\) Likewise, Medicare is a public health insurance program that provides coverage to those persons over the age of sixty-five.\(^\text{17}\) It is important to note that these programs are not comprehensive and often present more administrative obstacles than benefits for a large percentage of the disenfranchised populations that they were created to serve.

In all fairness both programs are plagued with a significant number of challenges. The distribution of benefits in monetary terms amongst the groups they serve is just one of the many challenges that both Medicare and Medicaid face. For example, women and children account for almost 75 percent of Medicaid recipients, yet make up only a quarter of the programs expenditures. The bulk of Medicaid expenditures go to the elderly and the disabled. In other words, Medicaid provides two types of coverage – low cost


\(^{17}\) Ibid.
coverage for low-income families and children; and high-cost coverage for the elderly and disabled. 18

A second challenge is the relationship of Medicaid/Medicare benefits in relation to other programs. Historically, Medicaid was linked to the benefits of AFDC. Those who applied for AFDC, and were eligible, were automatically enrolled in Medicaid for health insurance coverage. This provided beneficiaries with free health care for almost all health care provider services. However, the link between Medicaid and AFDC severely limited Medicaid’s success in three key ways. First, the benefits were typically only available to single mothers, leaving most two-parent families without coverage. Second, the income cutoffs for welfare varied widely between states and were characteristically very low. Third, the stigma of the “Welfare Queen” and other administrative problems associated with public assistance kept many eligible families from applying for benefits. 19 The stigma of public assistance is an issue that policymakers still grapple with today. AFDC was, what is known as, an “entitlement” program which means that any family who meets the requirements could receive assistance. During the welfare reforms of the 1960’s work incentives were added to the program (both financial and non-financial) to encourage recipients to work. These reforms were established in part to address the stigma of the “lazy” welfare recipient. By the 1970’s, the first work requirements were added to emphasize the importance of working and its rewards while simultaneously discouraging others from abusing the system. By the time President Ronald Regan took


19 Ibid., 57.
office, work requirements included provisions that allowed states to require welfare recipients to work in exchange for benefits.\textsuperscript{20}

It was not until 1984 that the link between Medicaid and AFDC was eliminated under the Deficit Reduction Act. The Deficit Reduction Act required that states cover all children in families whose income made them eligible for AFDC, as long as they were born after September 1, 1983.\textsuperscript{21} This meant that all children under a year of age, whose family income qualified for AFDC, were covered. Families with older children were to be phased in during the succeeding years. The reform of the social safety net in the United States had only just begun.

Succeeding years saw the expansion of Medicaid benefits to include coverage for all children under the age of 19 whose family incomes fell below the federal poverty line. By 2003, all low-income children were eligible for Medicaid.\textsuperscript{22} All things considered, a substantial measure of success can be attributed to Medicaid. The program was created in the hopes of improving child health, reducing mortality, reducing hospitalizations and diminishing preventable sickness and has succeeded, if only in part, in meeting these goals. Despite its measured success, Medicaid and other public health insurance programs have real limitations as to what they can accomplish for the nation’s most severely disenfranchised populations.


\textsuperscript{21} Currie, The Invisible Safety Net: Protecting the Nation's Poor Children and Families, 37.

\textsuperscript{22} Ibid.
Considering today’s volatile economic and political climate it is no wonder that the social safety net, as we know it, has come under attack from all sides. These attacks are hardly new: the Regan administration slashed funding for many of the programs created by Roosevelt and Johnson and many have never recovered. The cuts to these programs, and more, occurred just as America was entering its deepest recession since World War II. Unemployment rates ranged around 9.5 percent during 1982-1983.\textsuperscript{23} Ironically, the cuts in some programs masked the generosity of the safety net programs. In other words, as people became poorer more of them became eligible for benefits under the stricter public assistance requirements.

Dissatisfied with its progress, or lack thereof, Reagan administration made these cuts based on the assumption that the ‘War on Poverty’ had failed. Similar thinking prevailed in the years succeeding Reagan, in 1996 [when] Bill Clinton set out to “end welfare as we know it.”\textsuperscript{24} The perception that these programs do not work continues to undermine public support for the social safety net, placing the already disenfranchised populations they serve on the edge of a precipice.

One may ask how exactly immigrants fit into this picture. Those immigrants who arrived in the United States legally are eligible for Medicaid depending upon their date of entry into the country. Those who arrived before August 1996, and met all of the supplementary requirements, were considered eligible on a state-by-state basis. Those immigrants who arrived legally into the United States after August of 1996 are ineligible.

\textsuperscript{23} Currie, \textit{The Invisible Safety Net: Protecting the Nation's Poor Children and Families}, 142.

to receive Medicaid benefits until they have been in the country for a minimum of five years. The only exception to this rule is for those legal immigrants who receive Social Security benefits (SSI); those that receive SSI are deemed eligible to receive Medicaid before the five-year bar.\(^\text{25}\)

On the other hand, undocumented immigrants are unequivocally ineligible to receive basic Medicaid benefits. With the exception of one caveat, undocumented immigrants may receive treatment if they qualify for emergency care. Under the federal Emergency Medical Treatment and Labor Act (EMTALA), all Medicaid recipient hospitals are required to attend to anyone in an emergency medical condition regardless of legal status or ability to pay. EMTALA imposes these obligations on Medicare participating hospitals that offer emergency services, which amounts to about 98 percent of all hospitals in the United States.\(^\text{26}\) Passed as a part of the Consolidated Omnibus Reconciliation Act (COBRA) of 1986, EMTALA has three main requirements for hospitals: (1) hospitals must perform a medical screening examination (MSE) on any person who requests care and determine whether an emergency medical condition (EMC) exists; (2) if an EMC exists, hospital staff must either stabilize that condition to the extent of their ability or transfer the patient to another hospital with the appropriate capabilities; and (3) hospitals with specialized capabilities or facilities (e.g., burn units) are required to


accept transfers of patients in need of such specialized services if they have the capacity to treat them.²⁷

The Centers for Medicare and Medicaid Services (CMS), previously known as the Health Care Financing Administration (HCFA), oversees the enforcement of EMTALA and has established regulations that reinforce its goals of ensuring patient access to emergency medical care and preventing the practice of patient dumping for financial reasons.²⁸ Patient dumping refers to the practice of transferring patients (typically from private to public hospitals) based on their lack of insurance, minority status or unemployment. It has been proven that patients who are transferred in the midst of a medical emergency are twice as likely to die as those treated at the transferring hospital.²⁹ For its part, EMTALA did assure that the indigent and undocumented would have legal access to a minimum of emergency medical care treatment.

A significant ramification of barring undocumented immigrants from receiving Medicaid benefits is that it severely limits their access to primary health care services. Primary health care services include: prevention and treatment of common diseases and injuries, basic emergency services, referrals hospitals and specialists, dental care, prenatal care, immunizations, and health promotion.³⁰ For the most part, states and local

---


²⁹ Ibid.

communities have had to pick up where the federal government has left off in order to address the needs of their individual communities. In fact, communities that have well developed safety nets in place are generally more prepared to assist undocumented immigrants than communities that do not have them. A well-developed safety net may include both public and private networks of hospitals, health care centers, and charities. These sorts of safety net programs can usually be found in major cities where there are historically large numbers of immigrant populations already in place. These immigrant populations have developed a network to assist one another to face obstacles such as lack of insurance, language barriers, or deportation. These built-in systems of support are far more advantageous to recent arrivals that establish themselves in a city with a large immigrant community already in place as compared to those immigrants that are experiencing those same difficulties in a community where the immigrant population is relatively new and small. For example, major cities such as Boston, Seattle, Indianapolis and Cleveland all have public hospitals and large numbers of community health centers that focus on immigrant groups. In comparison, other smaller communities have had to address growing immigrant population by developing new service capacities as the demand for these services has increased.

The capacities of newly developed health centers and community programs for uninsured persons are largely inclusive of undocumented immigrants. Still, there are others that do require citizenship status and therefore do not treat undocumented

---

immigrants. The publicizing of one’s uninsured status puts undocumented immigrants at even greater risk with the passage of President Barack Obama’s Patient Protection and Affordable Care Act of 2010 (PPACA), which requires that all citizens and permanent residents to obtain health insurance through Medicaid or private insurers. There is also a risk that exposing the uninsured status of undocumented immigrants who enter a hospital, health center, or community clinic would make the uninsured person synonymous with the undocumented immigrant. The ramifications of the PPACA and other legislative reforms will be discussed in more depth in Chapter 3.

Alternatively, undocumented immigrants have the choice of applying to private insurance (if they can afford it) or alternative public insurance programs that provide coverage to patients regardless of their immigration status. Since these public insurance programs are taxpayer-funded, their survival remains precarious as conservative groups attack the use of tax dollars to provide services for undocumented immigrants and local governments continue to struggle with growing budget cuts in a weak economy.32 One example of this type of public health insurance program is the DC Health Care Alliance, one of the most generous taxpayer funded programs of its type.33

The current political climate has strongly influenced the way communities respond to serving undocumented immigrants and their experience with the US social safety net. In recent years, tension has risen among communities that have seen growing...


33 Ibid.
numbers of undocumented immigrants, especially over the use of taxpayer funds for public services that serve immigrants. One example is Arizona’s Proposition 200, which was passed by voters in November 2004 that required state and local employees screening applicants for public programs to report undocumented persons to federal immigration authorities. While health services were excluded, community health centers in Phoenix reported a temporary drop in the use of their services by undocumented patients after the Proposition took effect.  

Without question the economic burden of budget constraints are being felt everywhere. The growing demand of insured patients have put pressures on safety net providers who are already stretched by their limited resources, such as they have never been before. Federal policy makers have chosen to limit their public assistance, leaving undocumented immigrants with little choice in how they seek primary health care services without the risk of outing themselves to federal authorities. This is where state and local organizations have had to step in to provide what little they can in way of services. As communities face their inevitably changing demographics in these continuously uncertain economic times, the federal government may have to rethink their position on assisting state and local programs with this issue. Considering that undocumented immigrants are disproportionately impacted by these social safety net policies, it is critical to understand their changing demographics in the United States in order to comprehend what impact these policies will have on the population at large. The following Chapter will discuss the demographics of immigrants in more detail.

---

A HISTORY OF U.S. IMMIGRATION AND UNDOCUMENTED IMMIGRANTS

The United States is a nation of immigrants, a land where our forbearers came to in hopes of beginning anew.¹ Yet, to this day immigrants still give rise to a number of fundamental questions in the American psyche. What does it mean to be American? Who is included? Who is excluded? Therefore, in order to comprehend the plight of the undocumented immigrant in the United States it is critical to understand what it means to be “illegal.” There are two primary types of illegal aliens in the United States: (1) those who have crossed the southern border illegally or via some other form of unlawful entry; and (2) those who have entered the country with a valid temporary visa and have overstayed there terms.² These two types of undocumented immigrants comprise almost 4 percent of the total U.S. population, about 11.5 million people.³ Immigrants who enter the United States legally in general fall into 1 of 4 categories: (1) Legal permanent residents (LPRs) - those persons who have been granted lawful permanent residence in the U.S.; (2) Refugees or asylum recipients - those who have applied for residency to avoid persecution in their home country; (3) Naturalized immigrants - those persons, age 18 and


over, who have been granted legal status as a resident of the U.S. for a minimum period of time and can therefore apply for citizenship. Most LPRs become eligible for naturalization within five years of obtaining their status; and (4) Non-immigrant admissions – are those persons who have been authorized to stay in the U.S. for a limited period of time such as businessmen and diplomats. The numbers for both legal and illegal immigrants have fluctuated over the years; more recently illegal immigration has declined after reaching a peak between the years of 2000-2004 when their numbers reached about 3.3 million.

Meanwhile, legal immigration has also seen growth in the last few years. According to the Department of Homeland Security Immigration statistics for 2010, there were over 1 million legal immigrants who gained LPR status that same year. Likewise, in 2010 there were 619,913 persons who were naturalized and 159 million nonimmigrant admission statuses granted in the United States. This said the process to apply for legal status is a very long and harrowing road for undocumented immigrants. Especially since over the years more and more restrictive measures have been put into place to apply for any form of legal status in the United States. Applying for LPR, asylum, and/or naturalization is a process that can average anywhere from one year up to five years depending on what status the immigrant is seeking. As a result, thousands of immigrants are left in a limbo somewhere between legal and illegal status, in danger of deportation.

---


The reality is that any immigrant, who has entered the country illegally or overstayed their visa, will be subject to deportation, i.e., the forced removal of an unauthorized person from the United States back to their country of origin. To enforce deportation the United States maintains and manages a series of processes that include apprehension, detention, removal, and or return of any individual who is deemed in violation of the McCarran-Walter Immigration and Nationality Act of 1952.

