

Immigrant health care in the United States: What ails our system?

Current policies regarding health care for the growing immigrant population can result in delayed diagnoses, more disease in the community, and higher morbidity and mortality.

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Is everyone in the United States entitled to health care? If so, how much does each person deserve? If not, how should it be allocated? And, perhaps most crucially, who pays for it? These questions have been raised in presidential debates, editorial columns, and conversations around the country. The debate already bears the weight of failed proposals and personal frustrations, but it takes on additional intensity when applied to people who are in this country without documentation. The problem of undocumented immigration has broad economic, political, and cultural implications, but as health care providers, our primary concern is with the medical needs of our patients and communities.

THE SCOPE OF THE PROBLEM

Nearly 46 million people in the United States are currently estimated to be without health insurance, representing approximately 15% of the total population.^{1,2} For the native-born, the uninsured rate is 12.7%, but among noncitizens, a group that includes temporary workers, foreign students, permanent legal residents, and those here without documentation, the rate is 43.8%.^{1,3} This difference means that noncitizens are vastly overrepresented within the population of uninsured persons.² Moreover, the number of immigrants without insurance, including those entering with or without documentation, is growing. Government estimates as of January 2005 place the number of undocumented immigrants at 10.5 million, representing 29% of the total foreign-born population.^{4,5}

IMMIGRANT USE OF HEALTH CARE

Immigrants and the native-born use health care resources differently, with immigrants typically accessing them less frequently. Figure 1 (page 35) compares health care access by citizens and noncitizens.⁶ The majority of health care received by undocumented immigrants comes through emergency departments (EDs), while most of the remaining care is obtained through public clinics and community health centers.^{3,4}

A national study comparing health care expenditures between immigrants and those born in the United States found that native-born adults and their children consume statistically significantly more dollars per capita for health



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care.² The one exception is that children of immigrants have a higher per capita expenditure for ED visits than do children of the native-born when adjusted to take into account age, ethnicity, poverty level, insurance status, and patient-reported health status.²

A 2000 study uncovered additional differences between native-born and foreign-born residents regardless of their citizenship status. The study showed that immigrants were more likely to have no health insurance, report fewer medical conditions, spend less on health care, have fewer interactions with the health care system, and have lower household incomes.⁴ These differences were magnified when the native-born were compared with undocumented immigrants.⁷

Interestingly, immigrants in general and the undocumented in particular report lower levels of cancer, heart disease, arthritis, depression, hypertension, and asthma than do the native-born. Researchers attribute lower rates of health care usage and lower reported chronic disease to several factors. The first consideration is that compared with the native-born population, immigrants are relatively young, resulting in a healthier immigrant population. The second is that the process of migration itself, especially in cases of people entering without documentation, may positively select for health since the less healthy are unable to make the often arduous journey.⁷

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A third possibility is that many immigrants, especially the undocumented, may avoid seeking health care for fear of being noticed by authorities. Immigrants are more likely to wait until they are acutely ill and then access emergency care rather than seek preventive care earlier in the disease process.³ Figure 2 (page 36) shows a comparison of ED use by citizens versus noncitizens.⁶

Other reasons may be financial. Given the low number with health insurance and an average income approximately 25% that of the native-born, undocumented immigrants may not be able to afford preventive health care and may have

“Some states reported decreases in the numbers of children being vaccinated after stricter Medicaid requirements were passed.”

chronic medical conditions that have yet to be diagnosed or treated.² One of the reasons so few immigrants have health insurance may be that lack of health insurance is associated with lower education levels, higher poverty rates, and less-skilled jobs that are less likely to provide health insurance.⁸ The exception to this pattern is immigrants who are in the United States with refugee or asylum status. These individuals are more likely to have insurance because they are granted immediate access to welfare and Medicaid.⁹

GOVERNMENT POLICIES

Public funding for preventive and ongoing health care for the poor occurs primarily through Medicaid, the costs of which are usually split equally between federal and state governments.¹⁰ In 1996, as part of welfare reform, the Personal Work and Responsibility Reconciliation Act reduced immigrants' access to Medicaid by delaying eligibility for federal benefits until after they had attained permanent resident status for five years and denying benefits to undocumented and nonpermanent residents. The net effect of this policy change was to shift responsibility for immi-

grant health care from the federal government to state and local governments.³

Emergency medical care is treated differently. The Emergency Medical Treatment and Active Labor Act (EMTALA) of 1985 requires that anyone who enters a hospital with an emergency or in active labor be screened and treated until ready for discharge or stable for transfer, regardless of that individual's ability to pay. Emergency Medicaid does not require proof of citizenship or residency and thus can be used by anyone in the United States, including visitors, foreign students, and undocumented immigrants.¹¹

