Undocumented Immigrants and Healthcare in the United States of America

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Abstract

Undocumented immigrants in the United States lack healthcare rights. The healthcare system does not work in their favor, and these immigrants are often excluded from healthcare legislation. Other factors such as workplace exploitation and the fear of authorities amplify the risks for undocumented immigrants' health. This thesis seeks to elaborate on the different aspects that impact the health and healthcare of undocumented immigrants, and it does so by analyzing national, state and local laws and policies. State and local laws provide an interesting insight into points of improvement of the U.S. healthcare system on a national level. In order for improvements to be made to the system, public support for inclusion of undocumented immigrants in healthcare reform needs to be increased. To achieve this, public debate on inclusion of undocumented immigrants in healthcare reform is imperative, and correctly informing these debates even more so. Debate on this topic is often misinformed, and this could be improved by increasing attention to factual research and empirical evidence, and providing the American public with that information.

Keywords: undocumented, immigration, healthcare, policy.

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Important terms and abbreviations:

- Affordable Care Act (ACA)
- Children's Health Insurance Program (CHIP)
- Deferred Action for Childhood Arrivals (DACA)
- Emergency Medical Treatment and Active Labor Act (EMTALA)

Introduction

Healthcare and the insurance coverage of healthcare form an important part of political debates in the United States of America. At the time of writing, the United States is undergoing its democratic process in order to install the next president for the term of 2020-2024, in which healthcare and undocumented immigration are important issues. The concept of Medicare for All was an important spearpoint of senator Bernie Sanders (D-VT), and received a lot of attention both from the senator himself as well as from his opponents.

Considering the ongoing global crisis of the virus designated as COVID-19, more popularly known as Coronavirus, the most vulnerable in our global society have become even more prevalent in recent news and everyday conversations. Officially designated by the World Health Organization (or WHO) as a pandemic, the virus is painfully exposing the faults in the American healthcare system, with the United States of America wielding the absolute highest documented number of total COVID-19 cases in the world, sporting no less than 2 million cases as of June 2020[1]. COVID-19 is not the first hiccup to expose the faults in American healthcare, however. The system suffers under various malfunctions, and these issues hurt the people that the system is supposed to help. Moreover, the very design of the healthcare system excludes certain individuals from care that they may need, even though these people live and work in the United States of America. One of the communities that are bleeding disproportionately due to the flaws in the system are undocumented immigrants.

The aim of this thesis is to explore the difficulties that undocumented immigrants experience with the healthcare system and its supporting social structures, with the leading research question being: “In which ways are undocumented immigrants adversely affected by the current U.S. healthcare system?” To answer this question, this thesis consists of four chapters, each one discussing a different aspect of undocumented immigrants’ problems with the American healthcare system in a predominantly socio-political light. The contents of these chapters have been analyzed with the assumption that undocumented immigrants are, indeed, negatively affected by this system. Chapter I introduces us to the American legislative environment, discussing the most important laws that directly impact or lack impact on the healthcare rights of undocumented immigrants. Chapter II focuses on the direct and indirect consequences of (the lack of) legislative decision making for this community. This chapter also looks at how socio-economic circumstances impact the health of this group. Chapter III

[1] See Worldometer: https://www.worldometers.info/coronavirus/?utm_campaign=homeAdvegas1?.

delves further into the affected lives of undocumented immigrants and state-level legislation, discussing several studies that have treated the subject matter of care for undocumented immigrants in the context of states' individual laws and programs. Finally, chapter IV discusses United States political debates, public opinion, and informative efforts involved with undocumented immigrants and advocacy for their inclusion in policy reform.

This layout has been chosen and carefully adhered to in order to provide the reader with a clear image of the difficult situation that undocumented immigrants in the United States generally endure, in response to the question as to how this group is affected adversely by the American healthcare system. Although research on the topic spans wide, particular case studies have been selected and legislative decisions and issues have been included in order to provide an accurate general portrayal of undocumented immigrants' experiences with this healthcare system.

Chapter I

The American Legislative Healthcare Panorama

Acts involving healthcare and Americans' rights to healthcare have been prevalent in U.S. politics throughout the twentieth century up until this very day. A number of acts have been passed by Congress, and some have made a considerable impact on the U.S. healthcare panorama. Among the most historically famous acts involving healthcare and government assistance in healthcare issues of low-income households are the Medicaid and Medicare programs. Signed into law in 1965 by president Lyndon B. Johnson, the Medicare and Medicaid programs have become an integral part of American social security. With states averaging 20 percent in population coverage by Medicaid and 14% coverage by Medicare in 2018 [2], the two acts have become vital to the American health insurance panorama. The same graph that has been used to provide the statistics above indicates that 49% of all insured Americans are insured through their employers, and 6% have some form of insurance bought from private companies, together making up 55% of the U.S. health insurance system[3]. This demonstrates that even though the U.S. government has provided a substantial healthcare coverage system, the healthcare system is still largely based on people's employment status. Especially in the case of undocumented immigrants, this dynamic forms a substantial hurdle in acquiring health insurance coverage, due to their often disadvantageous position in the labor market. How this works will be further elaborated in chapter II, but for now this depicts that the American insurance panorama does not work in their favor.

Former U.S. President, Barack Obama, posed healthcare for the American people as an important issue in his campaign. President Obama addressed the American public about his proposal for reform in the contemporary healthcare system in 2009. The Patient Protection and Affordable Care Act was indeed expected to help many Americans in their experienced problems with the contemporary healthcare system. Undocumented immigrants, however, were excluded from this bill (Galarneau 422). This remains the situation up until this day.

