



ANA ISSUE BRIEF

*Information and analysis on topics affecting nurses,
the profession and health care.*

Nursing Beyond Borders: Access to Health Care for Documented and Undocumented Immigrants Living in the US

Key Points

Immigration continues to be a politically divisive issue. However, ANA firmly believes immigrants, whether documented or not, should have access to quality health care, including the opportunity to purchase insurance.

Contrary to common belief or political rhetoric, giving this population access to insurance is an evidence-based way to actually reduce health care costs.

Resolved, that the American Nurses Association will reaffirm its position that all individuals living in the U.S., including documented and undocumented immigrants, have access to health care; and

Resolved, that the American Nurses Association will educate nurses regarding the wide-ranging social, economic and political ramifications of undocumented immigrants' lack of access to healthcare services.

—ANA House of Delegates, 2010

Immigrants and health disparities

Several socioeconomic factors indicate that immigrants (both documented and undocumented) are at greater risk for poor health. First, the rate of poverty for undocumented immigrants rose from 23.3 percent in 2008 to 25.1 percent in 2009. Second, the proportion of the immigrant population without health insurance in 2009 was nearly two and one-half times that of the U.S.-born population (U.S. Census Bureau, 2010). Third, current legislative policy and the new health care reform legislation continue to pose obstacles to the accessibility of health services for both documented and undocumented immigrants.

In 2010, the American Nurses Association (ANA) reaffirmed its longstanding position that health care is a basic human right for all people, and issued a resolution stipulating that all individuals living in the US—documented or not—should have access to health care (American Nurses Association, 2010a).

By taking this position, ANA joins with other international nursing organizations in promoting health care for all migrant peoples (International Council of Nurses, 2006). It also remains faithful to its ethical responsibility as a professional nursing association to speak collectively for nurses in affirming the dignity of all people irrespective of their life situation, and in advocating for change in health policies which affect accessibility, quality, and cost of health care (ANA, 2001).



“Limiting and excluding immigrants from adequate health care coverage—including Medicaid and CHIP—similarly increases the health care costs and possible public health risk to the larger U.S. population ”

Passage of the health care reform legislation Patient Protection and Affordable Care Act of 2010(PPACA) does not provide adequate access to health care for either documented or undocumented immigrants. Accessibility of affordable health insurance is essential to broaden the cost-sharing of health care across a wider distribution of people and to diminish the burden of disease for a vulnerable, underserved population (Hotez, 2008; Hotez, 2010). Limiting immigrants from adequate health care coverage—including Medicaid and CHIP—similarly increases the health care costs and possible public health risks (Hotez, 2008; Livingston, Minushkin, & Cohn, 2008).

The ANA continues to advocate that health reform be expanded so all immigrants have access to affordable health care. The ANA urges nurses and other nursing organizations to be advocates for immigrants as well; and to be attentive to the needs of immigrant families, to assist them in accessing available health care resources, to ensure culturally competent care for them, and to work together for the equitable distribution and availability of health care within the US and abroad (Strange, 2009).

Socio-Economic and Political Context

Various socio-economic and political factors over the last forty years have increasingly contributed to the industrialization of the U.S. health care system, with the provision of health care—the “product”—being increasingly subject to market forces (Strange, 2009). Competition among providers, overuse of costly treatments and technology, rising costs of medications, sharply rising insurance premiums, and increasing need for chronic disease management—all account for much of the inflation of health care costs such that in 2007 the US spent \$2.2 trillion on health care or 16.2 percent of its Gross Domestic Product (Consumer Reports, 2008; Kaiser, 2009). As a result, health care has become a “limited commodity” that more people are unable to afford due to the prohibitive cost of health insurance and increasing out-of-pocket expenses (Kaiser, 2009).

Cost-containment strategies like “managed-care” insurance programs developed over the years to limit expenses such as provider time, costly medications, and high-priced diagnostic tests (Jecker & Braddock, 2008). As “managed-care” plans, government-sponsored programs like Medicare and Medicaid provide health insurance for the elderly and disabled (Medicare), as well as for those who are younger but have low-incomes (Medicaid). The services these government plans cover, however, are subject to competitive market and political forces as policymakers determine *how* limited public resources are to be allocated and *for whom*.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 marked a shift in immigrant policy by differentiating between *types of immigrants* (documented and undocumented), and differentiating between *legal immigrants* and *naturalized citizens* in their eligibility for health and social services (Derose, Escarce & Lurie, 2007). It stated documented immigrants must wait five years for Medicaid eligibility, and undocumented immigrants remain



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ineligible indefinitely. The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) softened the restrictions of the welfare reform act for documented immigrants by giving states the option to provide Medicaid and CHIP benefits to lawfully residing children and pregnant women regardless of their date of entry to the US (National Immigration Law Center, 2010). Undocumented immigrants continued to be ineligible for any government-funded program.

