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An Institutional Interpretation**

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ABSTRACT

We examine the institutions that comprise the American health system and their relationship to a surging immigrant population. The clash between the system and this human flow originates in the large number of immigrants who are unauthorized, poor, and uninsured and, hence, unable to access a system largely based on ability to pay. Basic concepts from sociological theory are brought to bear on the analysis of this clash and its consequences. Data from a recently completed study of health institutions in three areas of the United States is used as empirical basis to illustrate various aspects of this complex relation. Implications of our results for theory and future health policy are discussed.

The American health system features a bewildering complexity of institutions, barriers to entry, programs to bypass them, contradictory requirements, and red tape. So complex has the system become that it not only defies understanding but leads analysts to be themselves ensnared in its own web, adopting its “logic” and language as the only way to make sense of at least some of the system’s features. This opacity is ultimately the consequence of the contradiction between a definition of health care as a scarce good to be purchased or sold in the market, and the definition of health as a human right to be rendered accessible to all.

The struggles between institutions and organized groups advocating each of these positions have cumulated over time, leading to the present self-contradictory institutional landscape. Making sense of the system as a whole requires escaping its logic and making use of conceptual tools that transcend its language. For this purpose, we seek to put to use in this paper insights borrowed from sociological theory in general and the sociology of institutions, in particular. As it turns out, most of these ideas trace their origin or have close affinity to the intellectual legacy of the classics, including Weber, Marx, and Simmel. Their analyses of class and status, legitimacy and its sources, charisma and related concepts can play a significant role in the effort to unravel the institutional morass that we face.

To complicate matters further, American society confronts at present another great challenge with the seemingly unstoppable immigration from south of the border and from elsewhere in the less developed world. Immigrants and children of immigrants currently number approximately 60 million or a fifth of the American population. They include an estimated 12 million unauthorized immigrants, mostly poor and poorly educated laborers. This human wave eventually comes into contact with the American health system, leading to a clash whose multiple dimensions are poorly understood. Immigrants, in particular the poor and unauthorized,

are also mostly uninsured. When in need, their claims on the health system are based on their humanity rather than on their resources or entitlements. These claims encounter precisely the core dilemma of the system, facing a resolute barrier among medical institutions committed to the concept of health as a commodity.

To analyze this confrontation properly, it is also necessary to understand the root causes of contemporary U.S.-bound immigration in general and unauthorized migration in particular. For this task, the same conceptual tools mentioned previously play a pivotal role. To illustrate conclusions of our conceptual study and extend it in new ways, we make use of results from a recently-completed comparative study of health care institutions in three regions of the United States.

This source, labeled the Health and Immigration Study (HIS), was aimed at understanding both the internal organization of health care institutions and their coping mechanisms when confronted with rising demand from a surging immigrant population. The study used the same methodology to investigate these mechanisms in three areas of the country, as described by administrators, direct care givers, patients and their representatives. In total, HIS investigated forty such institutions in depth in Southern California, Southern Florida, and Central New Jersey and conducted supplementary interviews with twenty-two leaders of immigrant organizations, patient representatives, and expert informants. The patterns and the puzzles that emerged from the study provide the empirical anchor for the following analysis.

The American Health System

a. An Institutional Map

The American health system is dominated by an array of large institutions – public and private hospital systems – supplemented by thousands of clinics and hundreds of thousands of private practice health professionals. The system makes services routinely accessible to those entitled to care through purchase of commercial insurance or through membership in certain privileged categories, such as armed forces veterans. These entitlements are anything but unqualified, and a number of requirements and barriers to care are confronted even by those covered. These constraints are linked to the fact that health insurance is also a market good and, hence, its quality is linked to its price, leading to different levels of access and care.

Those not entitled to work-related insurance or lacking membership in special categories of the population can purchase individual insurance policies generally at a high cost. It is at this point that the definition of health care as a human right comes into play: As the uninsured and unable to pay cannot be left dying in the streets, a parallel safety net system has been constructed, by fits and starts, consisting of networks of federal- and state-subsidized clinics and health programs, as well as federally-mandated access to care in emergency situations.

Hospitals, clinics, and private practitioners can be compensated for care of those lacking work-related or self-purchased insurance, if they are citizens or long-term legal residents and fall under certain officially specified categories as follows:

- Very old
- Very young
- Disabled
- Very Poor

Eligibility must be documented and is checked carefully before access is granted to the various federal programs such as Medicare, Medicaid, or the network of Federally Qualified

Health Clinics (FQHCs). A number of states and counties have chosen to expand this safety net with programs that do not require proof of citizenship or legal permanent residence, but still demand records documenting local residence and low or no income. Programs like New Jersey's Charity Care or the Jackson System of satellite clinics in South Florida are examples. Persons unable to document local residence and indigence fall into the lowest tier of the safety net, consisting of an assortment of free clinics created by private philanthropy or hospital emergency rooms when extremely ill. By law, emergency rooms must provide care in these situations, although the quality of that care varies significantly – from simply “stabilizing” the patient and sending him or her away to granting access to inpatient hospital services. Emergency rooms bill for services and their charges can be economically ruinous, leading many poor patients to avoid them even when in need.²

For the most part, the network of clinics catering to the uninsured and indigent population provide primary medical services, assistance with some chronic conditions, and specialized programs deemed necessary to prevent the spread of infectious diseases, such as AIDS or tuberculosis, to the general population. Patients in need of longer-term care – such as diabetics and pregnant women – or who require the attention of specialists face progressively greater barriers and longer waiting periods. Barriers to care are especially high for those outside federal or state charity systems whose access to long-term or specialty services is a lottery – a chance encounter with a motivated advocate or a compassionate professional.³

The differences in access, quality, and promptness of services provided by the American system are stark. An ocean separates the clean halls, prompt attention, and almost doting care received by properly insured or otherwise paying patients for whose favors hospitals compete and those carrying a charity card or no card at all. For hospitalization or specialty care, poor

patients – especially those outside federal or state programs – depend on the goodwill of individual professionals. Many do not make it. According to a recent estimate by the Urban Institute, 27,000 preventable deaths occur in the United States every year due to lack of health insurance (Krugman 2008). Even those with access to official safety net programs must often wait long periods to see a specialist and the quality of services that they receive varies significantly across health institutions and regions.⁴

b. Health and the Class Structure

A significant corollary of these conflicting definitions of health is that they have made access to health care a good marker of class position. While in other developed societies, universalistic programs have reduced or eliminated health care as a stratifying concept, this is not the case in the United States. The concept of class refers to large, discrete aggregates of the population characterized by possession or exclusion from significant power-conferring resources. Figure 1 borrows a recent “map” of the American class structure, based on differential possession of wealth or access to wealth conferring resources.⁵ Dominant classes and top segments of the subordinate classes, such as elite workers, benefit from the exclusivity and quality of services geared to those able to cover the costs of health as a market good. At the top of the class structure, insurance is often unnecessary or can be supplemented with other expensive services, such as private duty nursing, the executive floor of private hospitals, specialized chefs, and the like.

Figure 1 about here

Access to health care through insurance extends down to the class of “common workers” or, at least, to selected segments of it. This is, by and large, the largest component of the adult working population. Those who by dint of unionization, government employment, or jobs in large, well-capitalized firms are eligible for work-related insurance also form part, albeit in more restricted ways, the health-privileged classes. Low-paid workers in private industry or services and petty entrepreneurs often lack the income to purchase commercial insurance. They thus join the unemployed and redundant workers at the bottom of the class structure forming the mass of the health disadvantaged. The plight of low-paid common workers is augmented by their paltry incomes often being defined as too high to qualify for government-subsidized indigent care (Light 1992; Martinez 2008).