Historically, the Immigration and Naturalization Service (INS) handled all cases of deportation. The INS was a federal agency established in 1933 charged with overseeing matters related to naturalization, immigration services, and border patrol. After a massive government restructuring in the aftermath of the September 11th attacks, the INS was broken up and brought under the umbrella of the Department of Homeland Security (DHS). Today twenty-two previously separate agencies are housed under the DHS, in an effort to deter events such as September 11th from happening again. The Department of Homeland Security was established by the Homeland Security Act, which was passed in November 2002. In 2003, the U.S. Immigration and Customs Enforcement (ICE) agency was established under the DHS and today oversees the enforcement of all deportation matters in the United States.

As such, the DHS estimated that in 2010 there were 387,242 removals of undocumented immigrants from the United States. 6 Removals are the compulsory deportation of any individual deemed inadmissible or deportable based on an order of removal from the United States. Any unauthorized persons who are removed from the

---

U.S. and subsequently reenter will face administrative and criminal consequences if caught. Apart from removals, there were an estimated 476,405 returns of unauthorized immigrants in 2010. Returns refers to the confirmed movement of an unauthorized person out of the U.S. that is not based on an order of removal. These “voluntary” returns are those persons who have been apprehended by the U.S. Border Patrol and are returned to their country of origin. The number of removals has steadily risen as security and patrols have increased at the border.

Despite these efforts, it is estimated that on average 70 percent of undocumented immigrants who are caught at the border and returned to their country of origin reattempt to cross the border immediately. There are any number of reasons for why undocumented immigrants may risk crossing the border and these go far beyond the full scope of this paper. Nevertheless, it is important to recognize factors such as poverty, social and political instability in their country of origin, and violence. In fact, it is the shifting immigration laws and its implementation that have given rise to many of the problems associated with illegal immigration. A longstanding history of discords between U.S. economic, political and immigration policies lies at the heart of immigration problems.

The United States began restricting the entrance of immigrants by passing the Immigration Act of 1921. In 1924, Congress passed the Second Quota Act or Johnson-Reed Act that established an annual limit of 150,000 immigrants in addition to their

---

7 Department of Homeland Security, Yearbook of Immigration Statistics, 94.

8 Ibid.

9 Lemay, Illegal Immigration, 3.
wives and children. Beginning in 1927, the maximum number of immigrant entries from any country would be “a number which bears the same ratio to 150,000 as the number of inhabitants in the United States in 1920 having that national origin bears to the number of white inhabitants of the United States.”¹⁰ Thus began the quota system, which favored and ensured the predominance of Northern and Western European immigrants over other racial and ethnic groups entering the United States.

The disparaging racial and ethnic discrimination implicit in U.S. immigration policy would take another twenty four years to readdress. Even the harrowing details that emerged during World War II (WWII) of the treatment of Jews and other racial and ethnic groups did little to change immigration policy in the United States. At the time, there were no special provisions for refuges and all visa applicants were required to have a sponsor.¹¹ It was not until three years after the war that Congress passed the Displaced Persons Act of 1948 and the Refugee Relief Act of 1953 that permitted the admission of hundreds of thousands of displaced Europeans. In 1952, Congress passed the McCarran-Walter Act that left the quota system intact despite President Harry S. Truman’s best efforts. President Truman described the Act as “un-American” and discriminatory against immigrants from Eastern Europe. Consequently, President Truman vetoed the bill, but his veto was ultimately overturned by a vote of 278 to 113 in the House, and 57 to 26 in the Senate.¹²

¹¹ Martin and Midgley, Immigration: Shaping and Reshaping America, 5.
It was not until eight years later when President John F. Kennedy was in office and the civil rights movement had begun, that the U.S. saw an end to the explicit racial and ethnic discrimination of American immigration policy. In an effort to combat the blatant racial discrimination implicit in U.S. immigration policy, President Kennedy proposed eliminating the quota system and instead giving priority to immigrants who had special skills that would be of use to the United States. In 1965, the passage of the Hart-Cellar Act repealed the McCarran-Walter Act of 1952 and its national quota system. The Hart Cellar Act replaced the national quotas system with a system of preferences and family reunification. In fact, thereafter 80 percent of citizenship statuses were granted to immigrants with family sponsors. One point of clarification that should be made is that up until 1965, immigration restrictions (i.e. national quotas) did not apply to countries in the Western Hemisphere, particularly Mexico. This was largely due to economic reasons and the power of the agricultural lobby.

Inflow of Mexican labor proved quite beneficial to the United States in the late 1960’s and early 1970’s, during the period of severe labor shortages caused by the Vietnam War. Mexican immigrants were encouraged to come to the United States to work. Beneficiaries of these Mexican workers were employers in the agricultural sector that had suffered severe labor losses when workers chose to abandon their farms for more lucrative jobs. The agricultural industry was now able to supplement their depleted labor force by hiring migrant workers for less pay then they would have paid for American workers. The number of Mexican immigrants increased dramatically in the years

---

following the successful implementation of the Bracero Program, the first guest worker program of its kind in the United States.\textsuperscript{14}

The Bracero Program originally began in 1942, during WWII that granted U.S. employers permission to import workers from Mexico on a provisional basis. Immigrant workers were typically granted a 9-month stay. Throughout the war and in its aftermath the Bracero Program continued to expand as the economy grew and more workers were needed to fill the shortages. By 1949, Congress enacted the Agricultural Act that codified laws and provisions for the Bracero Program. The Bracero Program reached its peak in the 1960’s and it is estimated that more than 5 million Mexicans participated in the program during its twenty years of implementation.\textsuperscript{15} But by the mid-1960’s various restrictionist, patriotic and labor union groups began protesting the Bracero Program. Political unrest eventually led to its demise in 1964. It was shortly thereafter that the Hart-Cellar Act of 1965 was passed and for the first time ever, America closed it’s “backdoor” to immigrants in the Western hemisphere.

This was a pivotal moment in U.S. immigration history. The Hart-Cellar shifted the focus of American immigration policy. No longer was U.S. immigration policy concerned with the national origin of immigrants. Instead immigration policy was refocused on two groups: (1) those immigrants who possessed a special skill that was considered advantageous to the U.S.; or (2) immigrants with relatives already living in the United States who could act as sponsors. This dramatic change in immigration policy

\textsuperscript{14} Lemay, \textit{Illegal Immigration}, 4.

\textsuperscript{15} Ibid.
marked the birth of illegal immigration, as it is more commonly known today. What was once a controlled mechanism of entry for temporary immigrant workers was replaced with an influx of “illegal immigrants” who were essentially the same people who had participated in the Bracero Program.\(^\text{16}\) The only difference is that now they had no legitimate means of working in American agriculture.

The end of the Bracero Program marked the end of one era in immigration policy, and the beginning of another. The agricultural industry was forced into a difficult position: either raise wages to attract domestic workers, move production overseas for cheaper labor, or shut down.\(^\text{17}\) For many employers, none of these options fared better than just continuing to hire the thousands of Mexican immigrants who continued to come regularly to the United States for work, only this time without authorization. Ironically, it was because of the time that these immigrants had spent participating in the Bracero Program previously that allowed many of them to establish the knowledge, relationships, and mechanisms necessary to continue to live and survive in the United States, albeit illegally. This was a major advantage for the employers in the agricultural sector and they continued to hire undocumented immigrants long after the end of the Bracero Program. It was not until 1986, with the passage of the Immigration Reform and Control Act (IRCA) that it became illegal for employers to hire undocumented immigrants.\(^\text{18}\)

---

\(^{16}\) Lemay, *Illegal Immigration*, 4.

\(^{17}\) Ibid.

Inevitably, the ramifications of this change in immigration policy were felt across the country. Shifts in the United States immigration policy had effectively transformed temporary workers into undocumented workers. Furthermore, since undocumented workers could no longer freely travel back and forth to their country of origin they chose to stay permanently in the United States rather than risk leaving and not being able to re-enter without being deported. The changes did not stop there. IRCA had made it illegal for employers to hire undocumented immigrants, leaving thousands of immigrant workers who did not have legal documentation without employment. Up until that point, communities of immigrants who had been previously concentrated in the states along the border such as California, New Mexico, and Arizona then began to disperse throughout the country in search of work opportunities. Not only has the geographical makeup become more diverse since the Bracero Program, but also so has the ethnic and racial composition of immigrants in the United States.

Once predominately European, the amendments to the Hart-Cellar Act of 1965 prompted a rise in the number of immigrants from Latin America and Asia. A Congressional Research Service study looking at residency trends of unauthorized immigrants since 1986 concluded that of the estimated 3.2 million undocumented immigrants living in the United States approximately 69 percent were from Mexico, 23 percent were from Canada and South America, 6 percent were from Asia, and 2 percent from Europe.\(^\text{19}\) By 2010, the estimated number of undocumented immigrants living in the

U.S. has risen to 11.2 million with an estimated 57 percent from Mexico, 23 percent from Latin America, 4 percent from Canada and Europe, 12 percent from Asia, and another 4 percent from other countries.\textsuperscript{20}

Historically, there is no denying that the racial and ethnic make up of undocumented immigrants has been a contentious issue both politically, economically and socially. Today, racial and ethnic prejudices continue to constrain the Administration’s stance on immigration, policy deliberation and implementation. The Federation for American Immigration Reform (FAIR) states that immigration is directly responsible for overpopulation, environmental degradation, unemployment, wage depression, rising costs of public health care, and rising crime rates.\textsuperscript{21} While other groups such as the Border Action Network combat the stereotypes and racism associated with being undocumented and advocate open borders. Open borders refer to the liberal egalitarian theory that states have a duty to maintain transparent borders and admitting anyone who seeks entry to that state.\textsuperscript{22}

Generally, public opinion has tended to sway back and forth, usually a function of prevailing economic circumstances and demand in the labor market. For example, in the early 1990’s when the economy expanded and the labor market tightened, public opinion


of immigration was more tolerant. The Public Policy Institute of California issued a poll in 1999 that found that “52 percent of Californians considered Mexican immigrants a benefit to the state because of their labor skills.”\textsuperscript{23} Thirteen years later sentiments towards immigration are not so favorable. Against the backdrops of the global economic recession that started in 2008 and the terrorist attacks of September 11, 2001, many Americans have become highly divided on the questions surrounding immigration and its social and economic benefits/costs to the United States.

Known as the “storm-door era,” September 11, 2001 marked a sensitive time in U.S. policy formulation. The September 11\textsuperscript{th} attacks brought with it an onslaught of legislation that were both directly and indirectly tied to immigration. The reason was that most lawmakers considered immigration to be a vehicle by which terrorists could infiltrate the United States. Two of the major pieces of legislation to result from the “storm-door era” were the Homeland Security Act, which established the DHS, and the USA Patriot Act. The Patriot Act, which stands for Uniting and Strengthening America by Providing Appropriate Tools Required to Intercept and Obstruct Terrorism Act, was President George Bush’s response to the United States newest top priority: antiterrorism. The Patriot Act granted unprecedented powers to the Attorney General and the Justice Department to infringe on the civil liberties of U.S. citizens, to monitor students and resident aliens, to expand surveillance powers, and to detain and expedite the removal of noncitizens that are even suspected of links to terrorist organizations.\textsuperscript{24} Proponents of the

\textsuperscript{23} Martin and Midgley, \textit{Immigration: Shaping and Reshaping America}, 16.

\textsuperscript{24} LeMay, \textit{Illegal Immigration}, 22.
Patriot Act believed the legislation essential to deter future terrorist acts; its critics believed that the law only trampled on the civil liberties of citizens and provided legal channels for the racial profiling of persons from the Middle East. Since the enactment of the Patriot Act, it has been used as a means of deportation against undocumented immigrants who have even the slightest affiliation with a terrorist organization. The Patriot Act defined a terrorist organization as any or all groups that had ever used or threatened violence in any way whether it is a political group or a prolife group. By applying such a broad definition of a terrorist organization, the government has been given the power to deny and deport any undocumented immigrant with any minimal affiliation to seemingly harmless organizations.

Needless to say the post September 11 hysteria has had sweeping ramifications for all immigrant groups. Racial profiling, racism and stereotyping are a part of a bitter reality that most, if not all, immigrants must face today. Considering that Hispanics make up the largest immigrant group in the United States, it goes without saying that legislation such as the Patriot Act and others have had the largest impact on their community. A prime example is Arizona’s controversial S.B. 1070. S.B. 1070 that was first signed into law in April 2010 by their Republican governor Janice “Jan” Brewer, codified crimes and penalties for the enforcement of immigration laws that were meant to begin on July 29, 2010. The law made it illegal for undocumented immigrants to be stopped by


authorities and not have their proper legal documentation on hand. The bill caused immediate controversy, once again igniting public debate on immigration issues.

