Immigrants and Health Care

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I. Introduction

Immigrants and undocumented immigrants in particular, are a growing segment of the population in the United States. Despite efforts to prevent illegal entry into this country, the trend will most likely continue as long as there are employment opportunities in the U.S. for low-skilled workers. It is not as important to illegal immigration that the economy is thriving in the U.S., just that the economy is relatively better than the Mexican economy, the country of origin for the majority of unauthorized aliens. This population group is especially vulnerable due to the language barrier, poor education, low wages, isolation from family, lack of health insurance, and their illegal status.

This paper seeks to investigate health care related issues for immigrants in the United States, but in particular for the undocumented immigrant population, with a focus on Hispanic immigrants. Because of the inherent difficulty in obtaining information about the illegal population, it is necessary to use information concerning all types immigrants, and in some cases, information regarding the U.S. Latino population in general. The data reveals the abysmal inequalities in health care access and utilization between the U.S. population as a whole and the Hispanic population.

II. An Overview of U.S. Immigration in Quantity and Scope

Any discussion of immigrants in the United States, requires a clear understanding of the different classifications and terminology used to describe citizen and immigrant groups. These classifications ultimately determine eligibility for various programs. Citizens of the United States can be either native-born or naturalized; native-born citizens are born in the U.S. or are born abroad to U.S. citizen parents. Naturalized citizens are foreign-born people who first become legal permanent residents of the United States; after a minimum of five years as legal permanent residents, they are eligible to become U.S. citizens through the process of naturalization. (Immigrant spouses of citizens qualify in three years.) Legal (or lawful) permanent residents (LPRs) are the largest category of immigrants in the United States. They qualify to live in the U.S. permanently and have proper documentation. Refugees and asylees are immigrants seeking haven in the United States because of a fear of persecution in their native countries.[I] "Persecution or the fear thereof must be based on the alien's race, religion, nationality, membership in a particular social group, or political opinion."[II] Usually, the government promises refugees admission to the U.S. before leaving their home country, whereas asylees typically arrive in the United States and then seek admittance. Both groups are eligible for legal permanent resident status after one year of continuously living in the U.S. There is a cap of 10,000 on the number of accepted asylees each year; Congress can place quotas on the number of refugees as well. Nonimmigrants are people who seek entrance to the United States for a temporary period of time; they may enter on a tourist, student, or temporary worker visa, for example. Undocumented immigrants are in the country illegally because they either entered the country without inspection, overstayed their

temporary visa, or violated the terms of their visa; some illegal aliens may become legal permanent residents.[III]

In 1999, the U.S. Census Bureau estimated the foreign-born population of the United States in 1997 to be 9.7% of the total population, which equates to 25,869,900 people. The fastest growing region of origination is Latin America; in 1960, only 9% of immigrants arrived from Latin American countries, but in 1997, Latin Americans comprised 51% of the immigrant population. More specifically, Mexico is the largest contributor of immigrants, both legal and illegal, to the United States. In 1998, 131,575 Mexicans entered the US legally as immigrants.[IV] As an indication of the number of undocumented Mexican immigrants wanting to reside within the United States, the Immigration and Naturalization Service (INS) reports that 1,728,422 Mexicans were deportable in the fiscal year 2000 for 'entry without inspection'; 1.6 million of these apprehensions were along the southwest border of the United States, which was a 7% increase from the previous year.[V]

Illegal immigration causes concern among U.S. citizens for various reasons, among which are anxieties over cost, crime, and after September 11, 2001, national security. Of the immigrant population in the United States, undocumented aliens comprise 22% of the population. Approximately 60% of illegal immigrants entered the U.S. without inspection, while overstaying a visa accounts for about 40% of the illegal population. The INS estimates that approximately 5 million illegal aliens were living in the United States in October 1996, with an annual growth rate of 275,000 new immigrants. This would place projected numbers for 2002 at approximately 6.4 million undocumented immigrants within the borders of the United States.[VI]

The vast majority of illegal aliens were born in Spanish-speaking countries of Latin America; of the estimated 5 million illegal immigrants in 1996, approximately 3.6 million, or 72%, were from Mexico, El Salvador, Guatemala, Honduras, Dominican Republic, Nicaragua, Colombia, Ecuador, and Peru. Mexico is by far the most common country of origin with an estimated undocumented population in the U.S. of 2.7 million in 1996.[VII] The Mexican equivalent of the U.S. Census Bureau (CONAPO) estimates that in 2000, there were three million unauthorized Mexicans in the United States, along with 5.5 million authorized immigrants. The majority of Mexicans in the United States have a low level of education; almost half of all Mexicans in the U.S. have an eighth grade education or below and an additional 13.7% have between a ninth and an eleventh grade education. Almost three-fourths of all Mexican immigrants, legal and illegal, live in poverty.[VIII] These immigrants are among the *working* poor, however; more than 90% of the undocumented immigrants from Mexico have a person in the family who works.[IX] Since 63% of the Mexican population in the U.S. has less than a high school education, it is unlikely they will be able to climb out of poverty, especially when coupled with the illegal status of many.

Illegal immigrants come to the United States for many reasons, but the primary factor is work. More than 50% of unauthorized immigrants in a California study said that employment is the most important reason they are in the U.S., but a desire to be with family and friends is also an important motivating factor with approximately one-third of the respondents. Other less significant factors include education and political reasons, either in their home country or in the U.S.[X] Despite the commonly held opinion, social services provided by the United States government are not a strong influence on

immigration. California Governor Pete Wilson spoke of the need to "limit or eliminate 'the giant magnet of federal incentives' that draw foreigners into the country illegally," but his claim is unsubstantiated by a survey that found less than one percent of undocumented immigrants cited social services as their primary reason for entering the United States.[XI] Undocumented immigrants are eligible for very few benefits from the government, so social services cannot be an influential factor. As long as job opportunities are available in the U.S. for illegal Latinos, it appears the current immigration trends will continue.

It is incorrect to assume that illegal Hispanic immigration is largely a problem for only the southwestern border states and for Florida because the population of undocumented Latinos is growing across the country. In 1996, the INS estimated that two million of the unauthorized immigrants in the U.S. resided in California, with 700,000 in Texas, 540,000 in New York, and 350,000 in Florida. These numbers are not representative of the Latino population exclusively, but since Latinos comprise 72% of the undocumented population, they should provide an adequate approximation.[XII] The Hispanic population in general is growing in the United States and spreading into states not usually associated with Spanish speakers. North Carolina, for example, experienced a 393.9% growth of Hispanics from 1990-2000, and during the same period, Minnesota, a state far from the southern border, had a Hispanic growth of 166.1%.[XIII] While the general Hispanic population is not equivalent to the illegal population, the U.S. Hispanic population tends to be poorer and has a higher rate of uninsured people than the general citizen population of the United States. Many people in this population group also experience the same language difficulties that unauthorized immigrants do. Therefore,

the general Hispanic population can be a useful indicator of the illegal immigrant population from a relative standpoint.