This map of the American class structure is, of course, subject to a number of exceptions and regional variations. Still, it is useful in clarifying the overall picture, as well as several key features. These include, for example, the anomaly that the class of redundant workers that comprises the homeless and the long-term unemployed, benefits from both official programs and private philanthropy targeted on the poorest of the poor. They are generally eligible for MEDICAID and federally qualified health clinics can be fully compensated for their care (CMS 2008). The bottom rungs of the class of common workers are not so lucky: their paltry incomes exclude them from access to MEDICAID and, if they seek help in an FQHC or similar clinic, they are subjected to sliding-scale fees. Indigent health care thus creates a perverse disincentive for people seeking to move into paid employment since they face the catch-22 of losing their health benefits if they start receiving a regular salary.

c. Sources of Legitimacy

Disparities in access and quality of health care in America could not be sustained if they were unaccompanied by some plausible explanation for their existence. Sociological analyses of class have long emphasized that differences in wealth and life chances lead inevitably to efforts by those in positions of privilege to justify their situation through ideological means. If effective, these ideologies have the effect of stabilizing the social order, by persuading the underprivileged to acquiesce to their own condition (Weber [1922] 1947; Gramsci [1927-33] 1971; Mills 1959).

Three such justifications have been advanced to legitimize the American health system. The first points simply to the safety net provided by government and private philanthropy through Medicaid, supplementary state charity programs, and free clinics. The argument usually ends with the statement that, when in real need, “everyone can go to the emergency room”. This justification merely asserts that the present system suffices to meet the health needs of the entire population requiring, at best, incremental improvements.

The second claim calls attention to the excellence of American medicine and argues that it would not have achieved this quality had it been socialized like in Europe. The excellent hospitals and clinics at the top of the system are frequently mentioned to buttress the argument that the American health care is “the best in the world”.⁶ This statement conveniently neglects the fact that it is “best” for those at the top of the class structure, but can be much worse for the masses at the bottom.

A third, and more sophisticated, form of legitimation is based on a concept coined by economists and labeled “moral hazard” (Gladwell 2005). As applied to the health field, the idea is that if care were free and universal, people would take advantage of it and overuse the system,

leading to its breakdown. Proponents of moral hazard employ analogies such as “free beer,” asserting that, when a good costs nothing, it is over-consumed because the discipline imposed by the price mechanism disappears. According to this logic, the costs of health care in America are necessary to maintain this discipline and, hence, prevent the system from being overwhelmed. “Moral hazard” was one of the most effective ideological weapons used against the last credible attempt to universalize the American health system during the early days of the Clinton Administration (Gladwell 2005).

Aside from justifying the system as a whole, moral hazard finds practical expression in the series of copayment and sliding scale fees demanded of even poor patients in subsidized facilities as deterrents to overuse. This theory derives straight from the postulates of neoclassical economics and draws its main empirical base from the behavior of corporate actors and banks. In the health field, on the other hand, the evidence sustaining it is thin at best. There is so far no experimental or other scientific evidence proving that public health care is necessarily abused (Ostrom 1990; Shen and Zuckerman 2005). Just as people do not call the police every day or attend every free concert just because doing so costs nothing, there is no empirical proof that they will necessarily overwhelm hospitals were health to be redefined as a universal right. As in other areas where the rational action paradigm has been brought to bear on practical problems, the deductive plausibility of the theory clashes with contrary facts on the ground (Granovetter 1985; Sullivan 1989; Massey 2007). We will return to this point on the basis of findings from our institutional study below.

d. Moral Hazard in Practice: Face-to-Face Legitimation

A common, and commonly-told experience is that of patients in pain or suffering a serious illness who are confronted at the entrance of American clinics or emergency rooms by clerks performing a “wallet biopsy” for an insurance card or demanding detailed evidence of eligibility for a government program. Such practices derive directly from the concept of care as a scarce good and are legitimated by the theory of moral hazard.

While this theory provides good ideological cover for the system as a whole, this is not the language one hears from those entrusted with the administration of health institutions. Hospital directors repeat like a mantra that the mission of their institution is to provide “compassionate care” and to be of service to their communities. Physicians and nurses assert, almost universally that they offer their services on an equal basis to all, “regardless of their ability to pay”. In hospital after hospital, we heard sincere and persuasive reaffirmations of the Hippocratic Oath from health providers who firmly believe that this is what they are doing. Patients generally confirm these statements by acknowledging that, once admitted, they receive care without questions about their economic status.⁷

The gap between such lofty beliefs and the realities confronted by many of the same patients in the waiting rooms is handled by a division of labor that entrusts enforcement of the rules to a line of clerical personnel. The frequently adversarial character of the initial patient-institution encounter does not involve a nurse, much less a physician, but a clerk.⁸ Administrators may sincerely believe in the noble mission of their institution, but they are also entrusted with its financial viability. In the absence of a universal health system, this means, in essence, that care seekers must be converted into “paying patients”, either on their own or through some form of governmental subsidy. Hence, the need for lengthy forms.

Administrators, of course, do not handle the forms directly, but delegate these encounters to clerical personnel.

The clerical line thus fulfills a double role: first, by protecting the financial health of the institution and, second, by insulating its medical personnel from the economic realities on the ground (Krugman 2008; Martinez 2008). Caregivers can continue to inhabit their Hippocratic bubble oblivious of the fact that the patients that they see, “without regard to their ability to pay,” have been previously screened on that basis by the clerical staff. Before the doors to the coveted examination room are laid open, patients have been turned -- whether knowingly or not -- into paying patients. Figure 2 portrays the structure of the system.

Figure 2 about here

The American Immigration System

As of 2007, the foreign-born population of the United States reached 37.9 million, the highest absolute number ever. Immigrants now account for one in eight of all U.S. residents; up from one in 16 in 1980 and one in 13 in 1990 (Center for Immigration Studies 2007). The number of immigrants has been rising six times faster than the native-born population during the last decade. In cities like Los Angeles, Miami, and New York, immigrants already constitute from one-third to the majority of the population (Portes and Rumbaut 2006). More important, the migrant flow shows no sign of abating, fueled by two major streams: First, foreign professionals and technicians have been arriving in large numbers to meet labor demand in high-tech industries, health, and other sectors of the economy; over 100,000 persons classified as

professionals, executives, and managers entered the U.S. on an annual basis during the 1990s. The H-1-B program, established in 1990 for temporary hiring of foreign professionals, grew by leaps and bounds, bringing over 400,000 skilled workers and their families by the mid-2000s (Portes and Rumbaut 2006: Ch. 2; Office of Immigration Statistics 2004).

Second, demand in labor-intensive sectors of the economy, such as agriculture, construction, and personal services has fueled massive inflows of unskilled and poorly educated migrants. In the absence of regular channels for entry, this movement has gone underground, entering the country clandestinely and creating large clusters of migrant workers who live and work without any legal standing or protection. The unauthorized population of the United States is currently estimated at 12 million. Despite repeated efforts to enforce the borders, the flow continues, driven by the strong combination of employer demand and lack of employment options in sending nations (Massey *et. al.* 2002; Office of Immigration Statistics 2006).

The twin streams of the American immigration system are interpretable under the same conceptual class framework used in the first part of this paper. The propertied classes have benefited greatly from the flexibility that access to foreign labor provides. Corporations at the cutting edge of new technologies have actively lobbied for the continuation and expansion of the H-1-B program and other legal immigration channels to create a steady supply of foreign engineers, software programmers, and technicians. These migrants not only prevent skilled labor bottlenecks in high-tech industries, but also contribute to keep a lid on salaries paid to this personnel (Portes and Rumbaut 2006: Ch. 4; Alarcon 1999).

Smaller firms in labor-intensive sectors such as agriculture, construction, services, and low-skill manufacturing not only benefit, but actually require a steady supply of manual foreign workers for their survival. Declining fertility and rising levels of education of the native labor

force have led to a steadily dwindling supply of workers willing to perform manual labor for a low wage (Congressional Budget Office 2005). In this context, access to an abundant supply of unskilled laborers from Mexico, Central America, and elsewhere is a godsend for firms and their owners. The question of why such migrant flow must come underground is resolved once we realize that the vulnerability accompanying unauthorized status in the United States redounds to the benefit of firms by reducing costs and increasing the flexibility of this labor supply (Cornelius 1998, 2001; Massey 2007).

