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STRETCHING THE SAFETY NET TO SERVE UNDOCUMENTED IMMIGRANTS: COMMUNITY RESPONSES TO HEALTH NEEDS

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A small but increasing proportion of immigrants to the United States is undocumented. Because most undocumented immigrants lack health insurance, they primarily rely on safety net providers for care. Communities with more developed safety nets and historically large numbers of immigrants appear more adept at caring for both legal and undocumented immigrants, according to Center for Studying Health System Change's (HSC) 2005 site visits to 12 nationally representative communities. Communities with less experience caring for immigrant populations and less-developed safety nets face challenges caring for this population, but many are taking steps to improve their ability to meet immigrant needs. As the number of immigrants in the U.S. grows, the need to develop community health care capacity for immigrants will intensify.

Undocumented Immigrants and Health Care Coverage

While immigration into the United States has decreased since peaking in 2000,[1] immigration levels remain high. Recent reports indicate that an increasing proportion of immigrants lack health insurance,[2] and more newly arrived immigrants are undocumented, in part because of a decline in visas granted after the 2001 terrorist attacks.[3,4] Though precise estimates are difficult, more than 10 million undocumented immigrants live in the United States, almost one third (29%) of the foreign-born population.[5]

Latinos represent the majority of the undocumented group. Nearly two-thirds are concentrated in eight states, including five states with HSC site-visit communities (see Data Source)—California, New York, Florida, New Jersey and Arizona—but growth has been rapid in other areas as well.[6]

Immigrants in general are significantly more likely to be uninsured than native citizens, and while immigrants are as likely to work, a disproportionate number work in low-wage jobs that do not offer health coverage.[7] Immigrants also have lower rates of public coverage. Federal law generally prohibits legal immigrants from enrolling in Medicaid and the State Children's Health Insurance Program (SCHIP) for the first five years they reside in the United States. Undocumented immigrants generally are ineligible for Medicaid or SCHIP regardless of their length of residency in the United States.

However, all immigrants are eligible for emergency Medicaid, which covers treatment for a medical emergency, regardless of their status. Also, hospital emergency departments generally must screen and stabilize all people with an emergency medical condition under the federal Emergency Medical Treatment and Labor Act.

During HSC's 2005 site visits, researchers examined health care services available to undocumented immigrants. Obtaining specific information about undocumented immigrants was difficult because health care providers reported not attempting to distinguish patients by documentation status. HSC particularly focused on the roles of safety net providers—the group of hospitals, community health centers or free clinics, and, in some cases, local health departments—that provide the bulk of care to low-income, uninsured people. As part of their mission, safety net providers are generally open to seeing all patients and often rely heavily on public funding. Despite not differentiating patients by legal status, many respondents recognized the unique circumstances of illegal immigrant patients, shedding light on how providers and communities are responding to the issues presented by this group, as well as those of the larger immigrant population.

A Spectrum of Community Need, Readiness and Response

The perceived size of the undocumented immigrant populations and the subsequent demand on local heath care systems varied across the 12 HSC communities. At one end of the spectrum are Orange County, Miami, Phoenix and northern New Jersey—communities with long immigrant

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histories and larger numbers of undocumented residents. At the other end are such communities as Syracuse and Lansing that have limited numbers of undocumented immigrants, mostly seasonal migrant workers, who place little demand on health care services. In between fall the other HSC communities—Boston, Cleveland, Seattle, Greenville, Indianapolis and Little Rock—the latter three experiencing more recent growth in their Latino populations, including undocumented immigrants. A number of factors influence communities' responses to undocumented immigrants' health care needs, including:

Safety Net Capacity

In general, a community with a well-developed safety net is more prepared to serve undocumented immigrants—patients who are uninsured, have limited English proficiency and face many barriers to integrating into American society, including the fear of deportation. A well-developed safety net may include a relatively extensive network of public or private hospitals and community health centers that tries to respond to charity care needs. For example, Boston, Seattle, Indianapolis and Cleveland have public hospitals and a relatively robust number of community health centers, including organizations that focus on Latinos and other immigrant groups. Communities with well-developed safety nets may be more adept at serving undocumented immigrants than communities with less extensive safety nets, because they are used to dealing with populations that need more help and often have extra support services in place to help these persons.