The substantial size of the undocumented population in the United States, in conjunction with its rate of growth, renders it a vital issue of concern. No state in the country can ignore the issues related to immigration, and more specifically to illegal Latino immigration, because Hispanic populations are growing across the United States as more immigrants arrive and seek jobs in less saturated environments in states farther from the border. A primary concern should be what health care will this country be responsible for and willing to provide to this largely working poor population.

III. Immigrants and Public Benefits Eligibility

Eligibility for public benefits now depends on a classification system for immigrants that the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 created. This legislation excluded many legal immigrants from benefits that were previously available to them under the law by dividing all immigrants into two categories: qualified and non-qualified. Legal status has always been a requirement for most federal programs, so the situation of undocumented aliens did not change as drastically as it did for legal immigrants in the United States. In general, qualified aliens are those who entered the U.S. legally before August 22, 1996. Unauthorized immigrants, as well as legal immigrants who entered after August 22, 1996 *and* have been in the United States for less than five years, are not qualified for public benefits that use federal funds. States may choose to pass legislation that specifically grants state benefits, using only state funds, to the non-qualified immigrants however.[XIV]

Medicaid is an important public benefit that can greatly improve the health of low-income people in the United States. Under PRWORA, states must provide Medicaid coverage to certain qualified immigrants who meet income eligibility requirements. These classifications of immigrants include permanent residents, refugees, asylees, aliens that have a withheld deportation, honorably discharged veterans and their spouses or unmarried children, aliens on active duty in the military and their spouses or unmarried children, and immigrants who are eligible for Supplemental Security Income (SSI). States must also provide Medicaid to certain groups of income-eligible immigrants who entered the U.S. after August 22, 1996 that the federal government has exempted from the five-year ban on services. These exemptions include refugees, asylees, aliens that have a withheld deportation, honorably discharged veterans and their spouses or

unmarried children, aliens on active duty in the military and their spouses or unmarried children, Amerasian immigrants[1], and American Indians born in Canada. State governments may extend Medicaid benefits to other qualified immigrants who do not fall within the federal mandatory coverage classifications. Non-qualified immigrants, illegal immigrants and legal immigrants who have been in the U.S. for less than five years, are not eligible for Medicaid.[XV]

Non-qualified immigrants are eligible for *emergency* Medicaid regardless of their immigration status. The Department of Health and Human Services asserts that an applicant's failure to document citizenship or immigration status of himself or anyone else in the household cannot be grounds for denying emergency Medicaid benefits.[XVI] For purposes of Medicaid-eligibility determination, an 'emergency' is defined as

> a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction to any bodily organ or part.[XVII]

There is widespread debate concerning the wisdom of only providing responsive care instead of utilizing preventative care for immigrants among the medical community.

Out of concern for public health, immigrants are also eligible for testing and treatment of communicable diseases, despite their immigration status. Patients can be treated for symptoms of a communicable disease "whether or not such symptoms are

[1] Amerasian immigrants are children from Cambodia, Korea, Laos, Thailand, or Vietnam who were fathered by U.S. citizens between 1950-1982 (INS). Their families are allowed to immigrate as well.

caused by a communicable disease."[XVIII] Therefore, a slight loophole does exist that creates more opportunities to provide health care to sick immigrants in need. Motivated by the same concern for public health, the government will administer free immunizations to children through the Vaccines for Children (VCF) program, which began in 1994. This program does not depend on the immigration status of the children or families; therefore, undocumented immigrant children are eligible for Diphtheria, Pertussis, Tetanus, Mumps, Measles, Rubella, Polio, Hepatitis B, and Hemophilus Influenza B vaccines. All children who receive Medicaid, are uninsured, whose private insurance does not cover vaccines, or are Native Americans are eligible for free vaccines through VCF.[XIX]

Supplemental Security Income (SSI) is a federal public benefit that provides cash assistance and recipients of SSI are automatically eligible for Medicaid coverage as well. Coverage for this public benefit only pertains to certain groups of qualified immigrants due to limitations imposed after the passage of PRWORA. Legal immigrants who received SSI, or had an application pending, before August 22, 1996, are eligible for continuing SSI payments if they meet the program requirements. Immigrants who lived in the United States before August 22, 1996, but became disabled after that date are also eligible. Veterans, active duty personnel, their spouses, and unmarried children are eligible for SSI if they are qualified immigrants, as are refugees, asylees, and immigrants that have a withheld deportation. Legal permanent residents who have forty work quarters, American Indians, victims of trafficking, and "certain very elderly SSI recipients who may have difficulty establishing their citizenship status" are all eligible for SSI benefits as well.[XX]

In addition to emergency Medicaid, immunizations, and treatment of communicable diseases, there are other services available to aliens without regard to their immigration status. Non-qualified immigrants are eligible for short term, non-cash, in-kind disaster relief, as well as continuation of housing assistance if they received it before August 22, 1996. Illegal immigrants can also attend public schools and take advantage of the free or reduced school breakfast and lunch program. Additionally, the Summer Food Service Program and the Child and Adult Care Food Program are available to non-qualified immigrants.[XXI] The program, Women, Infants, and Children (WIC), provides "a combination of nutritional supplementation, nutritional education and counseling, and increased access to health care and social service providers for pregnant, breast feeding, and postpartum women; infants; and children up to the age of five years."[XXII] These nutritional supplements are available to non-qualified immigrants who meet income eligibility and are at nutritional risk. Illegal immigrants can also participate in programs "necessary to protect life or safety" without providing proof of their immigration status. Such programs include, child and adult protection services, violence and abuse prevention, mental illness or substance abuse treatment, short-term shelter or housing assistance, such as a battered women's shelters, shelter during adverse weather conditions, soup kitchens, food banks, senior nutrition programs, medical, public health, mental, disability, or substance abuse services necessary to protect life or safety, programs to protect the life and safety of workers, children, youth, or community residents, and other services necessary for the protection of life and safety.[XXIII] Despite their illegal status, immigrants can still gain access to a substantial number of short-term

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programs. Whether or not immigrants are aware of program availability or utilize the services are separate issues.

