4 ¿Puerta Abierta o Puerta Cerrada?

Citizenship, Health Care, and Welfare Reform in New Mexico

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Voz del pueblo, voz del cielo.
[Voice of the people, voice of heaven.]

—Dicho (Mexican Proverb)

There are numerous studies that assess the impact of welfare reform on immigrants (Acevedo-Garcia et al. 1997; Brown, Ojeda et al. 1999; Brown, Wyn et al. 1999; Capps 2001; Capps et al. 2002; Ellwood and Ku 1998; Feld and Power 2000; Fix 2001; Fix and Passel 1999, 2002; Guendelman, Hailpin Schauffler, and Pearl 2001; Ku and Matani 2000, 2001; Loue, Faust, and Bunce 2000). However, among the collection of current research, no study includes the voices of people from New Mexico. This chapter presents information on the impact of the 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) on immigrants living in New Mexico (documented and undocumented). It includes interviews with immigrants, service providers, health care practitioners, advocates, researchers, and policymakers. Their collective voices provide a unique story revealing experiences of immigrants and new challenges imposed on the safety net serving them.

The analysis establishes the critical link between citizenship and unequal access to health care. It also provides insights into how policy debates surrounding citizenship and immigration after welfare reform are rooted in conflicting beliefs regarding economics, social commitment, politics, self-determination, and human rights. The

policy outcomes of these debates result in both an open- and closed-door approach toward immigrants. Documenting integrative accounts of how people are "getting by" after welfare reform is necessary in order to develop federal and state policies that promote public health and more equitable access to health care and public benefits. This is especially urgent in a postreform and post–September 11 society on the cusp of the reauthorization of welfare reform. Immigrants face fear and hostility, especially during a failing economy and war on terrorism. Thus, welfare reform policies at the federal and state levels will be heavily shaped to reflect a "closed door" toward recent and low-income immigrants.

DATA COLLECTION AND METHODS

To place state-specific research in the context of other work, we conducted a literature review of over 120 articles and reports searching key words such as "welfare and immigration reform," "health care access," and "immigrant health" from peer-reviewed journals, legal documents, and policy think tanks. We also conducted interviews for several research projects from February 2001 through March 2002: a pilot study sponsored by the W. K. Kellogg Doctoral Health Policy Research Program; Senate Joint Memorial 52, a collaborative study conducted for the 2001 New Mexico State Legislature and funded by the New Mexico Department of Health; and *Con el Corazón Partido*/With a Split Heart, a special production of the KUNM radio station. Researchers conducted thirty-five interviews in English and Spanish by telephone and in person with immigrant women, policymakers, public health and human service administrators, physicians and nurses, case managers and human rights advocates. Tapes were transcribed and translated from Spanish to English. We also gathered news articles from local papers during the interview period 2001–2002 in order to establish a context of the public dialogue and debates regarding immigrants. We coded, correlated, and analyzed interview notes, minutes from public forums, news articles, and transcribed tapes. Recurring themes were interconnected into the story line that follows.

Central interview questions included (1) How are immigrants getting by after the 1996 PRWORA? (2) What are their experiences in seeking health care and public benefits? (3) What are the barriers? and (4) What are the potential solutions? In the course of interviewing, general policy questions emerged, such as How has the New Mexico safety net system been affected by the 1996 PRWORA? And who is responsible for serving immigrants?

The following news articles, accounts, and stories are real. All names given are fictitious except for the elected public figures.[1] The interviews and other qualitative data collection allowed us to study the social, economic, and political context of New Mexico as a host state to immigrants and obtain a glimpse of how immigrants are faring after welfare reform.

THE "STATE" OF THE STATE

According to a report by the Urban Institute, New Mexico faces some of the most daunting challenges among the fifty states in providing adequate health care for its low-income residents (Wallin 1998). In 1999, New Mexico had the fifth highest unemployment rate in the nation at 5.6 percent compared to the national figure of 4.2 percent (Research 2000). New Mexico was second to the District of Columbia with the highest percent poor population, at 19.3 percent, compared to 13.3 percent for the United States in general (U.S. Bureau of the Census 2001). In 1999, 20.7 percent of New Mexico's population lived in poverty compared to the national average of 11.8 percent. On the basis of composite health measures, New Mexico ranked as the fourth unhealthiest state in the nation. U.S. Senator Jeff Bingaman (D-New Mexico) says health care access is closely tied to the economic health of New Mexico: "A lot of the effort in health care, a lot of the focus on health care, I think fails to recognize the intimate connection between the quality of the health of the health care delivery system, on the one hand, and the economic development activities that are going on."

The statistics speak for themselves, according to Senator Bingaman and demonstrates that poor states like New Mexico are affected by their economic reality:

> The Bureau of Health Professions indicates that we are thirty-third in the nations in the number of physicians per capita. We are forty-fourth in the nations in the number of nurses per capita. We are forty-second in the nation in the number of pharmacists per capita. We are forty-ninth in the nation in the number of dentists per capita, and thirty-fifth in the number of home health care aids or providers. As I see it, we are in the unfortunate circumstance of having something of a downward spiral going on, and it's been going on for many years. That is, the higher the number of people who are uninsured, the heavier the burden that is shifted to employers. Those employers who want to provide health care and do provide health care to their employees find out that they have to pay more and more because of the high number of uninsured.