Attempts to stop the unauthorized flow have taken the form so far of campaigns for militarizing the country's border and erecting fences to prevent new entries. These "get tough" policies, prompted by the public clamor against clandestine immigration, have had consequences that are precisely the opposite of those intended: instead of getting rid of the unauthorized population, these policies have *increased* it by keeping it bottled up on the U.S. side of the border (Massey *et. al.* 2002; Espenshade 1994). Unskilled migrant workers have kept coming, but expanded border enforcement has significantly increased the costs and dangers of crossing. Once on the American side, migrants are loathe to repeat the experience and, hence, are unlikely to return home (Portes 2007).

In contrast to the previous cyclical pattern, when Mexican and Central American workers came to the U.S. for temporary work spells in agriculture and construction eventually to go home, present conditions compel them to stay (Cornelius 2001). Once settled, the logical next step is to bring their families. In this fashion, a large population living in conditions of severe disadvantage has been created. Situated in the lowest rungs of the class of common workers, this population -- numbering in the millions and increasing by the day -- represents a convenient labor reservoir for a broad array of industries, serving their interests in multiple ways.⁹

At some point, this human wave comes into contact with American health institutions, an encounter that necessarily leads to a new set of fortuitous consequences that neither the architects of the health system nor those of contemporary immigration could have anticipated. As we have seen, both systems are riddled with contradictions. Not surprisingly, their encounter exacerbates these tensions.

The Clash

The surging immigrant population presents American health institutions with a series of challenges. They can be resumed in a fourfold set of handicaps:

- Lack of English fluency
- Different cultural definitions of illness and health
- Tenuous legal status and residential instability
- Poverty and lack of insurance

Professional immigrants with high levels of human capital are much better able to overcome these constraints. They have both legal status and work-linked health insurance and are commonly fluent in English. Still, even among them, problems of linguistic and cultural translation are quite frequent. Professionals from non-English speaking countries may have enough command of the language to meet their work obligations, but not to express their health needs. The latter may be defined quite differently, as when Korean and Chinese professionals complain of “lack of energy” to refer to physical ailments or sheer depression. Such discrepancies are commonly reported by U.S. physicians and administrators and have prompted a number of hospitals and clinics to hire “cultural mediators” to try to bridge the gap.¹⁰

The problems posed by legal professional immigrants pale by comparison with the human wave of undocumented peasants and workers coming to fill positions in agriculture and other labor intensive industries. Most of these migrants are young and healthy, at least initially. They must be in order to face the hurdles of border crossing and engage in demanding manual work. In time, however, illnesses and chronic conditions will appear. The challenge that this rising population poses to health care institutions derive, ultimately, from four features:

- Its numbers
- Its poverty
- Its lack of education
- Its lack of legal status

Each of these conditions branches into a number of difficulties and bottlenecks documented at length in the course of HIS interviews:

- Lack of legal status not only renders migrants ineligible for federal Medicaid, but also makes them reluctant to approach any official-looking institution for fear of detention and deportation. As a consequence, they commonly end up at the emergency room or, when lucky, into a free clinic when seriously ill. At that point, handling their condition becomes both more difficult and more expensive, because it often requires inpatient and specialty care.¹¹ Firm owners who profit mightily from this source of labor assume no responsibility for these costs.
- Lack of education leads to a proliferation of folk beliefs about illness and health among migrant workers, to their preferences for folk healers and home remedies, to their inability to read and understand medical labels, and to their difficulty in following protracted treatment. There is widespread ignorance about proper

nutritional practices and basic hygiene leading to the emergence and aggravation of chronic conditions.

- Migrant workers are poor, but not indigent; that is, they are not part of the class of redundant workers (see Figure 1) since they are precisely in demand to fill the harshest and lowest-paid positions in the labor market. Paltry wages and unstable work conditions branch into several consequences: First, while migrants may be eligible for some federal- or state-subsidized care, their incomes prevent them from accessing free services and puts them instead into a sliding scale of up-front payments that they are commonly unable to afford. Second, the frantic search for work forces these migrants to move from place to place, preventing them from establishing permanent homes and, hence, meeting the local residence requirements demanded by state and county health agencies.

Third, similar work demands often lead migrant patients to skip medical appointments and fail to follow prescribed treatment. As a clinic coordinator in Miami complained: “I lined up a \$100,000 operation for a Salvadoran migrant, and he failed to show up because he had a job paying him \$50 on that day.”¹²

Finally, low wages also mean poor nutrition, as workers on the move and without a regular home life come to depend on the fast food industry. Obesity, diabetes, and related chronic conditions have been rising fast among migrants as a direct consequence of these new dietary practices.

As noted previously, an unexpected effect of the militarization of the border has been the end of the previous commuting pattern by Mexican and Central American workers. As a result, the migrant population has been transformed from one formed predominantly by single males to

one composed of families. The relative youth of this population and the cultural norms of the rural communities from which many of their members come lead to high rates of fertility. A wave of pregnancies among migrant women confront the health system with a new set of challenges that combine all the handicaps seen previously: poor and uneducated migrant women have difficulty in accessing pre-natal care and, if able to do so, in following nutritional and hygienic instructions. Several informants reported that folk beliefs lead many women to treat pregnancy as a “natural” condition, not requiring medical attention. As a consequence, they are woefully unprepared when complications arise.¹³

All these problems could be readily handled if they only affected a small number of newcomers, but this is not the case. The systemic need of the American economy for low-wage labor migration has led to the arrival of such workers by the hundreds of thousands, leading to their growing impact on health institutions. The health system has been forced to come up with a new set of coping strategies given the increase of the immigrant population, its distinct health needs, and the potential public hazards posed by infectious diseases. By the same token, the clash between immigration and health institutions has brought into sharp relief the contradictions and limitations of the American health system. Figure 3 summarizes the situation.

Figure 3 about here

Coping Strategies

The tension between the two conflicting definitions of health in America is resolved, at the rhetorical level, with normative statements about the need to provide “compassionate care” by administrative personnel and with vigorous reassertions of the Hippocratic Oath by health

professionals. However, as in other areas of social life, there is considerable distance between what is said and what is done. Facing the set of complex challenges outlined in Figure 3, hospitals, clinics, and government-sponsored programs adjust, although they do so in different ways.

More than half a century ago, Robert K. Merton analyzed another vital feature of American social life, namely race. In his classic, “Discrimination and the American Creed” (Merton 1948), Merton examined the distance between what the country professed in terms of foundational principles of human rights and equality of opportunity for all and how Americans of color were actually treated in practice. The gap between principle and deed gave rise to his famous two-by-two typology where, in between “all-weather” liberals and “all-weather” bigots, there existed a sizable number of “fair-weather” liberals who tolerated discrimination against blacks even against their beliefs and “fair-weather” bigots who, being prejudiced, failed to enact their beliefs because of external social pressure (Merton 1948). The typology was focused on individuals and aimed at guiding policy for reducing the American racial gap, by calling attention to the importance of actual behavior over subjective beliefs.

In parallel fashion, it is possible to analyze the slippage between institutionalized goals and principles of the American health system and actual coping practices as it faces a rising tide of immigration. In the course of our study, we found hospitals and clinics that adhered firmly to the principle of health as a commodity and practiced what they preached by resolutely avoiding non-paying patients in general and uninsured immigrants in particular. At the other end, free clinics and a few religiously-imbued hospitals vigorously endorsed the belief of health as a universal right and sought, as far as their means permitted, to put that belief into practice. In between, there are shades of grey where normative principles and convictions are mixed, leading

to different outcomes. By criss-crossing the two alternative definitions of health care, it is possible to arrive at a typology of different coping strategies. These are presented in Figure 4.

Figure 4 about here

1. “*Escapists*”

Escapism is that institutional stance for which the problem of a large unauthorized population and rising numbers of poor and uninsured migrants does not officially exist. Denial of its existence takes the form of ineligibility for public health programs and of direct refusal of care. This stance characterizes governmental policies at all levels operating on the premises that the uninsured migrant population does not deserve recognition or erecting so many constraints and barriers as to effectively deny it access.