The *New York Times* described the law as the “broadest and strictest immigration measure in generations.” President Obama publically criticized the law at a naturalization ceremony for service members and stated: “to undermine basic notions of fairness that we cherish as Americans, as well as the trust between police and our communities that is so crucial to keeping us safe.” Before the law could be implemented the U.S. Department of Justice (DOJ) filed a lawsuit seeking an injunction on the basis that the law was unconstitutional.

Thousands protested the law in cities all around the United States and on July 28, 2010, a day before the law was meant to go into effect, Judge Susan Bolton granted the Department of Justice’s request for injunction based on the following provisions: “state law officers determining immigration status during any lawful stop; the requirement to carry alien registration documents; the prohibition on applying for work if unauthorized; and permission for warrantless arrests if there is probable cause the offense would make the person is removable from the United States.” Governor Brewer appealed the injunction and case was sent to the 9th U.S. Circuit Court of appeals. In April 2011, the 9th Circuit Court upheld the injunction.

__________


28 Ibid.

In August of 2011, Governor Brewer chose to appeal directly to the U.S. Supreme Court and the case began oral arguments in April 2012. One June 25, 2012 the Supreme Court issued its decision, striking down three of the four provisions in the law. The Justices’ decision reinforced that it is at the discretion of the federal government to establish and regulate immigration law, not the states. However, all eight Justices (Justice Elena Kagan recused herself from the case)\(^\text{30}\) agreed and upheld the most controversial provision of the law, allowing local law enforcement to investigate the immigration status of an individual who is stopped or detained if there is reasonable suspicion that they are undocumented.

In response, the American Civil Liberties Union (ACLU) requested to block the remaining provision on the basis of racial profiling, fearing further discrimination on the predominantly Hispanic population of Arizona. However, Judge Bolton ruled that the federal court could not block the provision on the possibility of racial profiling alone thereby upholding the Supreme Courts decision. Considering that Arizona has a population of some two million Hispanics, including an estimated 400,000 undocumented immigrants, S.B. 1070 will, without a doubt, disproportionately affect their Hispanic community (Mexicans in particular).\(^\text{31}\)

This impact extends far beyond Arizona: Hispanic communities across the United States have continued to grow and are projected to continue to do so. The Pew Hispanic


Center states that nearly two-thirds of all Hispanics in the United States today self identify as Mexican and nine out of ten of the largest Hispanic origin groups account for about a quarter of the U.S. Hispanic Population. The ten largest Hispanic groups (which make up 92 percent of the Hispanic population) in the United States today are: Mexicans, Cubans, Puerto Ricans, Guatemalans, Salvadoran, Dominican, Peruvian, Colombian, Honduran, and Ecuadorian.

According to the 2010 U.S. Census data there are an estimated 1.6 million Salvadoran immigrants living in the United States with over 247,000 living in the states of Maryland and Virginia alone. Salvadorans are also the largest immigrant group in Washington, DC, accounting for approximately 17 thousand residents. As Salvadoran, and other Hispanic groups continue to rise in numbers, it becomes increasingly crucial to have sound policies in place that ensure that these groups’ basic needs are being met just as any other immigrant group that came before them. Failure to do so will only further marginalize larger and larger numbers of people, as Hispanics become a dominating presence in the United States.

Currently, health care is one of the most highly contentious subjects surrounding the debate on immigration. As was discussed in Chapter 1, government health insurance does not effectively meet the primary care needs of undocumented immigrants. For


33 Ibid.

example, in 2011 there were an estimated 9.7 million uninsured adult noncitizens. Only about 40 percent of undocumented immigrants are able to afford private insurance, leaving an additional 60 percent without coverage and thereby preventing them from receiving regular access to preventative primary health care services. The ramifications of these barriers to access extend far beyond the individual and spread into the community.

The Centers for Disease Control and Prevention (CDC) list the various communicable diseases that are of public health significance. They include tuberculosis, syphilis, chancroid, gonorrhea, granuloma inguinale, lymphogranuloma venereum, and leprosy. The list of vaccine preventable diseases are: mumps, measles, rubella, polio, tetanus, diphtheria, pertussis, haemophilus influenzae type B, rotavirus, hepatitis A and B, meningocococcal disease, varicella, pneumococcal pneumonia, and influenza. These are just a few of the communicable diseases that spread amongst immigrants, travelers, and the general public. To assist in preventing further spread of diseases such as these, the McCarran-Walter Immigration and Nationality Act of 1952 and the Public Health Service Act of 1944 established the authority that requires that all refugees and immigrants entering the country (legally) must undergo a medical screening, to identify those immigrants with inadmissible health conditions. However herein lies the dilemma, while these screenings are conducted on the thousands of immigrants who enter

---


37 Ibid.
the United States legally, there are thousands more who had entered the country illegally and forced to bypass health screenings.

Generally speaking, undocumented immigrants have had to live in substandard conditions in their country of origin and travel under harsh circumstances to enter the United States, exacerbating any previous diseases they might have already been exposed to. Limiting the access of undocumented immigrants to primary health care services will continue to weaken the efforts of the U.S. to fight the spread of communicable diseases among the general population. In 2008, there were over 5,000 deaths associated with human immunodeficiency virus (HIV) disease, influenza and pneumonia for adults between the ages of 25 and 44 in the United States. That same year, there were 48,000 deaths associated with influenza and pneumonia for adults age 65 and older.\(^{38}\) This is not meant to imply that undocumented immigrants are the sole carriers, nor transmitters of communicable diseases but only that the health related conditions of noncitizens left untreated contribute to these numbers.

Considering the high percentage of undocumented immigrants who lack health insurance and therefore access to regular preventative primary care treatment, it is more likely that the number of cases of communicable diseases, left untreated, will continue to grow. Even with alternative access to health care services such as, community health centers and public health insurance, noncitizens are less likely to seek to out medical attention for fear of deportation, discrimination, and language barriers. For that reason, it

cannot be assumed that the lack of health insurance is the only barrier to preventative primary health care services for undocumented immigrants. There are many complex and interwoven political, social, and economic issues at play in this discussion. These economic and social factors will be explored in further detail in Chapters 4 and 5. First and foremost, it is important to understand how and why undocumented immigrants are limited in their access to primary care services in the United States. Historically, U.S. health policy legislation has specifically targeted recent immigrants and noncitizens blatantly limiting their access to essential health services. The next chapter will explore specific pieces of legislation that have made this possible as well as their consequences.
CHAPTER 3

A HISTORY OF HEALTH POLICY LEGISLATION IN THE UNITED STATES

Health and sickness is one issue that does not discriminate between the rich and poor. For this reason, debates surrounding healthcare have become increasingly polarizing. This is especially true in the United States where healthcare is treated as a commodity. In other words, the wealthier the person the better quality services they can afford, while those who are less affluent are forced to make do with what little they can pay for. To offset the disparities in the availability of primary and emergency health care services for those who are less affluent, the U.S. has become increasingly reliant on the services provided by the social safety net. The problem is that the U.S. social safety net is riddled with holes. While many rely on it, over the years the social safety net has become increasingly broken, leaving large numbers of people without access to the most basic primary health services.

The social safety net is a conglomeration of public and private social programs that provide a wide range of services to the disadvantaged. These programs are enacted through various pieces of federal, state and local legislation. Unfortunately, much of the legislation enacted in support of the social safety net (particularly health care) has been enacted in response to specific situations, in turn creating piecemeal policies. The resultant patchwork approach to health policy that is neither particularly functional, nor

---


rational, for the purposes of addressing the nation’s underserved populations. Instead
health legislation has almost always been enacted as a knee-jerk reaction to disasters,
interest groups, and hyper ideological debates.3

The reactive approach to health care policy is nothing new. The conceptualization
of health care policy as a part of the social safety net began to gain momentum during
World War II (1941-1945). As the United States began recruiting men to serve in the
armed forces, the health care system’s deficiencies were widely exposed. At the time
approximately, 9 million men were deemed unfit for service due to health problems and
mental illness.4 The health of African Americans was among the worst. “For example, in
1940 the infant mortality rate for African Americans was almost twice the infant
mortality rate for whites.”5 This situation highlighted the inequality of health care in the
United States at this time and the need for more research surrounding health issues
became increasingly clear. In 1944, Congress passed the Public Health Services Act
(PHSA). The PHSA gave the Public Health Service control of the National Institutes of
Health (NIH). In turn, the NIH gave grants to researchers for the purposes of addressing
“war-related medical problems.”6 The reality of the extent of the health disparities in the
United States became increasingly apparent when President Franklin D. Roosevelt

3 Andy Alaszewski and Patrick Brown, Making Health Policy: A Critical Introduction (Malden,

4 Cynthia Moniz and Stephen Gorin, Health and Mental Health Care Policy: a Biopsychosocial

5 Ibid.

6 Ibid., 27.
commissioned a post war report on government grants awarded to science to address “what could be done to aid, ‘the war of science against disease’.”

Most of the basic forms of social programs that exist today were first implemented throughout 1960s and 1970s in the period after World War II. The U.S. economy was rebounding from the Great Depression and prosperity was shedding a greater light on the harsh conditions of poverty. To address this issue, the United States government felt it was best to intervene by implementing various social policies that were meant to address and prevent the conditions of poverty. At the time shifts in the cultural, political and economic ideologies made these changes an attractive option for many. Henceforth, the United States was putting in a concerted effort to ensure that the nation’s workforce would be educated, healthy and prosperous. To achieve this goal the U.S. government expanded its role in the regulation and implementation of education, financial aid and job training. Simultaneously, the Civil Rights Movement, which began in the early 1960s, encouraged federal involvement in a wide variety of social issues, fostering subsequent expansion of laws that “prohibited discrimination in employment housing, education and other areas.” The U.S. was on the path to major social reforms.

Likewise, the reform of health policy was an inevitable course of events. It all began with the reform and expansion of the nation’s health center capacities to extend access to other rural and urban areas. The foundation of the nation’s first community

---


9 Ibid., 23.
based health centers emerged from two key pieces of legislation: the Migrant Health Act of 1962 and the Economic Opportunity Act of 1964.\(^{10}\) Both pieces of legislation were instrumental in the creation of migrant and neighborhood health centers. These were among the first centers of its kind to receive federal monies to support and address the serious lack of access to primary health care services across the country. By the 1970’s, over 100 community health centers had been established under the Economic Opportunity Act of 1964.\(^{11}\)

There were many more changes on the horizon. By 1965, Congress had established Medicare under Title XVIII of the Social Security Act in order to provide health insurance to persons 65 and older. Simultaneously, Medicaid was established under Title XIX of the Social Security Act to provide health care to individuals and families with low incomes. Both programs have greatly reduced poverty, hardship, and risk among the nations largest disenfranchised groups particularly women and minorities.\(^{12}\) However, the implementation of these new programs was not without controversy and many of the same issues continue to plague them today. Presently, Medicare has become the nation’s largest source of publicly funded health insurance. It is estimated that Medicare “accounts for 15 percent of total federal spending and 21 percent


\(^{12}\) Ibid.
of total national health spending.” Currently, the cost of Medicare and Medicaid programs has become the most highly contentious political and economic debate around the country. Publicly, undocumented immigrants are charged with raising the costs of both programs though they are largely ineligible to receive their benefits.

An alternative resource for undocumented immigrants has historically been community health centers. In 1975, the Community Health Centers program was authorized under Section (§)330 of the Public Health Services Act. The Community Health Centers program expanded the access of what were neighborhood health centers to community-based centers that served larger populations with limited access to health care services. However, it was not until the Health Centers Consolidation Act of 1996 that health centers were consolidated and reauthorized to provide services to the four previously separate federal programs: community health centers, migrant health centers, health care for the homeless, and healthcare for public housing residents.

Originally, community health centers (CHCs) were established to provide primary health care services to low-income residents in urban and rural areas. However, the rising costs of health care, coupled with population growth, economic decline and growing numbers of migrant populations have created a much greater demand for CHC services than previously thought. Today, CHCs typically serve a much more varied population than just low-income residents or migrants. In 2011, CHCs provided 80 million patient visits in 1,128 organizations across more than 8,500 service sites. Of there 20.2 million

---


patients “93 percent were below 200 percent poverty, 72 percent were below 100 percent poverty and 36 percent were uninsured.”  