Non-qualified immigrants cannot receive "federal public benefits." This consists of "any grant, contract, loan, professional license, or commercial license provided by an agency of the United States or by appropriated funds of the United States." This also includes "any welfare, health, disability benefit, or any other similar benefit for which payments or assistance are provided to an individual, household or family eligibility unit by an agency of the United States or by appropriated funds of the United States."[XXIV]

Food Stamps help meet the nutritional needs of low-income families. Sufficient food, in conjunction with a well-balanced diet, is essential to maintaining health. PRWORA restricted food stamps to qualified (entered before August 22, 1996) immigrant children under the age of 18 and elderly persons who were born before August 22, 1931. Certain people with disabilities and legal permanent residents with at least 40 work quarters in the United States may also be eligible. Refugees, asylees, and those granted deferred removal status can qualify for food stamps for the first seven years.[XXV] Congress enacted legislation in May 2002 that will permit qualified immigrants who have lived in the U.S. at least five years as qualified immigrants to receive food stamps. This legislation also removed the seven year limit for refugees, asylees, and those granted deferred removal status; these new regulations will take effect April 1, 2003. The same legislation allows qualified immigrant children to be eligible for food stamps regardless of their date of entry; this part of the bill will be effective October 1, 2003.[XXVI] Undocumented immigrants cannot receive food stamps.

Temporary Assistance for Needy Families (TANF) is a state block grant that the federal government funds. Immigrants who entered the United States after August 22, 1996 are ineligible for TANF funds for the first five years. States may choose, however, to provide benefits to the non-qualified immigrants, so long as they do not use federal funds to do so. The federal government gives states great flexibility in administering TANF funds, so states can determine the eligibility requirements for qualified immigrants.[XXVII] Refugees, asylees, and those granted deferred removal status are also eligible to receive TANF benefits during their first five years in the United States.[XXVIII] Federal TANF funds are not available to illegal immigrants.

The State Children's Health Insurance Programs (CHIP) is a federal means tested public benefit designed to cover previously uninsured children throughout the United States. Immigrant children are only eligible if they resided in the U.S. before August 22, 1996 or if they have lived in the United States as qualified immigrants for at least five years. Refugees, asylees, and those granted deferred removal status can receive CHIP without the five year waiting period. States do have the option of supplementing the federal insurance plan with their own funds; in Texas, for example, qualified children are eligible during the five year ban for state funded insurance.[XXIX] Federal CHIP funds cannot provide insurance to illegal immigrant children.

If anything, the legal issues surrounding immigration are complex. The mixed immigration status of many families accentuates this complexity. For example, 23% of all Texas children have one or more parents who are not a citizen, and 34% of low-income children are from mixed status families in Texas.[XXX] The children in these families are *citizens*; they do not fall into classifications of qualified and non-qualified

based on immigration status. Therefore, a citizen child can receive full Medicaid benefits for non-emergency care, as well as TANF, Food Stamps, and CHIP, while the rest of his family cannot.

Undocumented parents in these mixed status families can apply for federal benefits for their citizen children, assuming they meet the other program requirements. The Department of Health and Human Services recommends that states "permit individual household members to declare early in the application process that they are not applying for Food Stamps [or other benefits], and therefore, they will not need to disclose their citizenship or establish their immigration status."[XXXI] Social workers will still evaluate these non-applicants to determine the income eligibility of the applicant, i.e. the child, but the non-applicants will not have to provide a Social Security number or immigration papers. States can also "have "child-only" rules that allow needy children to receive TANF benefits even if other family members are ineligible." Additionally, the Department urges states to utilize the flexibility in TANF to encourage participation in the program among eligible immigrant families by reducing fears related to the INS.[XXXII] Even though there will not be a sufficient quantity for an entire family if only a child is eligible for Food Stamps or TANF, the entire family may benefit to some extent by their presence. However, parents who do not have adequate nutrition or do not have access to non-emergency health care may be ill more often and less capable of taking care of their children, which may cause long-term problems.

IV. Access to and Utilization of Health Care Resources

It is very difficult to obtain data on the health of undocumented immigrants and their access to care because of the nature of the population. It is a transitory group of people who not only move frequently while in the United States, but also cross the border numerous times. An undocumented immigrant may work for several months or years in the U.S., and then return to his country of origin only to enter the U.S. again the following year. Some undocumented immigrants come to the United States to make it their new home, but there are still obstacles in acquiring information for this group. The primary obstacle is that illegal immigrants are reluctant to say they are illegal when completing forms or answering questions on a survey. They are not an "official" part of society, so it is complicated to even obtain an accurate estimate of the total undocumented population, much less data on their health.

One way to make inferences about the undocumented Latino population is to study the health of the general Hispanic population in the United States. This group may contain citizens, legal permanent residents, other various types of legal immigrants, and illegal immigrants of Hispanic origin, although it is unlikely many illegal immigrants participated in the studies and surveys. The health of Hispanics in the U.S. tends to be worse than that of non-Hispanic whites; they are also more likely to be poor and uninsured. If this is true of the general Hispanic population, surely it is even more so the case for undocumented immigrants living on the fringes of society. This is not an ideal method for gathering information about the undocumented population, but researchers need to conduct more studies in order to characterize undocumented immigrants adequately.

Health insurance is one of the primary determinants for access to care among people of all ethnic backgrounds. Therefore, the high rate of uninsurance for Latinos in the United States is alarming. In 1997, 36% of non-elderly Latinos were uninsured compared with only 14% of the white, non-Latino population. When considering only low-income (below 200% of the federal poverty level) Latinos, the percentage of uninsured, non-elderly people jumped to 45% of the population. The percentage also rose to 29% for whites. This is a considerable portion of the population considering 58% of Latinos in the U.S. lived below 200% of the poverty level in 1997, while only 24% of whites were low-income.[XXXIII] In an evaluation of only immigrant children, 56% of non-citizen Latino children with a non-citizen parent and 21% of Latino citizen children with a non-citizen parent are uninsured; only ten percent of white citizen children with U.S. born parents lack health insurance. It should be noted that 'non-citizen' can refer to both legal immigrants and illegal immigrants.[XXXIV] The citizenship of the child has a dramatic reductive effect on the rate of uninsurance, presumably because of eligibility for programs such as Medicaid and CHIP. Elderly Latinos were also more likely to not have supplemental insurance to accompany their Medicare coverage; a quarter of elderly Latinos, compared with 10% of elderly whites, lack supplemental coverage.[XXXV]