Communities experiencing rapid growth in both legal and illegal Latino immigrants have responded by developing new service capacity. In Little Rock, religiously affiliated free clinics have been a longstanding source of care for Latino immigrants. More recently, because of increasing numbers of Latino patients, Children's Hospital is planning a family clinic targeted at Latinos in conjunction with the Little Rock Community Health Center. In Indianapolis, Wishard Hospital opened the Pecar Health Center, where the majority of patients are Spanish-speaking and providers are bilingual. And some safety net providers in Greenville have expanded in the region between Greenville and Spartanburg, which has experienced significant population growth, including undocumented immigrants. Other community programs for uninsured persons are for the most part inclusive of undocumented immigrants. For example, the Wishard Health Advantage program in Indianapolis and the Ingham Health Plan in Lansing, both managed care programs for low-income, uninsured persons, require only that a person be a county resident and meet certain income guidelines. On the other hand, Medwell Access, a physician charity care program in Greenville, does not treat non-citizens.

Many safety net providers reported increased demand for services from uninsured patients. As part of this group, undocumented immigrants can typically access primary care through safety net providers, but providers report more difficulty referring undocumented immigrants for specialty care. In several communities, waiting times to see specialists in safety net hospitals have reportedly increased, with waiting times the longest for the uninsured. Other problem areas mentioned include the provision of chronic care treatment, mental health care and obtaining affordable prescription drugs, because program rules often impede services for undocumented patients. For example, most drug manufacturer patient assistance programs require citizenship or legal immigrant status.

Community Diversity

Regardless of their insurance or legal status, immigrants often face language and cultural barriers in accessing health care. Communities with more immigrants are a step ahead in bridging language gaps and providing culturally sensitive care than communities with less experience. In Phoenix, Orange County, Miami and northern New Jersey, safety net providers are often bilingual, and multilingual signage is common in hospitals and clinics. For example, University Hospital in northern New Jersey now has all forms and signage in Spanish and French Creole, as well as Spanish-speaking in-house translators.

Communities with historically less diverse populations that have faced recent

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increases in immigrants have responded to language and cultural gaps by developing more formal programs. For example, Medverse, a grant-funded four-hospital collaboration in Greenville, offers translation and interpretation services to the hospitals and other providers at reduced cost. In addition, Wishard Hospital in Indianapolis created the Hispanic Health Project 10 years ago, which has grown to include more than 20 bilingual interpreters and has been used as a model for other area hospitals. Yet, respondents in both communities still noted a growing need for more interpretation services, citing lack of money to hire interpreters and not enough interpreters in the community as obstacles.

Communities that have yet to experience large numbers of immigrants typically have not made such basic changes as having on-staff interpreters or multilingual signage in hospitals. However, in part because Syracuse and Lansing have been refugee resettlement sites for some time, there have been efforts to improve language barriers for non-English speaking persons. For example, the Westside Family Health Center in Syracuse has bilingual providers for the majority of its patients, and the local refugee center also provides interpreters for the health center. While federal civil rights laws require health care providers receiving federal funding to provide language assistance to patients with limited English proficiency, respondents across the 12 communities did not cite the requirements as a driving force behind developing this capacity.

Language and cultural barriers can impact access to and quality of care. Problems discussing symptoms or treatment regimens can lead to misdiagnoses, as well as patient noncompliance with suggested therapy.[8] These problems are reportedly magnified for undocumented immigrants. Market observers noted that it is common for undocumented immigrants to withhold basic contact information and medical histories, which can hinder provider assessments. Health care providers and others consistently said that undocumented immigrants delay seeking care because they fear being detained or deported by immigration officials. Thus, when they do show up for care, they often are in more serious condition.

Political Climate

Political sentiments also affect community responses to serving undocumented immigrants and their experience with the health care system. Tension has risen in some communities with many undocumented immigrants, particularly over publicly financed services being used by undocumented persons. In Arizona, voters passed Proposition 200 in November 2004, which requires state and local employees screening applicants for public programs to report undocumented persons to federal immigration officials. Although health services are excluded from the law, community health centers in Phoenix reported a temporary drop in the use of services by undocumented patients after the proposition took effect. Likewise, California witnessed earlier unsuccessful ballot initiatives to curtail services for undocumented immigrants. Little backlash against undocumented immigrants was evident in the other communities, with the exception of Little Rock, where state legislation was introduced but rejected that would have denied undocumented persons access to all publicly financed services.