Despite the controversies surrounding the rising costs of community health centers and other health clinics, it is important to note that federal subsidies are not their only source of funding. The Health Resources and Services Administration (HRSA) have strictly limited the funds granted to community health centers to finance direct services only. Therefore, CHCs must rely on various sources for revenue. In 2010, health center revenue was a totaled $12.7 billion - 15 percent state/local/private grants and/or contracts; 23 percent federal grants; 3 percent other revenue; 6 percent self-pay; 7 percent private; other public 3 percent; 6 percent Medicare; and 38 percent Medicaid. Nevertheless, Medicare reimbursement remains critical to the sustainability of community health centers due to the populations they serve. In other words, a majority of the patients that these health centers and clinics serve are dependent on Medicare.

In 1989, Congress established the Federally Qualified Health Centers (FQHC) program to assure that funds appropriated to health centers were being used to provide

---


16 The term Community Health Centers and health clinics are used interchangeably.


direct primary care services alone. In order for a community health center to become eligible for FQHC status they must fulfill certain requirements. The health center must be designated as follows:

(1) Located in a HRSA-designated Medically Underserved Area/Population (MUA/P);
(2) have a governing with a majority (51 percent or more) of patients on the Board of Directors;
(3) provide comprehensive primary health and supportive services;
(4) provide services available to all;
(5) provide comprehensive primary health care services with fees adjusted on a sliding scale; and
(6) meet performance and accountability requirements.

Since the first year of its implementation FQHCs have seen significant growth both in both capacity and funding. In 2003, there were 890 FQHC grantees that provided service to 3,600 sites. That year grant expenditures reached $1.47 billion. Currently, the fiscal year (FY) appropriation for the 2012 Omnibus Appropriations Act funds the Health Centers Program at $2.78 billion. The latest Census data from 2010 reveals that

19 Kaiser Family Foundation, “Community Health Centers: The Challenge of Growing to Meet the Need for Primary Care in Medically Underserved Communities,” 4.


these funds support 1,124 health centers nationally, that provide primary health care services to approximately 19 million people annually.\textsuperscript{23}

There seems to be no end in sight for the growing demand for these alternative sources of health care service providers. In 2010, there were an estimated 49.9 million uninsured persons living in the United States, up 900,000 million from 2009.\textsuperscript{24} It is evident that the need to address the issue of access to primary health care services is growing more urgent. Nevertheless, the social, economic and political implications of health care policy combined with the charged emotions surrounding the debate on undocumented immigrants make it an extremely complex and hot button issue. For this reason, it is of utmost importance to understand the historical context behind the above-mentioned pieces of legislation. This will provide a lens through which to analyze the impact that said legislation has had one of the most disenfranchised populations living in the United States today, undocumented immigrants.

Undocumented immigrants are those foreign born individuals who have entered the United States illegally, lack valid documentation to verify their legal status, or have overstayed their visas.\textsuperscript{25} By the end of the 20\textsuperscript{th} century, large waves of immigrants from Mexico and Latin America sparked public outcries. In part, this was due to the fact that

\begin{itemize}
\end{itemize}
the influx of new immigrants were characterized as mostly poor, migrant, low-wage workers, causing some to argue that the “generous welfare state was attracting illegal immigrants.” While this allegation has not been corroborated, the onslaught of criticism brought with it a new era of legislative reform. The nations shifting attitudes towards the impoverished, undocumented and needy became increasingly hostile as the economy growth that the United States experienced post World War II began to wane. Social reform and all types of assistance programs became easy targets. Efforts to reform the social safety net, in earnest, began in the 1960s. However, the first piece of major legislative reform did not occur until 1996 with the Personal Responsibility and Work Opportunity Act (PRWORA).

PRWORA brought with it a number of major social policy changes that reverberated throughout the nation, but particularly for new and undocumented immigrants. First, PRWORA ended Aid to Families with Dependent Children (AFDC) and replaced it with the more restrictive Temporary Assistance for Needy Families (TANF). In addition, it placed stiff restrictions on the eligibility of both legal and undocumented immigrants, specifically, for those immigrants who entered the country after August 22, 1996. Immigrants who entered the country after this date were considered ineligible to receive “federal means-tested public benefits” for their first 5 years of residency in the U.S. While there are exceptions, the state is also allowed to

27 Also known as the Welfare Reform Act of 1996. Public Law 104–193 104th Congress.
impose further restrictions on public benefits eligibility beyond the 5 year residency requirement. For those immigrants who arrived prior to August 22, 1996 the state is allowed to determine the eligibility for receipt of TANF and Medicaid benefits for those “qualified aliens.” Prior to the passage of the PRWORA, publicly funded CHCs routinely provided necessary health services regardless of a persons legal status.

Congress had accomplished its goal, effectively denying “all federally funded medical assistance to unqualified [undocumented] aliens.” As a result, undocumented immigrants were now ineligible to receive a majority of public benefits. The passage of PRWORA marked the end of an era. However, it did not completely remove all public assistance for undocumented immigrants. There are two notable exceptions -- Medicaid funds can be used to provide for the treatment of “emergency medical condition(s)”

---

29 ‘Federal public benefit’ means-- (A) any grant, contract, loan, professional license, or commercial license provided by an agency of the United States or by appropriated funds of the United States; and (B) any retirement, welfare, health, disability, public or assisted housing, postsecondary education, food assistance, unemployment benefit, or any other similar benefit for which payments or assistance are provided to an individual, household, or family eligibility unit by an agency of the United States or by appropriated funds of the United States.


31 Personal Responsibility and Work Opportunity Act, § 402 (b).


33 Lewis v. Thompson, 252 F.3d (2d Cir. 2000).

34 Personal Responsibility and Work Opportunity Act, § 401 (a).
and “assistance with respect to immunizable diseases and for testing and treatment of symptoms of communicable diseases.”35, 36

Proponents of the PRWORA believed it would stem the flow of undocumented immigrants who were thought to be abusing the system. According to the Congressional Budget Office, the law was projected to save an estimated $55 billion over 6 years due largely to the reduction in benefits to undocumented immigrants.37 The actual costs in comparison to the savings of the PRWORA are extremely complex and beyond the scope of this paper. However, it is important to note the contextual framework under which the PRWORA was passed.

By 1997, there were 16.7 million undocumented immigrants living in the United States.38 Of those 16.7 million non-citizens, 43 percent of children were uninsured and 12 percent of the elderly were uninsured; while only 14 percent of non-immigrant children and 1 percent of non-immigrant elderly were considered uninsured.39 Just one year after the passage of the PRWORA over 16 million persons lacked health insurance along with

35 Personal Responsibility and Work Opportunity Act, § 401 (b).

36 Kline, “National Policy and Access to Health Care, 9. Communicable diseases include vaccine preventable diseases, but are not limited to: mumps, measles, rubella, polio, tetanus and diphtheria toxoids, pertussis, Haemophilus influenzae type B, rotavirus, hepatitis A & B, meningococcal disease, varicella, influenza, and pneumococcal pneumonia.


39 Ibid., 917.
any viable means to by which to obtain consistent coverage. Undocumented immigrants now faced a harsh dilemma either to (a) pay for services out of pocket with whatever resources they had, or (b) wait until a condition worsened to the point of critical or emergency care.

The Protection and Affordable Care Act of 2010 will have even more significant impact on undocumented immigrants and their ability to access both public and private safety net programs alike. PPACA will establish a comprehensive set of health insurance reforms that will be implemented over a set span of time, most of which will occur in 2014. The goal of PPACA is to decrease the number of uninsured persons in the United States, while also decreasing the cost of health care. The law will require most citizens to purchase health insurance coverage with some exceptions, which include: undocumented immigrants; some religious groups; those whose family income is so low they don't have to file a tax return; those who earn so little that health insurance premiums, after federal subsidies and employer contributions, would total more than 8 percent of their income; and those who already have insurance through Medicaid, Medicare, an employer or veteran's health program. Consequently, the exposure of being uninsured puts undocumented immigrants at even greater risk by making “uninsured” synonymous with “undocumented”.

Even those undocumented immigrants who have been granted temporary provisionary status will be excluded from the benefits of the PPACA. In August 2012,

---

40 Compilation of Patient Protection and Affordable Care Act, Public Law 111-148, § 1411, 111th Cong., 2d sess. (June 9, 2010), 147-51.
President Obama issued an Executive Order granting undocumented immigrants a reprieve from deportation if they had (i) entered the United States before reaching their 16th birthday; (ii) have continuously resided in the United States continuously since June 15, 2007, up to the present time, (iii) are under the age of 31 as of June 15, 2012; (iv) entered the U.S. without inspection before June 15, 2012; (v) are currently in school, have graduated or obtained your certificate of completion from high school; (vi) have obtained their general educational development certification; (vi) or are a honorably discharged veteran of the Coast Guard or Armed Forces of the United States; (vii) have not been convicted of a felony, significant misdemeanor, or three or more misdemeanors, and do not otherwise pose a threat; (viii) and are present in the United States on June 15, 2012, and at the time of the request.\(^{41}\) Shortly after issuing his executive order, the Department of Homeland Security issued a statement that the PPACA would only cover those immigrants who are here “lawfully.”\(^{42}\) Which means that those undocumented immigrants who are granted temporary work status will not qualify to apply for lower cost health insurance coverage or the pre-existing condition plans guarantees despite being permitted to work in the United States and simultaneously pay taxes. This further marginalizes this population by increasing their costs of health coverage, while others are to be offered the same coverage at a reduced cost.

---


Despite these barriers to access, states have offered little protection to undocumented immigrants. In fact, PRWORA § 434 states, “no state or local government entity may be prohibited, or in any way restricted, from sending to or receiving from the Immigration and Naturalization Service information regarding the immigration status, lawful or unlawful, of an alien in the United States.” 43 Since states now have the authority to report on the legal status of undocumented immigrants, fear of potential deportation has risen among immigrant populations, erecting yet another barrier between undocumented immigrants and the receipt of critical primary health care services. Undocumented immigrants must weigh the consequences of facing possible deportation or seeking medical care. Facing those odds, immigrants are much more likely to refrain from seeking medical care than risk being deported to their country of origin. This situation creates an undesirable and avoidable public health outcomes. The rising number of undocumented immigrants arriving in the United States annually creates the potential for the spread of communicable diseases. Additionally, the fact that undocumented immigrants are more likely to live in high-risk communities raises the threat of exposure of communicable diseases to the public at-large. 44 In other words, limiting access of undocumented immigrants from receiving primary care services only further jeopardizes public health since immigrants will be more likely to wait until their medical situation has severely worsened before seeking treatment.

As it is, undocumented immigrants are among the most vulnerable social groups


in the United States. On average they make “less money, live in substandard conditions, enter the country through means that pose a threat to their health, have jobs that are considered hazardous to their health, have no health insurance, and virtually no political clout.” This leaves them particularly susceptible to the consequences of a piecemeal health policy system. While states must provide undocumented immigrants with emergency medical aid, immunizations, testing and treatment for communicable diseases, Medicaid funds can only be used for emergency aid. Should a state wish to provide additional funding for programs such as prenatal or preventative care, they would have to fund these independently and pass separate state laws.

For Hispanics, the nation’s largest growing immigrant population the implications of US health policy are especially discouraging. In 2010, there were approximately 15.3 million Hispanics who were uninsured. Hispanics comprise two (Mexican and El Salvadoran) of the five largest undocumented immigrant groups residing in the United States. A key example of a disproportionately impacted Hispanic group in the United States is Salvadoran immigrants. In 2008, there were approximately 1.1 million Salvadoran immigrants residing in the United States. The largest wave of Salvadoran

---


46 Ibid.


immigrants began in the early 1980s and lasted throughout the 1990s due in large part to the rising incidence of violence in San Salvador, natural disasters and family reunification.\textsuperscript{49, 50} Contrary to popular belief, there is little evidence that immigrants came to the U.S. to take advantage of public benefits. Rather, economic opportunities and U.S. demand for work seemed to be the driving motivation.\textsuperscript{51}

As civil war and unrest took hold of San Salvador in the early 1980’s a growing number of Salvadoran migrants fled the country. Their reception upon arriving in the United States was unwelcoming at best. At the time, the United States was just starting to turn its attention towards the rising costs of Medicare and undocumented immigrants were the easiest targets for states to blame. As a result, the United States Immigration and Naturalization Service (INS), as it was then known, implemented a particularly tough standard for evaluating Salvadoran petitions for asylum.\textsuperscript{52} Petitioners needed to demonstrate a “clear probability of persecution for reasons of race, religion, nationality, membership of a particular social group, or opinion.”\textsuperscript{53} This language was codified with the passage of the REAL ID Act in 2005. From the start of the Salvadoran exodus to the United States until May of 1987, the INS effectively rejected over 95 percent of all


\textsuperscript{52} Jones, “Causes of Salvadoran Migration to the United States,” 183.