Even for citizens, the health care system is complicated and not very effective. In addition to having a poor economy, shortage of health care professionals, and low rates of employer-offered health insurance, New Mexico leads the nation with the highest number of uninsured residents. Senator Bingaman explains:

> According to the census data, New Mexico has 427,000 people who are uninsured. That's 23.8 percent of our population in the year 2000. Among the total uninsured, 123,000 are children. This is the highest uninsured rate of any state in the union. But underlying these statistics are other grim statistics that we're all too familiar with: we have the second worst immunization rate for children in the country. We have the worst rate of prenatal care coverage of any state in the country. We have one of the highest suicide rates among our adolescents of any state in the country. When you combine the shortage of health care professionals in our workforce with this high uninsured rate, you find substantial deficiencies in our health care delivery system around the state, and really in all parts of the state.

The 1996 PRWORA has created a system in which the receiving state governments, can, by law, maintain a closed-door stance of exclusionary welfare policies. When critical funding decisions need to be made, who is compromised first and cut from eligibility in order to cut costs? Immigrants. Thus, "welfare reform represented a watershed in the nation's immigrant integration policies, for the first time barring legal immigrants from federal means-tested public benefits, and effectively conditioning those benefits on citizenship" (Fix 2001). This legal process of determining eligibility for benefits is really about creating categories of belonging, identifying through citizenship status those defined as the "deserving poor," worthy of welfare benefits. In fact, the language of the 1996 PRWORA defines the parameters of belonging, setting a tone that compromises and dehumanizes an immigrant's social position before even arriving in New Mexico. Section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act states that "an alien who is not a qualified alien, is not eligible for any Federal public benefit" (Human Services Policy, Office of the Assistant Secretary for Planning and Evaluation, 2000).

Exclusionary policy reforms create public perceptions that draw a clear line between "us" and "those people" categorized as "aliens." The rhetoric of "alien" and "otherness" creates stronger social restrictions on who qualifies for privileges and rights and who is to be omitted by the nature of their skin color, language, or national origin. An immigrant rights advocate explains:

> What we have done politically is that we have created these tiers of human beings: Who has access to education? Who has access to work? Who has access to health care? Right. And it's not even the documented and undocumented anymore. It's that the undocumented have X amount of rights, the legal permanent residents have X amount of rights, the U.S. citizens have X amount of rights. And when we create those tiers of citizenship, those categories of human beings, people internalize that and people start to see undocumented immigrants differently. They are different, because they have different rights and a totally different experience.

NEW MEXICO DEBATES ON WHETHER TO OPEN THE DOOR TO IMMIGRANTS

Who Comes to New Mexico? And Why?

Of the 1,819,046 estimated total population of New Mexico, 120,000 are legal documented immigrants and 40,000 are undocumented immigrants.[2] The undocumented population comprises less than 0.7 percent of the state's total population. Today, over three-fourths (78 percent) of the immigrants admitted to New Mexico are from Mexico. Immigrants admitted to New Mexico also originate from a number of Asian countries, including Vietnam (2.9 percent of all admitted immigrants), Mainland China (1.5 percent), the Philippines (1.5 percent), and India (1.4 percent).[3] Even though Hispanics comprise the largest proportion of immigrants in New Mexico, over 90 percent are native born. This is higher than the national average of over 64 percent.[4]

Many immigrants cross the Mexico–New Mexico border after suffering economic hardship. They come without a permit and stay. Some tourists/visitors decide to stay when their visa time period expires. When they overstay their visa they become an "illegal alien." Those people do not have an option to apply to a program, nor can they obtain a Social Security number. The reasons for staying are primarily economic. For example, they may decide to stay and work for an indefinite time, save some money, and go back to their countries. Or, they may end up getting married, or supported by a family member. Immigration laws for the ones who come temporarily have become extremely difficult. Ramona is the wife of an employed legal permanent resident. Her family reunited after her husband spent seven years working as a mechanic in Albuquerque, New Mexico, while she and her three children lived separately in a small town in Chihuahua, Mexico. They decided that Ramona and the children

should move with him, and with his permanent residency status, he could apply for her and the children's legal status. After going several years without preventive screening, she finally received a gynecological checkup that diagnosed her with a severe dysplasia. She did not have the money to pay for lab work or follow-up treatment and did not qualify for public assistance due to her legal status. Ramona best expresses the common struggle experienced by immigrants: "I sometimes worry so much about my husband getting into an accident or any of my children getting a disease. Then we cannot afford to pay the doctors and the medicines. May God give me strength and patience to wait for my Social Security number so I can work. May my family not be in a hard situation."

Do Immigrants "Pay Their Way" or Do They "Drain" the State's Welfare System?

Although undocumented immigrants have come to New Mexico primarily for economic opportunity, their employment rates are low. As a result, the vast majority of undocumented Hispanics are living below poverty. In New Mexico, families with a foreign-born Hispanic householder are more than twice as likely to be in poverty. The mean family income of native-born Hispanic families is 42.2 percent higher than that of immigrant families.[5]

Nonetheless, immigrants living in New Mexico—documented or undocumented—contribute much to the state's economy and pay taxes. For example, Mexican immigrants are overrepresentative in low-income labor force such as the agricultural, construction, food, janitorial, and domestic service sectors in New Mexico. They pay taxes and help stimulate the economy by spending their hard earned wages on food, housing, education, health care, and other consumer products. However, they are not eligible to participate equally in society and claim basic public and health benefits. Many respondents agreed that immigrants pay their way but are not reaping the benefits. One legal advocate stated:

> There are people in New Mexico who are here, whether they're legal here or not, they are here. They are working and they are contributing taxpayers in the community. I mean, since we at least still have a tax on food, and tax some things that we buy, whether you are here legally, and you buy something in the state of New Mexico you're paying taxes. And if you're a taxpayer, then there are certain things one would like to have the benefit of. Like some of the health care and other benefits that are available through state tax dollars.