Advocacy/Community Interest Groups

In most of the HSC communities, ethnic-affiliated, religious or other nongovernmental organizations are the nexus for a wide range of human services for immigrants. Influential immigrant advocacy groups are often found in communities with a longstanding history of immigrants and well-developed safety nets. Many advocates sponsor or collaborate with community health centers or free clinics oriented toward the health needs of uninsured immigrants.

Community groups are active in trying to improve health status and bridge language and cultural gaps for people with limited English proficiency. For example, Latino Health Access in Orange County has community workers in neighborhoods trying to improve Latino public health through free programs in such areas as diabetes self-management, mental health, women's health and obesity prevention. The Community Health Access Program in Seattle, which helps connect people with health care services or coverage, uses a telephone interpreter service to assist people, and about half of its staff speaks Spanish.

Financial Resources

In most communities, there is little resistance to allowing publicly financed providers to care for undocumented patients, but most communities have not provided or received additional funds to support providers serving this population. Care is usually financed through general sources, including disproportionate share hospital payments, grants to federally qualified health centers, cross-subsidization through cost shifting by hospitals and in physician practices, and in some cases, emergency Medicaid coverage.

Some states use state funds or a federal SCHIP option to cover undocumented children or pregnant women. Eight of the 12 states with HSC communities provide some form of coverage for prenatal care or children regardless of immigration status.[9] For example, Arkansas' ARKids program extends coverage for prenatal care for low-income immigrants regardless of legal status. In Washington, the Legislature recently reinstated the state-funded Children's Health Program, providing coverage for non-citizen immigrant children ineligible for other public assistance.[10] A waiting list reportedly already exists for this program, which will initially accept about 4,000 children.

Safety net providers in Orange County, Phoenix and Miami are facing increasing strain in part because of unstable finances and growing numbers of uninsured persons, including many undocumented immigrants. Financial problems have prompted Maricopa Medical Center, the public hospital in Phoenix, to curtail nonemergency care for undocumented immigrants. The hospital also worked with the Mexican Consulate to link people to services available in Mexico. In Orange County, similar efforts are underway. Safety net providers in Boston, Seattle and Cleveland also are facing increased demand by uninsured patients, but the strain from undocumented patients is less acute.

At the time of the site visits, providers in the HSC communities had not yet received any funding from the Medicare Modernization Act of 2003, which pro-

Data Source

Every two years, HSC researchers visit 12 nationally representative metropolitan communities to track changes in local health care markets. The 12 communities are Boston; Cleveland; Greenville, S.C.; Indianapolis; Lansing, Mich.; Little Rock, Ark.; Miami; northern New Jersey; Orange County, Calif.; Phoenix; Seattle; and Syracuse, N.Y. In 2005, HSC researchers interviewed health care providers and an array of observers in government and community agencies to explore how communities serve undocumented immigrant populations, including: the major sources of care for undocumented immigrants, the main challenges in meeting their health care needs, and community-wide initiatives that may be underway.

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vides funds to help hospitals and other health care providers with costs of providing emergency care to undocumented immigrants.[11] Providers reportedly could start filing claims for emergency services provided to eligible patients beginning in May 2005. While federal officials dropped a requirement that hospitals inquire about patients' immigration status to receive funds, confusion persists about how hospitals will seek information indirectly and with what impact on immigrants' care-seeking behavior. A few respondents in Phoenix were hopeful that the funding would impact providers favorably but noted that the money would still be insufficient to cover the full costs of caring for the undocumented population.

Implications

Federal policy makers have opted to provide minimal public assistance to legal immigrants for at least five years after their arrival in the United States, and with the exception of emergency care, undocumented immigrants receive virtually no assistance. But at the state and local level, both private organizations and governments have been more inclined to provide assistance.

As communities across the country face increasing numbers of immigrants, including a small but growing group that is undocumented and uninsured, demands on local safety net providers are likely to grow. Safety net providers in communities with historically large numbers of immigrants have taken steps to improve access to care for immigrants, including undocumented persons. Other communities new to serving immigrant populations are beginning to address these needs but face challenges. As the number of immigrants in the United States grows, the need for communities to develop adequate resources to meet immigrant health care needs will intensify, stretching an already-strained safety net. These constraints may lead the federal government to revisit its role in this issue.

Notes

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