At the federal level, Medicaid bars both unauthorized and recently-arrived migrants from benefits. At the local level, county and city governments, exemplified by San Diego’s Board of Supervisors, have implemented a series of measures to effectively prevent use of their health facilities and the expenditure of public monies for unauthorized migrants.¹⁴ Such policies are escapist because denying the existence to this population does not make it disappear. Instead the worsening of its health conditions due to lack of care eventually turns into far more serious and more expensive outcomes, bearing on the general population. Ill and poor immigrants do not just die; they get worse until being forced into emergency rooms. At that point, they cannot be put in the street and the costs of caring for their condition creates greater strain on the public purse than having provided preventive attention in the first place. Migrants suffering from contagious diseases such as TB and AIDS do not go home or otherwise disappear. They just

keep living in the community further imperiling the health of all, native and migrant alike. The chief operating officer of a non-profit hospital in San Diego catering to a mostly Mexican immigrant population describes the situation as follows:

Everybody arrives in a catastrophic condition because they do not receive proper medical care on a regular basis and the main reason is fear of detention and deportation.... There is out there a new subculture of people who do not receive regular care; a shadow world of people who are in the country but are denied any assistance.¹⁵

Institutional escapism leads to unexpected consequences, as the proliferating and unattended health needs of an officially non-existent population inevitably turn back on its proponents. Other federal and state programs officially provide access to health care to all, regardless of legal status but they pile so many bureaucratic requirements as to disenfranchise a large proportion of poor immigrants. Federally Qualified Health Clinics, for example, are mandated by law to see everyone, but they require proof of residence and proof of income and, failing this, upfront payments that effectively discourage many care-seekers. The network of satellite clinics anchored by the Jackson Hospital in Miami operates on the basis of the same principles, asking would-be patients for proof of income in the form of income tax returns or letters from employers and proof of residence in the form of utility receipts.¹⁶

Such requirements define an officially “needy” population that does not really exist and rule out the real one: migrants employed in informal jobs, racing from one place of work to another, and living six to an apartment can scarcely produce income tax forms or six months of utility bills. People who are able to come up with such documents are actually those less in need.

Local experts in Miami-Dade estimate that up to half of the uninsured migrant population is excluded from the “free” health care system by these requirements (Health Council of South Florida 2008).

2. “*Profit-Seekers*”

These are institutions that regard the health needs of the population as a business opportunity and health care as a commercial good. For the most part, these are for-profit clinics and hospital chains, although some non-profit institutions also fall into this category as they seek growth by paying close attention to the bottom line. Administrators of these institutions often voice the familiar messages of compassionate care and community service, although one does not need to scratch the surface much to find the real motive. Thus, the head nurse of a large for-profit hospital in Miami, after extensive declarations about her institution making no distinctions between the insured and uninsured, the legal and the unauthorized, finally comes to the bottom line:

The analogy that is given is that when you go to a department store to purchase goods, you don’t go to the cashier and say, “I don’t have any money to pay you today.” You have to pay for what you consume. This is the philosophy here; yes, we’re going to take care of you to the best of our abilities but, please, we’ve provided a service so we expect to be paid.¹⁷

The director of the emergency room of a large central New Jersey hospital summarizes the philosophy of his institution as follows:

To run away from uninsured patients. Immigrant patients are fine so long as they have good insurance.¹⁸

This particular hospital is a non-profit institution run by a network of long-time administrators who prioritize preserving their well-paid jobs. To do so and to keep the hospital afloat, they have an unstated policy of discouraging the uninsured. They will not be treated in regular examining rooms and, if cared for in the emergency room, they are made to fill extensive forms in order to extract compensation from one or another government program.

Profit-seekers range from administrators bent on keeping their institutions and their own high-paid jobs secure by catering to the insured or at least those eligible for official subsidies, all the way to specialists and “concierge” establishments that refuse Medicaid, Medicare, and other government programs in favor of just of paying patients. This model epitomizes the extreme profit-seeking stance by rejecting the notion that health care could be a universal right. Concierge medicine is exclusively for the well-heeled; others are on their own. The assistant medical director of one of the few free clinics in San Diego evaluated the “concierge” model as follows:

These hospitals charge specific fees to have unlimited access to doctors. It’s also about doctors saying, “I’m only going to care for people who can afford to pay me a certain amount of money.”

Really, it’s about betraying medicine and selling your soul.¹⁹

The profit-seeking cell in Figure 4 is populated by a wide variety of players in the American health system. Aside from concierge establishments and for-profit chains, it

encompasses specialist practices that refuse care to the uninsured and even to those with a Medicaid card. In Monroe County in the tip of Florida, practically no specialist accepts Medicaid. Buses are reported to run periodically from the Keys to Homestead in the mainland, the only place in the area where needy patients could see a specialist. As a senior doctor at the Baptist Hospital in that city put it:

...the social contract expired a long time ago and nothing has been put into its place.²⁰

This is the situation prompting advocates for the uninsured in the area to launch a campaign to persuade specialists to take “just one patient a month.”

Also included in this cell of Figure 4 are managed care companies catering to the Medicare-insured population. They receive a capitation fee from the Federal Health and Human Services Department for eligible patients and make their profit by keeping the difference between what they receive from the government and what costs them to keep their patients healthy.²¹ In theory, this practice promotes efficiency because it motivates clinic managers to eliminate the duplications and overlaps so common elsewhere. In practice, they select, and are selected by healthier people whose medical costs are below the average cost on which premiums are based. Besides risk selection, capitation contains a built-in incentive for managers to cut corners by postponing expensive procedures, shortening hospital stays, and trying to unenroll the older and sicker patients. Profits tied to “efficiency” can easily turn into victimization of patients, particularly the elderly. These perverse incentives have already given rise to at least one major scandal in South Florida, involving the now-defunct HMO, International Medical Centers.²²

Chains of for-profit hospitals and managed-care centers routinely lack any facilities for the uninsured population who are only cared for in extreme circumstances in the emergency rooms. Hospitals are built in suburban areas, out of reach by the poor. As seen previously, many formally “non-profit” hospitals can also fall into this category, as their administrators are bent on preserving or enhancing their own positions. The prevalence of this type of institution is a natural consequence of the class character of the American health system. Only such a system could create an entire industry based on collecting payment from hard-pressed patients or “Medicare millionaires” who become wealthy at the expense of the public purse.

3. “Angels”

These are institutions motivated by the conviction that health care is a right that should be available to all. Due to the hold exercised on public policy by moral hazard theory, this conviction is not the governing principle of the American health system (Gladwell 2005). Hence, care for the uninsured, especially those who lack legal status in the country, is relegated to a small number of philanthropic institutions. Not surprisingly, religiously-affiliated clinics and hospitals are at the forefront in this sphere, although they are not the only ones.

This is the cell in Figure 4 occupied by “free clinics” where everyone is seen and where admission requirements are minimal. In stark opposition to most hospitals’ ERs, where, according to one administrator, “every patient carries a dollar sign on the forehead,”²³ patients simply sign their names in an entry form, give an address (real or fictitious), and are not subjected to any questioning regarding incomes or ability to pay. They are not billed for services either. Free clinics are outpatient facilities that provide a range of primary care services, as well as attention to poor people with chronic conditions such as diabetes and hypertension. They

have no beds and, for patients requiring hospitalization, they must commonly rely on institutional connections or negotiations with the staff of larger hospitals .