Immigrants and Latinos to do not utilize health care to the same extent as do citizens and whites in the United States. In 1996, only 16% of whites did not have a usual source of care, but 30% of Latinos lacked a regular medical care provider.[XXXVI] Thirty-seven percent of low-income non-citizens, compared with 19% of low-income citizens, did not have a usual source of care in 1997. A doctor's office was the primary source of care for 43% of low-income citizens, but only 20% of low-income non-citizens

usually received care from a doctor's office in 1997.[XXXVII] Even among people who classify themselves as in fair to poor health, uninsured Latinos are less likely to see a doctor than are uninsured whites; twenty-four percent of uninsured Hispanic women in poor health did have a doctor visit in the past year, while 13% of uninsured white women did not. Among uninsured men of similar health, the numbers rise sharply; forty percent of Latinos and 29% of whites did not see a doctor in the past year.[XXXVIII]

A 1996-1997 study of only undocumented Latino immigrants finds even starker implications for health in two California counties, Los Angeles and Fresno. In the under 65 population, 84% of undocumented Latinos in Los Angeles County and 68% in Fresno County are uninsured. This is significantly higher than the statistics for the general Hispanic population in the United States. Moreover, only 19% of all people nationally were uninsured at that time.[XXXIX] During the year before the survey, 38.2% of the illegal immigrants over age 16 at both sites had a doctor's visit; this is considerably lower than the total U.S. population, in which almost 75% saw a physician over the same period. Even the undocumented immigrants with at least one appointment saw the doctor fewer times than did the general U.S. population over the past year; illegal immigrants saw the doctor an average of 3.9 times over both sites, while the general population saw a physician 6.2 times. Undocumented immigrants were most likely to see a doctor at a health clinic; only 8% of illegal immigrants in Los Angeles County went to a private doctor's office.[XL] Nine percent of the unauthorized immigrants in Fresno County reported an inability to obtain health care in the last year; the primary reason they cited was not being able to afford the care.[XLI] An additional obstacle that many undocumented Latinos face is communication; fifty-nine percent in Fresno County said they cannot

communicate with a medical professional at all, and an additional 31% reported not being able to communicate very well.[XLII]

Another article, which cites information from the National Agricultural Workers Survey (NAWS) and the California Agricultural Workers' Health Survey (CAWHS), reveals more about the nature of health care in the immigrant population. In the surveys for the fiscal years 1997 and 1998, 79% of the workers were born in Mexico or Central America and 61% lived in poverty. Half of the Hispanic farm workers earned less than $7,500 a year and the survey estimated that approximately 52% of all farm workers in the United States were undocumented immigrants. In California, 31% of male farm workers had never visited a doctor or clinic, and only 48% had been to a doctor within the past two years; half of the men had never been to a dentist and more than two-thirds had never had an eye examination. Farm workers paid for most health care visits that they did have at their own expense, which had a serious impact on how often they sought care.[XLIII]

A study of tuberculosis in Tarrant County (Fort Worth), Texas reveals more information about the health of illegal immigrants. Approximately 10% of the cases were in the undocumented Hispanic immigrant population, and of those 50% exhibited a resistance to at least one type of drug used to treat tuberculosis. Only 11% of the native U.S. citizen population with tuberculosis in Tarrant County showed a similar resistance. Six out of the seven patients who had a resistance to multiple drugs, which increases the difficulty of treating tuberculosis, were from Mexico. Sixty-one percent of the U.S. native population entered the hospital for tuberculosis in Tarrant County and they remained in the hospital for a median of 15 days. The statistics are very different, however, for the undocumented population; only ten percent of the illegal immigrants

were hospitalized, and they had a median stay of 8.5 days in the hospital. This study demonstrates that in this Texas county, undocumented immigrants were more likely to have a resistance to the tuberculosis drugs, yet were less likely to enter the hospital, and if they did, they had a shorter stay.[XLIV]

There are also ethnic disparities in the care of HIV patients. HIV/AIDS was the fifth leading cause of death for Latinos in 1996, but it is not one of the top five causes of death for the white population. It is possible that there is not as strong of an effort to educate the Hispanic population on AIDS; it might be a matter of information not being available in Spanish, or it could be because of countless other factors. Among those who are HIV positive, 23% of Latinos had one or no doctor visits in the past six months; only 11% of whites had that few of visits. HIV positive Latinos who are under a doctor's care are also less likely to use pharmaceuticals than whites. In 1996, 32% of whites "needed but did not receive combination therapy," whereas 44% of Latinos did not. Combination therapy is the most effective method of treating HIV.[XLV]

Latinos face a more challenging situation in the United States in attempting to obtain health care than do whites. They are less likely to have insurance and they are more likely to be poor; these factors create an obvious financial barrier to care. These financial barriers, coupled with the language barrier that many Hispanic people face, may be sufficient to prevent or delay medical care. These obstacles are only accentuated for illegal immigrants; they tend to be even poorer, are more likely to be uninsured, have fewer English language skills, and fear deportation. When Hispanics and immigrants do obtain care, it is often of a lower quality.

V. The Consequences of Being Uninsured

As previously noted, Hispanics, and illegal Hispanic immigrants in particular, are more likely to not have insurance in the United States. Additionally, the majority of illegal immigrants are also classified as low-income. These two factors are obviously interconnected because low wage, 'off the record' jobs are unlikely to provide insurance. Moreover, illegal immigrants would have difficulty purchasing health insurance independently because of the prohibitive cost. The inability to obtain insurance, either through an employer, independently, or through the government, has a serious impact on overall health.

The effect of not having insurance manifests itself in the actual preventative tests and treatments that medical personnel can provide to improve long-term health. Heart disease was the leading cause of death for whites, African-Americans, Hispanics, Native Americans, and Asian Americans in 1996, yet 40% of uninsured adults did not receive a simple test for cholesterol screening in 1997-98; while still high, only 18% of insured adults did not receive the same test.[XLVI] Hypertension is another important risk factor that health professionals can monitor. Twenty percent of uninsured people did not have their blood pressure monitored during the year, compared with 6% of the insured population.[XLVII] During the same time period, cancer was the second leading cause of death for all the above-mentioned ethnic groups, but there were significant differences in important screening methods for two female cancers. Eleven percent of insured women did not have a mammogram in the last two years, but 32% of uninsured women had not. Similarly, only 6% of insured women did not have a Pap test during the past three years, but 20% of uninsured women did not have one.[XLVIII] Beneficial tests that can have a

significant role in diagnosing deadly diseases are not reaching a large portion of the population.[2]