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[2] See "Medicare" and "Medicaid" headers in table on Health Insurance Coverage by the Kaiser Family Foundation: https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[3] See "Employer" and "Non-group" header in table on Health Insurance Coverage table by Kaiser Family Foundation.

This is not necessarily out of the ordinary, as undocumented immigrants are usually not taken into consideration in the design of laws or administration's programs involving healthcare. So too in the Children's Health Insurance Program (CHIP), which has been instated by the U.S. government in 1997 with the Balanced Budget Act. CHIP "provides low-cost health coverage to children in families that earn too much money to qualify for Medicaid but not enough to buy private insurance."[4] The official name of the program differs per state, and details are filled in by states themselves. The Federal Government provides funding for the program, and it is being monitored by states' Medicaid departments. Undocumented immigrants cannot apply for this program, just as they cannot apply for Medicaid assistance. Here, too, we see that undocumented immigrants have been left completely out of consideration.

In a handful of legislation cases, however, we see an important difference. Among the most notable pieces of legislation that did, in fact, explicitly consider undocumented immigrants is the Emergency Medical Treatment and Active Labor Act (EMTALA), instated in 1986 by the U.S. Congress under the banner of the Consolidated Omnibus Budget Reconciliation Act (COBRA). Undocumented immigrants could no longer be denied an Emergency Medical Screening from the emergency departments of hospitals due to inability to pay. Seen from the point of view that undocumented immigrants had practically no healthcare rights prior to this, it was definitely a step in the right direction.

Nonetheless, this is only a marginal improvement for these people's healthcare situation, given that this is practically the only medical right which undocumented immigrants have, at least on a federal level. Follow-up treatments that may be medically required do not have to be provided by hospitals if the patient has no means of pay. Furthermore, this act was approved by Congress in 1986, which as of the time of writing has been nearly 35 years ago. Since then, little has changed that directly impacts the access to healthcare of undocumented immigrants, at least on a national level.

That being said, several improvements to healthcare access have been made through non-healthcare related acts instated by the U.S. Congress and programs brought to life in recent years that do benefit the healthcare situation of specific subgroups of undocumented immigrants. Among these improvements is the Deferred Action for Childhood Arrivals (DACA) program. Instated by President Obama in 2012, "the program provides temporary relief from deportation and work authorization to qualifying young immigrants who arrived in the United States as minors" (Aulema 1). By July 2019, the U.S. Citizenship and Immigration

[4] See HealthCare.gov: https://www.healthcare.gov/glossary/childrens-health-insurance-program-chip/, par. 1.

Services (USCIS) had received approximately 900,000 initial applications, of which it accepted 825,000 and denied 80,000 (Aulema 2).

Looking at the purpose of the program, it has made a successful impact for undocumented immigrants who arrived in the U.S. when they were young. This positive impact is also observed in the health and healthcare of this group. A 2018 study by Osea Giuntella and Jakub Lonsky found that although there was little evidence on a direct increase in healthcare use, "DACA-eligible individuals after 2012 were less likely to delay care because of financial constraints (-20%)" (Giuntella et al. 11). Adding up to that, the study observed a decrease of 5% in cost-related inability to pursue specialized medical care (Giuntella et al. 11). The study also reports that there was a 36% decreased likeliness of reporting depression and 50% decrease in the likelihood of feeling hopeless among individuals with income below the federal poverty level (Giuntella et al. 12), significantly increasing the overall mental well-being of this group.

A different, although very important, issue in terms of legislation is that of difference in healthcare provision between different states. States are provided with general guidelines and requirements in regards to how their healthcare system should function. As in many areas of politics and society in the United States, however, this aspect also falls under the state and often even local governments to fill in. Every state has a form of both Medicare and Medicaid, for example, but fill in their own details. This is also the case with CHIP, which every state mandates, but has such an individual freedom in terms of mandating that it even has a different designated name in some states. This also means that while the healthcare system in one state might take great care of its undocumented immigrants, another state might simply deny undocumented immigrants any form of aid if the need arises.

Particular cases have arisen over the past few years regarding communities that provide more assistance to undocumented immigrants than usual, both in their states and in the rest of the country. These cities are often designated as "sanctuary cities," and have become even more prominent in their advocacy for undocumented immigrants' rights in response to the strict immigration policy of the Trump administration, although these areas were already present on the American political panorama prior to this administration. Sanctuary cities provide protections, which can range from defensive measures such as preventing deportation by federal authorities to progressive action, even to the extent of "providing irregular migrants with all the privileges of residency irrespective of citizenship status" (Hoye 71).

Sanctuary cities eliminate many worries of its undocumented residents. These communities "recognize undocumented immigrants as contributors to and benefactors of shared resources" (Aboii 6). Among the general improvements to health care for undocumented immigrants, these communities provide vaccinations, follow-up care, and affordable medications (Aboii 6). Thus, sanctuary cities are important to the undocumented patients' healthcare panorama, and will be revisited among our case studies in chapter III. Naturally, these sanctuary cities in and of themselves are a positive development in the area of healthcare and undocumented immigration in general. Nonetheless, these improvements are only very local, and they do not enjoy the endorsement of every U.S. citizen or the federal government itself, for that matter.