Free clinics rely on contributions from private donors, support from religiously-affiliated hospitals and philanthropic organizations, creative use of governmental programs, and volunteering by physicians, both generalists and specialists. The level of commitment to charitable work among physicians varies greatly, with some clinics reporting that they have little trouble gaining access to specialists, while others complain about the scarcity of specialists willing to provide at least some free care. Clinics are often anchored by one or two motivated general practitioners who use their social connections to recruit volunteer specialists or get needy patients to them. But the process is haphazard. At St. Vincent de Paul in San Diego, the elderly volunteer ophthalmologist has recently died and the medical director is “shaking the trees” to find a new one. Proper treatment of diabetes, which is pervasive among the poor, including many immigrants, requires regular visits to an ophthalmologist. At St. John Bosco, in Miami, a long line of pregnant migrant women await their turn to see the single retired Cuban gynecologist offering his services for free.²⁴

Despite these limitations, free clinics generally do a good job in providing primary care for their target population. Scarcity of resources is compensated by a level of commitment among caregivers and staff empathy with the patients seldom seen in for-profit or secular non-profit facilities. “Care for the poor need not be poor care,” says Dr. N., the charismatic director of the Open Door Clinic in Homestead, Florida.²⁵ The rub comes when a patient needs hospitalization or major surgery. Unless it is an emergency, this is a difficult contingency to negotiate. Clinic staff become advocates in these situations, searching, cajoling, and even shaming hospitals into opening their doors. Free clinics with a direct linkage to a non-profit

hospital are in a much better position. This is the case, for example, at Open Door, which is affiliated with the large Baptist Hospital in Miami. St. John's Clinic in downtown New Brunswick maintains a similar relation with nearby St. Peter's Hospital.²⁶

In all cases observed, the funding and operation of these institutions depend on the presence of a charismatic leader – priest, pastor or physician – moved by the plight of the dispossessed and their exclusion from proper care. At St. Vincent de Paul, it is Father J., a Catholic priest, who has managed to build an impressive facility providing refuge, housing, food, and medical and dental care for the homeless and for an increasing number of immigrants in San Diego. At Open Door, it is Dr. N., who is simultaneously therapist, administrator, fundraiser, and patient advocate. The clinic literally “runs on her.”²⁷ At Good News Clinic, also in Homestead, it is Baptist pastor M. and his wife, a medical administrator, who, with a budget of less than half a million dollars annually, manage to provide quality care for a large population of migrant farm laborers and poor African-Americans in their community. At St. John's in New Brunswick, Dr. S. plays the pivotal role, working as the single full-time physician while recruiting specialists and young residents at nearby St. Peter's to provide their services for free.²⁸

The concept of “charisma”, originally theorized by Weber ([1922] 1947), is central for populating this cell; otherwise, it would be empty. Official charity care is commonly hampered by regulations, barriers, and exclusions that make it fit more properly into the escapist cell. This is the case, for example, of many FQHCs – the closest thing resembling free care in the federal health system – which are still limited by rules and requirements difficult to overcome by the most vulnerable.²⁹

To grant access to health care, no questions asked and no billing later, requires extraordinary effort in America. Compassion is not enough since it cannot always be translated

directly into practice: money must be found to build facilities; committed staff must be recruited and paid; equipment must be bought, even patients must be recruited since they are often ignorant of the existence of these facilities or fearful of making use of them. Good News Clinic, for example, placed itself right next to a Baptist church in order to prevent raids by Immigration and Customs Enforcement (ICE) agents that would scare away its mostly undocumented users. Coordinating these tasks, while motivating the staff and maintaining an optimistic stance in the face of official inertia is beyond the capabilities of the average provider or administrator. Leaders of these facilities are certainly not run-of-the-mill administrators.

The philanthropic medicine that these clinics dispense is obviously no substitute for universal coverage. It is a toss-up whether a poor, uninsured migrant would find his or her way into one; and whether, if really ill, clinic staff can pry open the doors of a nearby hospital. The limited level of care that free clinics can provide, not due to their intentions but to the scarcity of resources, makes only a dent on the health needs of uninsured immigrants and cannot prevent the spread of contagious diseases affecting them to the general public. As Dr. C., one of the medical directors at St. Vincent de Paul in San Diego, remarked:

I would tell the San Diego Board of Supervisors that, no matter how conservative you are, your exposure to disease doesn't care about borders. If you don't treat the foreign-born population, you're increasing the risk of disease among all members of the community, not just those without papers. Preventable diseases don't care what your tax bracket is; they don't care about your political ideology. All that matters, as far as they are concerned, is that no one was there to prevent their spread...³⁰

4. *Good Samaritans*

The final cell includes those institutions that take a more eclectic approach, seeking to integrate the two conflicting definitions of health care into some kind of synthesis. These are uniformly non-profit hospitals and clinics, although not all non-profits fit in. Good Samaritan institutions are in the business of health care, but possess simultaneously a “sense of mission” toward the poor and uninsured. They are commonly, but not always, religiously affiliated and are guided by institutional principles that prioritize human values. Their business model is always the same: to make themselves attractive to a paying clientele because of quality of services but to reserve a sizable portion of profits for charity care.

Thus, Baptist Hospital in Miami – one of the largest health institutions in the area – sets aside a substantial proportion of its budget to care for the uninsured and encourages specialists in its staff to dedicate a certain portion of their time to serve this population. This is what allows free clinics like Good News to operate, since they can call on these resources and refer patients requiring hospitalization or surgery directly to Baptist. St. Vincent de Paul in San Diego is not so lucky. One of its chief nurses reports that, when a medical emergency arises, the patient is put in an ambulance and it is then the driver’s decision what hospital to go to. This is a consequence of the clinic operating on its own, without strong support from a larger medical institution.³¹

St. Johns’ Clinic in New Brunswick, New Jersey, operates under the umbrella of St. Peter’s University Hospital, dependent on the Catholic Diocese of Metuchen. As in the case of Baptist, St. Peter’s supports the clinic financially and makes its clinical resources available for referrals. However, since the medical staff at St. Peter’s does not cover all the specialties and is dependent for some on private practice doctors, bottlenecks arise. The clinic’s director reports

that specialists uniformly expect to be paid for their services and finding volunteers among them is often difficult.³²

St. Francis Hospital in Trenton, New Jersey, another Catholic institution, displays a level of commitment to the needs of its poor patients that is truly extraordinary. Trenton is a rustbelt city whose industrial base has been eviscerated by global restructuring and whose population was, until recently, mostly poor and black. During the last two decades or so, an influx of laborers from Mexico and Central America has been added to the mix. These are mostly undocumented migrants and almost all are uninsured. Hence, they have not increased the city's slim population of paying patients, while having greatly raised its overall health needs.³³ The administrators of St. Francis have met this challenge with serenity and have somehow managed to extend free care to the immigrants, no questions asked about their legal status. St. Francis even operates a walk-in clinic in an area dubbed by an informant as Trenton's "war zone." The hospital is funded by contributions from the Catholic hospital system, philanthropic donations, and New Jersey's Charity Care. Despite the challenge placed on its resources by the rise in the migrant population, St. Francis seems to be holding its own. Its top administrator states:

One of the things we say here is that there is only one standard of care. I don't care if you're fully insured, a prisoner, uninsured or an immigrant with no documents, there is a single standard...and we do follow those cases all the way through. We were founded back in 1874 by the Sisters of St. Francis and that tradition has continued; that makes a difference because of the culture of a faith-based environment.³⁴

Not all Good Samaritan institutions are religiously affiliated. In San Diego, Rady Children's Hospital confronts a patient base that is 44 percent foreign-born, mostly Mexican and mostly unauthorized. It also confronts a County Board of Supervisors that has made every effort to insure that "not a single dollar be spent in the health of illegal immigrants and their children".³⁵ Of late, the Board has sought to make it compulsory that every uninsured or underinsured person seeking health care must show proof of citizenship or long-term legal residence (Connaughton 2007). The Chief Operating Officer at Rady at the time of the interview addresses the moral dilemma created by this situation:

It is hard but not impossible for anyone to look into the eyes of an adult and say, "Sorry, we can't treat you because you're not a citizen of this country," but to take the same position with a child who may have a brain tumor requiring immediate attention, and who may die if that attention is not provided, is beyond the capacity of any doctor...the laws being passed will create new impossible situations for our health care personnel.³⁶

Against this grim context, Rady does everything possible to provide access to the uninsured. It has cultural mediators who ease communication between health providers and patients in various languages, mainly Spanish. The hospital spends between \$350,000 and \$400,000 every year on translator services and cultural mediation. Rady is a sizable institution with 3,000 professional staff, including 700 affiliated doctors and 700-800 therapists; it sees up to 1,000 patients daily and has 250 authorized beds for inpatients. To survive, the hospital relies on philanthropic donations and, like Baptist in Miami, it allocates a substantial share of its resources to charity.³⁷

Recently, it has sought to network with medical institutions in Mexico that can provide regular and follow-up services to patients ineligible for care in the U.S. because of their legal status. While the level of medical expertise and resources in Mexico is not up to U.S. standards, Rady administrators see this as a practical way of taking advantage of its geographic location in order to confront a difficult situation. They have just signed an agreement with a hospital in Tijuana to create a long-term health care partnership serving the uninsured and undocumented migrants.³⁸

Good Samaritans represent the exception in our sample of institutions. Among the challenges that they confront, three are paramount: First, competition from other institutions unburdened by “a sense of mission” and, hence, able to avoid or discourage the poor. Second, red tape and bureaucratic obstacles in obtaining reimbursement from government programs: compensation from such programs tends to be paltry. Third, a decline in volunteerism among caregivers, in particular much needed specialists. We listened repeatedly about the scarcity of volunteer specialist prompting immigrant organizations in Miami to campaign for doctors to see “just one patient a month.”³⁹

The Theory of Moral Hazard Revisited

Free clinics and Good Samaritan hospitals set themselves up for what economists believe are the dangers of moral hazard. This is especially true when the quality of services that some of these facilities dispense and their level of concern for patients are as good as those in medical institutions requiring payment. Surely, savvy individuals will see an opportunity to get something for nothing and these compassionate institutions will be forced to close, crushed by free riding. This is the theory; the practice is very different. *None* of the fifteen free clinics and

Good Samaritan hospitals that we studied complained of being overwhelmed by poor immigrants. They had plenty of complaints, certainly, about scarcity of resources and official red tape, but a vast mass of care seekers who could pay and did not was not one of them.