Late detection of heart disease or cancer drastically reduces the rate of successful outcomes. Differences in detection rates and mortality do exist, in fact, between insured and uninsured populations. Fifty-four percent of insured women with breast cancer received an early stage diagnosis when the cancer was still localized, while doctors only diagnosed 44% of uninsured women with breast cancer at a similar stage of progression. This study also shows that uninsured women, ages 35-49, are 1.6 times more likely to die of breast cancer than are insured women.[3] Other late-stage cancer diagnoses are more probable in uninsured people than in insured people, as well. The uninsured have a 1.7 times greater risk of receiving a late-stage diagnosis of colorectal cancer, 2.6 times greater probability of late-stage melanoma, 1.4 times greater chance of late-stage breast cancer, and 1.5 times greater likelihood of late-stage prostate cancer. The uninsured also have a 1.7 times greater risk of dying from colorectal cancer than do the insured. [4] XLIX

Lack of insurance also translates into lower levels of care for patients once they do receive a diagnosis of a health problem. Among patients who had acute heart attacks in 1994-96, the uninsured patients had a 0.64 probability of receiving a cardiac catheterization in comparison with the insured patients. Additionally, the uninsured had a 0.78 probability of undergoing coronary artery bypass surgery in comparison with insured patients. This lower quality of care manifested itself in a 1.29 greater probability

[2]All of the statistics for cardiovascular and cancer screenings in this paragraph are statistically significant after controlling for age, sex, race/ethnicity, region, employment, education, and income.
[3] Statistically significant after adjusting for age, race, marital status, income, and number of co-existing diagnoses.

[4] Statistically significant after adjusting for age, sex, race/ethnicity, comorbidity, marital status (when appropriate), smoking status, socioeconomic status, education, stage at diagnosis, and treatment.

that an uninsured patient would die in the hospital.[5] A reduced number of procedures and treatment for the uninsured is also apparent in trauma care. An uninsured patient had a 0.68 probability of having a surgical procedure when compared with insured patients of similar injury severity in 1990. Uninsured patients were also less likely to benefit from physical therapy as part of their recovery process; they only had a 0.61 probability of receiving it in comparison with insured patients. Overall, uninsured patients were 2.15 times more likely to die while in the hospital for trauma-related care.[6] [L]

Heath insurance status impacts prenatal care, as well. In 1990, uninsured mothers were 6.7 times more likely than insured mothers to have no prenatal care. Of those that did receive care, uninsured women were 2.5 times more likely to delay the beginning of prenatal care. Additionally, it was 2.5 times more probable that an uninsured mother would not have an adequate number of doctor visits prior to giving birth.[7] [LI] Prenatal care has a positive impact on birth weights. An infant with a low birth weight is 1.49 times more likely to be in some type of special education class later in childhood. Low birth weight children also have a 1.38 times greater risk for being enrolled in special education for a developmental delay, learning disability, or an emotional problem than are normal birth weight babies.[8] [LII] Insurance status also impacts the mortality of newly born babies among low income families; infants of uninsured mothers had a 1.6 times greater risk of

[5] Statistically significant after adjusting for social factors, demographic factors, clinical symptoms, and comorbidities common among cardiac patients.
[6] Statistically significant after adjusting for age, sex, race, injury severity score, and comorbidity.

[7] Statistically significant after adjusting for mother's insurance status, race/ethnicity, birthplace, age, parity, education, and marital status.
[8] Statistically significant after adjusting for factors associated with need for special education, including family's home environment, the child's characteristics (age, sex, race/ethnicity), and geographic influences.

death during the first month of life and a 1.5 times greater risk during the post-neonatal period in 1998.[9] [LIII]

Health insurance status also impacts the number of primary care visits that a child has. Primary care, as defined by the American Academy of Pediatrics, is "accessible and affordable, first contact, continuous and comprehensive, and coordinated to meet the health needs of the individual and family being served."[LIV] Uninsured children who exhibited symptoms for four illnesses were less likely to see a primary care doctor than were insured children with similar symptoms for the respective illnesses. There was a 1.72 greater probability that an uninsured child would not see a physician for pharyngitis, 1.85 greater chance for acute earache, 2.12 greater likelihood for recurrent ear infections, and a 1.72 greater probability for asthma.[10] These results are an indication that some health needs of children are unmet because they lack health insurance.[LV]

Health insurance status also has a role in influencing the future health of people.

Adults ages 51-61 participated in a study from 1992-1996 that evaluated self-reported health characteristics in conjunction with insurance status. Only 8.3% of the continuously insured adults during this time period reported a decline in health, whereas 16.1% of the intermittently uninsured and 21.6% of the continuously uninsured population reported a similar decline in health. The relative risk for experiencing a major decline in health for the continuously uninsured was 1.63 and was 1.41 for the intermittently uninsured. The study also evaluated changes in mobility through activities such as climbing stairs or walking short distances. The continuously uninsured had a

[9] Statistically significant after adjusting for mother's age, education, race/ethnicity, income, health and pregnancy history, and WIC participation.
[10] Statistically significant after adjusting for sex, family size, race/ethnicity, and place of residence (urban or rural).

23% greater risk of developing a physical difficulty than did the continuously insured during this period.[11] This study, along with the others, indicates that health insurance is a critical factor in determining health outcomes.[LVI]

The overwhelming statistics that indicate that the uninsured or those that do not receive regular medical care are in poorer health, have more educational needs, and have a higher mortality risk are sufficient to indicate the need for a more equitable health care system. There are no reasons why the undocumented immigrant population will not experience the same effects of receiving poor health care or of not having insurance that the rest of the population does. In fact, it is quite possible that undocumented immigrants will suffer even worse consequences because they frequently lack a support structure of family and friends that can help meet financial needs at a critical time. Prenatal care is an especially important preventative measure for all members of society that can help protect the life and health of both the mother and child. It is important to acknowledge the possibility that insurance is simply a proxy for good health behaviors and that no insurance is a proxy for bad health behaviors.

[10] Statistically significant after adjusting for age, sex, race/ethnicity, marital status, educational level, household income, past or current smoking, alcohol consumption, body-mass index, number of chronic conditions, and presence or absence of a change in overall health in the previous year.

VI. Society's Obligations

A. Health Care for All

In order to discuss society's obligations to illegal immigrants in relation to health care, one must first establish society's obligations to people. Health care is a basic need that all people have, regardless of their race or immigration status.