Nationally, the legislation and provision of medical rights for undocumented immigrants are lacking. Even in an age where social justice seems all the more important and new injustices seem to be brought to light every day, severe change has yet to be made in this area. As will be further elaborated on in chapter IV, public opinion on undocumented immigrants' inclusion in healthcare legislation is very polarized. In general, supporting legislation in favor of undocumented immigrants could quickly alter a political candidate's standing with the American public, be they either candidate for a national or local position. On their webpage about Health Coverage and Care of Undocumented Immigrants the Kaiser Family Foundation (KFF) confirms that Democratic presidential candidates have shown support for expanding coverage to undocumented immigrants before, but that concrete proposals have not yet been made.[5]

As far as suggestions made in terms of altering legislation, KFF indicates that such an expansion would depend on several contextual factors, such as types of coverage and benefits provided. The foundation also states that part of the increase in expenses for broader coverage would be offset by the "existing resources currently going toward care for undocumented immigrants" (par. 13). These currently used resources primarily exist in inefficient care and the heightened costs of treatments for undocumented patients. These issues are caused by the fact that many of these immigrants lack any medical rights except for EMTALA, which only grants them access to immediate care for life-threatening situations. The lack of any other medical rights beyond EMTALA creates problems for both undocumented patients as well as care deliverers, and practically wastes money where it could be used more efficiently.

Interestingly, the majority of these improvements have been made under Democratic administrations. The Obama Administration has actually provided some of the most drastic

[5] See "Health Coverage and Care of Undocumented Immigrants," by KFF: https://www.kff.org/disparities-policy/issue-brief/health-coverage-and-care-of-undocumented-immigrants/, par. 13.

changes in healthcare legislation in the past decade or two. Although only part of this work actually benefits undocumented immigrants, it is still a remarkable improvement. Unfortunately, this work by the former Democratic President and his administration is fiercely opposed by the current Republican President of the United States, Donald J. Trump. Vigorously attacking undocumented immigrants in his speeches and public rallies, the country's current President forms another issue on the already substantial portfolio of problems relating to their health that undocumented immigrants have to deal with.

This chapter has explained the most important pieces of legislation involving healthcare coverage and provision among undocumented immigrants in the United States. As these acts and programs portray a clear image of the legislative panorama of healthcare for undocumented immigrants, we can see that several major steps have been made since the mid-twentieth century, although undocumented immigrants are still largely excluded from lawful medical benefits.

Chapter II

The Consequences of Exclusion from Legislative Decision Making

The indifference towards undocumented immigrants in the healthcare system of the United States is harmful for these people. Inquiries have been made into how undocumented immigrants are affected by their legal status and the effect that this status has on their lives in terms of healthcare. As many of these inquiries point out, undocumented immigrants find themselves caught in a loop of conditions that pose a serious threat to these people's health and livelihood. These conditions do not link solely and directly to healthcare provision, but rather connect to different policy areas and conditions in the United States that together create dangerous environments for undocumented immigrants.

An undocumented status directly impacts immigrants' livelihoods in the United States, which in turn affects these immigrants' health. Unsafe working as well as living conditions are among the direct effects of one's legal status (Samra et al. 792). A dangerous daily environment naturally impacts the well-being of the persons involved. Someone who does physical labor under dangerous conditions has a higher risk of directly impeding their health than someone who works behind a desk, under relatively safe labor conditions. Given undocumented immigrants' legal status, they are often driven into taking on such risky jobs, which increases their likelihood of directly sustaining physical injuries. Meanwhile, these types of jobs often lack healthcare benefits from the employer and provide compensation that is insufficient for these people to be able to afford private healthcare (Torres et al. 440). Taken together, these factors create a circle of disadvantages for undocumented immigrants, which makes it virtually impossible for these immigrants to either physically or financially recover from a potentially severe injury. They have to live with the possibility that they could suffer either physically and/or financially, if they sustain any severe mental or physical impairment.

Furthermore, their legal status increases undocumented immigrants' reluctancy in searching for any kind of help, be it either legal or medical. In terms of legal aid, undocumented immigrants are reluctant to seek help from authorities when being exploited by their employer. They lack protective rights in workplaces that U.S. citizens have, which increases their vulnerability to workplace exploitation (Torres et al 440). At the same time, they fear contacting authorities about exploitation due to their fear of being registered as an

undocumented person. In his 2017 article in the Guardian about how President Donald Trump's immigration policy enables worker exploitation[6], Sam Levin describes that "undocumented workers refused to cooperate with U.S. Department of Labor (DoL) investigations due to deportation fears" (par. 1). The interviewees of the DoL even state that undocumented workers tried to run for the doors when they saw a government official entering the workplace (Levin par. 5). This does not only affect the effectiveness and workability of the DoL representatives, but enables exploitative employers in the same manner. This same fear of authority makes these immigrants reluctant to seek medical help (Rath par. 4). If an undocumented immigrant suffers a severe internal or external condition or injury so grave that they need a medical screening, they will be helped by a facility connected to the government.

As these immigrants fear deportation, they also fear being registered as undocumented persons, which could set in motion their deportation. This is also reflected in this group's healthcare utilization: compared to U.S. citizens, undocumented immigrants in 2015 had an 85% lower chance to have used healthcare in the previous year (Torres et al. 444). Fear of authorities is not the only factor in this grave difference, naturally, but it does play an important role. The entire social and medical situation of undocumented immigrants is a cumulation of several important factors. First, undocumented immigrants experience difficult working conditions, with job opportunities often lacking medical benefits and offering too low of a paygrade for the immigrants to afford private health insurance, while at the same time yielding a higher risk of physical injuries. Second, their legal status excludes these immigrants from certain labor rights, which heightens their vulnerability to exploitation. Finally, they fear authorities to such a degree that they would rather suffer under workplace exploitation and/or certain medical conditions, than risk their livelihood in the U.S. by reporting to authorities. Together, these factors put these people's health and lives at risk.