The state is not the only benefactor of immigrants who pay their way. According to a study conducted by the National Academy of Sciences, immigrants make indispensable contributions to our economy. They add about $10 billion each year to the U.S. economy. In 1997, immigrant households paid an estimated $133 billion in direct taxes to federal, state, and local governments. The typical immigrant and his or her descendants pay an estimated $80,000 more in taxes than they will receive in local, state, and federal benefits over their lifetime.[6]

Welfare Reform and Immigrants in New Mexico

New Mexico has not conducted a quantitative analysis specifically on immigrants and public services after welfare reform. However, findings from other studies demonstrate that use of public benefits by the foreign born is either similar to or less than the native born after 1996 (Berk 2000; Fix and Passel 1999, 2002; Kramer 1997; Ono and Becerra 2000). The New Mexico Human Services Department provides Medicaid, State Children's Health Insurance, and Temporary Assistance for Needy Families to qualified immigrants after the five-year ban *if* they are eligible.[7] However, the most recent immigrants and those immigrants who are fearful or have been discouraged from seeking benefits are less likely to apply for food stamps and other benefits.

For example, Irma is married to a legal permanent resident. She and her husband are from Juárez, Mexico. They have three daughters, ages fourteen, sixteen, and three. The two eldest were born in Juárez, and the youngest was born in the United States. She and her family have felt the impact after 1996: "Before 1996—before we got here—it was easier to get food stamps. Not anymore. Now it is more difficult, even though it is said that a child who is born here should receive all the benefits. But it is very difficult to receive them because there are more requirements. Up until now, I still haven't been able to obtain benefits for my daughter."

Many other immigrants in this study had similar experiences. In fact, other immigrants shared that they were legally advised to refrain from applying for benefits. Cecilia's husband, who is a U.S. citizen, submitted an application on her behalf for residency. As a result, Cecilia was able to obtain a working permit and Social Security number, become employed, and pay taxes. However, while legal status was still not officially determined, she and her husband were advised not to apply for any government subsidy: "I entered this country with a tourist visa. I entered with permission to be here in this country. When I was processing my documents, the attorneys that were helping me

told me that I could not apply for anything because I would risk my documents not getting processed. And even though my husband is a citizen, I might be denied residency."

Despite the evidence that immigrants pay their way, the debate ensues as to whether to "open the door" to immigrants or to "leave the door closed" through policy changes or status quota. To open the door to immigrants under the 1996 PRWORA law, New Mexico could enact legislation that restores immigrant eligibility for public benefits. This allows the state and local tax money to cover nonemergency care and other medical benefits to immigrants, without regard to their status as citizens or aliens. Under the existing closed door, New Mexico's policy states that aliens who meet all criteria for Medicaid—but for their undocumented or nonqualified status—are eligible only for emergency services, for the duration of the emergency. Natural childbirth is defined (by federal guidelines) as an emergency. Nursing home and dialysis services do not qualify as emergency services. Pursuant to federal law (1996 PRWORA), legal aliens who enter the country after August 1996, even with legal permanent resident status, are subject to a five-year bar from Medicaid coverage, with some exceptions (i.e., refugees, active military, and veterans). Aliens who entered the country prior to August 1996 are subject to the regulations in effect prior to enactment of PRWORA.

The decision on whether to change existing state law or to leave it as stated above has become so heated that during the Forty-fifth Legislature, First Session 2001, the New Mexico State Senate and House of Representatives enacted Senate Joint Memorial 52 requesting "the Department of Health, the Health Policy Commission and Human Services Department to evaluate the provision of health care to immigrants, especially those documented immigrants in the United States for fewer than five years and undocumented immigrants."[8] The results of the study were debated at a health and human services interim committee meeting in December 2001. Owing to the concerns outlined by the study, a new piece of legislation was proposed in January 2002 but never passed committee. Senator Linda Lopez (D-New Mexico) indicated her strong dissatisfaction with the decision:

> Sadly to say, this past legislative session, there was a Senate Joint Memorial that actually never made it out to the floor. I tried to remove it from the committee during the last few days, and there was some opposition from the other side of the aisle. The intent, actually, was just to direct the appropriate department intern committee to investigate exactly what the concerns are within the immigrant community; if they are receiving health care, if not why not, the cost associated, just a full study as to what's affecting our health care system in relation to the immigrant and to our state.

With a closed-door welfare reform policy, immigrants continue to struggle with accessing basic health care for themselves and their children (citizens and noncitizens alike). All research respondents expressed concern about limited access to health care as a result of the 1996 PRWORA establishing a bar on immigrants' access to Medicaid. One legal advocate interviewed said:

> There are lots of people whose health care status was affected by the changes in the welfare law, and a group of those people were immigrants, documented immigrants. People who had been able to get certain benefits before, couldn't get them now, which is different than people who are not documented, folks who come into the country and are not documented never had a right to, for example, Medicaid, but had access to other kinds of health care. So, there became a struggle as to whether or not people who were not documented or people who were documented still could have access to certain kinds of health care benefits in this country.

