



Immigrants and Health Care — At the Intersection of Two Broken Systems

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At a primary care clinic in Montgomery County, Maryland, where I volunteer, the patients are uninsured immigrants from Latin America or West Africa. Many are day laborers, house cleaners, or

construction workers; most do not speak English. Several months ago, I saw a middle-aged Hispanic baker with profound weakness, fatigue, limb swelling, and severe muscle pain, who had to be hospitalized for myxedema. Fortunately, a local charity agreed to pay most of her hospital costs, and she's now receiving thyroid hormone-replacement therapy — but with regular care, her hypothyroidism could have been diagnosed earlier and hospitalization averted. Another day, I tried to persuade a reticent West African man who had been tortured in prison that psychological counseling might help his chronic pain. However, mental health services for uninsured

immigrants are sparse, and the man was reluctant to venture to a distant part of Washington, D.C., to a program for torture survivors. A third patient, a man in his 40s, came in with a nearly empty bottle of eyedrops, which he had brought from Ghana to take for glaucoma. The disease had already blinded him in one eye, and the vision in his other eye had been fluctuating. He needed a complete eye exam and visual-field testing, but arranging timely referrals to specialists is often difficult for caregivers treating the uninsured. I wrote him a prescription, and we managed to set up an appointment at a hospital-based ophthalmology clinic that ac-

cepts a limited number of uninsured patients.

For recent immigrants — especially the estimated 12 million who are here illegally — seeking health care often involves daunting encounters with a fragmented, bewildering, and hostile system. The reason most immigrants come here is to work and earn money; on average, they are younger and healthier than native-born Americans, and they tend to avoid going to the doctor. Many work for employers who don't offer health insurance, and they can't afford insurance premiums or medical care. They face language and cultural barriers, and many illegal immigrants fear that visiting a hospital or clinic may draw the attention of immigration officials. Although anti-immigrant sentiment is fueled by the belief that immigrants can obtain federal benefits, 1996 welfare-reform legislation greatly restricted im-

migrants' access to programs such as Medicaid, shifting most health care responsibility to state and local governments. The law requires that immigrants wait 5 years after obtaining lawful permanent residency (a "green card") to apply for federal benefits. In response, some states and localities — for instance, Illinois, New York, the District of Columbia, and certain California counties — have used their own funds to expand health insurance coverage even for undocumented immigrant children and pregnant women with low incomes. Other states, however, such as Arizona, Colorado, Georgia, and Virginia, have passed laws making it even more difficult for noncitizens to gain access to health services.

Whether or not they have health insurance, immigrants overall have much lower per capita health care expenditures than native-born Americans,¹ and recent analyses indicate that they contribute more to the economy in taxes than they receive in public benefits. In a study from the RAND Corporation, researchers estimated that undocumented adult immigrants, who make up about 3.2% of the population, account for only about 1.5% of U.S. medical costs.² Many immigrants do not seek medical treatment unless they are injured or acutely ill; at our clinic, patients with type 2 diabetes often have florid symptoms and even incipient renal damage by the time their disease is diagnosed.

One study found that annual per capita expenses for health care were 86% lower for uninsured immigrant children than for uninsured U.S.-born children — but emergency department expenditures were more than

three times as high.¹ Although U.S. hospitals must provide emergency care without first asking about income, insurance, or citizenship, early diagnosis and treatment in a primary care setting are both medically preferable and a better use of resources. "If people keep postponing medical care because they're so concerned about being sent back over the border," noted Elizabeth Benson Forer, executive director of the Venice Family Clinic, a venerable free clinic in Los Angeles that serves many immigrants, "then you can end up with some pretty horrendous health situations."

Immigrants live, work, and attend school in communities throughout the country; laws and bureaucratic barriers that reduce their use of key preventive health services, such as immunizations and screenings for infectious disease, make for bad public health policy, and denying immigrants primary care ultimately increases health care costs for everyone. For example, labor and delivery costs for undocumented immigrant women are covered under the federal and state emergency Medicaid program, but most states do not cover prenatal care, and there is no coverage for family planning. Some of my patients say they would like to use oral contraceptives or an intrauterine device or undergo a tubal ligation, but they can't afford it. And immigrants, like native-born Americans, are vulnerable to chronic diseases; as my colleague, nurse practitioner Lois Wessel, notes, "Even the 25-year-old day laborers are eventually going to become 45-year-olds, probably still undocumented, with hypertension and diabetes. . . . Life in

America is going to make them become not so healthy."

