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Barriers to Health Care Access for Immigrants

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The Immigrant Health Care Project, hosted by the Center for Migration and Development, is a systematic attempt to investigate, on the basis of quantitative and qualitative data, the health-related needs and medical conditions surrounding immigrants in various parts of the United States.

During a visit to San Diego as part of that initiative, I listened as an internist in a community health clinic described the frustrations ensuing from the treatment of uninsured immigrants: “With women giving birth, we had them sit or drive around until they were five centimeters dilated—then they’d be admitted as an ‘emergency’!”

Unpacking that statement would take a book. Involved in the account would be federal programs designed to underpay physicians and hospitals for services catering to the poor; the right of hospitals to demand \$5,000 to \$15,000 in cash before admitting uninsured patients for an operation and, paradoxically, the requirement to provide emergency care. The last directive passed in response to an inescapable fact: emergency rooms were performing “wallet biopsies.” Patients arriving by ambulance were told to go somewhere else if they didn’t carry insurance or cash.

The organizational and financial obstacles that immigrants face in obtaining health care can only be understood as part of a national approach that allows employers to decide whether or not they will offer health insurance and how much coverage they will provide. That leaves county, state, and federal governments to fill in large gaps. Employers want to hold down costs and legislators want to minimize taxes. The resultant patchwork is the most inequitable, inefficient, unstable, and expensive in the industrial world. That most providers and insurers are corporations seeking short-term profits accentuates the problem. About 45 million people nationwide lack insurance and another 80 million have incomplete coverage. The number of uninsured has been rising by more than 3000 a day since 2000.



Responses to Welfare Reform

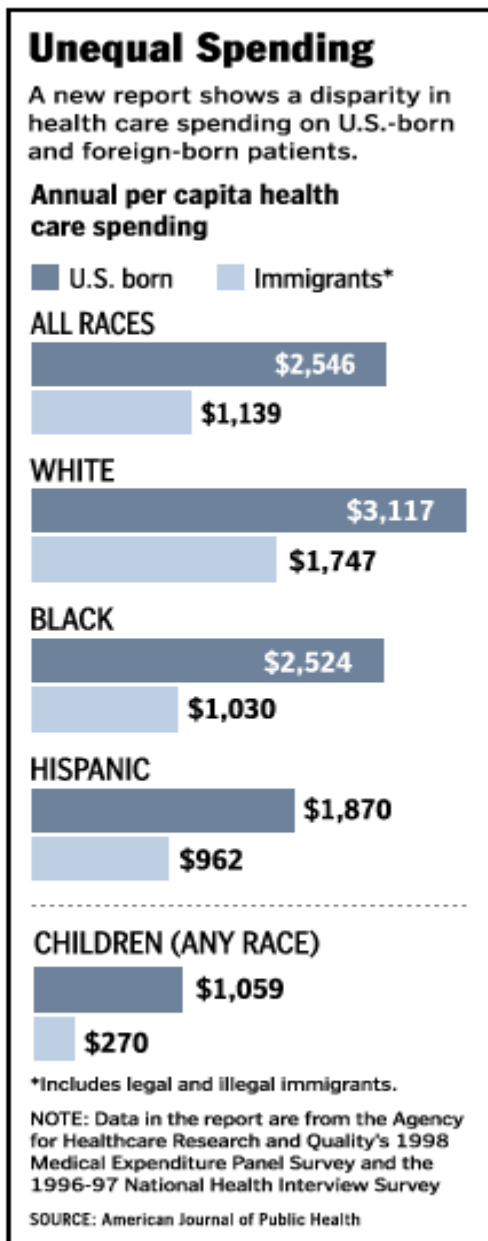
A growing influx of foreigners starting in 1970 has aroused anti-immigrant sentiments. The Welfare Reform Act of 1996, for example, prohibited states from using federal funds to provide Medicaid coverage under a State Children’s Health Insurance Program (SCHIP) or Temporary Assistance for Needy Families (TANF) for most immigrants unless they had lived in the U.S. five years or longer. This proviso extended to legal permanent residents. Exempted were some refugees and exiles arriving under programs that offer public assistance and medical benefits. Unauthorized immigrants have no right to Medicaid or other government funded services. As a result, approximately 45% of non-citizen immigrant adults and children are uninsured, compared to about 18% of naturalized citizens. The difference is largely explained by the differential capacity of citizens and non-citizens to purchase private insurance.

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Immigrants, especially those recently arrived, are much more likely to hold low-wage jobs and to work in small businesses or in sectors (like agriculture and services) where employers are less willing to provide health insurance. They also tend to be younger and have less education. Among people who are sick, immigrants have markedly lower outpatient, inpatient, and prescription expenditures than citizens but present much higher emergency-room costs. Denying them access to medical care leaves immigrants sicker and less able to work, until a costly emergency visit is the only option.