> A viable and fair health care system is a "public good" in which all citizens have a stake. All share a common human vulnerability to disease, disability, and death. All of us face the future without knowing when or how urgently we will need health services. . . . All have a stake in a healthy populace above and beyond the stake each has in his or her personal health.[LVII]

Larry Churchill believes that all people should have a basic, guaranteed level of health care because of the goals of security and solidarity. He defines security in the context of health care as "the freedom of persons to live without fear that their basic health concerns will go unattended, and freedom from financial impoverishment when seeking or receiving care."[LVIII] Solidarity he says is "the sense of community that emerges from acknowledgment of shared benefits and burdens."[LIX] It is rational to seek solidarity in health care he argues because everyone needs health care resources at some point; the resources are scarce and public funds support the resources to some extent. Churchill continues to explain that solidarity has "to do with the urge to belong, to see one's own situation as like that of others, [and] to notice and affirm affinities in the human condition."[LX] These dual goals can influence the creation of a just health care system that provides medical attention to all people.

Churchill contends that the most effective way to convince people that they should support some form of universal health care is through self-interest because relying

on people's benevolence is not sufficient. When one relies on self-interest, the inherent instability and insecurity in the current medical climate provide a strong motivating force to consider the plight of the uninsured and those who lack adequate medical coverage because there is often not much separating the insured from the uninsured. People can lose insurance coverage by changing jobs, but even those with insurance face more of a financial burden as deductibles increase. Those with insurance can also be underinsured, meaning that a serious illness would be financially devastating; the number of uninsured almost doubles when one considers the underinsured in the group as well.[LXI] Financial susceptibility from medical problems is also a concern for people who work for self-insured employers. The Employee Retirement and Income Security Act of 1974 (ERISA) permits self-insured businesses to decide what they will cover and when they will cover it; this means employers can reduce insurance benefits even after a person becomes sick.[LXII] Because of the volatility in health insurance, it is to everyone's benefit to establish safety net programs that ensure at least a minimum level of primary care.

Churchill utilizes David Hume's theory of justice to assist the self-interest argument. Hume thought justice was a creation of society, rather than something that was part of human nature. Although created, justice is a necessary addition to society because it enables people to coexist peacefully[LXIII]: "I observe, that it will be for my interest to leave another in the possession of his goods, *provided* he will act in the same manner with regard to me."[LXIV] This "desire for justice as a moral ideal results from our sympathy with others, which enables us to identify, and identify with, a public good."[LXV] Churchill applies these ideas of possessions and the public good to health care; for any person to have security in his access to medical care, all people must have access to care.

These arguments have a similar parallel in the writings of Immanuel Kant. Although Churchill nor Hume rely on beneficence to formulate a theory of justice, it is still an important quality that is most likely factoring into people's individual decisions to support health care access for everyone. Kant discusses benevolence in a general manner, rather than in terms of a specific application; beneficence, he contends, is an imperfect duty to others that all people have. When the action of not helping someone is put into the form of a universal maxim, it does not fail the contradiction-in-conception test. It does, however, fail the contradiction-in-will test:

> For a will which resolved in this way would contradict itself, inasmuch as cases might often arise in which one would have need of the love and sympathy of others and in which he would deprive himself, by such a law of nature springing from his own will, of all hope of the aid he wants for himself.[LXVI]

Human beings are mortal creatures with weaknesses and needs; these vulnerabilities intrinsic to human life create the need for help from others. Likewise, all people need health care at some point in their life because the body is frail and susceptible to illness and disease. It is not logical to will a universal law, in Kant's terminology, in which a person refuses to assist others in the effort to secure health care because it prevents others from doing the same for you, should the need arise. This is illustrative of Churchill's point about the role of self-interest as a motivating factor in, ironically, a benevolent act.[12] It is also crucial for each person to recognize his own vulnerability to losing health

[12] Kant would not support the notion that self-interest should be a motivating factor; for him, there is only one proper reason to act – out of duty.

coverage; "the precariousness of insurability means that both insured and uninsured already belong together in the same risk pool."[LXVII]

Health care is necessary for each person in order to improve the quality of life. No one person can have security in the assurance of future medical care and coverage if there are still members of society who cannot access care or if there are members for whom a severe illness would be financially ruinous.

> Justice cannot exist without a mutually held sense of what is good based ultimately on what is fair to all. As Hume says, justice must be self-conscious because just actions are sometimes contrary to our immediate self-interest, and some even run counter to the immediate interests of others. Justice, which is of great consequence for our long-term interests, requires that we acknowledge our interdependence and perhaps sacrifice some short-term benefits.[LXVIII]

One of the consequences of being human is the innate weakness that all people have – mortality. That weakness requires humans to interact and to depend on others to meet some of their needs. One of the greatest needs is health care, which all people deserve.

B. Health Care for Undocumented Immigrants

Undocumented immigrants are just as human as citizens of the United States are. They have the same weaknesses and vulnerabilities to disease as any other person. In fact, they may even be more susceptible to certain diseases because of inadequate vaccination programs in their home countries. They enter the United States, in the majority of instances, to work, not to receive social services. Because medical care is not the motivation behind placing their life at risk during a dangerous border crossing, it is unlikely that caring for undocumented immigrants will increase the rate of illegal border crossings. There are many additional reasons to provide primary care services to undocumented immigrants beyond the reasons to provide care to citizens of the United States.

Kant's theory is applicable to illegal immigrants as well. The United States generally has a strong economy, but that may not always be the case. Just as Mexicans and other Hispanic immigrants come to the United States without documentation, U.S. citizens may one day enter other countries illegally in search of work to support their families. If that were to happen, the U.S. citizens would not want to be denied health care because of their illegal status. Therefore, it would be a contradiction-in-will to deny health care to undocumented immigrants in the United States.

One of the greatest opportunities for preventative care exists in prenatal doctor's visits. A doctor can monitor the health of the mother and the baby throughout pregnancy, and prenatal care provides the opportunity to educate the mother on proper nutrition. Most undocumented immigrants are uninsured and poor; therefore, it is unlikely that the mothers can pay for prenatal care without some type of assistance. This cost effective treatment is an invaluable way to improve the health outcomes of babies that will be born

as United States citizens, at which point the government will have an obligation to pay for their care through Medicaid. These children are as much a part of the next generation of Americans as are any children born to citizen parents. It is to the public benefit to ensure that these babies begin life with as solid a foundation as possible. For every dollar spent on prenatal treatment, studies estimate that $1.70 to $3.38 is saved from the reduction or prevention of neonatal complications. When researchers consider undocumented women exclusively, the estimated savings jump to $13.00 for every dollar spent on prenatal care that includes screening for STD's. Preventing a case of fetal HIV through early screening of the mother saves a staggering $400 for every dollar spent.[LXIX] A study conducted in Los Angeles County found that adverse outcomes of pregnancy related only to untreated sexually transmitted diseases would cost an additional $5.1-$9.2 million. That is a 19.2-34.9% increase over projected savings from not providing publicly funded prenatal care to undocumented immigrants.[LXX] From a consequentialist perspective, the economic benefits alone of providing prenatal care to undocumented women are sufficient to create a moral obligation for funding. In addition, the public good is something in which all people have an interest; the possibility of decreasing birth defects and future liabilities to society provides a utilitarian reason for funding prenatal care for the undocumented immigrant women.