This also becomes apparent in research into undocumented immigrants' overall health and long-term healthcare. In a 2017 article titled *Undocumented Patients and Rehabilitation Services*, Michelle Gittler and three other professionals working with undocumented immigrants and rehabilitation services explain how they experience these immigrants' struggles with American healthcare in the field of post-acute care. Judy L. Thomas, MD, of University of Texas (UT) Health Houston Medical School, states that one of the issues that

[6] See *The Guardian.* "Immigration Crackdown Enables Worker Exploitation, Labor Department Staff Say," by Sam Levin. https://www.theguardian.com/us-news/2017/mar/30/undocumented-workers-deportation-fears-trump-administration-department-labor.

concern the staff of Lyndon B. Johnson (LBJ) Hospital in Houston is that the undocumented patients they receive are often already suffering from "more advanced disease due to lack of primary medical care, early diagnosis, or treatment" (Gittler et al. 406). She explains that cases of conditions such as strokes tend to be somewhat graver due to these patients' lack of diagnoses and treatment, and wounds of "patients with undiagnosed or poorly treated diabetes so severe and even life threatening as to not uncommonly require lower extremity amputation" (Gittler et al. 406). What follows is that visits to emergency departments become relatively regular for patients with chronic diseases and an inability to pay. This regularity of visits to hospitals' emergency departments is a consequence of the fact that EMTALA, which has been discussed in Chapter I, is one of the very few acts defining undocumented immigrants' healthcare rights in the U.S.

These detrimental factors naturally impact the mental well-being among this group as well. This notion is prevalent among undocumented immigrants across the continental U.S. "Depression and isolation are common among this mostly low-income population" (Rath par. 5). Unfortunately, large-scale studies of mental health among the undocumented population of the United States is too scarce to give an accurate overview. Edith Gonzalez, however, has written an interesting dissertation on the subject of mental health experiences among Mexican undocumented individuals, for which she interviewed several of such individuals.

In her dissertation titled *Salud Mental: The Conceptualization and Experience of Mental Health among Undocumented Mexican Immigrants* she analyzed several aspects of the problem of mental health in this group. She identified that among the majority of participants there were reports of mental health stigmatization in their social environment (Gonzalez 72). While this might be a problem that is more closely related to the subgroups own comportment, it was still identified as being a relevant problem for these undocumented immigrants. The stigmatization of mental health problems among this subgroup leads to coping with such problems in isolation, without seeking any form of external help (Gonzalez 73). As they rarely seek help with mental health problems, they also conform to the stigmatizing message and image of mental health problems (Gonzalez 78) in their communities, enforcing a culture which negates these kinds of problems. In turn, this augments the risk that mental health problems pose for this subgroup.

At the same time, however, participants also reported that external supportive systems had the ability to provide enough support to change the stigmatized image of mental healthcare. A supportive environment, such as family and friends, but also faith could positively alter participants' perspective on mental health and its stigma (Gonzalez 99).

Although this was not applicable to all participants, support could positively impact an undocumented person's thoughts on seeking help for their mental problems. The author also visits the theme of fear of authorities, with the constant fear of deportation, as we have seen before, being very active among these immigrants (Gonzalez 82). Gonzalez also treats the factor of obstacles for these people in dealing with their mental health past their fears of stigmatization and/or deportation. They mostly reported being hindered by their inability to pay for treatments and limited accessibility due to their undocumented status (Gonzalez 92).

All of these aspects impact the health of undocumented immigrants within the United States on a daily basis. Not only are undocumented immigrants discriminated against by many U.S. laws and programs, they also experience a large number of difficulties due to this discrimination in the areas of mental and physical health, while at the same time being reluctant in seeking help, both within their communities as well as with institutions that could provide them with proper care. One very important factor and perhaps the most impactful one seems to be their undocumented status and the fear of deportation that entails this status. This does not only affect their healthcare accessibility and thus negatively affect their physical health, but also impacts their mental well-being over time, which is already in danger due to their generally adverse socio-economic situation. These are some of the most general consequences that undocumented immigrants experience due to decision making in law and policy matters in the United States. These consequences and experiences, however, can differ greatly based on state, regional, and local healthcare policies. This is the third chapter's subject matter.

Chapter III

Case Studies of State and Local Policies

Regional and local healthcare policies in the United States impact the inequity between healthcare options available to undocumented immigrants throughout the United States. These policies and differences will be further examined in this chapter in order to build a general idea of how severe the impact of federal and state healthcare policies can be. Due to the scope limits of this thesis, an in-depth assessment of local policies cannot be reached. This thesis will, however, attempt to provide a range of interesting cases extracted from articles discussing local healthcare cases of undocumented immigrants, with important connections to healthcare policies within the United States in order to highlight the differences between state and local policies.

The first of these cases is the healthcare coverage and usage of undocumented immigrant women from Central America residing in the city of Houston, Texas. This case has been researched by Jane R. Montealegre and Beatrice J. Selwyn, who questioned around 200 individuals of the target group in this city. Because research on undocumented immigrants' healthcare usage usually focuses on immigrants from Mexico, these scholars focused on undocumented Central-American women, as they were concerned that the usual, one-sided method of evaluating healthcare coverage could potentially mask "important determinants of healthcare coverage and use among specific subgroups" (Montealegre et al. 204). They reaffirm that the collection of accurate data among this group is difficult, due to an important factor that has been discussed in chapter II, namely fear of authority.

Nonetheless, these scholars managed to collect relevant data from approximately 200 undocumented Central American women in terms of healthcare use and coverage in a large city of one of the most conservative states in the United States. The study found that around 35% of the total number of participants had some form of healthcare coverage. Of this group, around 88% were covered by a "publicly funded program," which was singled out to consist of the Harris County Hospital District program for 84% of coverage and Medicaid for the remaining 4% of this group (Montealegre et al. 206). The Harris County Hospital District program is a local program which assists families that live off of an income below 150% of

the federal poverty level.[7] Interestingly, the website of this program also specifically states that the program is not an official healthcare coverage program, but rather assists the poor people of this district in paying for their medical expenses.