Recently, a bipartisan group of U.S. senators, with White House support, introduced an immigration bill that offered the best chance in years of achieving substantial reform of a dysfunctional system. However, the bill met with opposition from both conservatives and liberals and was killed in the Senate this past June, quashing all hope of immigration reform during the current administration. State legislatures this year are considering a record number of anti-immigrant measures, and the Senate bill's demise heightens their chances of passage. "You will see the states and cities scrambling to pass their own laws and regulations, and you're going to get a completely contradictory set of policies," Senator John McCain (R-AZ) predicted in a *Washington Post* article on July 8. In many areas of the country, one consequence is likely to be reduced access to health care for immigrants.

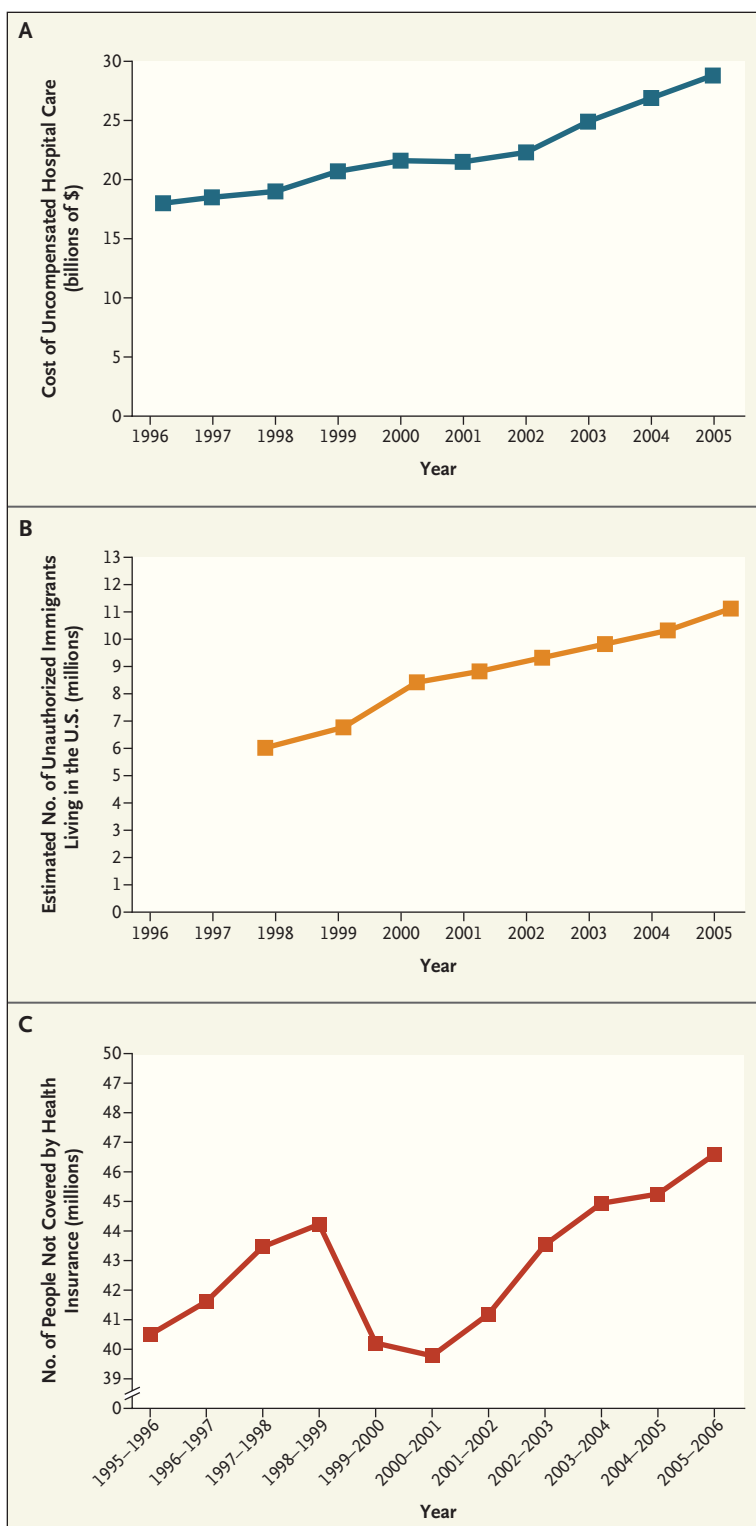
Noncitizens make up about 20% of the 46 million uninsured people in the United States. Hospitals generally do not collect information on patient immigration status, and there are no reliable national figures on hospital costs for undocumented immigrants. Nevertheless, the soaring cost of uncompensated care (see graph A) has made the problem of providing care for uninsured immigrants a hot political issue, particularly in border states and those (such as the southeastern states) whose immigrant populations have grown rapidly in recent years. Some uninsured immigrants needing emergency treatment (including pregnant women, children, adults