At Good News Clinic in Homestead, Florida, the administrator reported only one such case in the institution's 13-year history. While Good News does not ask for proof of income or length of local residence, it is evident that its patient population is composed of migrant laborers and uninsured poor natives. The problem faced by this clinic was not free riding, but exactly the opposite: the reluctance of many migrants to come in either out of fear of deportation or cultural norms that prevent seeking medical care unless seriously ill. Similarly, the director at Open Door Clinic in the same city reported that, in the early days, staff "had to go in the fields, to bring migrants in." They would not come on their own despite the facilities being entirely free.⁴⁰ Similar results have been reported for Mexican migrant laborers in California. In both cases, it is not only fear of deportation, but fear of losing a day's work that stand behind the reluctance to access free care. A recent journalistic investigation of migrants in California agriculture supports this point:

Immigrants interviewed amid the vineyards of Madera and the cantaloupe fields of Mendota said they had faced numerous obstacles to pursuing conventional medical care. Above all, they said was cost, but other factors included fear of deportation and long waits for treatment...even if farm workers in Madera can afford the local clinic sliding fees, they cannot afford to miss work while waiting up to six hours to be seen. Rosie Q. Valdovinos, a lettuce picker, put it this way: "To go to a doctor, you miss a day

of work. You miss a day, and the next day you're gone." (Sack 2008: 3).

The situation is the same in New Jersey. At the Robert Wood Johnson Hospital in Hamilton, the head of the Family Clinic, reports similar problems in bringing in reluctant migrant mothers and getting them accustomed to regular care. When asked about the major difficulty confronted by the clinic, excess patient load was the least of her concerns. Instead, she complained about the inability of the hospital to advertise more broadly the services of the Family Clinic among the poor and uninsured population in Trenton. Prodded again as to whether the hospital had put pressure on her to reduce the free care load, she promptly dismissed the question: "Somehow, Robert Wood Johnson finds the means to keep these services open to all. My concern is that needy people are not coming in."⁴¹

At St. Johns' Community Health Center in New Brunswick, its director complained about the lack of space and the difficulty of getting specialists not on the staff of the parent hospital (St. Peter's) to volunteer. Excess patient load, by unauthorized immigrants or the native poor, was not one of his problems.⁴² In Chula Vista, California, Dr. C. of St. Vincent de Paul takes his mobile health unit into a poor Mexican area, seeking to make its services more readily available and to overcome migrants' distrust:

I am always very careful to explore, during the first visit, how long it took them to come see me. Many months go by before they get enough information to trust me. (One will say) "My aunt saw you," or "My daughter convinced me to see you." So, delivering care is not just about bringing the mobile unit out, putting it in a

parking lot, and waiting for patients to arrive, it's about seeing family members and creating networks of trust by word of mouth.

Trust is, by far, the most important thing.⁴³

These practical concerns are miles away from the world of moral hazard theorists. The reason why the theory does not apply in these instances is that seeking medical care is not a festive occasion. It is not likely that many people would check into a hospital for leisure as if it were a tourist hotel. Hospitals are dangerous places unless one really needs them. Medical systems in the rest of the developed world, which are based on the principle of health as a basic and universal right, do not normally report being overwhelmed by free riders (Gladwell 2005; Light 2000). In the specific case of migrant workers, they are simply too busy making a living to seek entertainment by visiting clinics needlessly. If unauthorized, the time pressures of holding multiple jobs are compounded by the fear of detection and deportation. Such are the reasons why, even when free care is available, clinics and hospitals have not been overwhelmed by a giant wave of poor immigrants.

St. Vincent de Paul in San Diego does not even bill for its services. To gain access, all a patient has to do is to write his or her name on a piece of paper. Even so, it is underwhelmed by uninsured migrants needing care, to the point that mobile units have to be sent out looking for them. The theory of moral hazard finds no support in these data. Instead, the character of the theory as ideological justification is strongly suggested by the evidence. It is not patient overuse, but the need to preserve a *status quo* that benefits dominant classes that underlies this strategy of legitimation.

Conclusion

Twin articles in a recent number of *Issues*, the journal of the National Academy of Sciences, addressed the unsustainable growth of health care costs in the United States by making two points: first, that the problem was due much less to the growth of the population eligible for Medicare than to the rise of *per capita* medical costs; second, that regions of the country with a lower density of specialist physicians and hospitals and a greater proportion of generalists delivered equal-quality health care for much lower costs.

The first article, by the director of the Congressional Budget Office, presents charts showing that the real crisis of the American health system does not lie in the much touted arrival of the baby boomer generation to eligible age for Medicare, but in the seemingly unstoppable rise in the costs of hospital services and drugs per patient. The second article shows the virtues of general practice medicine and demonstrates that, where there are more expensive specialists to be paid, the system responds by paying them through a general rise in costs without comparable improvement in the quality of care (Orszag 2008; Fisher 2008).

All of this is well and good, but neither article recognizes that the problem each addresses is a symptom, not the cause, of the more fundamental disease. The present system operates with a capitalist logic where patients are a business opportunity and where revenues increase by focusing on specialized procedures for covered patients, resulting in institutional fragmentation and inefficiency. Drug companies and hospitals do this not out of malice, but because present institutional rules provide incentives to do so. As one of our New Jersey medical informants acknowledged, when a Medicare-eligible patient enters the hospital, the doctor has every incentive to keep him or her there longer and call in other colleagues for consultations. Each is paid by the government on a fee-for-service basis and networks of reciprocity thus get built

among participating doctors. And, “while the patient is in, why not throw in a colonoscopy as well.”⁴⁴

These problems will not be solved by threatening fines for abusers or imposing caps on reimbursements. Knowledgeable actors – both individual and institutional – will find ways around such controls. The only solution is a fundamental reorganization of the system by rebuilding it around a definition of health care as a universal right and the provision of services to all, regardless of class position. Health care as a privilege and medicine for profit can still exist, but they will be limited to those able to pay. As in other aspects of life in capitalist societies, the key issue is not the ceiling, but the floor. The health care floor, is limited today largely to the emergency room and the free clinics run by a few compassionate actors.

Unauthorized migrant workers are confined to that floor. The paradox of their situation lies in that, while they provide needed labor for vast sectors of the U.S. economy, they must do so without legal status and without health insurance. This contributes to explaining the well-documented fact that while working-age immigrants generally arrive healthy, their health progressively deteriorates with time of residence in the United States (Viruell-Fuentes 2007; Vega and Amaro 1994). Obesity, diabetes, hypertension, and related illnesses become widespread in this population, a fact documented in the research literature and by our own study.

A fundamental difficulty faced by anyone seeking to understand the American health system is its opacity. To decipher the basic institutional contours of the system, it is necessary to do two things: First, to adopt a stance of studied ignorance toward the swamp of bureaucratic rules and obscure terminology built in the course of decades and falsely claiming attention as *the* object of study. Second, to bring to bear tools from sociological theory and political economy as a means to cut through the thicket of pseudo-problems to identify the fundamental institutional

logic. This paper has sought to take a first step in that direction by importing and applying the theory of social class, the concepts of unintended consequences and of charisma, and a typology inspired by Merton's analysis of intentions *vs.* realities into the analysis of the American health system.