Another reason to provide non-emergency primary care to undocumented immigrants is that they are already supporting indigent care through local taxes in certain jurisdictions. For example, Texas has three methods of providing care to uninsured or indigent patients, one of which is a public hospital. Local taxes, such as a sales tax or a use tax, fund these hospitals. Illegal immigrants contribute to these local taxes just as

citizens do because they are active members of society engaging in the economy. Their wages are often in cash and off-the-books, thus undocumented immigrants normally do not pay federal or state income taxes; however, these taxes are not the ones funding public hospitals. It is unjust to deny health care to an entire segment of the population when they have an equal claim to the benefits by virtue of their tax support.[LXXI]

It is also important to provide primary care to illegal immigrants because it can have a significant effect on the quality of health. Delayed treatment of diseases often causes a person to be more seriously ill than he would have been if he had been treated at the initial onset of symptoms; this delay could result in death if, for example, a person is not screened for warning signs of a heart attack. It is also wrong to allow someone to suffer repeatedly from a disease like asthma, diabetes, or cancer when medication could help control the symptoms and complications, thus reducing pain and the number of trips to the emergency room.

An additional reason for providing primary care to undocumented immigrants is the added protection of the public health. Many Hispanic illegal immigrants come from countries that do not have a childhood immunization program that is as aggressive as the one in the United States. A person could be carrying and spreading a disease long before he actually realizes he is sick. Even at that point, a person may not seek care in an emergency room because his disease might not seem that serious to him. The federal government does currently require treatment of communicable diseases for illegal immigrants, but a person may not come to a doctor complaining of symptoms related to such diseases. By providing primary care to undocumented immigrants, it may allow for earlier detection of communicable diseases as part of a routine screening of at-risk

populations. This would help reduce the threat to community health as a whole.[LXXII] When a threat is universal, it is to the public benefit to act in everyone's best interest.

Another reason to treat undocumented immigrants is the growing number of "mixed families," which means there is a citizen child and at least one non-citizen parent; the non-citizen parent could be a legal or illegal immigrant. In Texas, 23% of all children belong to a mixed family and the percentage increases to 34% when considering only the children at or below 200% of the poverty line.[LXXIII] Because of their status as citizens, the children are eligible for federal benefits programs, but the non-citizen adults are not. If the adults are in poorer health because of their inability to access care, the child could ultimately suffer because of the decreased capabilities of his parent. In a severe situation, the child of a single parent could be left without proper supervision because of the parent's untreated illness. There is also concern that undocumented parents may be less likely to apply for benefits for their citizen child, which could possibly decrease the child's well being. Supporters of immigrant care worry that "access to health care for some, but not all, members of a family could diminish the quality of care for children with coverage. For example, a family might try to share one prescription of antibiotics, preventing the covered child from being treated fully."[LXXIV]

Although other social services have valuable qualities to alleviate need, the moral mandate is not as clear as it is in medical care. Most can subsist without TANF or Food Stamps, but very few, especially not uneducated, poor undocumented immigrants, can medically treat themselves. It is to the benefit of everyone to provide care for undocumented immigrants. At the very least, the federal government should not prohibit local jurisdictions from using their own funds to treat undocumented and non-qualified

immigrants in a primary care setting. Emergency treatment alone is not sufficient to ensure the well being of immigrants; more preventative and maintenance care will improve the quality of life of the immigrants and it will also benefit society.

VII. The Future

The future of immigrant health care depends in large part on several federal legislative bills that are pending consideration. Many of these bills attempt to correct problems created for documented and undocumented immigrants by the Personal Responsibility and Work Opportunity Reconciliation Act in 1996. They are largely an effort to clarify what services states and local communities can provide to illegal immigrants. PRWORA requires that individual states must pass a new law after 1996, even if there is already an existing one, that allows for state funding of health care for undocumented immigrants. PRWORA does not mention any penalties, however, for state or local governments who provide care for illegal immigrants without a state law.

A situation in Harris County (Houston), Texas exemplifies some of the confusion and frustration surrounding immigrant health care. Local officials "proposed a formal policy that would permit all county residents who met eligibility standards to obtain non-acute health care – such as doctor's visits, physical therapy, and disease management services – regardless of their immigration status."[LXXV] Problems arose, however, when the Harris County attorney asked the Texas Attorney General for an opinion on the legality of the proposal. The Attorney General, John Cornyn, offered a non-binding opinion in July 2001 that stated the hospital district policy was in violation of PRWORA and would constitute an unauthorized expenditure of public funds because the Texas legislature had not passed a provision explicitly allowing for the care of undocumented immigrants; he suggested that the hospital district might be placing some of its federal and state funding at risk by providing non-emergency care to undocumented immigrants.[LXXVI] Some in the state say that legislation passed in 1999 does permit for the care of illegal immigrants. Opponents of PRWORA, however, argue that PRWORA

itself is unconstitutional because it violates the equal protection clause of the 14th Amendment by differentiating between citizens and immigrants. Some opponents also claim that PRWORA usurps the powers guaranteed by the 10th Amendment for the states and the people. Various federal circuit courts have ruled PRWORA constitutional, though, because differences are justifiable from the standpoint of the 14th Amendment if there is a "rational basis." However, in 2001, the New York Court of Appeals found a NY law, which denied state-funded Medicaid to certain immigrants (not undocumented, just non-qualified), unconstitutional because it violated the equal protection clauses of the US and the NY constitutions.[LXXVII] New legislation at the state level that permits primary care for undocumented immigrants would solve the legal issues in Texas, but federal clarification of PRWORA would have the greatest impact because of the national reach of immigrant and welfare issues.

One such federal bill came before Congress in July of 2001. U.S. Representative Gene Green of Texas introduced this piece of legislation (H.R. 2635) that explicitly affirms that states may treat illegal immigrants for health problems in situations less severe than emergencies. The health of the person can be better cared for because this legislation allows state and local governments to provide preventative and primary care to undocumented immigrants without fear of funding consequences;[LXXVIII] this is significant because it allows a continuity of care that should help prevent major crises for diseases that respond well to ongoing treatment, such as asthma and diabetes.