The most common reasons for not obtaining health care, as reported by immigrants were financial barriers and inability to pay, lack of Spanish-speaking medical and social services personnel, lack of a regular source of care, and inability to get preventive and specialty care. Other barriers to accessing health services included fear of being a "public charge" and affecting one's legal status, transportation issues, difficulty getting an appointment, long waiting time at the emergency room, and misinformation regarding Medicaid and public benefits eligibility rules.

Consequently, adequate access to health care services can significantly influence health outcomes. Multiple barriers—such as the inability to pay for costs and lack of a regular source of care—have a devastating impact on the health of families (adults and children) composed of citizens and noncitizens, also known as "mixed-status families." The 2000 Census Bureau figures show that people who were not born in the United States were three times as likely as U.S.-born residents to lack insurance. Studies conducted after 1996 have reported that the majority of noncitizens and their children are at a high risk of being uninsured and face serious gaps in receiving health care and public benefits (Ku and Matani 2000).

A September 2001 Policy Brief by New Mexico Voices for Children reports that parents who are able to obtain preventive health care for themselves are more likely to procure preventive care for their children. Furthermore, if children have health insurance but their parents do not, they are less likely to receive preventive care than are children in families where children and adults are insured. Another study conducted by

the Albuquerque Community Health Partnership on children with asthma found that recent immigrant parents of asthmatic children dealt with severe episodes of asthma by delaying care until a time of crisis.[9] Delayed care-seeking behavior patterns were attributed to language barriers and/or confusion in navigating the medical system in the United States. Most parents described the visit to the clinic/hospital, confronting the bureaucratic medical system, and dealing with a lack of interpretive services as the root causes of their heightened feelings of terror and fear. These circumstances were further complicated when the families were undocumented.

BARRIERS TO ACCESSING HEALTH CARE AFTER WELFARE REFORM

The Link between Citizenship and Health Access after Welfare Reform

Why does citizenship matter? Because citizenship is a condition created under the 1996 PRWORA in determining eligibility for public benefits and access to health care. Thus, citizenship matters because it is a category of belonging through which we make claims on each other and the state (Williams 1998). The context of "belonging" in the United States truly determines access to services, education, employment, and health care. Furthermore, the production of health is determined by having access to these different forms of capital: financial, social, political, human, and cultural.[10]

In addition to the harsh realities that native-born citizens face in New Mexico, immigrants encounter additional barriers when seeking preventive medicine, treatment for disease and illness, and even emergency medical care. A good example of the intersecting barriers created as a result of citizenship, language, and socioeconomic status was best expressed by Teresa's experience during pregnancy. Teresa immigrated to New Mexico with her husband Pablo after a period of eight months of unemployment in Durango, Mexico. She had been employed in a minimum-wage job but was fired due to her pregnancy. She and her husband moved to the United States with the hope of finding work. They moved in with her brother Carlos, a legal permanent resident. She had sudden fainting spells and collapsed several times, making her pregnancy high-risk. Being a recent non-English-speaking Mexican immigrant, she was aware of her legal and financial situation and, as a result, expected difficulties. However, she felt overt discrimination immediately:

> I was feeling bad because I would go to the clinic. I was seven months pregnant when I arrived here. I would go looking for care. I would struggle to get my appointments, I'd struggle for everything. When you've just arrived, you have no means to move around. You have no work and you have no money. I would have an appointment at the clinic. And I felt, you know, I was sad. Still, when I said I did not speak English they wouldn't give me the attention I needed. I would ask if someone spoke Spanish at the clinic, then she would talk to me roughly. I would ask myself "why do they treat me like this?" then you start feeling the rejection, so then you tell yourself, we don't fit here, because we're not from here. We don't fit here, we just don't fit.

Among the stories shared by immigrants, there developed a pattern of multiple issues, not just one, but a combination of issues that interacted to create barriers. Among the most common barriers were costs of care, lack of health insurance, mixed-status family issues, misinformation, language, and having to use an emergency room as a regular source of care.

Costs of Care and Lack of Health Insurance

According to the research literature, the top two indicators inhibiting access are lack of health insurance coverage and lack or limited linkage to a regular source of care.[11] The 2000 Census Bureau figures show that people who were not born in the United States were three times as likely as U.S.-born residents to lack insurance. Data from the Current Population Survey indicates that undocumented immigrants are less likely than other Hispanics to have insurance coverage.[12] Studies conducted after 1996 report that the majority of noncitizens and their children are at high risk of being uninsured and face serious gaps in receiving health care and public benefits (Ku and Matani 2000). Obtaining employee-sponsored insurance is another barrier, but this is also associated with being marginalized in the service sector, difficulty in maintaining regular work, and earning a decent living wage. When immigrants were asked why they were not able to access health care, the most common reason was financial hardships, including costs and lack of health insurance. This is echoed by Irma, who states, "I'm concerned that I won't be able to pay on time. Since 1996 when they began to fine those businesses that had undocumented workers, my company let many people go. I was one of them. Before then, I was not worried about not being able to pay for medical care."