Cost of Uncompensated Care (Panel A), Number of Unauthorized Immigrants (Panel B), and Number of Uninsured People (Panel C) in the United States.

The annual cost to U.S. hospitals of uncompensated care (charity care plus bad debt) has been rising, although the fraction of total hospital expenses represented by such care has remained relatively constant at about 5 to 6% since 1980. The number of unauthorized immigrants present in the United States has also been increasing, although the estimates are uncertain. Treatment of unauthorized immigrants contributes to uncompensated care costs, but the main reason such costs are increasing is the rise in the number of people who lack health insurance. Immigrants represent only about 20% of the uninsured. Data on uncompensated care are from the American Hospital Association; data on unauthorized immigrants are from the Pew Hispanic Center; data on the uninsured are from the U.S. Census Bureau.

with dependent children, and elderly, blind, or disabled patients with incomes below Medicaid thresholds) qualify for emergency Medicaid coverage. In many other cases, hospitals receive no payment for their care, although in 2003 Congress appropriated \$250 million per year for 4 years (starting in 2005) to partially compensate hospitals for treating undocumented immigrants.

A recent study found that although emergency Medicaid spending for immigrants in North Carolina grew by 28% between 2001 and 2004, it still represented less than 1% of the state's Medicaid budget.³ More than 80% of that spending was for childbirth and complications of pregnancy, and major injuries accounted for nearly one third of the rest. In California, emergency Medicaid spending for uninsured immigrants for fiscal year 2007 exceeded \$941 million, according to Kim Belshé, secretary of the California Health and Human Services Agency. "Clearly, there are medical needs faced by this population," said Belshé, "and the emergency room is not the most cost-effective



place for [addressing] them." In addition, undocumented immigrants may account for as much as \$750 million annually of the cost of uncompensated care in California hospitals — about 10% of the annual total — since they represent about 10% of the

state's emergency department patients, according to Jan Emerson, vice president of external affairs for the California Hospital Association. "Almost half of the hospitals in California are currently operating in the red," she said. "It would not be fair to place the blame solely on undocumented immigrants, but certainly, they are a contributing factor."

The chief sources of outpatient care for uninsured immigrants are public clinics and community health centers. Such clinics are often sparse in suburban and rural areas that have recently faced an influx of immigrants. Even in cities with strong community-clinic networks and a long history of serving immigrants, access to care is uneven. For example, at the Venice Family Clinic, a bilingual nurse educator runs health and exercise classes in Spanish and English for patients with diabetes, pregnant women receive free state-subsidized prenatal care, and there are regularly scheduled clinic sessions for victims of torture and human trafficking. Yet arranging specialty referrals is a constant challenge — it usually entails sending patients to outpatient clinics at county hospitals, where some have to wait as long as a year for an appointment. In the Washington, D.C., area uninsured women, including undocumented immigrants, can get free annual mammograms and Pap smears through subsidized cancer-screening programs, but follow-up treatment for abnormal findings other than cancer is usually not included, and many clients have no source of primary care, as noted by nurse practitioner Wessel, who works monthly at one such pro-

gram. "Patients come in year after year" for Pap smears — "but they've never had their blood pressure checked," she said. "We don't check it, because all we're financed to do is cervical- and breast-cancer screening."