Although a large portion of the interviewed women in the study were covered by a local healthcare program, the scope of this program is only limited. However, considering that around four out of five undocumented women who did receive financial aid for medical purposes were (partially) covered by a local hospital district program, it is not difficult to imagine that this subgroup would experience an even more difficult situation had they been dependent on national programs and laws.

The scholars behind this study also acknowledge that it lacks data on pregnancy status and past pregnancies. As over 90% of the participants were of child-bearing age, this aspect could play into the accessibility of healthcare aid among this group (Montealegre et al. 209). In addition to the finding that 20% of interviewed women reported limited clinic availability, a quarter of these women also reported experiencing fear of being deported when seeking to utilize healthcare facilities (Montealegre 209), similar to what we have seen before on a general and national level.

The second case study involves the accessibility of diabetes care in particular among Mexican Immigrants in the designated sanctuary cities of the San Francisco Bay Area and Chicago. Similar to the first case study that we discussed, the scholars of this study reemphasize the fact that the majority of undocumented immigrants in the United States are of Mexican origin, and add up to this statistic that "Mexican Americans are more likely to be at greater risk for morbidity and mortality related to chronic illness, particularly diabetes" (Iten et al. 229-230). The researchers analyzed and interpreted data from a cross-sectional survey and study of medical records of low-income patients taken in the aforementioned areas of interest, covering 401 subjects, of which 31% were U.S.-born Mexican Americans, 41.4% were documented Mexican immigrants, and 27.7% were undocumented Mexican immigrants (Iten et al. 232).

The study found that there was no significant difference in physician trust and communication with physicians between these groups (Iten et al. 232). In contrast, the study did find that undocumented Mexican immigrants were 20% more likely to experience barriers in persistent diabetic self-care (referring to dietetic and medicinal discipline) compared to U.S.-born Mexican Americans, and reported some form of impact on their therapy by their

[7] See "Patient Eligibility." *Harris Health System*: https://www.harrishealth.org/access-care/patient-eligibility#tabGroup12.

jobs (Iten et al. 232). On the same page, this study remarkably reinforces the fact that clinical outcomes for these three groups did not differ significantly, regardless of the heightened experience in barriers to self-care as discussed. This finding is intriguing in terms of what this suggests for local healthcare policies compared to national ones.

Although this study specifically looks at diabetes care, the relatively equal level of healthiness between these three groups suggests that the involved sanctuary cities are successful, at least to some extent, in providing healthcare for the undocumented immigrants in their regions. As the scholars themselves point out, however, sample size and the lack of similar research in non-sanctuary areas limits definite conclusions that can be drawn from this study (Iten et al. 235). This also applies to conclusions in terms of sanctuary cities' healthcare policies and direct impact on undocumented immigrants' health. Nonetheless, this case study provides a fascinating insight into undocumented immigrants' healthcare access and benefits of such access, and at least gives us an implication of how healthcare policies for undocumented immigrants could be handled with a positive outcome.

Our third case study is an extensive research on the access to and use of Californian healthcare facilities by a "representative sample of all nonelderly Latino and U.S.-born non-Latino white adults (N=51.387)" (Ortega et al. 919). Of this group 3053 individuals were undocumented, non-white Latino immigrants. Around 60%, or 30,000 subjects, were classified as being non-Latino white, U.S.-born citizens. The remaining subjects were classified in groups of U.S.-born; naturalized citizens; and Green Card holders. The study primarily reinforces the national pattern of poor healthcare access for undocumented immigrants, especially compared to U.S.-born citizens:

> undocumented Latinos were the least likely to have a usual source of care other than the ED (61%), were the least likely to have visited the ED (14%), the least likely to have had a doctor visit (58%), and reported having the fewest mean number of doctor visits (Ortega et al. 921).

The provision of regular care by Emergency Departments (EDs) for many undocumented immigrants recurs in this study, which is a consequence of the fact that the EMTALA is one of the few national laws in the area of healthcare access and provision that actually include undocumented immigrants. Correspondingly, the number of total doctor visits is also the lowest among this group, while only 25% of the undocumented immigrants reported very good health (Ortega et al. 921). The study, however, provides an important contrast as well. This subgroup of undocumented immigrants significantly differed positively in two areas:

mental well-being and physical health.

The study found that undocumented Latinos were the least likely to "report experiencing serious psychological distress over the past year," together with U.S.-born non-Latino whites, with only 4.3% of the first and 3.5% of the latter group reporting such an experience compared to the other groups in this study (Ortega et al. 921). Additionally, undocumented Latinos were least likely to report a need for help with psychological health, having seen a mental health professional, and were least likely to report use of alcoholic substances or drugs (Ortega et al. 921). It is difficult to determine whether these data actually signify positive mental health for undocumented Latinos in California, as the study also reports that those undocumented Latinos who were insured "had significantly lower odds of having an insurance plan that covered behavioral health services," next to which this group was most likely to disregard seeking help in mental health due to the treatment costs (Ortega et al. 921).

Nonetheless, this study seems to indicate that the mental health of undocumented Latinos in California is generally good. The other area in which undocumented Latinos scored relatively well is physical health, specifically weight-related health, with this group being the least likely among the test subjects to have been diagnosed with obesity, overweight in general, high blood pressure, or asthma (Ortega et al. 923). In light of these data, it is safe to say that at least a partition of undocumented Latinos in California do not suffer behavioral or weight-related issues. Nonetheless, the scholars also emphasize that among those who do need help with their health in these areas experience a significantly high barrier in accessing such healthcare. This barrier is either experienced as a high cost to treatment, or exclusion of such treatments from their healthcare plans, for the small subgroup of undocumented Latinos who are actually insured in some way (Ortega et al. 923).