Salvadoran petitions.\textsuperscript{54}

Up until the late 1980’s, Salvadorans were effectively singled out from amongst all other immigrant groups for denial of asylum petitions at much higher percentages “while one-forth to two-thirds of Iranians, Eastern Europeans and Asians were approved for asylum, relatively few Salvadorans.”\textsuperscript{55} At the same time, the Executive branch had been granting temporary blanket relief for immigrants from other specific countries that feared returning to their homeland under the “Extended Voluntary Departure” (EVD) regulations for years.\textsuperscript{56} Countries that received EVD include: (i) Uganda 1978-1986 (ii) Nicaragua 1979-1980 (iii) Afghanistan 1980-1985 and (iv) Poland 1982-1989.\textsuperscript{57} Yet, Salvadorans continued to be discriminated against. In April 1985, Alan Nelson, then Commissioner of the INS, stated that allowing Salvadorans’ protection under EVD regulations could “lead to an invasion of feet people magnifying the migration from that region, making what we already see as a stream become a torrent.”\textsuperscript{58}

Nevertheless, by 1990 the tides had begun to change in favor of Salvadoran immigrants with the passage of the Immigration Act of 1990 (IMMACT). IMMACT

\textsuperscript{54} Jones, “Causes of Salvadoran Migration to the United States,” 184.


\textsuperscript{56} Ibid.

\textsuperscript{57} House Committee on the Judiciary, \textit{Oversight Hearing on Issues Arising from Past Designations of Temporary Protected Status and Fraud in Prior Amnesty Programs}, 106th Cong., 1st sess., 1999, H. Hrg. 871, serial 71, 67-78. “Extended Voluntary Departure” (later rechristened “Deferred Enforced Departure”) for aliens from specific countries as a temporary grant of blanket relief from deportation for nationals of certain countries who feared returning to their homelands. In effect, EVD was an exercise of prosecutorial discretion by the Attorney General in deciding not to force the departure of nationals of a certain country.

\textsuperscript{58} Guthman, “Underground Railroad, 1980’s Style,” 1.
formally established the Attorney General’s authority to provide Temporary Protected Status (TPS) to undocumented persons who are unable to return to their country of origin because of ongoing armed conflict, environmental disaster, or other extraordinary and temporary conditions. In 2003, the authority to grant and revoke TPS was transferred from the Attorney General to the Secretary of Homeland Security. The passage of IMMIGRANT was a victory for thousands of Salvadoran immigrants awaiting deportation. Section §303 of IMMIGRANT specifically designated protective status for Salvadorans, for what was originally a period of 18 months. As a result, almost 200,000 undocumented Salvadorans avoided deportation. Even after TPS expired for Salvadorans, the INS chose not to deport them by simply reverting to the practice of EVD, which was now called Deferred Enforced Departure (DED).

Contrary to the argument of many immigration restrictionists that undocumented immigrants are depleting the nation of limited resources, the reality is, that they are integral parts of the U.S. economy. Today, more than half of Salvadoran immigrants in the United States reside in California and Texas. There is also a large concentration of Salvadoran immigrants living in New York, the District of Columbia, Maryland, and Virginia. Over the years these numbers have steadily increased. In 2010 U.S. Census


60 House Committee on the Judiciary, Oversight Hearing on Issues Arising from Past Designations of Temporary Protected Status and Fraud in Prior Amnesty Programs, 74.

61 Ibid.

data calculated that there were over 81,000 immigrants living in Washington, DC alone. Today, Hispanics make up 3.6 percent of that population, or 21,760 people in Washington, D.C.\(^65\) According to the Institute for Taxation and Economic Policy unauthorized immigrants in Washington, DC paid $26.4 million in state and local taxes in 2010.\(^64\) Moreover, if all undocumented immigrants were suddenly removed from Washington, DC, the District would lose “1.1 billion in economic activity, $490.5 million in gross product, and approximately 5,400 jobs.”\(^65\) These statistics demonstrate that there is a reciprocal beneficial relationship between the United States and unauthorized immigrants.

With those statistics in mind, it is time to come to the realization that there is no going back. The United States cannot and will not shut its borders by removing and excluding all foreign-born undocumented immigrants. Since that is not a viable option, there must be some remedial approach that will provide undocumented immigrants with the necessary access to primary health care. Without these services the health status of this growing population will only continue to deteriorate, ultimately, jeopardizing the


health of the general public. The public has a vested interest in this debate – not only for their health but also for the economic costs. The risk of transmission of communicable diseases and the rising costs of health care will only be exacerbated in years to come. A study by the American College of Physicians in 2008 showed that consistent availability of primary health services was associated with better outcomes and lower costs.66

The United States has woven together a series of legislation meant to tackle primary health care disparities and while they have made great strides, much more needs to be done. As the United States morphs into the global economy and becomes more demographically diverse, their fledgling health policy will not be enough to keep pace with the growing health issues. For this reason, it is of the utmost importance to provide marginal communities, in this case undocumented immigrants, with the necessary basic health care if the U.S. seeks to sustain a healthy and productive population. Avoiding these problems will ultimately cost much more than the initial expense of implementing primary and preventative care services for undocumented immigrants.

This situation endangers their health, and puts all public health at risk. In the past decade, infectious disease-related deaths in the United States have nearly doubled to approximately 170,000 annually.67 The hurdles that undocumented immigrants face in gaining access to primary health care services create a serious threat by exposing the general public to untreated strains of new and re-emerging infectious diseases, in turn, negatively impacting both the social and economic development of the United States. As


noted earlier, economists have termed this situation an external diseconomy and explains it that the “socially optimal price of a good [in this case health care] causing a diseconomy should be above its marginal cost”. In other words, the up-front cost of providing primary health care services to undocumented immigrants is far less than the future social and economic costs of not doing so. However, public opinions on this subject vary dramatically for a number of reasons. Many believe that undocumented immigrants are not entitled to public benefits and instead raise the costs to be borne by citizens and other taxpayers. The extent to which these accusations are true are still unclear and warrant further exploration, Chapter 4 will explore the economic of access in more detail.
CHAPTER 4

THE ECONOMIC IMPLICATIONS OF LIMITING THE ACCESS OF PRIMARY HEALTH CARE SERVICES TO UNDOCUMENTED IMMIGRANTS

Sooner or later one form or another of external diseconomy becomes recognized as a major social problem and the hands of central or local authorities are forced by the clamor of the public that something must be done.

—Edward Mishan, *Welfare Criteria for External Effects*

The tensions surrounding immigration policies and the rising costs of health care have been simmering for the last few decades. Undocumented immigrants are often criticized for contributing to the rising cost of health care in the United States. However, it remains unclear to what extent this is true and in what context. As noted in chapter 3, in recent years, there have been a number of pieces of legislation enacted that have erected barriers for undocumented immigrants from receiving primary care benefits. These barriers were meant to single out noncitizens, thereby saving the federal government the expense of their care. However, these same limiting policies have had widespread repercussions on a much larger community. The backlash against undocumented immigrants has fostered a system that permits the marginalization of a particularly vulnerable section of the population. This paper argues that the federal government has created external diseconomies under its health care system by increasing documentation requirements for receiving Medicaid, reducing funding for social safety net programs and by cutting the payments for public hospitals.

As explained earlier, external diseconomies can be defined as the “damages, or negative effects, inflicted on outsiders by activities of an entity which are not recognized
explicitly as costs by that entity, and for which the outsiders are not adequately compensated." For the purposes of this paper, the term refers to the reduced access of undocumented immigrants to primary health care services and its unintended consequences. Federal and state regulations have singled out undocumented immigrants as contributing to their mounting debt and the rising costs of health care and have therefore chosen to implement a number of different policies and legislation to tackle the perceived threat. Its timing could not be any more inauspicious: the United States currently is estimated to be $14.8 trillion in debt after having emerged from the longest recession since the Great Depression. As a result, immigrants have once again become the moving target.

However, creating obstacles to preventative care services for a large segment of an already disadvantaged community is a double-edged sword. Health, in and of itself, is the one of the most important foundations of any community. Imposing barriers to access primary health services to a segment of that community is nothing more than a disservice to the whole. Limiting undocumented immigrants from receiving essential health services will cost the United States and its citizens more money in the long-term, namely, raising the costs of health care, increasing emergency Medicaid fund expenditures, and putting public health at risk through the spread of communicable diseases. These consequences are external diseconomies that were unaccounted for when policy makers sought to

---


restrict immigrants from participating in the U.S. social safety net. The impacts will have a domino effect on a number of other economic, social and public health policies.

What scholars refer to, as welfare economics, is a school of thought concerned with explaining how market failures prompt the desirability of administrative intervention. In this instance, market failure pertains to the selling and purchasing of health insurance. It is assumed that health insurance coverage facilitates citizens’ access to primary health care services on a regular basis. However, the market has failed. Rising numbers of uninsured and underinsured persons have led to calls for extensive federal intervention in the market. As was discussed in Chapter 3, the Patient Protection and Affordable Care Act was passed into law by President Barack Obama and is estimated to provide healthcare for an additional 30 million people in the United States by 2019. Yet as of 2011, there remained over 48 million non-elderly adults, between the ages of 19 and 64 who were uninsured.

The question is what this federal intervention would mean for undocumented immigrants? With the implementation of PPACA there is increased concern that the designation of “uninsured” will become synonymous with “undocumented.” This may spark more controversy surrounding what health service benefits the undocumented immigrants do or do not receive. Currently, noncitizens and legal residents who have been in the U.S. for less than five years are effectively ineligible to receive Medicaid benefits with the exception of emergency medical services (“emergency Medicaid”).

---


States can choose whether or not to supplement the cost for additional services to support this group of uninsured. As of 2007, only 23 states had chosen to use their funds to provide additional coverage for the recently legal and noncitizen populations.\(^5\)

Having little options, undocumented immigrants are more likely than naturalized citizens and U.S. natives to rely on emergency Medicaid. The Department of Health and Human Services reported that the number of emergency department visits in the U.S. had increased by 23 percent in 2010.\(^6\) However, since hospitals typically do not inquire a person’s legal status, it cannot be ascertained what percentage of this increase is attributed to the treatment of undocumented immigrants. A study conducted in 2007 looked at the emergency Medicaid expenditures of North Carolina from 2001 to 2004 to determine the socio-economic characteristics of the population who utilized emergency Medicaid during this period. Using administrative claims data, the study found that the highest cost that could be attributed to undocumented immigrants were emergency Medicaid expenditures for labor and delivery. However, spending for the elderly and disabled patients was growing at a much faster rate, increasing by 28 percent during those four years.\(^7\) The study concluded that emergency Medicaid only accounted for less than one percent of North Carolina’s total spending.\(^8\) Furthermore, only five percent of the


\(^7\) Dubard and Massing, “Trends in Emergency Medicaid Expenditures for Recent and Undocumented Immigrants,” 1085.
total undocumented immigrant population of North Carolina accounted for emergency Medicaid expenses. Since undocumented immigrants represented such a small percentage of the emergency Medicaid expenditures in North Carolina it can be surmised that these funds were in fact being used to supplement treatment for other disenfranchised groups who had nowhere else to turn to for provider care. In other words, the emergency Medicaid funds were being used to fill the gap between insurance coverage and the social safety net.

Taking a broader view, the case of North Carolina illustrates the gaps in health care coverage for immigrants and citizens alike across the United States. Specifically, the case highlights how the welfare reforms of 1996 actually shifted a large part of the burden of cost onto the shoulders of the state as new immigrants, non citizens, and the impoverished look for alternatives to make up for the social net coverage that was lost. As a result, states have had to become increasingly involved in the development and sustainability of social safety net programs to provide services for the portion of their population that has been left unattended.

Indeed, states, with and without strong safety nets, have felt the burden of growing numbers of patients in need of primary health care services. From 1994 to 2000 the uncompensated care costs for hospitals rose almost 60 percent, amounting to approximately $26 billion. What percentage of this is attributable to undocumented

---


9 Ibid., 1090.

10 Ibid.
immigrants is unknown. Undocumented immigrants are only one small segment of the population that relies on social safety net programs. Other groups include the mentally and physically disabled, the elderly, and the poor. As noted below large cities have generally had more experience in managing and dealing with the needs of these populations. Other smaller cities that have seen burgeoning immigrant communities in recent years have had a harder time developing the necessary programs to address the needs of these groups.

Cities such as Boston, New York, Seattle, San Diego and Cleveland have relatively large networks of public and private hospitals, community health centers, religious centers, and a network of other public and private organizations that offer assistance to undocumented immigrants. In response to the rapid growth of the Latino population in the U.S., many of these organizations have catered to their needs. Their services include legal assistance to apply for citizenship, psychological services, education, English as a second language classes, as well as health services. Many of them work in conjunction with hospitals and other public and private networks in mutual support.