If nothing else, our study shows that the key analytic focus should be the institutions themselves rather than the individuals – patients and health providers – that populate them. For it is in the framework of rules and the contradictory goals embodied in different institutions that one must go to find the root causes of the present situation. To the extent that the logic of escapism and the profit drive continue to dominate this institutional scene, the uninsured in general and poor immigrants in particular will continue to face formidable barriers in gaining access to health care, compounding the inequalities that set the United States apart from the rest of the developed world.

Figure 1
A Typology of the Modern Class Structure

Class	Percent of the Population	Economic Characteristics	Empirical Indicators	Health Profile
<i>Dominant:</i> Grand Capitalists	0.1%	Ownership or control of businesses of international scope. Capital in the hundreds of millions of dollars	Annual incomes in the tens of millions or higher; named philanthropies and institutions of national and international reach	Access to elite health care and institutions. No insurance needed.
Capitalists	0.5%	Ownership or control of businesses of regional or national scope. Capital in the tens of millions	Annual incomes in the millions; named philanthropies and institutions of local reach	Ditto.
Rentiers	2.1%	Diversified financial/business investments in the millions. No direct control of large firms	Annual incomes in the hundreds of thousands or higher; paid work optional. Modest social or philanthropic recognition, but no independent institutional influence	Access to elite health care through self-insurance or high-cost commercial insurance.

Figure 1, continued

<i>Class</i>	Percent of the Population	Economic Characteristics	Empirical Indicators	Health Profile
<i>Subordinate:</i> Elite Workers	15%	Possession of exceptional skills in demand by major institutions. Rapid accumulation of wealth from paid work	Annual salaries in the hundreds of thousands or higher. Awards and honors based on career achievements	Access to elite health care through top-level employer-provided insurance.
Common Workers in Larger Firms	25%	Possession of standard occupational skills in regular demand by employers. Little or no wealth accumulation	Annual salaries in the tens of thousands; home ownership as the principal form of investment. Little or no occupational recognition	Employer-based health insurance. Modest co-premiums and co-payments.
Common Workers in Smaller Firms	35%			No health insurance or limited insurance with risk selection and high co-premium and co-payments
Petty Entrepreneurs	12%	Self-employment in small businesses requiring owner's labor. Provision of goods and services directly to the public or under subcontract to larger firms	Fluctuating annual incomes in the tens of thousands; higher incomes in exceptional cases. No occupational security or recognition	Uninsured or self-insured with high deductibles and co-payments.
Redundant Workers	10%	Excluded from labor market because of dated skills or work attitudes. Dependence on government assistance and casual work	Fluctuating annual incomes in the thousands. Personal survival through government assistance, informal jobs, and petty criminal activities	Uninsured. Access to care through Medicaid; state and county indigent programs.

Source: Adapted from Portes (2000). See original article for definitional criteria.

Figure 2
The American Health System

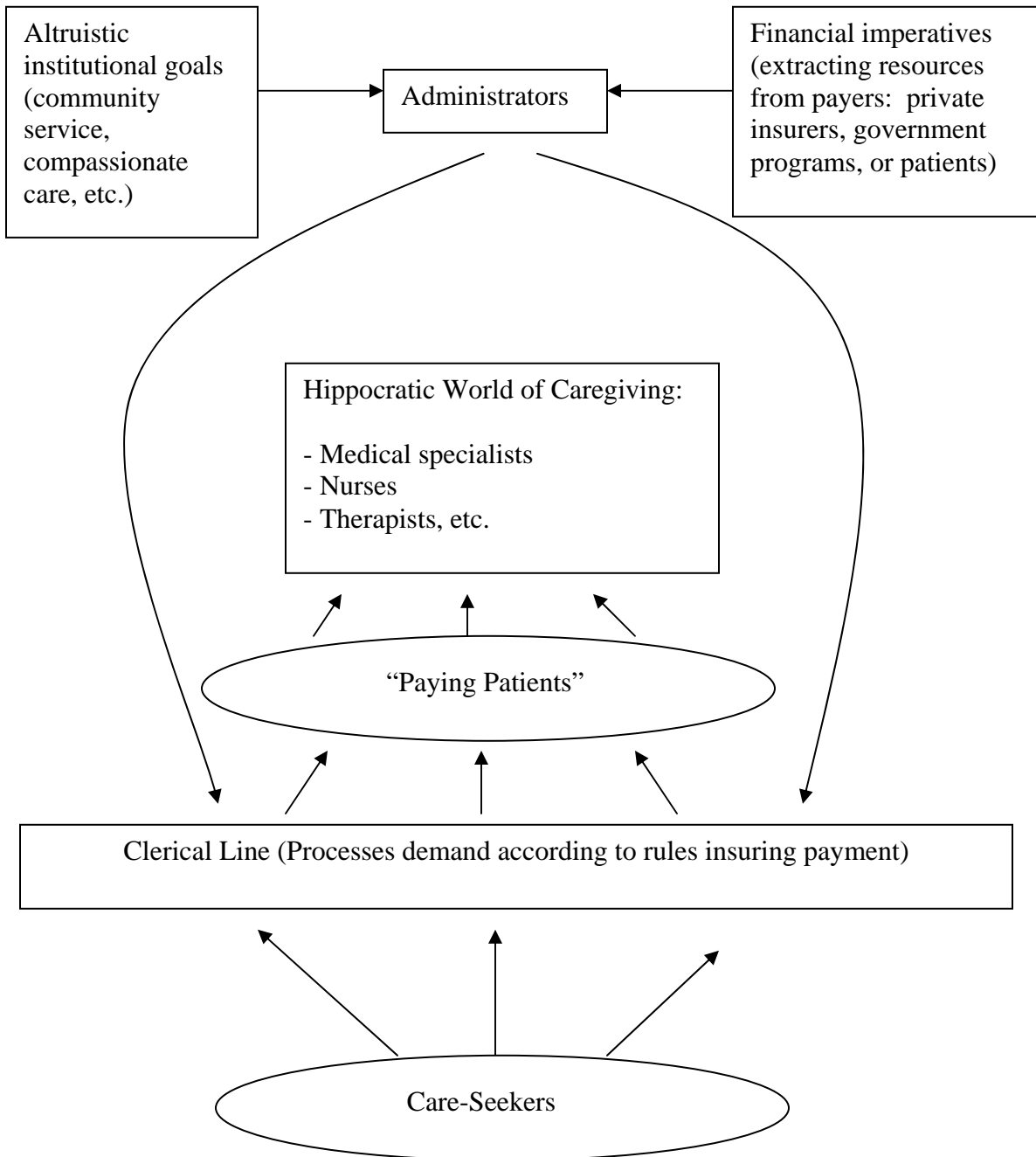


Figure 3
Characteristics of the Low-Skill Immigrant Population of
the United States and its Health Consequences