Among the undocumented Latinos who were insured, 33% reported receiving coverage by California's version of Medicaid, named Emergency Medi-Cal. The scholars emphasize that this type of coverage only validates emergency care and neglects follow-up care for those patients who require it (Ortega et al. 924). Similar to the case study among Central American women in the city of Houston, Texas, California's Medicaid coverage also extends out to pregnant women regardless of documentation status. The scholars indicate the possibility that some reports of Medi-Cal coverage originate from this extension (Ortega et al. 924). Thus, we see a relatively familiar pattern in healthcare coverage and health of the undocumented Latino population in California. That being said, it is interesting to see how the undocumented Latinos in this study actually score more positively on mental and physical

well-being than reported healthcare accessibility and coverage would suggest.

Our fourth and last case takes us to the undocumented population of New York City. In a 2015 report of the Hastings Center and the New York Immigration Coalition, Nancy Berlinger, Claudia Calhoon, Michael K. Gusmano, and Jackie Vimo investigated possibilities and recommendations for policy changes in healthcare access for undocumented immigrants. At the time of writing, around 500,000 immigrants lived in New York City, of which 250,000 enjoyed some form of insurance, and 250,000 remained uninsured (Berlinger et al. 4). The report states that the two largest safety-net systems in the city are the New York City Health and Hospitals Corporation (HHC), "the nation's largest public hospital system," and the Federally Qualified Health Centers (FQHS), or community health centers (5). The report also states that although Medicaid is important to the provision of healthcare to the undocumented population of the city, there are faults in the system.

As we have seen before in undocumented immigrants' healthcare access throughout the United States, the Emergency Department is one of the most important care providers to this group. In line with other critics of the EMTALA, the authors of this report reaffirm that emergency healthcare only provides for acute, life-saving care, and negates "the long-term consequences of initiating life-saving or life-sustaining treatment and excludes some treatments that would typically constitute appropriate medical care for specific life-threatening conditions" (Berlinger et al. 6). This critique is validated by the several faults that exist in non-acute care necessities. Emergency Medicaid does not cover medical instruments that are needed to effectively manage chronic conditions, lacks coverage for expensive but effective treatments for advanced diseases, and does not provide for the need of several undocumented patients who require post-acute care (Berlinger et al. 6-7).

On the same pages of this report, the authors state that these inconvenient measures which circumvent direct treatment have a chance to eventually lead to higher costs anyway, due to the fact that emergency admissions might reoccur for patients with chronic conditions or advanced diseases. Moreover, they claim that the burden of this coverage problem predominantly falls on the primary care provider (7), impeding efficiency of high Emergency Medicare spending as well as impeding the efficiency of actual care itself. From page 11 up until page 15 of the report the authors compare several regional healthcare programs for the uninsured and give recommendations to the city's stakeholders based on these other programs and the problems that the authors have analyzed. As these aspects are still just recommendations and analyses, however, they are not yet defining of the current situation in New York City. As our last case, this report provides an important contrast and different

angle on how healthcare in the United States can be arranged locally. That being said, this report, too, portrays negative healthcare circumstances for undocumented populations.

These case studies provide different images of healthcare access among undocumented populations. Nonetheless, they all seem to indicate a general trend in healthcare access for undocumented populations in the United States. While some localities, like the San Francisco Bay Area and the city district of Chicago provide a relatively beneficial healthcare plan for undocumented immigrants or subgroups among these immigrants, the general trend seems to be that undocumented immigrants do not receive a lot of attention in terms of healthcare and tied costs, and that many undocumented immigrants have a fear of reporting to governmental healthcare authorities due to their immigrant status. Furthermore, the New York City case study emphasizes the fact that the efficiency of existing policies lacks refinement. The results of these studies stress the importance of improved healthcare policies that benefit undocumented immigrants. For that to find traction, however, the public discourse on undocumented immigrants and healthcare needs to be addressed as well. This brings us to chapter IV of this thesis.

Chapter IV

The Necessity of Public and Political Debate

Undocumented immigration and what rights they should have are some of the hottest topics in discussions and political debates in Europe as well as the United States of America. In the United States most undocumented immigrants arrive through Mexico from Mexico itself and Central and South America. This is also represented by the research done into undocumented immigrants across the United States, where the focus lies largely on Latinx immigrants and oftentimes even more specifically on Mexican immigrants. As the first three chapters have explained and hopefully made crystal clear, undocumented immigrants have long been marginalized in the United States, and the actual rights they enjoy are very basic and bare. Unfortunately, this general absence of the undocumented population in American laws is being strongly enforced by public opinion on these people and their rights. Among the arguments often heard against representation of undocumented immigrants in laws is that undocumented people don't pay taxes as well as that they would take away needed resources from people who reside legally inside U.S. borders. How true are these claims? And do they justify exclusion from laws and programs as is the case now?

A recurring theme in political and public debates is that lower-class American citizens supposedly see undocumented immigrants as an economic threat. As Gabriel R. Sanchez and Shannon Sanchez-Youngman explain in their article "The Politics of the HealthCare Reform Debate: Public Support of Including Undocumented Immigrants and Their Children in Reform Efforts in the U.S.", theories of economic self-interest would suggest that undocumented immigrants come to the United States solely for their own economic benefit, which would bring them in extreme discredit with lower-class citizens as these citizens' jobs are usually the ones that are taken over by low-wage working undocumented immigrants (449). In terms of economic impact this would mean that undocumented immigration does, in fact, impact the socio-economic situation of lower-class citizens. The economic impact of these immigrants would, in turn, increase the distrust among lower-class citizens according to theories of economic threat, which would decrease the support among this subgroup for including undocumented immigrants in healthcare reform.