A prime example of such safety net health centers is the Spanish Catholic Center (SCC) in Washington, D.C., which has served a largely Hispanic immigrant community for the past forty-five years. Built as part of the Archdiocese of Washington, the SCC provides a wide range of medical, dental, job training, food pantries and legal services in
four locations throughout D.C. and Maryland. The demand for the services of SCC, and other community clinics like it, has grown exponentially in the last few years as the immigrant population in the District of Columbia, Maryland and Virginia has grown. To accommodate the growing number of patients and to facilitate their treatment, the SCC staff is conversant in over eight languages. To finance its programs the SCC must rely on donations given directly to the Center, funds from the Catholic Church and volunteers.

The District of Columbia has made strides in attempting to support organizations such as the SCC and La Clinica del Pueblo, another health clinic that provides services to a large proportion of Hispanic immigrants. In 2010, the D.C. Department of Health awarded the SCC with $250,000 to improve health outcomes by reducing the incidence of “cardiovascular diseases, hypertension, diabetes, cholesterol, nutrition and obesity to the Hispanic community in one of the poorest districts of D.C., Ward 1.” This attention is particularly important since these infirmities disproportionately affect the Hispanic community, and D.C. has a very large Hispanic immigrant community approximately 44 percent of its total immigrant population. La Clinica del Pueblo received $275,000 to “assess the needs of the Hispanic community and determine the current level of knowledge, attitudes and behavior towards nutrition, fitness, and stress management. The

---


data will be used to address barriers and improve health care messaging [in the District].”

As was briefly mentioned in Chapter 1, most community health centers that provide no-cost or low-cost treatment serve undocumented immigrants since they do not request data on citizenship and treat all patients who are either underinsured or uninsured. Still, there are others that do not provide treatment for undocumented immigrants, such as Medwell Access in Greenville, South Carolina. Understandably, some centers just do not have the capacity to treat everyone who walks through their doors at no cost and treating undocumented immigrants can present additional challenges when patients require follow up for chronic mental or physical maladies, or even prescription medicine. For the most part, undocumented immigrants simply cannot afford the cost of post-treatment care especially when a preliminary visit to a private primary physicians office, range anywhere from $49 to $89 in out of pocket expenses. Consequently, cost presents a significant barrier for undocumented immigrants’ access to primary health care services.

Undocumented immigrants are predominantly more susceptible to this barrier than other disenfranchised groups because of their legal status. There are a number of other factors that contribute to their disadvantaged position even more than the homeless

14 DC Department of Health, “DC Department of Health Awards $1 Million Worth of Grant Funds,” 1.


and other racial and ethnic minorities. First, undocumented immigrants are more likely to have physically strenuous jobs with low pay and no benefits. The lack of benefits and the shortage of economic resources to treat acute conditions in a timely fashion raise the likelihood of developing chronic health conditions. This, in turn, results in higher uncompensated care costs for the hospitals and clinics that treat them. Herein lies the greatest public concern regarding the cost of treatment for undocumented immigrants and is often cited as the reason for regulating immigration into the United States.

Hospitals have had to take on the largest portion of debt resulting from uncompensated care costs. In general, the government has cut back on reimbursements for hospital’s uncompensated care costs even though the number of uninsured persons has declined by only 0.6 percent since 2010. Furthermore, the enactment of PPACA will continue to reduce those amounts even further. Currently, the government spends about $20 billion dollars in disproportionate share hospital (DSH) payments to assist hospitals in poor and rural areas that serve a large proportion of the uninsured and Medicare dependent (including undocumented immigrants). Since PPACA is meant to reduce the number of uninsured persons in the United States, funding for uncompensated care will be dramatically reduced after its full implementation in 2019. Yet, hospitals are still federally obligated to treat any person, regardless of their legal status, in an emergency situation. The funding cuts endanger the lives and wellbeing of the estimated 11 million

---


undocumented immigrants living in the United States today. The loss in funding could signify that hospitals may simply no longer have the financial means to treat them.

While it is true that undocumented immigrants do add to the uncompensated care costs of emergency Medicaid, the belief that they alone raise the cost of health care is unfounded. The largest percentage of uncompensated care costs spent on behalf of undocumented immigrants is that of labor and delivery.\(^1\) Along with trauma, labor and delivery amounts to the most expensive uncompensated care costs for public and private hospitals.\(^2\) Likewise, the principal reason for undocumented immigrants hospitalization was attributed to childbirth and pregnancy complications.\(^3\) Nevertheless, undocumented immigrants are not the sole recipients of emergency Medicaid funds: the indigent, the uninsured and the underinsured contribute the rising cost of uncompensated care funds. However, the general public tends to assume that a large percentage, if not all, is directly related to the number of undocumented immigrants in this country. This popular belief is loosely based off of two primary assumptions. First, that a majority of undocumented immigrants are uninsured. Second, that the lack of insurance increases their reliance on emergency care that in turn accounts for a significant portion of uncompensated costs.

\(^1\) Dubard and Massing, “Trends in Emergency Medicaid Expenditures for Recent and Undocumented Immigrants,” 1090.


\(^3\) Dubard and Massing, “Trends in Emergency Medicaid Expenditures for Recent and Undocumented Immigrants,” 1088.
becoming a public charge. The U.S. Citizenship and Immigration Services’ (CIS) defines public charge as an individual who is likely to become “primarily dependent on the government for subsistence, as demonstrated by either the receipt of public cash assistance for income maintenance, or institutionalization for long-term care at government expense.” Immigration restrictionists have often invoked the label of public charge on immigrants to fight for stricter immigration policies. However, it should be noted that, contrary to conventional wisdom, undocumented immigrants do contribute to the U.S. economy. The Center for American Progress estimates that noncitizens contribute $7 billion in Social Security revenues and another $1.5 billion in Medicare taxes annually. Nevertheless, the concept of public charge has long been part of the ideology of American immigration policy.

U.S. immigration law stipulates that any immigrant declared a public charge is ineligible for legal status. To determine whether an immigrant is considered a public charge the DHS evaluates each applicant on a number of different factors including: age, health, family status, assets, resources, financial status, education, and skills.

---


25 Department of Homeland Security, “Public Charge Fact Sheet,” U.S. Citizenship and Immigration Services,
Historically, the concept of public charge has largely allowed the exclusion of broad immigrant categories. For example, pregnant low-income women would be considered a public charge when taking into account the costs of labor and delivery.\textsuperscript{26} Scholar Lisa Park argues that public charge provisions actually reinforce the marginalized status of undocumented immigrants.\textsuperscript{27} In other words, immigrant labor is profitable for the United States because it is cheaper, yet their low wages derive from immigrants’ undocumented status. Therefore, public charge provisions reinforce the subordination of undocumented immigrants making them both profitable for, and dependent on, the United States at the same time.

Despite the political sensitivities that surround the debate over undocumented immigrants and health care, recent evidence suggests that the cost of providing health care to noncitizens is actually lower than providing services to U.S. natives.\textsuperscript{28} A study conducted in 2009 compared national trends in public spending for health care of adult naturalized citizens and immigrant noncitizens relative to U.S. natives. The study concluded that expenditures for undocumented immigrants were consistently lower than those for naturalized citizens and natives born Americans during the years 1999 to


\textsuperscript{27} Ibid., 57-58.

This would suggest, that contrary to popular belief, undocumented immigrants do not contribute disproportionately to high health care costs relative to native-born Americans. In fact, the study found that in 2006, total per capita spending for noncitizens was $1,904, while that for native-born citizens was approximately $3,723. After 1999, spending for undocumented immigrants increased by only $500 while, spending for U.S. natives increased by nearly $1,000. Overall, health care spending for noncitizens was lower than that of naturalized citizens every year. However, the study concluded that undocumented immigrants were more likely to have a visit classified as uncompensated care, which should come as no surprise considering their circumstances.

The 1996 welfare reforms was the starting point of a vicious cycle. The reforms that were meant to limit undocumented immigrants from receiving public funds by raising the bar to access in an effort to reduce health costs has only facilitated a shift in financial burden. Inevitably undocumented immigrants will, at some point or another, require medical assistance that will ultimately qualify them for access to emergency Medicaid or uncompensated care funds. By that time the immigrants’ medical conditions are likely to be critical and consequently the cost of their care is likely to significantly increase.

In fact, federal and state regulations that restrict undocumented immigrants from accessing social safety net programs have had a far-reaching impact on a much larger

\[\text{29 Stimpson, Wilson, and Eschbach, “Trends in Health Care Spending for Immigrants in the United States,” 548.}\]

\[\text{30 Ibid., 547.}\]

\[\text{31 Ibid.}\]
share of the population than previously expected. The underinsured and the uninsured rely on the very same programs that serve the undocumented community. The Current Population Survey for 2011, conducted by the U.S. Census Bureau, estimates that 15.7 percent of people living in the United States are uninsured, or 48.6 million people. By underfunding the social safety net and raising the obstacle of documentation requirements the United States places undue burden on a community of people that is disproportionality marginalized. Ultimately, this places the health of this community at risk and thereby jeopardizes the success of larger public health goals.

The Deficit Reduction Act of 2005, signed into law by President George W. Bush, established the requirement that all Medicaid applicants must provide proof of citizenship with either a passport, birth certificate, or social security card. This requirement, which went into effect on July 1, 2006, put the health of racial minorities, American Indians, and other poor people at risk of losing Medicaid coverage if they are unable to provide the necessary documentation. The Congressional Budget Office estimates that the new requirement will save Medicaid $220 million over five years and $735 million over 10 years.\textsuperscript{32} In addition, CBO expects that 35,000 people will lose coverage by 2015.\textsuperscript{33} While it is assumed that most of them will be undocumented immigrants, the legislation has the potential for cutting off health benefits for thousands of others who do not have access to those types of qualifying documents. For this reason, more undocumented immigrants, the underinsured and the uninsured have had to increasingly rely on community clinics,


\textsuperscript{33} Ibid.
which form part of the social safety net for access to primary health care services. It is evident that federal regulation and fiscal strain will continue to mount the pressure on hospitals and community clinics with potentially devastating consequences for the disadvantaged such as further limitation of access to services that these groups, nor any, should do without. Primary care services are the first line of defense with regards to public health and thereby allow for the prevention, treatment and containment of diseases.

In fact, racial minorities, the impoverished, and undocumented immigrants are especially prone to increased risk of suffering from various health problems, particularly infectious diseases.\(^{34}\) This is due, in part, to a number of factors such as: lack of education, lower incidence of immunizations for their children, less basic primary care, and harsh living and work conditions.\(^{35}\) In moving forward, U.S. health policy must find new ways to address these issues or risk putting the wellbeing of a large share of the general population at risk. Future generations of U.S. citizens are also at risk: studies show that undocumented immigrants who do not receive prenatal care are four times more likely to result in premature births and low birth weights.\(^{36}\) The availability of prenatal care for undocumented immigrants would result in both lower short term and


\(^{35}\) Ibid.

long term costs on government spending. Yet many states still do not provide prenatal services for noncitizens.\textsuperscript{37, 38}

Another potential cost to consider is the spread of communicable diseases. The containment and control of communicable diseases has been a primary concern for the U.S. since the early 1940’s. All in all, if the United States wishes to maintain early detection of communicable diseases before they spread, undocumented immigrants will need to have access to primary health care services. This would ultimately result in better health services for the general population and reduction in the amount of federal and state dollars in the long term to supplant emergency Medicaid and uncompensated care costs. A case in point is the incidence of tuberculosis (TB), an example of both the economic and social cost of an untreated communicable disease. Tuberculosis is a highly contagious bacterial infection of the lungs. In 2002, the Centers for Disease Control and Prevention (CDC) released a study that concluded that immigration has been the driving force in the reemergence of TB in the United States, which has historically had relatively low incidence in comparison to other countries.\textsuperscript{39} Furthermore, the study found that the incidence of TB only gradually declined after the first seven years of residence in the


This suggests that the initial medical inspection of legal immigrants into the country is not enough to stem the wave of TB infection.

All physicians are required to report cases of TB to the public health department in order to maintain official record of exposure, ensure patient compliance, and prevent contagion. Though somewhat unlikely, this reporting system may function as a potential flag for authorities concerning the status of undocumented immigrants. However, the risk can vary from state to state. While all patients have the right to privacy under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, there are certain health professionals who are required to report any undocumented immigrant case they must come across to ICE. For example, in 2007 an undocumented Mexican teenager from Georgia was detained and deported for refusing treatment for his diagnosed active case of TB. Therefore, there are no assurances that an undocumented immigrant will be exempt from deportation for going to the doctor for treatment.

In summary, the federal regulations, increased document requirements for public assistance, and decreased funding have had a major impact on the ability of undocumented immigrants to access primary health care services. However, they are not the only population that is suffering the consequences. Though most of these systematic policy changes were directed towards noncitizens, they have had an equal impact on the newly legal, racial minorities and impoverished communities of the United States.