As a result of these costs and changes after 1996, it was typical for immigrants to delay seeking care or miss getting medical screenings and/or treatment for health problems because they could not afford it. Although these problems occurred before 1996, the PRWORA exacerbated barriers, resulting in delayed and/or inadequate medical care. When they did finally get care, in some cases, their health condition or disease had severely progressed. This was the situation for Carmen who has been in the United States for eight years. Neither she nor her husband, nor their four children, are documented. Carmen is over fifty years of age and finally received a diagnosis for her breast cancer because her age qualified her to be eligible for diagnostic and screening services through a Centers for Disease Control program. As a result of the financial loans Carmen's neighbors and friends gave her, she was able to return to the hospital after the diagnosis to obtain a mastectomy. Carmen explained:

> They told me that it was cancer and that it was spreading, and that my heart was failing. And they asked my daughter if they should just operate on me first, or if they should start chemotherapy. So they went ahead and operated on my breast. When I was about to be admitted to the hospital they told me I needed to pay $2,000. And so then, they didn't want to assist me. They gave some papers and sent me to Mexico. Well, we finally gave them $2,000 and they did the mastectomy on me. But, until then they wouldn't operate, and later they sent me a bill for $14,000.

Respondents reported that hospital administrators refused services to immigrants who are willing to pay but can't afford the costs. A primary health care physician at a publicly funded hospital spoke of this practice toward uninsured immigrants: "I know of several cases in which the hospital has refused [to treat immigrants]. The administration is refusing surgeries unless the families are able to come with the full payment of the surgery, or half, 50 percent of the payment, before they actually did the surgery, and that's impossible. And that's tens of thousands of dollars."

Mixed-Status Families

Welfare reform policies that deny health care and public benefits to noncitizens are likely to have broad spillover effects on citizen children who live in the great majority of immigrant families of mixed status.[13] In other words, denying health care to non-citizen parents of U.S. citizen children has implications for the well-being of those families

and children. Multiple barriers like the inability to pay for costs or a lack of a regular source of care have a devastating impact on the health of families (adults and children) composed of citizens and noncitizens, also known as "mixed-status families." Maria, a legal permanent resident, reported along with other parents, similar problems they are facing getting health care for their children:

> Currently, my children don't have any medical care, in spite of them being American citizens. Well, first, I don't speak the language. I can't fill out the paperwork and I can't find anyone who speaks my language and can help me. Second, because of the hard times we're having economically, it's been difficult to pay medical insurance. We just can't pay for medical insurance.

Several health and human service providers also expressed concern for the health of the immigrant families and their children. A social worker explains:

> Childrens Medical Services receives referrals for children with special needs and immigrant children are not eligible for health care coverage. There is the mixed-status family issue; if one parent is a lawful permanent resident, the other may not be, et cetera. There are all sorts of mixed-status folks surviving on public benefits that only one family member receives. There is also a lot of misunderstanding among mixed-status families or families obtaining residency. Out of fear of being public charge, families are reluctant to apply [for benefits for which they are eligible].

Misinformation

Lack of information regarding eligibility criteria and individual rights remains a challenge for immigrants and service providers. A social worker reported:

> Since PRWORA, the situation is very confusing to immigrants to understand what they qualify for and what they don't qualify for. I have had many people come into my office whose children are legal but they were afraid to apply for Medicaid because they were in the process of applying for lawful permanent residency. Policies are confusing for both applicants and those working in agencies. Even agency staff are not clear about what residents are eligible for.

Also lacking is information regarding individual rights; many immigrants fear that applying for or accessing services will affect them as

they travel through the legal process to stay in this country. A health educator who speaks with immigrants about this said:

> People would rather not receive services and evade legal services. I have seen women who are in the process of getting their legal residency or who are undocumented and had a child here. The child has the right to get Medicaid so they go apply. When the mother gets interviewed and Medicaid finds out that the mother can't support the health services of the child, that may also affect the legal process.

For low-income immigrants, many of whom are elderly, disabled, or not fully proficient in English, the technicalities of PRWORA may be incomprehensible. An immigrant rights advocate explained: "I think a lot of the supplemental services that are not provided to immigrants really harms the health of the family and even for those services that are available to them, they don't know."

Language

Language is found to be the leading barrier to accessing and utilizing health care services (Ku and Matani 2001; Solis et al. 1990). In addition to citizenship status, language has a distinct role in helping people navigate and access social benefits and health care. This disproportionately affects immigrants. Immigrants expressed that they are treated differently than other patients who have private health insurance and speak English. For example, Irma shared, "There are times when there is someone to translate. But there are other times when I have to use my daughter [as my interpreter]. I've been treated differently more so because of language. Because of this, I have had many problems. I've had to wait just because of that."

Communicating with a physician and medical personnel is significant to building trust, developing a patient–provider relationship, acquiring preventive screening, and establishing a reliable and regular source of care (Suarez 1994). Studies that examine the relationship between language and health care find that Spanish speakers were less likely than English-speaking Hispanics to have a usual source of health care (Kirkman-Liff and Mondragon 1991; Schur and Albers 1996). For example, when Maria, a legal permanent resident, called the State's Children Health Insurance Medicaid program for her U.S.-born children to obtain information, she found she could not even get an appointment time for dental care for her children:

> The secretary talked too quickly. She didn't give me the opportunity to express that I can't speak or understand English very well. She tried to speak to me in Spanish, but not very well. She didn't give me the opportunity to say excuse me, I'm going to make a note of the address and I'd like to ask some questions. She simply hung up. She took no interest. She cut me off. Second, I wanted to go to a dentist. She was very busy and she was the only one who spoke Spanish. The receptionist and I couldn't agree on an appointment time.