In reality, however, the study found that a disadvantageous economic situation among lower-class citizens did not significantly affect the subgroup's views of healthcare reform inclusion of these undocumented immigrants (Sanchez et al. 456-457). As the authors reiterate on page 457 and 458, the results actually suggest that this subgroup becomes more supportive of "providing for these vulnerable populations when compared to those with less health related financial burdens." This disproves the theory that white, lower-class American citizens would commonly oppose inclusion of undocumented immigrants in healthcare reform.

As such, the hypothesis that lower-class American citizens would perceive a threat in terms of healthcare coverage in the undocumented population is refutable, and the use of this hypothesis in political debates about healthcare reform can be assumed to be an unreliable tool used by opponents of undocumented immigrants' inclusion in order to polarize the public's position on this issue. The more well faring classes in the United States tend to have a more liberal view when it comes to the impact of undocumented immigration on the job market (Sanchez et al. 449-450), and so they are subsequently less critical of undocumented immigrants receiving support. These views are also reflected in this groups' opinion on undocumented immigrants' inclusion in healthcare reform, which is generally more in favor of inclusion rather than exclusion.

Regardless of the impact of unemployment and class status, however, the subjects of this study generally did not agree that undocumented immigrants should be included in healthcare reform. Interesting to note is that a significant distinction is made between adults and children when it comes to healthcare reform inclusion, with only 26% agreeing that undocumented adults should be included, while 52% actually agreed that undocumented children should be included (Sanchez et al. 456). A possible explanation for this disparity is the moral and ethical thoughts that involve providing a child with its needed care, but this theory cannot be confirmed given the scope of the research. Nevertheless, this information provides interesting contrast, as we can see that people generally treat children differently than adults when it comes to their rights in healthcare. The remaining 48% that claimed to be against child inclusion in healthcare reform remain a large proportion of the subjects, meaning that public opinion on inclusion of undocumented immigrants in healthcare is still heavily negative.

Opposition against undocumented immigrants' inclusion is partially driven by widespread discriminating views of undocumented immigrants among documented residents in the United States. Political figures in the United States tend to form debates around issues concerning undocumented people with a discriminating tone, very often employing "Us

versus Them" rhetoric. Accusing undocumented immigrants of substance abuse and decreasing public health is common among this rhetoric, as it is a great tool to influence the minds of the public. Michael T. Light, Ty Miller, and Brian C. Kelly investigated substance abuse and driving under influence in their 2017 report, based on data collected between 1990 and 2014.[8] In this report, the authors claim that "political rhetoric on the public health consequences of undocumented immigration has far outpaced empirical research" (1452). Their study has found no evidence that suggests an increase in driving under influence (DUI) or illegal drug use as a result of undocumented immigration during the researched time period, which was their primary hypothesis (Light et al. 1452). The lack of evidence disproves the claims that undocumented immigrants undergo excessive substance use and pose a significant drug-related threat to the U.S. population and government.

The authors of this report even found significant supporting evidence for their second hypothesis, which stated that undocumented immigration actually decreased drug use and DUI arrests based on 2 behavioral mechanisms (light et al. 1452). First, their own health behaviors influence the data on public health in general. Second, their own healthy behaviors also influence their peers within the community, reinforcing the positive impact of this group on the drug use problem and DUI problem in the United States. Undocumented immigrants have an overall positive impact on their local public health. As such, the authors' claim that political rhetoric has outpaced empirical research is correct. The results from the report testify in disproving claims that undocumented immigration endangers public health.

Another great influence on public opinion is the fear of many Americans that inclusion of undocumented immigrants would prove to be unaffordable. "Public opinion trends suggest that the American public is not likely to support policy efforts aimed at increasing coverage to the undocumented population largely due to perceptions of cost burdens associated with this segment of the foreign-born population" (Sanchez & Sanchez-Youngman 448). The economic issue of providing undocumented immigrants with healthcare is very controversial, with many people believing that including this group in healthcare reform debates would heighten the costs of public healthcare, for which legal residents in the United States would have to pay, albeit indirectly. These worries are partially justified, as a lot of taxpayers' money would go into providing healthcare for this population. There are, however, two important factors to this financial issue.

[8] See Light, Michael T., Ty Miller, and Brian C. Kelly. "Undocumented Immigration, Drug Problems, and Driving Under the Influence in the United States, 1990-2014." *American Journal of Public Health*, vol. 1017, no. 9, September 2017, pp. 1448-1554.

The first of these two factors is the idea that undocumented immigrants would not pay taxes. One of the most important financial arguments as to how inclusion of this group would augment the costs of public healthcare is the idea that these people would not pay taxes and would simply benefit off of the money that documented U.S. residents pay in taxes. In reality, however, undocumented immigrants pay large amounts of taxes, especially compared to the public services that they actually utilize. A 2007 report on myths that misinform the American public in healthcare reform debates, Meredith L. King takes the state of Texas as an example in healthcare expenditure for undocumented immigrants. In 2005, the undocumented population of the state comprised nearly seven percent of the state's population and paid around $480 million in taxes for social services, while the state's health care costs for that same group were only around $58 million (King 8). Moreover, the report constitutes that on a national level the Social Security Administration received $7 billion in Social Security tax revenues and $1.5 billion annually from the undocumented population at the time, while this group was not generally eligible for Medicare or Medicaid (King 8). While this does not necessarily mean that the cost of including undocumented immigrants in healthcare reform would be entirely offset by their share of paid taxes, the report does prove the argument that undocumented immigration would not pay taxes for possibly received services to be invalid.