Critics of the law have argued that “emergency” is poorly defined and can include true emergencies, such as gunshot wound, automobile trauma, and cardiac arrest, as well as cough, headache, hangnail, drug addiction, HIV infection, mental problem, or personality disorder.¹² Some opponents argue that EMTALA places an undue burden on the hospitals because it requires them to perform certain services without additional government compensation and amounts to an “unfunded federal mandate.”¹²

Because EDs must treat patients without regard to their ability to pay, many people without health insurance rely on these facilities for their primary care. This pattern has increased the overall costs of health care because treatment for a nonemergent condition is more expensive at an ED than at a primary care clinic.¹³

ASSOCIATED COSTS

Immigration is associated with increased expenditures that are mostly offset but not evenly distributed between service providers. State and local governments incur most of the costs of providing social services, such as education and health care, and in return, they receive sales and property taxes. In contrast, the federal government incurs few expenses but collects an unclaimed \$7 billion a year through the Social Security Administration, most of which is thought to be from undocumented immigrants. This unequal distribution of resources has increased the burden on state and local governments with large immigrant populations.⁸

The Government Accountability Office found that states with high immigration rates also had rapid rises in Emergency Medicaid expenses and increased demands on local

KEY POINTS

- Nearly 15% of the total US population is without health insurance, but among noncitizens, that rate is 43.8% and growing.
- Immigrants are more likely to have no health insurance, report fewer medical conditions, have fewer interactions with the health care system, have lower household incomes, and consume fewer dollars per capita of health care expenses than do the native-born.
- The majority of health care for undocumented immigrants comes through emergency departments. This has increased the overall costs of health care; changed our focus from preventive care to emergency treatment; contributed to delays in identifying illnesses until later, more advanced stages; and increased the level of disease within a community.
- A federal proposal to provide \$1 billion to help hospitals cover emergency treatment for uninsured undocumented immigrants was dropped out of fear that the requirement to know patients' immigration status would lead them to seek treatment even later than they were.
- Health care provider professional organizations have been consistently in favor of patients' rights regardless of their immigration status, have opposed legislation that would require health care providers to ask about a patient's immigration status, and need to continue to be advocates for our patients and our communities.