Effective communication between patient and provider remains a barrier for language minorities despite federal laws such as Title VI Policy Guidance (Title VI Prohibition Against National Origin Discrimination as it Affects Persons with Limited English Proficiency 2000) that require government-funded programs or services to ensure meaningful access to health and social services to persons with limited english proficiency. Several respondents were disturbed that quality health care is being severely undermined by the lack of Spanish-speaking medical professionals and/or interpreters. A health educator reported the following:

> Patients who do not speak English do not know how to explain symptoms to providers who only speak English. The doctor needs a translator and they are not available, which leads to bad health services for the patient. Institutions see translation as another expense that isn't worth it, so very frequently you see other members of the family providing translation. A disabled senior had to bring his child of eight years old to translate. He had to use oxygen and the child explained for some reason that the tube had to go into the ear. After a few weeks the man still was not feeling better and the doctor found out that he was not using the equipment properly, he was putting the oxygen in his ear because of the bad translation. This is very common. It is also common for doctors to call the cleaning staff to translate.

At the same time, immigrant families are struggling to get by:

> When we had insurance, and I spoke English and asked for services for my children—because one time my daughter had an emergency—I spoke in English and later they tried to speak to me in Spanish, but I didn't feel comfortable because the doctor didn't speak Spanish well enough. There were no translators. No doctor or nurse made me aware of a translator. I tried with the little English I know, I tried to explain the problem and that's how we communicated—with signs.

Unfortunately, the health care system is challenged with limited Spanish-proficient providers. This places the burden on immigrants to effectively navigate through the health care maze and communicate with health care professionals. Preventive health care and treatment is void or delayed as a result of language barriers. When people finally seek treatment it is most often on an emergency medical basis.

Lack of Regular Care and Emergency Room Use

Lacking a usual source of care has significant implications for the quality and continuity of care immigrants receive. According to respondents, accessing and paying for health services (preventive, specialty care, follow-up treatments, and hospitalizations) have become more problematic after welfare reform. As a result, they delay seeking care until it is an emergency or they go to Mexico for care. Irma, an undocumented immigrant who speaks limited English, stated the following:

> Now, they are not seeing people like before—one could go to the hospital without money and now they can't. Now they have to pay the whole cost upfront. I'm not sure, but I think they require all of the money for surgery. My husband is a resident. He does and has had insurance. He was being treated at the hospital, but there was a reason why he didn't want to go: because we had to wait a long time in the hospital emergency room. He had very severe pain and he got desperate. We preferred to return to our house. And during the next weekend, he went to Juárez [in Mexico], and they treated him there.

The health care that immigrants are forced to use as a regular source of care are emergency medical services. Despite the fact that immigrants are eligible for basic preventive care through a variety of safety net providers in New Mexico, emergency care remains a regular source of care for many of those who have no regular physician and no health insurance.[14] It should be noted that even under the 1996 PRWORA, all immigrants—including the undocumented—are entitled to emergency care and certain public health interventions. However, this reliance on emergency care is not a reasonable long-term solution given that the emergency medical delivery system is already overcrowded and overburdened with uncompensated care costs. Investing in preventive, primary, and secondary care offers an affordable and more humane and responsive policy option. A primary care physician and administrator reported:

> It's an issue that is not going to be resolved easily. But I think where it starts is at a primary care level, and identifying a primary care physician for everyone. If we can do that, if we can identify this primary care home for everyone, it's going to reduce the necessity of a lot of specialty and tertiary care. We can begin to keep people well. We can begin to address issues locally before they become issues that require hospitalization.

Research demonstrates the benefits of investing in preventive care. A California study found that for every dollar spent on prenatal care, $3.33 was saved in the cost of postnatal care and $4.63 was saved in incremental long-term costs (health care, childcare, special education, grade repeating).[15] Another California survey of undocumented immigrants seeking care in an emergency room found that 80 percent reported lack of funding (uninsurance) as the primary reason; 36 percent stated that they had difficulty getting care elsewhere because of their immigrant status; 51 percent did not know of another source of care; and 44 percent said that only the emergency room was acceptable as a source of care.[16] A maternal and child health study found that eliminating prenatal care for undocumented immigrants would increase the morbidity and costs related to undetected sexually transmitted diseases, which are screened for during prenatal care.[17] But, even if primary care is accessible, some low-income immigrants just cannot afford the screenings and the follow-up services needed. For example, the executive director of a local domestic violence shelter explained:

> Immigrant women are unable to access affordable and regular preventative health care and/or treatment. They are not able to get breast or pap exams or regular checkups or there is misinformation that they do not qualify to be eligible for those services. I don't know if people understand that $30 per hour for a checkup means giving up other basic living needs like food or transportation. If a client and her children only have $200 to live on per month, how could they afford to pay for a $30 doctor's visit? Then there is the follow-up care that is needed. Thirty dollars will pay for a visit at the local clinic, but then the doctor refers to the university hospital for more tests. Scanners cost $500 or more. So, it's what happens and the cost after that first visit!

Maria, an immigrant who has been in New Mexico since 1998, agreed: "In all the time I have lived in Albuquerque, I haven't had a mammogram or a pap smear. It's not that I don't want to do it; I'm afraid of what it will cost because I can't pay."

Not out of choice, but out of desperation, many immigrants continue to seek care in the emergency room for preventable illnesses since they have no other provider source on which to rely. One woman remembered the only time she had ever gone to the emergency room:

> I had very strong migraine. Because of the pain, I didn't go totally conscious of what was going on. . . . Because I went to the emergency room, I was there three or four hours and it cost more than a thousand dollars. From that moment on, my husband cancelled the insurance so we could pay the hospital. I continued to pay the hospital. And we still haven't finished paying. Now we had two payments to make and we preferred to pay what we owed to the hospital rather than continue with the insurance because we didn't want to be in debt. Because of the high costs, we don't feel we can get sick and go to the hospital anymore.