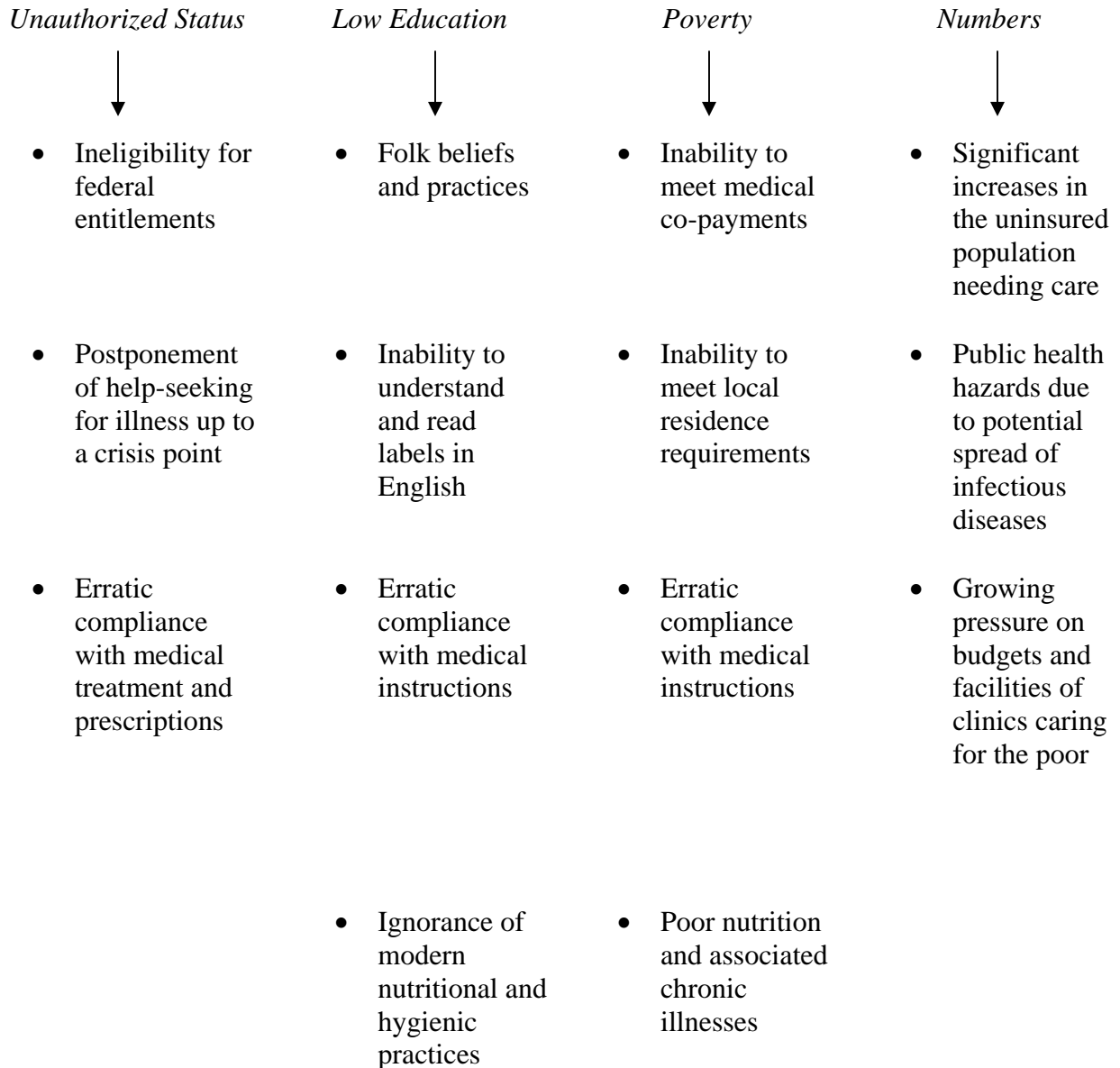


Figure 4
Institutional Orientations toward the
Uninsured Immigrant Population in the
American Health System

Health Care as a Market Good

		-	+
<i>Health Care as a Right</i>	-	I. “Escapists”	II. “Profit-Seekers”
	+	III. “Angels”	IV. “Good Samaritans”

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END NOTES

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² An exception to the general pattern is New Jersey where state funds pay for services to most poor patients and where a new law limits how much a hospital can charge others to the Medicaid payment rate plus ten percent. The federal law is known as EMTALA (Emergency Medical Treatment and Active Labor Act). It mandates hospital emergency room and other health services be provided to patients in critical condition, regardless of their ability to pay. The law does not prevent hospitals from billing patients afterwards.

³ Expert informant interviews with health professionals in San Diego, Miami, and New Jersey, Fall 2007, Spring and Summer 2008. Names and professional affiliations are omitted to protect confidentiality.

⁴ *Ibid.*

⁵ This typology is more fully developed in the original (Portes 2000).

⁶ During the 2008 Presidential campaign, Republican candidate John McCain adopted this slogan, repeating it frequently in his speeches. His platform for health reform in America, published in his webpage, also made use of this argument.

⁷ Direct observation in hospital emergency rooms and interviews with directors of hospitals and clinics and direct health providers conducted for the Immigration and the Health System (HIS) project, summer and fall 2007, spring 2008.

⁸ *Ibid.*

⁹ Unauthorized migrants seldom join the class of “redundant workers” precisely because they are here to work and are in demand by a multitude of employers. They also lack the legal standing to access welfare services available to the native-born. Low skill, lack of capital, and legal insecurity also prevent the vast majority from turning themselves into petty entrepreneurs (See Rosenfeld and Tienda 1999; Portes and Bach 1985).

¹⁰ HIS field interviews with hospital and clinic directors in Miami and New Jersey, Fall 2007 and Spring 2008.

¹¹ HIS field interviews in Miami, New Jersey, and San Diego, 2007-08.

¹² HIS field interview at the Rafael Peñalver Community Clinic, January 2008.

¹³ HIS field interviews with leaders and staff of the Healthy Start Program in Miami, July 2007 and with directors of family clinics in New Jersey, Spring 2008.

¹⁴ HIS field interviews with hospital managers and expert informants in San Diego, Summer and Fall 2002.

¹⁵ HIS field interview in San Diego, July 2007.

¹⁶ HIS interviews with leaders of the South Florida Health Alliance and administrators of free clinics in the area, July 2007 and May 2008. See also Health Council of South Florida (2008).

¹⁷ HIS field interview with chief nursing officer of a large for-profit hospital in Miami, November 2007.

¹⁸ HIS field interview in New Jersey, March 2008.

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- ¹⁹ HIS field interview with medical director of a free clinic and professor at UCSD Medical School, San Diego, July 2007.
- ²⁰ HIS field interview in Homestead, Florida, July 2008.
- ²¹ The capitation fee, commonly known as PMPM (“per month per member”) is commonly set at the county level or negotiated with individual HMOs.
- ²² For a detailed account of this incident, see Portes and Stepick (1993: Ch. 6).
- ²³ HIS field interview in Miami, December 2008.
- ²⁴ HIS field interviews in San Diego, July 2007 and Miami, July 2008. Names of clinics are real.
- ²⁵ HIS field interviews in Homestead, Florida July 2007.
- ²⁶ *Ibid.* HIS field interview in New Brunswick, NJ, March 2008. Names of institutions are real.
- ²⁷ Comment made by another physician at the clinic during our visit, July 19, 2007.
- ²⁸ HIS field interview in New Brunswick, NJ, March 2008.
- ²⁹ See Federally Qualified Health Center “Fact Sheet.” HHS Center for Medicare and Medicaid Services, 2008. A flavor of the bureaucratic entanglements of this program may be gleaned from this Fact Sheet’s description of reimbursement practices: “For example, FQHCs based in a hospital complete Worksheet M of Form CMS 2552-9...At the beginning of the FQHC’s fiscal year, the Fiscal Intermediary or A/B Medical Administrative Contractor calculates an interim all-inclusive visit costs based on either estimated allowable costs or on actual costs and visits from the previous cost reporting period.”
- ³⁰ HIS field interview in San Diego, July 2007.
- ³¹ HIS field interviews in Miami, July 2007 and July 2008, and in San Diego, October 2007.
- ³² HIS field interview in New Brunswick, NJ, March 2008.

³³ HIS field interview in Trenton, October 2007. Subsequent interviews with physicians and nurses at St. Francis were conducted in May and September 2008.

³⁴ HIS field interview in Trenton, October 2007.

³⁵ HIS field interview with officials of the City of San Diego, October 2007.

³⁶ HIS field interview in San Diego, July 2007. Name of the institution is real.

³⁷ *Ibid.*

³⁸ *Ibid.*

³⁹ HIS interview with leaders of South Florida's Health Alliance, July 2008.

⁴⁰ HIS field interviews in Homestead, Florida, July 2007 and July 2008.

⁴¹ HIS field interview in Hamilton, NJ, March 2008.

⁴² HIS field interview in New Brunswick, NJ, March 2008.

⁴³ HIS field visit and interview in San Diego, July 2007.

⁴⁴ HIS field interview in Edison, NJ, April 2008. These practices date back to the institutional design of Medicare and Medicaid in 1964 and to the DRG payment revisions in the 1980s.