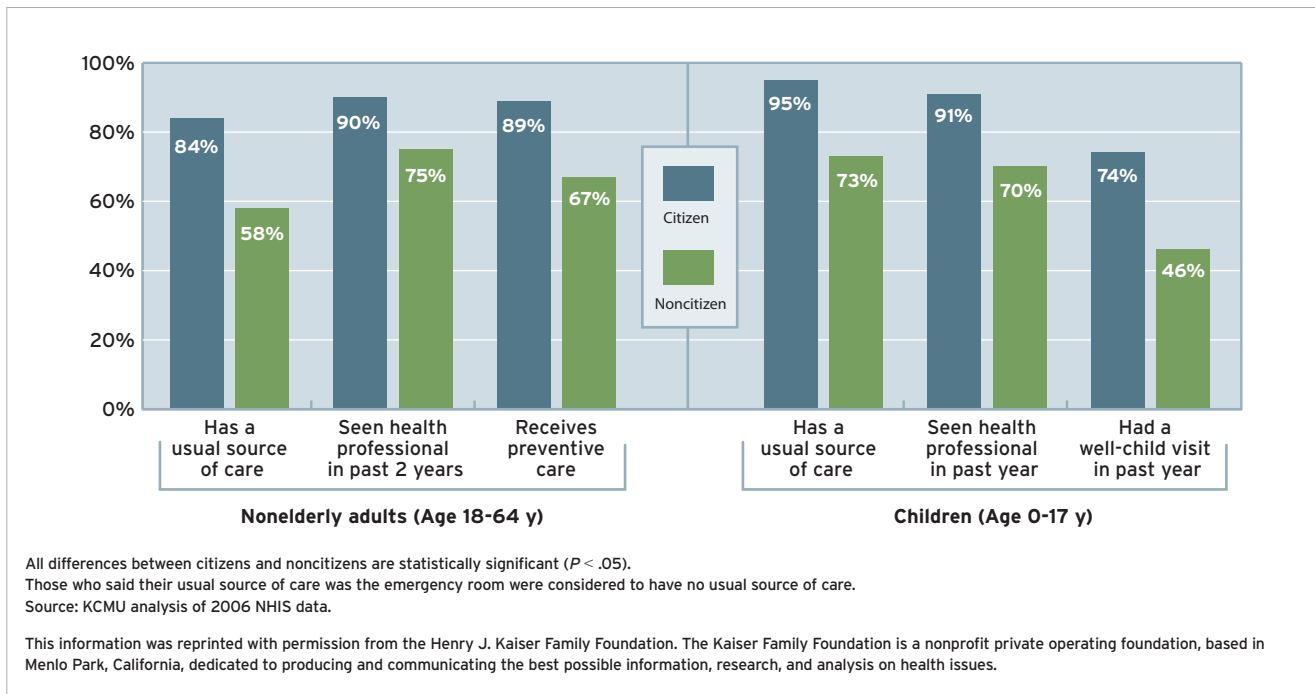


FIGURE 1. Access to and use of care for adults and children by citizenship status

EDs.⁴ In 2003, the federal government proposed providing \$1 billion over four years to help hospitals cover emergency treatment for uninsured undocumented immigrants. This proposal would have provided much-needed funds but would have required hospitals to inquire about patients' immigration status. The proposal was withdrawn in 2004 because of concerns that asking about immigration status would lead undocumented immigrants to seek treatment even later than they already were, thereby contributing to additional spread of disease within the community and more serious medical problems when patients finally did seek care.¹⁴

Undocumented immigrants pay a higher percentage (36%) of their health care expenses out of pocket than do native-born adults (20%). Additionally, a higher percentage of expenses generated by native-born adults (28%) are paid for by public sources compared with those of undocumented immigrants (23%).⁷ Even so, there are costs that are not covered, and hospitals are forced to absorb some of these. One estimate places unpaid hospital bills for undocumented immigrants at \$2 billion annually.²

The cost at the state level can be overwhelming, especially in California, which has more undocumented immigrants than any other state.⁵ One source estimated that the net cost of providing government services to undocumented immigrants in California was close to \$3 billion during one year alone.⁹ Undocumented immigrants are thought to be responsible for 10% of uncompensated hospital care in California and 10% of all ED visits. They may incur unpaid hospital expenses of \$750 million annually through charity care, unpaid bills, and care that is uncompensated by the federal

government. In addition, undocumented immigrants may account for \$941 million of Emergency Medicaid spending in California.³ This deficit may have contributed to the closings of 60 hospitals in that state between 1993 and 2003, many because of financial deficits from unpaid services.¹²

EFFECTS OF CURRENT PRACTICES

The large number of people without adequate health insurance negatively impacts community and personal health, adds to the strain on the US health care system, and increases the cost of health care. Poor access to health care changes our focus from preventive care to emergency treatment; contributes to delays in identifying illnesses until later, more advanced stages; and increases the level of disease within a community.

Prenatal care is one area in which prevention is clearly documented to be cost-effective. A number of neurologic birth defects can be prevented through inexpensive OTC folic acid supplements, but without adequate prenatal counseling, pregnant women may remain unaware of this fact. One study concluded that increasing public funding for prenatal care of undocumented immigrants would lower health care expenditures overall by decreasing the incidence of low-birth-weight babies, prematurity, and associated postnatal costs.¹⁵

Children of undocumented immigrants are more likely to lack a medical home and instead be brought to EDs in part because of parental fear that they will draw the attention of immigration authorities. When children receive their care in EDs, continuity of care is interrupted and they remain untreated until later stages of an illness. This pattern is present

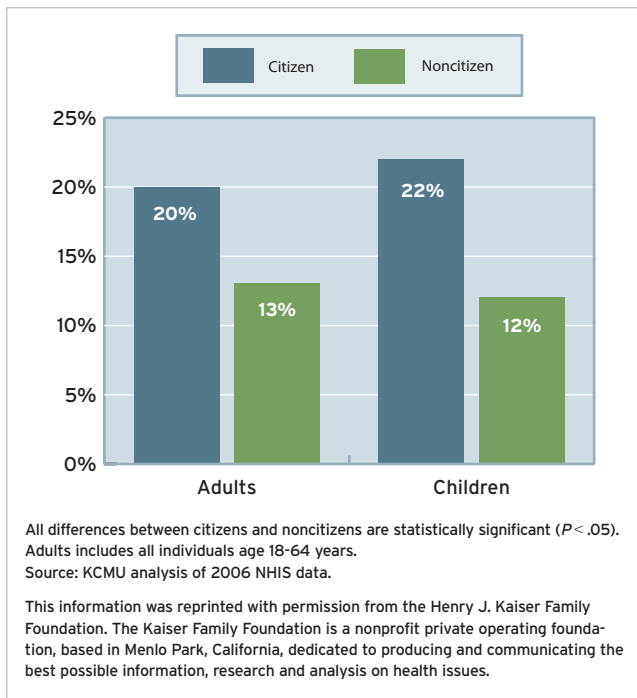


FIGURE 2. Percent of adults and children with an emergency room visit in the past year, 2006

even if the child has legal status but the parent does not. The overall result is a lower quality of care and a higher incidence of more serious illnesses requiring hospitalization, such as pneumonia or sepsis.¹⁶