Another respondent shared that she is worried about what to do if she gets sick, but in the meantime is doing her best to take care of her family's health by using self-diagnosis, home remedies, and traveling to Mexico to purchase more affordable medications:

> I go to Juárez, Chihuahua, Mexico. I know that it is against the law, but I do it anyway. I bring medicines from Mexico for my family. Because I am a nurse and because I know what my children need, I can administer them, for instance, antibiotics, medicines for my son's allergies, and other medicines I use at home. I am also inclined to use natural medicines. And they have given me good results with my children. My worry, however, is what might happen if we suffer an accident. Or if one of my children suffers an accident. That is beyond our reach. That is my worry.

Primary Care Clinics and Physicians Keep the Doors Open to Immigrants

"In a recent survey by the National Association of Community Health Centers, CHC directors ranked welfare reform as the number one issue negatively affecting their paying patient base."[18] Despite the fact that primary care clinics are absorbing the costs of uncompensated care to the outrageous number of uninsured New Mexicans, their doors remain open to immigrants. A physician from a community health center explained, "All safety net providers are working together

to try to determine, try to identify solutions to this growing issue of access to care for the uninsured and underinsured, and that includes the immigrant population." A primary health care physician at University of New Mexico Hospital agrees: "Just because somebody doesn't have the right documents or the right income, we're not going to let them have a heart attack in front of our clinic and keep the doors closed. We need to be responsible to the community."

In a memorandum to the Senate Joint Memorial 52 Workgroup on August 22, 2001, the New Mexico Border Health Advisory Council articulates their philosophy: "Do no harm, at best characterizes our focus on prevention, which provides the foundation for our efforts to maximize the quality of healthy living for every resident."[19]

Despite the fact that public health physicians and other health care practitioners keep their doors open to serving those in need, the battle continues for immigrants. On August 5, 2001, the *Albuquerque Journal* reported that "undocumented immigrants are caught in the battle" between federal and state policymakers, safety net hospitals, and front-line medical personnel. The dilemma of whether to provide care to undocumented immigrants has become more pronounced since the 1996 Welfare Reform Act: "Under the welfare reform act [*sic*], New Mexico can pass a law saying it wants to spend state and local tax money on immigrant health care, even if it can't use federal dollars. There are some fears that passing the state exemption could put New Mexico in the position of having a mandate to provide health care to immigrants but not enough money to do so."

The battle continues between immigrant advocates on one side and public hospitals on the other. Along these lines, an employee with the American Civil Liberties Union stated, "In New Mexico, it has put UNM Hospital, the state's largest public hospital, and the center for certain medical specialties, in the crossfires of some critics. The ACLU is taking a hard look at how the hospital treats immigrants, while the hospital administrator claims he's just following the law."

In the midst of the legal and financial debate, medical personnel and physicians stand behind their health care ethics: "Doctors take an oath that says they care for a person based on need, not on nationality or ability to pay. A large number of us believe we need to provide services to a patient regardless of national origins." The *Sun News* reported the following on August 18, 2001: "In a forum in *Las Cruces*, focused on immigrant health care, a physician from a women's health center said that she has donated much of her own time to treat illegal immigrants. 'I gave an oath to help people, regardless of citizenship,' she said."

NEW BORDERS (AFTER SEPTEMBER 11)

What Doors Remain Closed?

Policies impacting immigrants will be heavily shaped by the current global antiterrorist climate. In a post–September 11 society, we may anticipate that U.S. immigration policy will be more hostile than receptive toward new entrants. On October 27, 2001, Governor Gary Johnson (R-New Mexico) told a reporter from Channel 13 news that the state would step up enforcement efforts against the tens of thousands of undocumented immigrants believed to make their home in New Mexico.[20] "If you're not here legally, you're gonna be detained," Governor Johnson was quoted as saying, "and you're gonna be detained long enough to find out what it is you're here for and what it is that it's going to take to get you out of here."

In a failing economy, immigrants may become the new targets of blame and racial profiling. For example, on December 21, 2001, a DWI roadblock was set up by state police outside the city and attended by the U.S. Border Patrol. According to an article on January 18, 2002, in *Santa Fe New Mexican*, "Six people suspected to be drunken drivers were stopped at the checkpoint, while 17 people were detained by the Border Patrol, enforcement arm of the INS. Of the 17 detainees, 16 were returned to Mexico."

We argue that no matter the level of the "anti-immigrant" sentiment, states have the ongoing challenges of meeting the demands and needs of their current immigrant populations who pay taxes and make significant contributions to their economy and society.[21]

Solutions and Open Doors

Respondents offered a variety of solutions. They indicated the utility of offering more information in Spanish on eligibility and benefits; this could be accomplished through community institutions, including the schools, and on Spanish radio. Respondents also suggested that we reinvest state and county tax dollars to support preventive care to immigrants, especially care targeting children and pregnant women. A recurring recommendation was to invest in preventive care, which would, ultimately save the state, county, and safety net providers from the high cost of emergency medical care. One immigrant and director of a domestic violence shelter for women suggested, "When you look at preventive medicine, it is to benefit the state and county! Invest in people at the beginning. Keep the labor

force healthy. Undocumented immigrants are here to do landscaping, roofing, construction, but they have no worker's compensation or health insurance."