In states seeking to expand insurance coverage, the question of including undocumented immigrants is a thorny one. About 1 million of California's 4.8 million uninsured residents are undocumented adults, and about 136,000 are undocumented children.⁴ As part of a proposal for comprehensive health care reform, Governor Arnold Schwarzenegger is seeking to provide health insurance coverage (through Medicaid and the State Children's Health Insurance Program, or SCHIP) to all children with family incomes at or below 300% of the federal poverty level, regardless of immigration status. Although there is considerable public support for insuring undocumented immigrant children, Republican state legislators "do not believe that state general fund revenues should be invested in people who are here illegally," said health secretary Belshé — "and that extends to children."

The federal Medicaid program has always been restricted to U.S. citizens and legal residents, but recent federal and state laws designed to strengthen enforcement of eligibility rules have created new barriers, even for infants and children who are citizens, and have had a chilling effect on other programs providing health services for immigrants. The 2005 Deficit Reduction Act requires all persons applying for or renewing Medicaid coverage to provide proof of identity and U.S. citi-

zenship. Since that law went into effect, at least eight states have reported dramatic declines in Medicaid enrollment, and some Medicaid-eligible infants and children have gone without immunizations and needed medical care because of delays in coverage.⁵

In Georgia, which last year passed a law requiring immigrants to show proof of legal residency in many situations, "we've started seeing a lot of kids not going to the doctor," said Flavia Mercado, a pediatrician who runs the International Medical Center at Atlanta's Grady Memorial Hospital. "A lot of my clients are leaving and going to other states, and a couple are even going back to their country. Everyone is very fearful." She said that Atlanta organizations are scaling back health services for Hispanics and have stopped sponsoring Hispanic health fairs, fearing that they will be raided by police or immigration officials. Meanwhile, faced with rising health care costs and increasing numbers of uninsured persons, the state's Medicaid program has sharply reduced benefits: it recently stopped paying for prenatal care for high-risk women and for nonemergency hemodialysis. Although immigrants make up a minority of the uninsured, Mercado said media reports regularly blame illegal immigrants for the worsening problems of the state's health care system. Anger over high medical costs and reduced access to care no doubt contributes to anti-immigrant sentiment; the remedy, however, is not immigrant bashing, but health care reform.

"As an American citizen, I understand that you want to

make sure the resources are there for the right people,” Mercado said. “Yet how can you deny someone health access? If we don’t treat and prevent illness . . . our whole community is going to suffer.”

Dr. Okie is a contributing editor of the *Journal*.

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BECOMING A PHYSICIAN

Terra Firma — A Journey from Migrant Farm Labor to Neurosurgery

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“You will spend the rest of your life working in the fields,” my cousin told me when I arrived in the United States in the mid-1980s. This fate indeed appeared likely: a 19-year-old illegal migrant farm worker, I had no English language skills and no dependable means of support. I had grown up in a small Mexican farming community, where I began working at my father’s gas station at the age of 5. Our family was poor, and

we were subject to the diseases of poverty: my earliest memory is of my infant sister’s death from diarrhea when I was 3 years old. But my parents worked long hours and had always made enough money to feed us, until an economic crisis hit our country in the 1970s. Then they could no longer support the family, and although I trained to be a teacher, I could not put enough food on the table either.

Desperate for a livable in-

come, I packed my few belongings and, with \$65 in my pocket, crossed the U.S. border illegally. The first time I hopped the fence into California, I was caught

eating anything I could get, with hands bloodied from pulling weeds — the very same hands that today perform brain surgery.

My days as a farm worker



and sent back to Mexico, but I tried again and succeeded. I am not condoning illegal immigration; honestly, at the time, the law was far from the front of my mind. I was merely responding to the dream of a better life, the hope of escaping poverty so that one day I could return home triumphant. Reality, however, posed a stark contrast to the dream. I spent long days in the fields picking fruits and vegetables, sleeping under leaky camper shells,

taught me a great deal about economics, politics, and society. I learned that being illegal and poor in a foreign country could be more painful than any poverty I had previously experienced. I learned that our society sometimes treats us differently depending on the places we have been and the education we have obtained. When my cousin told me I would never escape that life of poverty, I became determined to prove him wrong. I took night