The second of these two factors is the inefficiency that exists in current healthcare methods available to undocumented immigrants. While EMTALA provides important resources for undocumented immigrants who need emergency care, it lacks in providing patients with durable, qualitative care. Naturally, long-term care is expensive, which means that such treatments would exact a severe impact on public health spending. At the same time, current measures and healthcare methods are often inefficient and do not prevent further financial burdens on the public health system. For example, a dialysis on the Emergency Department is 3.5 times as costly as a standard dialysis and a routinely needed dialysis increases the strain on Emergency Departments (Samra et al. 792). When we add up to this the physical and mental health complications that can ensue such life-threatening problems, public spending for undocumented people's healthcare could quickly mount up anyway, even though undocumented immigrants do not have many rights to financial help to begin with.

An alternative route for the United States to take could be to grant the undocumented population access to the Affordable Care Act. Access for the undocumented population to the ACA would allow them access to preventive care and could reduce their postponement of seeking needed care, which in turn could save costs and improve overall population health in

the long run (Ortega et al. 924). Inclusion of undocumented immigrants in the Affordable Care Act would also be beneficial to ACA beneficiaries in general. As Marketplace insurance exchanges are an important pillar of the ACA and affordable premiums depend on healthy individuals to offset risky populations, undocumented immigrants and their relatively better health outcomes compared to documented residents could potentially be beneficial to the act in general (Ortega et al 924).

These different issues that influence the public debate on undocumented immigration and healthcare reform in the United States are often misrepresented, misinterpreted or simply not taken into account. A more nuanced idea of how lower-class American citizens look at undocumented immigrants and their rights to healthcare could perhaps sway public debate into becoming less oppositional and less focused on the perception of these people as the "Other." More accurate representations of real-life data and information could also help this cause, such as the research into drug use and DUI we have seen above. Further in-depth studies into financial and health consequences of including undocumented immigrants in healthcare reform could improve the accuracy of argumentation, the factuality of debates concerning the issue, and in that way could hopefully persuade the American public of the benefits that universal healthcare could bring. Coverage of undocumented individuals does not have to mean a neglect of documented ones.

Conclusion

The general socio-economic and political position of undocumented immigrants in the United States is one of extreme adversity. As chapters II and III have portrayed, the problems that undocumented immigrants face concerning healthcare and financial help with care are grave although oftentimes remediable. Chapter I discussed national policies and depicted how national policies shape undocumented immigrants' rights in terms of healthcare. As this chapter also pointed out, the current laws and policies are insufficient in several aspects. While this thesis has focused predominantly on healthcare and undocumented immigrants' healthcare rights, several external issues affecting this group's livelihoods have been seen to impact these people's health circumstances as well. The lack of medical and financial rights restricts this groups' possibilities and access to affordable care.

Expansion of Medicare and Medicaid coverage over the past decades has benefitted undocumented immigrants to some extent, but the coverage of these programs is for a great deal dependent on state policies. The states' power within their own borders is important to the political system of the United States, but the grave differences in healthcare provision and rights of undocumented immigrants that exist between different states point out that these immigrants simply do not receive their needed medical care in some areas, affecting their own lives as well as those of the people around them. EMTALA is one of the most important national laws that these people can call upon in their most desperate times, but it is also very limited and does not provide any follow-up care. The lack of ongoing care increases the possibility of recurring visits to Emergency Departments and severe physical impairment for those people that need it. Programs like DACA and CHIP have benefitted many people within the undocumented community, but cannot solve every fault that exists within the current health system of the United States concerning undocumented immigrants. External factors like labor conditions and fear of authorities add up to the list of problems this group experiences in the U.S. healthcare system, together with the issue of public opinion on undocumented immigration and these people's rights to medical and financial help. As the current president of the United States, Donald J. Trump, has emphatically expressed his apathy for undocumented immigrants, change from the top-down is unlikely to happen soon.

It does not have to be this way. As chapter IV has explained, public debate around undocumented immigrants and healthcare reform has been influenced largely by ideologies and visions, while actual empirical research and facts have become less prevalent. Further

research and employment of empirical studies in political debates could improve public information and provide more informed public debates. If there had been willingness for reform in national, state and local policies, these people's issues could be addressed effectively. This thesis does not have any concrete answers as to how exactly the difficult and multi-faceted issues of undocumented immigrants and their healthcare could be solved entirely. It is imperative, however, to acknowledge that these problems exist in order for change and improvement to become feasible. Public opinion on these issues is often shaped by ideologies and political beliefs. I believe that many people that oppose inclusion of undocumented immigrants can come to be in favor of inclusion when the information that they are being provided on social and other media becomes more accurate and closer to the truth than is often the case now. As has been stated before, debate needs to become more informed and has to be repeatedly brought up in order for change to be followed through.

Further research on the topic of undocumented immigrants' contributions to American society, as well as their issues with the current healthcare system, could help to increase public support of undocumented immigrants' inclusion. I think that the focus of further research should rest on the undocumented immigrants' healthcare panorama across the United States, so as to make sure this information is relevant to the entire U.S. population. This does not mean that studies on state and local policies are unimportant. On the contrary, these cases can provide interesting examples of how the system could be improved. But if more research is to be conducted into these issues, it is important that the academic world calls the attention even more on these people and their place in American society.

This is not only in the interest of undocumented immigrants, but of the documented population of the United States as well. In order for this debate to be continued with as little misinformation as possible it is important to keep gathering information on the subject of undocumented immigration and healthcare and to maintain a pro-informational attitude. Only by informing ourselves and the people around us and by addressing misinformation when we encounter it can we make a valuable effort to improve the livelihoods of undocumented immigrants in the US.

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