---


Inevitably, these changes threaten the sustainability and maintenance of public health in the U.S. today considering the number of people that remain uninsured. Moreover, the rising cost of health care continues to present a significant risk to public health as more and more people choose to go without treatment for acute conditions that soon become more serious. The CDC estimates that, adults 18 to 64 years of age delayed receiving needed medical care in a 12-month period due to cost increased from nine percent in 1999 to 15 percent in 2009. While these estimates do not necessarily reflect the proportion of undocumented immigrants who also delay care, it can be surmised that the number would be much higher. Health policy targeting undocumented immigrants is in need of serious reform as their communities continue to grow. Immigrants, noncitizens and citizens alike, are a vital part of American life and market economy and are here to stay. Now it is up to policymakers to determine how best to control for these external diseconomies by efficiently regulating and supporting the U.S. social safety net. As one of the most vulnerable populations in the United States undocumented immigrants are disproportionately impacted by a number of limiting economic and social factors. The social barriers, combined with the economic limitations, exacerbate the challenges to access adequate primary health care services of immigrants. Tracking the social limitations, their changes and implications will become increasingly important in order to make better-informed policy decisions in the future.


43 Kathryn Derose, Jose Escarce, and Nicole Lurie, “Immigrants and Health Care: Sources of Vulnerability,” Health Affairs 26, no. 5 (September/October 2007): 1258-68.
CHAPTER 5

THE SOCIAL LIMITATIONS AND THEIR IMPLICATIONS FOR ACCESS TO PRIMARY HEALTH CARE SERVICES FOR UNDOCUMENTED IMMIGRANTS

The politics of deservingness and social belonging have clearly entered a stridently hostile era and concerns about immigrant dependency and personal responsibility have reached a level of moral panic.

—Lisa Sun-Hee Park, *Entitled to Nothing*

The social implications and limitations to health care can be just as detrimental to undocumented immigrants as the economic ones. In fact, the social barriers are more difficult to surmount than the financial hurdles because these are less clear-cut. To be undocumented and uninsured in the United States today is similar to having a proverbial target squarely on your back. The recent recession has ushered in an era of hostile politics directed particularly at immigrants. This harsh political environment has resulted in more stringent policy towards noncitizens as it is relates to health care. In September 2009, Representative Joe Wilson interrupted a speech by President Obama to a joint session of Congress shouting, “You lie!” as the President described his plan to reform health care. President Obama had just finished stating: “There are also those who claim that our reform effort will insure illegal immigrants. This, too, is false – the reforms I’m proposing would not apply to those who are here illegally.”¹ The ensuing debate on the health reform has since catapulted to national attention.

In this fractious debate, undocumented immigrants are still widely depicted as public charges, or persons financially dependent on government assistance. As was discussed in Chapter 4, contrary to popular belief, undocumented immigrants do pay their share of taxes, participate actively in the labor market and contribute to the creation of wealth in the United States. Nevertheless, they are largely blamed for raising the cost of hospitals’ uncompensated care and thereby raising the cost of health care. While it is true that undocumented immigrants do contribute to the uncompensated care costs of emergency Medicaid, they are not its sole beneficiaries. Emergency Medicaid funds provide services for a large segment of poor disenfranchised Americans.

Nonetheless, noncitizens are usually singled out as a cause of the increased cost of uncompensated care. As a result, federal and state legislation has begun targeting this population by limiting their access to public assistance benefits and generally to social safety net providers. Therefore, undocumented immigrants have become more dependent on the social safety net, and other public and private organizations that do not discriminate on the basis of legal status. While these programs are reliable sources of aid for undocumented immigrants and other impoverished persons, the increase in the number of patients combined with decreasing resources is beginning to take its toll. Without the social safety net, undocumented immigrants, the indigent, and the homeless would have little to no access to the most essential primary health care services that these organizations provide for them at low or no cost.

Primary health care services are the first line of defense in protecting public health. Access to basic emergency services, hospitals and specialists, dental care, prenatal
care, immunizations, and health education promotes and prevents the spread of common
disease and injury.\textsuperscript{2} These services are indispensible in order to maintain health,
wellbeing and a decent quality of life for any individual, and ergo the community.
Limiting the access of undocumented immigrants to these services jeopardizes public
health by risking the spread of diseases. The cost of long-term treatment will rise
whenever acute conditions that could have been treated cost-effectively at an early stage
are allowed to develop into chronic conditions. This is particularly dangerous in the case
of undocumented immigrants and racial minorities who are predisposed to certain health
conditions such as renal failure, cardiovascular disease, cerebrovascular disease and
certain types of cancer.\textsuperscript{3}

Even more concerning is the fact that the pressure on local health care systems
has increased as need for these services has multiplied. The Health Resources and
Services Administration (HRSA) states that the total number of patients served by health
centers in the United States have increased by 3.1 million since 2009.\textsuperscript{4} Overall, health
centers were treating 17.1 million people in 2009 and as of 2011 that number had jumped
to 20.2 million annually.\textsuperscript{5} Evidently, the spike in the number of people served reflects an
increased demand for the U.S. health care system to provide resources for the

\begin{itemize}
\item \textsuperscript{2} Health Canada, “About Primary Health Care,” 1.
\item \textsuperscript{4} Health Resources and Services Administration, “The Affordable Care Act and Health Centers,” Health Resources and Services Administration, \url{http://bphc.hrsa.gov/about/healthcenterfactsheet.pdf} (accessed September 28, 2012).
\item \textsuperscript{5} Ibid.
\end{itemize}
underinsured and the uninsured communities. Without local or community systems managing the provision of health care services in appropriate settings, the cost of these services will only continue to rise. For example, it is significantly more expensive to provide primary care in a hospital emergency room setting than in community health centers or in physicians’ offices.  

In general, social safety net providers are more prepared to serve undocumented immigrants. Community health centers and other social safety net programs have often developed long-standing relationships of trust with the immigrant populations they serve. This allows these centers and programs to provide more efficient, better quality and well rounded services to this population group. Public and private community hospitals are often less inclined to provide additional services to immigrants in part because they simply do not have the means, financially or capacity wise, to do so. The Emergency Medical Treatment and Active Labor Act of 1986 (EMTALA) obliges hospitals to treat all patients regardless of their ability to pay in a medical emergency. Beyond a medical emergency, hospitals have no further obligation to treat patients that are not experiencing an active medical crisis. As a result, community health centers and other health clinics have had to bear an increasingly heavy burden of supplying these much needed primary services to a growing number of people in the under privileged class.

Ironically, while federal and state reforms have specifically targeted the health of new and unauthorized immigrants, America still relies on them as a major source of

---


labor. This contradiction is laced with the implicit notions of belonging – or social citizenship. This notion defines to what extent a group of people are included or excluded from the benefits that accrue to full citizenship. In turn, these sub-groupings help define what particular groups of individuals are entitled to or not. Citizens are inherently entitled to share in the benefits of social welfare such as Medicaid, Medicare, and Social Security because they contribute taxes and other revenues to the government. On the other hand, undocumented immigrants are presumed, erroneously, to be taking advantage of the social welfare state in America by using resources that they did not work for or contribute to. While it is patently untrue that undocumented immigrants do not pay taxes, the public often cites this as the reason for limiting the access of undocumented immigrants from receiving public benefits.

The extent to which newly arrived immigrants and the undocumented have receive any benefits from the U.S. government has been the result of constant pressure from advocates at both federal and state levels to provide clarification of policy and regulations. However, as health care has become both privatized and regulated by the federal government, the more immigrants and the indigent have been singled out for exclusion. As noted earlier, by limiting and denying their access to primary health care services the federal and state governments risk the health of the general public. Most would probably consider that the range of services offered through the various networks of social safety net providers, public and private hospital systems a socially acceptable

---

8 Park, *Entitled to Nothing*, 141.

9 Ibid., 141-143.

10 Ibid., 146-147.
outcome. Yet, it is problematic that some 48 million adults living in the United States are uninsured. Greater fiscal and social efficiency might be achieved from expanding coverage of health insurance to improve immigrant health outcomes and worker productivity in general. Despite the health risks for the general population, public concern has remained focused on the perception that undocumented immigrants are public charges. This is a common misconception that comes from just taking into account the upfront cost of providing the uninsured with health coverage. However, the long-term costs due to lack of or denial of care will result in much higher costs for taxpayers, the insured and government in the end.

Many would likely disagree with this assessment, and question whether or not immigrants have any such rights to unlimited access to primary health care services in the United States. Without a doubt, undocumented immigrants are one of the most vulnerable classes in America. On average undocumented immigrants make less money than U.S. citizens, live in substandard conditions, enter the country through means that pose harm to their health, hold jobs that are hazardous to their health, lack health insurance, and have no political power. A combination of these circumstances result in generally poorer health and with even fewer means to treat it. Not having resources, undocumented immigrants may leave their health problems untreated until they have developed into

\[\text{\textsuperscript{11} Blumberg and Nichols, } Health Policy and the Uninsured, 40.}\]
\[\text{\textsuperscript{12} Ibid., 40-41.}\]
\[\text{\textsuperscript{13} Chesler, “Denying Undocumented Immigrants Access to Medicaid: A Denial of Their Equal Protection Rights,” 255-87.}\]
\[\text{\textsuperscript{14} Ibid.}\]
medical emergencies and the sick immigrants are obliged to use emergency Medicaid funds. Health professionals agree that this solution has detrimental effects on both undocumented immigrants and the general public.

Nevertheless, Congress and the Judiciary have held steadfast to the fixed notion that undocumented immigrants should be denied public benefits. The Supreme Court has seen two cases that have set the precedent for the rights of undocumented immigrants regarding the receipt of public benefits. The first such case to be presented before the Supreme Court in 1976 was Mathews v. Diaz whereby three legal permanent residents challenged the five year residency requirement that led to the denial of Medicaid coverage for them. The plaintiffs argued that the five-year residency requirement violated their right to due process. The Due Process Clause of the Fifth Amendment of the Constitution prohibits “the government from unfairly or arbitrarily depriving a person of life, liberty or property.” The Equal Protection Clause of the Fourteenth Amendment applies to states and “requires they give similar situated persons or classes similar treatment under the law.” Ultimately, the Court found that the residency requirement was constitutional and that Congress had the power to regulate on all matters regarding

15 Blumberg and Nichols, *Health Policy and the Uninsured*, 41.


18 Ibid.


20 Ibid.
immigration and naturalization.\textsuperscript{21} The significance of this case is that the Court determined that the residency requirement for legal immigrants does not deprive them due process and the classification of citizens and noncitizens remains at the discretion of Congress.

The second major Supreme Court case to rule on the rights of undocumented immigrants to receive public benefits was \textit{Plyler v. Doe} (1982). In \textit{Plyler v. Doe}, the Supreme Court found that a Texas law denying undocumented children access to free public education violated the Fourteenth Amendment’s Equal Protection Clause.\textsuperscript{22} While the Court upheld that education was not a right, it reasoned that if the states statute limited the rights afforded to people (particularly children) based on their citizenship status, it was subject to increased scrutiny. The scrutiny is to determine whether the law furthered some substantial goal of the state.\textsuperscript{23} The Court was careful to keep closely in line with the specifics of the case rather than ascertain access of undocumented immigrants to all publicly funded benefits.

Thus, the Supreme Court has effectively denied undocumented immigrants the right to certain public benefits though not all. It remains unclear what other public benefits would warrant increased scrutiny to justify the ineligibility of undocumented immigrants.\textsuperscript{24} What is clear is that the Judiciary has deferred the power to establish

\begin{flushright}
\textsuperscript{21} \textit{Blacks Law Dictionary}, 79.
\end{flushright}

\begin{flushright}
\textsuperscript{22} Chesler, “Denying Undocumented Immigrants Access to Medicaid: A Denial of Their Equal Protection Rights,” 262.
\end{flushright}

\begin{flushright}
\textsuperscript{23} Ibid.
\end{flushright}

\begin{flushright}
\textsuperscript{24} Ibid.
\end{flushright}
immigration policy to the Legislative branch. In turn, the Legislative branch has chosen to restrict the right of undocumented immigrants to access public benefits beyond public education for children. With limited access to public health benefits and subsequently their social safety net programs, noncitizens are at a huge disadvantage compared to other disenfranchised groups. Beyond the economic difficulties associated with receiving primary health care services undocumented immigrants must first overcome the social barriers that are also in place. Therefore, a closer look at what these barriers are is warranted, when discussing the social implications and limitations of access.