Medicaid does not serve as a safety net for most immigrants and their families. The complex eligibility requirements and still more intricate application process means that many low-income workers—immigrants as well as citizens—are eligible but not enrolled, or enrolled but then slide back to no coverage because they cannot meet renewal requirements. Ironically, the 1996 Welfare Reform Act did not reduce access by much because states and counties responded to compensate for the restriction on federal funds by using their own assets, expanding programs, and renewing efforts to streamline application processes. In other words, leaders in many states and counties reached out to help immigrants hit by anti-immigrant provisions. In many cases, this too expanded costs.



THE WASHINGTON POST

An Ethos of Succor

Amid this bleak picture, a strong commitment to help those in need was evident among clinicians and county and state leaders interviewed as part of the Immigrant Health Care Project. Physicians and nurses reached out to assist sick immigrants in any way they could and then found means to shoe-horn in more care than the rules allowed. As one doctor explained, there's a lot of general medicine you can do for the mother during a "well-baby visit."

Another doctor described the case of Angeles, a 64 year-old, uninsured woman with congestive heart failure so severe that she was admitted as an emergency and kept in the hospital for a week. The physician saw her every day, put her on medication from free samples, and hoped she would make it until her 65th birthday when she would become eligible for Medicare coverage. To meet the needs of patients like Angeles, physicians at some community health centers have built informal networks that help patients find specialists. The internist mentioned at the beginning of this brief called upon a cardiologist in her network to help manage Angeles' deadly condition until she could get a fully paid assessment and treatment plan.

If you have any questions or comments please contact Nancy Doolan at ndoolan@princeton.edu





An Ethos of Stinginess

In tension with the ethos of succor is the grudging approach of “safety net” programs burdened with requirements that catch people only after they fall. A case in point is legislation that directs emergency rooms to treat urgent cases but also allows them to bill for services. After providing mandated care on uninsured patients ERs present them with full-price bills, often three to four times more costly than what hospitals usually are paid from insurers or health plan providers. This practice keeps patients from getting even urgent care. A recently arrived immigrant who was treated in a Miami ER received a \$2,000 bill and was afraid to establish residency anywhere for fear of being tracked down to pay it.

The ethos of succor and the ethos of stinginess clash as providers demand proof of eligibility to get paid for services by public programs and aliens terrified of deportation refuse to provide information when they are sick or injured. Clinicians emphasize their desire to help the sick but point to existing requirements that make it impossible to fulfill that goal. In several states, however, the ethos of succor has prevailed—laws have been passed to fund services without asking questions that might lead to deportation.

Immigrants arrive in the United States looking for work and a new life. Employers seek them out. The proportion of low-income immigrant families with at least one working adult is substantially higher than in non-immigrant families. It is self-defeating not to provide immigrants with prompt, effective medical care so that they can remain productive. As Douglas Massey recommends in *Beyond Smoke and Mirrors* (Russell Sage Foundation Press, 2003), once immigrants are established, it makes sense to award them legal and labor rights that help them assimilate constructively to the receiving society. Massey’s arguments are compelling on both economic and human grounds. Curtailing immigrant access to health care will not deter border crossings but it will guarantee that many foreign born workers will suffer in ways that are costly to the larger society. ■

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Points Announcements:

CMD Fall 2005 Colloquium Series

The Center for Migration and Development is pleased to announce the following presenters for our Fall Colloquium Series.

- ❖ Valentina Mazzucato, University of Amsterdam
Wednesday, November 16 - 4:30 P.M.
"Africans in the Global Economy: Ghanaian Migrants" Transnational Networks"
- ❖ Deborah Yashar, Princeton University
Thursday, November 17 - 4:30 P.M.
"Citizenship regimes and the rise of indigenous movements"
- ❖ Richard Black, University of Sussex
Monday, November 21 - 4:30 P.M.
"Migration, Globalization, and Poverty."
- ❖ Miguel Angel Centeno, Princeton University and Sara Curran, University of Washington
Tuesday, December 6 - 4:30 P.M.
"Visualizing Globalization"
- ❖ Douglas Massey, Princeton University
Thursday, December 8 - 4:30 P.M.
"Social Capital and International Migration in Latin America"
- ❖ Harvey Molotch, New York University
Monday, December 12 - 12:15 P.M.
165 Wallace Hall
"Learning from the Material World: Toasters, Toilets, and Fashioning of Mankind"
Co-sponsored by the Culture and Inequality Workshop

Global Trade and Development: NAFTA and Beyond Alternative Disciplinary Perspectives in the Study of Development and Globalization

Associated themes:

- ❖ Can Globalization be Free?
- ❖ Development in a Global Age
- ❖ The Changing Character of Global Institutions
- ❖ Resistance and Compliance: Rethinking Civil Society
- ❖ A World of Nations? New Perspectives in Development
- ❖ Transnationalism from Above and Below
- ❖ The Future Face of NAFTA