The Hispanic Health Improvement Act of 2002 (the Bingaman Bill) has the potential to affect positively the quality of care that Hispanic citizens, legal immigrants, and illegal immigrants receive. It is consistent with some of the goals set forth by the

Department of Health and Human Services' Office of Minority Health; the Office states in its Access to Health Care Preamble, "Not only do they [Hispanics] lack accessible, affordable, available, affable, and portable health care, but they also are severely underrepresented in ownership of health-related enterprises."[LXXIX] One of the major barriers to Hispanic care is language; the Bingaman bill attempts to overcome this obstacle by proposing an increase to 90% reimbursement for translation services when Medicaid or CHIP covers the patient. This bill would also allow states to provide prenatal care and child health care to documented immigrants through Medicaid and CHIP without waiting five years, as currently required by law. This bill also clarifies PRWORA by reiterating that state and local governments may provide health care to illegal immigrants on a primary care basis with their own funds. Lastly, the Bingaman bill requires federal programs to collect data on the language, race, and ethnicity of participants to allow for improved demographic analysis.[LXXX] This bill would remove the fear of possible federal repercussions that is preventing some local communities from providing undocumented immigrant care.

A Senate finance bill is also awaiting passage that would reauthorize the federal funding for TANF. Congress will not address this until the 108th Congress reconvenes in January. This reauthorization seeks to change some of the harmful conditions that restrict legal immigrant access to public benefits despite their need. This change would permit states to provide TANF through their own funds to legal, otherwise qualified immigrants, during the five years before they are eligible for federal benefits. It also addresses a couple of issues that it has in common with the Hispanic Health Improvement Act; the finance bill clarifies that state and local governments can use their own funds to provide

health care for unauthorized immigrants, if they wish to do so. The bill also clarifies that states can pay for prenatal and child health care for authorized immigrants during the five year waiting period in which they are ineligible for federal benefits.[LXXXI]

Funding is obviously a major obstacle to providing health care at the local level to undocumented immigrants who are unable to pay for the services. In order to be able to continue this care, state and local governments are attempting to recover greater levels of their costs incurred from providing emergency care. One effort targets the INS because the agency brings ill or injured undocumented immigrants to emergency rooms, but does not pay for any part of their health care from their own budget; these immigrants sometimes receive injuries as a direct result of the INS attempts to capture them. Border counties also believe the federal government should increase its general level of reimbursement for undocumented health care. U.S. Representative Ciro Rodriguez of San Antonio said, "We have a moral responsibility to care for the injured and the sick, and I believe strongly that the federal government, especially given its responsibility for immigration, must step up to the plate and help our counties meet this moral imperative."[LXXXII] Several Senators have jointly introduced legislation to help ease the emergency care burden on local counties; Sens. John Kyl, John McCain, Jeff Bingaman, and Pete Domenici, all from border states, introduced a bill that would reimburse states and health care providers for up to $200 million a year. A separate bill for Medicare funding also provides for federal payments for undocumented care, but at a reduced level; only $48 million was marked for reimbursement. The bill has yet to pass because of other issues not related to immigration that are included in the bill, which raises the total price to $43 billion.[LXXXIII]

Another interesting solution is a binational health plan that would be available to both Mexican and U.S. citizens and would pay health care providers on both sides of the border. This proposed insurance plan is by no means a cover-all solution; it would most likely only benefit the families who are already more financially stable with legal jobs in the United States. Some Mexicans cross the border every day to work in the United States, but continue to live in Mexico and prefer to receive their health care in Mexico. Employer insurance does not cover Mexican doctors, however. This plan would also benefit legal immigrants who are living and working in the U.S. but return to Mexico for medical visits. There is a need for legal immigrant insurance coverage because PRWORA restricted documented immigrant access to programs such as Medicaid. Dr. Maria Alen, adjunct professor and clinical consultant to the South Texas Center for Rural Public Health, predicts that, "Insurance, HMOs, and Medicaid, extended to legal immigrants, can keep this large population out of our hospital emergency rooms."[LXXXIV]

California Blue Shield created a similar plan to the one Texas is considering in 2000; it covers medical care for Mexicans and Americans that live within 40 miles of the border and can be used in either country. This binational plan would help to decrease the financial burden of caring for legal immigrants, which would increase the resources available for undocumented health care.

A recent decision by President Bush can greatly impove the access to prenatal care for undocumented women and their unborn children. Before this decision, CHIP only covered children from birth to age 19 with health insurance; states had to obtain a waiver from the federal government to classify a fetus as a child, thus making him eligible for prenatal care under CHIP. In a September decision, Bush classified fetuses as

"unborn children," eliminating the need for states to seek a waiver. The unborn children of illegal immigrants will be U.S. citizens, so the decision also permits CHIP coverage for prenatal care of undocumented women. Some abortion advocates argue that this is simply an effort by the Bush administration to establish a fetus as a person. Secretary of Health and Human Services Tommy Thompson said, "This is a common-sense, compassionate measure to make sure that all children born in this country will come into the world as healthy as possible."[LXXXV] This new CHIP regulation became effective the beginning of November 2002. It has the potential to improve the birth outcomes for all low-income women in the United States, but particularly for undocumented immigrants.

The proposed legislation, if passed, would make great strides in improving the health care of Hispanics in the United States. The Bingaman Bill is particularly promising because it not only clarifies that local governments can use their own funds to pay for undocumented care, but it also confronts a real barrier to care, language.

Reimbursing health service providers at higher levels for translation services may encourage local clinics to more actively seek Hispanic patients since they will not be left with the bill for language translation. Federal legislation that reimburses states at higher levels for emergency Medicaid would also be beneficial because it would leave more available funds for states to provide primary health care to undocumented immigrants. The most promising new legislation is the regulation concerning CHIP that will enable undocumented women to obtain prenatal health care; this should overcome many of the financial barriers that prevent immigrant women from seeking prenatal care. A strong informational campaign is necessary to ensure that women know this service is available to them.

It is vitally important that state and the federal governments consider issues related to immigration because it is a growing trend in this country. As it becomes more difficult for foreigners to receive a visa because of stricter immigration laws that resulted from September 11, the United States may experience an increase in unauthorized immigration. Whether illegal immigration trends increase or remain steady, there will be a sizeable population of undocumented immigrants in this country that will have needs, some of which will concern health care. The government must act through legislation to provide for, or at the very least permit, health care for undocumented immigrants. The laws must be clear and straightforward so that local hospitals, clinics, and doctors do not fear possible repercussions from caring for the undocumented sick.

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