Under the 1996 PRWORA, New Mexico has the option of creating its own eligibility rules for immigrants for state-funded services; they can do this through formal state legislative enactment regarding eligibility. Beyond the economic argument, advocates, immigrants, and health practitioners look to government to act on principle. An advocate with the ACLU agreed: "As an ethical principal, I would think the government has a responsibility to ensure that citizens all enjoy a certain level of health security so that they can be contributing members of society."

Along the lines of "ethics" and "principle," several respondents believed in the goodwill of New Mexicans to take care of their own. A health advocate explained:

> Well, I think about many issues that involve undocumented residents of our state as just a human being related to another human being. And I think, you know, that we have a responsibility to one another that's pretty fundamental. That if we see somebody who needs help we reach out to each other if we can. And I think the laws should support that. Most New Mexicans operate from that stand, so that's what I love about New Mexico. There's an inherent generosity among New Mexicans to reach out to assist one another.

A recent Mexican immigrant and nurse expressed her wishes: "I understand that this city declared itself friendly towards immigrants, and I hope, with this mentality they'll open the doors to us." Finally, one immigrant, herself a human rights advocate, summed up the social and moral consequence of keeping the doors closed and limiting service provision:

> We all lose, immigrants and nonimmigrant alike. We need to be pro-human beings, and pro-human dignity. It's not about being pro-immigrant. For example just a few months ago in Albuquerque, there were fourteen ducks that died of starvation and lack of water in a trailer park because someone neglected and abandoned them. It received media attention and sparked a lot of concern by people who were outraged that these ducks were abandoned. That same week, fourteen Mejicanos had died in the desert because they were trying to cross the border and got abandoned by the person they paid to cross them. The media did not cover this and no one was outraged. We need to value human lives.

NOTES

The translation of the titleof this chapter is Open Door? A Closed Door?

1. U.S. Senator Jeff Bingaman, State Senator Linda Lopez, and Governor Gary Johnson.

2. U.S. Department of Justice, 1998, *I.N.S. Immigration and Emigration Census* (Washington, DC: Author), 197.

3. U.S. Immigration and Naturalization Service (INS) data on immigration for the 1990–1996 period. See Bureau of Business and Economic Research, University of New Mexico, 2000, *Racial Trends and Comparisons in New Mexico during the Late 20th Century: What the Census Tells Us* (Albuquerque: Author).

4. Data from the INS *Statistical Yearbooks*, 1990–1996 (see ibid.).

5. INS data on immigration to New Mexico and the United States for the 1990–1996 period (see ibid.).

6. National Research Council, National Academy of Sciences, 1997, *The New Americans: Economic, Demographic, and Fiscal Effects of Immigration* (Washington, DC: National Academy Press).

7. New Mexico Medicaid Coverage for Aliens. Human Services Department, submitted for Senate Joint Memorial 52 by Robert Beardsley, October 24, 2001.

8. *Senate Joint Memorial 52 Report: An Evaluation of the 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) on Access to Health Care and Public Benefits for Immigrants in New Mexico*. 2001, November. Alburquerque: New Mexico Department of Health, Health Policy Commission, Human Services Department and Senate Joint Memorial 52 Workgroup.

9. C. Hidalgo, 2001, *Report on Priority Needs and Interests of Parents of Children with Asthma in the La Mesa and Mission Avenue Elementary School Areas* (Alburquerque: Community Health Partnership, New Mexico Advocates for Children and Families).

10. M. Marmot, 2000, Multilevel Approaches to Understanding Social Determinants, in L. F. K. Berkman (Ed.), *Social Epidemiology* (Oxford: Oxford University Press), 349–367.

11. *Update Report on Access to Health Care for the American People*, 1983, Special Report 1 (Princeton, NJ: Robert Wood Johnson Foundation); *Access to Health Care in the United States: Results of a 1986 Survey*, 1983, Special Report 2 (Princeton, NJ: Robert Wood Johnson Foundation).

12. *Hispanic Access to Health Care: Significant Gaps Exist*, 1992, Report to Congressional Requesters (Washington, DC: U.S. General Accounting Office).

13. M. Fix and W. Zimmerman, 1999, *All Under One Roof: Mixed Status Families in an Era of Reform* (Washington, DC: Urban Institute).

14. Senate Joint Memorial 52 Report.

15. M. C. Lu et al., 2000, Elimination of Public Funding for Prenatal Care for Undocumented Immigrants in California: A Cost/Benefit Analysis. *American Journal of Obstetrics and Gynecology 182*(1), 233–239.

16. T. C. Chan, S. J. Krishel, K. J. Bramwell, and R. F. Clark, 1996, Survey of Illegal Immigrants Seen in an Emergency Department. *Western Journal of Medicine, 164*(3), 212–216.

17. H. Kuiper, G. A. Richwald, H. Rotblatt, S. Asch, 1999, The Communicable Disease Impact of Eliminating Publicly Funded Prenatal Care for Undocumented Immigrants. *Maternal and Child Health Journal, 3*(1): 39–52.

18. M. E. Lewin and S. Altman, 2000, *America's Health Care Safety Net: Intact but Endangered* (Washington, DC: Institute of Medicine, National Academy Press).

19. Senate Joint Memorial 52 Report.

20. Carol Greenhouse, 2001, November 7–13. Fitting the Profile in Scared New World. *Santa Fe Reporter*, p. 16.

21. Senate Joint Memorial 52 Report.

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