Children of undocumented immigrants are also less likely to receive vaccinations on schedule. Some states reported decreases in the numbers of children being vaccinated after stricter Medicaid requirements were passed.³ The presence of unimmunized individuals within a community leads to a decrease in “herd immunity” and an increase in the likelihood that a disease will move from an isolated outbreak to a significant community presence. Those people who are immunocompromised are then more likely to be exposed to a communicable illness and are at greater risk for more serious outcomes.

Atypical communicable diseases enter the United States through immigrants, who have been implicated in a 17% increase in tuberculosis in Virginia; a 188% increase near Washington, DC; and 81% of new cases in Queens, New York. In addition, more of these cases are due to drug-resistant bacterial strains than are those contracted from the native-born. Forty-two percent of all new tuberculosis cases are linked to immigrants, here both legally and illegally.¹² The sooner these cases are identified and treated, the fewer people in the community will be exposed, the more the spread of the illness will be limited, and the less microbial resistance will develop.

During the naturalization process, communicable diseases are generally identified and treated. In contrast, undocumented

immigrants may not be aware they have a disease or may not seek treatment for it; either of these scenarios can expose large segments of the community to illness.⁹ This situation is especially problematic when the disease is not typically found in a community, such as Chagas disease, malaria, leprosy, plague, polio, and dengue fever.¹² Community members are unlikely to recognize the early signs of an atypical illness or to have immunity to it. In addition, health care providers may not have adequate training or experience in identifying the disease and may misdiagnose patients, leading to delays in treatment.

HEALTH CARE PROVIDER RESPONSE

The AAPA, AMA, American Academy of Nurse Practitioners, American Osteopathic Association, and American Nurses Association have codes of ethics that address justice, nondiscrimination, and confidentiality.^{17,20} As such, they stand in opposition to legislation that would restrict health care providers from treating undocumented immigrants or require providers to report immigration violations. Accordingly, the response of health care provider professional organizations has been consistently in favor of patients’ rights regardless of their immigration status. These organizations have also opposed legislation that would require health care providers to ask about a patient’s immigration status.

When Medicaid eligibility requirements were changed and additional barriers created for undocumented mothers to get medical care for infants born in the United States, six organizations opposed it. According to the American Academy of Family Physicians; American Academy of Pediatrics; American College of Obstetricians and Gynecologists; Association of Women’s Health, Obstetric and Neonatal Nurses; March of Dimes; and National Association of Children’s Hospitals, that policy would lead to both delays and reductions in coverage of infants, as many parents would be unable to obtain the appropriate paperwork.¹⁶

Rick Kellerman, MD, former president of the American Academy of Family Physicians, summarized health care provider opposition to this restrictive legislation, stating:

There are humanistic, political, and practical reasons to minimize the barriers to newborns, in particular, getting care. I don’t think physicians want to be in a situation where they are enforcing the [immigration] law. It’s not fair to put either the physicians or children in the middle of U.S. immigration policy.¹⁶

Senate and House of Representatives bills proposed in 2005 and 2006 were designed to decrease illegal immigration, but they would also have made it a felony for health care providers to give care to undocumented immigrants. The bills did not pass, but major health care organizations were motivated to clarify their positions on these issues. The AMA passed a policy called “Opposition to Criminalization of Medical Care Provided to Undocumented Immigrant Patients,” and in May 2007 at its annual conference, the AAPA passed with near-unanimity a similar resolution stating that:

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The American Academy of Physician Assistants believes that all patients deserve access to health care and opposes the establishment of local, federal, or state initiatives that require health care providers to refuse care to undocumented persons or to report suspected undocumented persons to authorities.^{2,1}

CONCLUSION

The increasing numbers of undocumented immigrants residing in the United States are resulting in a large uninsured population. In addition to the societal, financial, and ethical problems this situation presents, health care workers face additional concerns regarding access to care, community health, and prevention of illness. While the health care community has consistently opposed legislation that would impede access to care, ongoing vigilance and education are needed to protect the health of all of our patients and communities. **JAAPA**

Katherine Footracer works in urgent care and family practice in Scotch Plains, New Jersey. She has indicated no relationships to disclose relating to the content of this article.

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