The first major hurdle noncitizens must face is the language barrier. Nonfinancial obstacles to access can be just as detrimental to immigrant health care as financial ones. Immigrants and their children must find a way to navigate the social and health networks in the United States with limited English proficiency. This is especially difficult for adults, who find it more challenging to learn a second language after years of learning, reading, writing and speaking in another.

Studies show that adults with limited English proficiency are less likely to have health coverage, and therefore make fewer physician visits, and receive less preventative care than those who speak English.25 As a result, the quality of care of noncitizens may be affected. Noncitizens must struggle with the possibility of not understanding their physicians or their instructions, which results in poor treatment effectiveness and overall poor satisfaction. Often, undocumented immigrants require the assistance of an interpreter to facilitate comprehension between the doctor and patient. However,

professionally trained interpreters in both hospitals and social safety net organizations are rare. Typically, such language facilitation is provided by ad-hoc interpreters such as a fellow co-worker, a friend, or other patients, an unsatisfactory arrangement that leaves open the possibility for miscommunication and diminishing the patient’s overall quality of care.

Recognizing the extent of the language barrier, the federal government has taken steps in an attempt to place interpreters in federally funded hospitals. Title VI of the Civil Rights Act has been understood to mean that federally funded health facilities provide interpreting services to patients upon request. The problem lies in the implementation of Title VI, many undocumented immigrants have no idea that they are entitled to request an interpreter, and not all facilities have the resources to provide one. In addition to Title VI, the U.S. Department of Health and Human Services issued a series of national directives for health care organizations in 2010 in an effort to assist programs in addressing their language needs. Needless to say, language remains a significant barrier to primary health care services for undocumented immigrants.

Another significant barrier to the access of health care services of immigrants are their non-legal status and their socio-economic background. Evidence shows that

26 Derose, Escarce, and Lurie, “Immigrants and Health Care: Sources of Vulnerability,” 1261.
27 Ibid.
29 Derose, Escarce, and Lurie, “Immigrants and Health Care: Sources of Vulnerability,” 1261.
undocumented immigrants have consistently lower rates of health insurance coverage than U.S. natives.\textsuperscript{31} As has been discussed, noncitizens are ineligible to receive public coverage benefits. Moreover, undocumented immigrants are also consistently less likely to receive employer benefits as full time workers. Only 50 percent of undocumented full time workers had health insurance coverage in comparison to 81 percent of nonimmigrant full time workers.\textsuperscript{32} Even compared to naturalized citizens, undocumented immigrants still had significantly lower rates of coverage. Naturally, these disparities impact the children of undocumented immigrants who have lower rates of coverage than the children of both naturalized immigrants and U.S. natives alike.\textsuperscript{33} This is applicable to both public and private insurance coverage, and as a result the children of undocumented immigrants often go without the basic standards of care. Contributing factors include: the cost of doctor visits, the language barrier, and the lack of proper education and information.

Related to the difficulty of undocumented immigrant’s legal status is their socio-economic background. Today, the American Dream as a measure of success is directly associated with higher education, occupation and earnings. The undocumented immigrants are at an immediate disadvantage because most had very little access if any to these opportunities in their country of origin. As a result, noncitizens fall behind the general curve of U.S. natives that have enjoyed the benefits of a public education system,


\textsuperscript{32} Ibid.

\textsuperscript{33} Derose, Escarce, and Lurie, “Immigrants and Health Care: Sources of Vulnerability,” 1260.
public health care, job training programs and other readily available services that undocumented immigrants do not have

Hispanics, the largest and fastest growing immigrant population in the United States today is particularly susceptible to the barriers of low socio-economic status. U.S. Census Data estimates that there were 13.2 million Hispanics living in poverty in 2011. The weighted poverty threshold for a family of three in 2011 was $17,916\textsuperscript{34} while Hispanics also accounted for the lowest median income ($38,624) in comparison to non-Hispanic Whites, Blacks and Asians.\textsuperscript{35} Furthermore, Hispanics have a much lower high school graduation rate (38 percent), in comparison to other groups such as African and Asian immigrants (87 percent).\textsuperscript{36} Higher education, but also general education plays a critical role in a noncitizen’s access to health care services. Cities that have newly developing immigrant communities may lack the services that other major cities have in place. The few that have been organized may be of little help to those immigrants who do not know of their availability. For this reason, public health awareness campaigns are so important, to educate those immigrants who may not know of local resources provided in, or around, their area of residence. Not only do public health awareness campaigns need to be carried out throughout cities, they need to be bilingual to truly capture the attention of the populations they are meant to serve.

\textsuperscript{34} U.S. Census Bureau, “Income, Poverty, and Health Insurance Coverage in the United States: 2011,” 49.

\textsuperscript{35} Ibid., 7-8; 13.

\textsuperscript{36} Derose, Escarce, and Lurie, “Immigrants and Health Care: Sources of Vulnerability,” 1259-60.
Moreover, fear plays a substantial role in keeping immigrants from seeking medical attention. Most undocumented immigrants fear that by going to a doctor they will be outing themselves to the authorities and inevitably be deported back to their country of origin. Many undocumented immigrants have fled their countries in search of a better life, leaving behind political strife, gangs, extreme poverty, or imminent danger to life. Many have an extreme fear of being deported back to their country and whatever awaits them there. As a result, most noncitizens will do everything in their power to stay as far below the radar as possible. Most immigrants fear any authority figure, be it a cop or a doctor, who may potentially report them to ICE. Though rare, there have been instances of the deportation of undocumented immigrants after visits to their physicians, such as the case of the teenager in Georgia discussed in Chapter 4. Their stories have been transformed into urban legends for immigrants and serve as a warning to be suspicious of authority figures, even doctors. Regardless of the fact that most hospitals typically do not inquire the legal status of their patients, undocumented immigrants rather err on the side of precaution.

Their fears are not totally unfounded. Considering their non-legal standing in the United States, they will be subject to deportation proceedings if caught regardless of the circumstances. Additionally, noncitizens have no political clout with which to fight on their behalf own behalf in the United States, and considering the current political climate it would be a losing battle. As unauthorized immigrants, they have no independent voice to express their opinions, nor a right to vote. Not having a vote in a democratic country is liable to invite a certain level of dismissiveness from politicians and policy makers alike.
Whether this dismissiveness is racial, historical, political or a little of each, immigrants and other racial minorities have long fought to shake the negative image associated with their heritage. Immigrants in particular have been painted as public charges since the inception of social welfare in the United States. The stigma associated with that label is attributable to a number of factors such as: differences in appearance and dress, religious practices, language barriers, accents, and skin tone. Furthermore, the media and its delineation of who is deserving and who is undeserving of benefiting from United States citizenship perpetuates the stigmatization of undocumented immigrants. Just two months ago, the debate was stirred up once again when President Obama announced an administrative measure for undocumented immigrants who had entered the country illegally as children, which would allow them to remain and work without fear of deportation for at least two years.

It is not surprising that marginalization by social stigma makes immigrants that much more reluctant to seek out health care services for fear of poor treatment. In addition, immigrant cultures may contribute to their reluctance to seek assistance. Contrary to the belief that all immigrants want handouts there are many cultures that consider charity as an insult to their sense of pride and work ethic. Therefore, many

---

37 Derose, Escarce, and Lurie, “Immigrants and Health Care: Sources of Vulnerability,” 1262.


39 Derose, Escarce, and Lurie, “Immigrants and Health Care: Sources of Vulnerability,” 1262.
immigrants opt for going without certain services to disassociate themselves from the shame of accepting any form of assistance.

The largest obstacle for undocumented immigrants has and continues to be federal legislation. The provisions of the 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) had the largest impact by far on the immigrant communities by barring legal immigrants from receiving public benefits for the first five years of their residency and simultaneously disqualifying all undocumented immigrants from these same benefits. The legislative push came after years of disenchantment with the welfare system. President Clinton signed PRWORA in an effort to stem the rising costs of public benefits and discourage those who were thought to be abusing the system. The so called “welfare queen” was described by Ronald Regan during his Presidential campaign in 1976. The welfare queen, otherwise thought of as a social pariah, was depicted as underprivileged mother abusing public benefits by engaging in behavior counterintuitive to the their receipt such as bearing illegitimate children, using drugs or participating in reckless behaviors. At the time of Regan’s campaign the stigma was largely attributed to African Americans and other racial minorities; undocumented immigrants were quickly included in this group.

The final barrier that undocumented immigrants must overcome for access to primary health care services is the capacity of the social safety net itself. While the number of community health centers has grown significantly in recent years, there remains a shortage of institutions, physicians, nurses and personnel. This is true especially in rural areas where the nearest hospital may still be 20 to 30 miles away, a
serious problem for undocumented immigrants who may not have access to a car or rely on other types of public transportation. These types of infrastructure deficiencies inhibit the access to quality preventative care services for immigrants endangering their health and that of those around them.

Needless to say any combination of these obstacles are can be truly daunting when navigating the social safety net in the United States. A more consistent policy framework is necessary to address the issues of undocumented immigrants in the U.S. health care system. So far the patchwork of programs, policies, organizations and initiatives have failed to provide adequate coverage for undocumented immigrants and the other 48 million citizens of the U.S. without coverage. Increased funding for social safety net programs will be necessary to stem the surge of patients who are increasingly dependent on their services, particularly noncitizens. While undocumented immigrants are encouraged to come to the United States for work they are denied access to some of the most basic primary care services that can be afforded and while not all pay their taxes many contribute a substantial amount.

The Institute for Taxation and Economic Policy (ITEP) estimates that in 2010, undocumented immigrants paid $1.2 billion in personal taxes, $1.6 billion in property taxes, and $8.4 billion in sales taxes, totaling $11.2 billion in state and local. 40 Washington, DC received $5.6 billion in personal taxes, $2.2 billion in property taxes, and $18.5 billion in sales taxes, totaling over $26.4 billion in total from undocumented

---

workers. 41 Despite contributing billions of dollars to the economy undocumented immigrants are still denied the right to receive or even have facilitated access to primary care services. Federal and state legislation have only served to further marginalize a vulnerable population. However, this is not a burden to be born solely by undocumented immigrants, whether others realize it or not. This situation will have consequences that may affect every citizen and noncitizen in the United States, both financially and in terms of public health. 42 Placing undocumented immigrants in this vulnerable position will create a multitude of problems for them and the general public. Sensible policy reformation is needed to assist this population as it continues to grow in the United States. Failure to do so will only exacerbate unsound and unpractical health care policy bearing much larger economic and social repercussions for citizens and noncitizens alike.

---

41 Immigration Policy Center, “Unauthorized Immigrants Pay Taxes, Too,” 1.

CONCLUSION

Undocumented immigrants are an integral part of the United States social and economic makeup. However, they are disproportionately limited in their access to primary health care services. These limitations are based on the assumption that undocumented immigrants account for the largest percentage of uncompensated care costs and as a result the increased cost of health care. While there is some truth to these assumptions, the exact share that can be solely attributed to undocumented immigrants remains unclear. Especially since emergency Medicaid and the social safety net are relied on heavily but a much larger percentage of the population that includes the underinsured, the uninsured, the indigent and other racial and ethnic minority groups.

Nevertheless, undocumented immigrants are often singled out as the sole consumers of the social safety net. Federal legislation and state policies have reinforced such notion by implementing a series of guidelines that have erected a multitude of barriers for undocumented immigrants to overcome in order to receive the most basic forms of primary health care services. This has been exacerbated by a piecemeal approach to health care policy. Historically, the United States has used immigration policy, social citizenship, and economic trends to determine the accessibility of health care services to undocumented immigrants. The problem inherent in this policy approach is that it is unequivocally short sighted. By limiting access of undocumented immigrants to primary health care services the United States is jeopardizing the health of the general population while simultaneously costing itself more money in emergency Medicaid expenditures.
To ensure the future prosperity of the United States the federal government will have to consider alternatives to current health care policies. One alternative may be to provide primary health care benefits for all immigrant children. Since immigrant children are entitled to public education, they should also be entitled to receive public health care benefits. Much like education, health care is essential to the sustainability and growth of a nation and if America wishes to ensure a healthy and productive workforce in the future such policy reforms are crucial.

Further research on this topic should explore the impact of the economic and social barriers discussed in the preceding chapters on the children of immigrants more in depth. For example, how does the legal status of immigrants impact the health care outcomes of their children? And what are its implications. Moreover, what impact this would have on the Hispanic community may be particularly important considering they are the largest and fastest growing immigrant community in the United States today. Additional study is need in this subject matter if there is ever going to be sound health care policy in the United States that will adequately address the needs of the uninsured and the underinsured.


Terrazas, Aaron. “Salvadoran Immigrants in the United States.” Migration Information Source.


United States Department of Health and Human Services. “2010 National Data.” Health Resources and Services Administration,  

———. “What is a Health Center?” Health Resources and Services Administration.  