PPACA, as amended by the Health Care and Education Reconciliation Act of 2010, does little to increase access to health insurance for the most vulnerable immigrants ([Table 1](#)). It retains the five-year waiting period for immigrants with legal status to obtain Medicaid (though states still have the option to provide coverage for children and pregnant women without a waiting period), and maintains the ineligibility of undocumented immigrants for Medicaid and CHIP. The law does not restrict undocumented immigrants from receiving emergency care or from seeking non-emergent care from community health centers or safety-net hospitals (National Immigration Law Center, 2010).

Demographic Data

Despite public perception, there was a decline in the number of undocumented immigrants entering the US between 2007 and 2009. Among the estimated 11.1 million undocumented immigrants now residing in the US, Latinos account for the overwhelming majority (four out of five) with 60 percent coming from Mexico and 20 percent coming from other Latin American and Caribbean nations (National Immigration Law Center, 2010). The number of foreign-born children also declined over the decade, while the number of U.S.-born children with at least one undocumented parent increased over the decade to 4 million in 2009 (Passel & Cohn, 2009).

Socioeconomic statistics

- The rate of poverty for non-citizen immigrants rose from 23.3 percent in 2008 to 25.1 percent in 2009 (ANA, 2010a).
- The rate of poverty for Latinos in the US increased from 23.2 percent in 2008 to 25.3 percent in 2009 (ANA, 2010a).
- Undocumented immigrant adults (ages 25-64 years) are more likely to have very low education levels than documented immigrants and U.S.-born adults. Among undocumented immigrants 18-24 ages years, 40 percent have not completed high school (Passel & Cohn, 2010).
- Most immigrants (45 percent of undocumented and 34 percent of documented) live in families with a spouse/partner and a child/children (Passel & Taylor, 2010).



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- Immigrants (documented and undocumented) account for 15.7 percent of the total adult population, and their children account for 23 percent of all children in the US who are 17 years of age and younger (85 percent of whom were born in the US) (Passel & Taylor, 2010).

Labor statistics

- In 2009, there were 7.8 million undocumented immigrants in the nation's workforce, a 5.1 percent share of the labor force of 154.8 million people (Passel & Cohn, 2010).
- Among men of working age (18-64) in 2009, 93 percent of undocumented immigrants were in the labor force compared to 86 percent of working-age immigrant men with legal status and 81 percent of U.S.-born men of working age (Derose, Escarce & Lurie, 2007).
- Among women of working age (18-64 years) in 2009, 58 percent of undocumented women were in the labor force compared to 66 percent of immigrant women with legal status and 72 percent of U.S.-born women. Undocumented women are more likely to report that they are not in the labor force because they are raising children at home than immigrant women with legal status or U.S.-born women (Passel & Cohn, 2010).
- There are high concentrations of undocumented workers in certain occupations: 25 percent of farm workers; 19 percent of building, grounds keeping, and maintenance workers; and 17 percent of construction workers (Passel & Cohn, 2009).
- The unemployment rate of the foreign born in 2009 (9.7 percent) was higher than that of the native born (9.2 percent) for the first time since 2003 (Griswold, 2009).

Health Statistics

Most immigrants come to the US to find work, and are usually younger and in better health than their counterparts who are U.S.-born. Their health status deteriorates over time, however, due to a number of different factors, including poor access to health care. Limited access to medical services and public health programs results in poorer health outcomes for immigrants and their children (Derose, Escarce & Lurie, 2007).

Many immigrants work for employers who do not provide health insurance. Most are in low-paying jobs so they cannot afford private insurance or out-of-pocket medical expenses (Kaiser, 2008; Wallace, Castaneda & Guendelman, 2007; Okie, 2007). Confusion regarding eligibility for government-funded programs (Medicare, Medicaid, and CHIP), fear of deportation, lack of English proficiency, and cultural barriers further limit immigrants' access to health care



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(Derose, Escarce & Lurie, 2007; Gorospe, 2006).

There is the persistent belief that undocumented immigrants pose a burden to the U.S. health system. One study, however, found that between 1999 and 2006, the publicly-funded health care expenditures for documented and undocumented adult immigrants were consistently lower than expenditures for adult U.S. citizens. In several states that provide state coverage for immigrants, additional analysis revealed that during the same timeframe, the average public expenditures per person were lower for immigrants than for citizens, \$780 and \$1,200 respectively (Stimpson, Wilson & Eschbach, 2010).

The varied patterns of health care needs and the blending of “documented” and “undocumented” individuals in immigrant families combine to make accessibility to adequate health care for immigrants a very complex issue. Research, moreover, has shown that use of health care facilities by immigrants—including the emergency department—is different than expected (Kaiser, 2008).

- In 2007, 59 percent of undocumented adults did not have health insurance—twice the rate of documented immigrants and four times the rate of native born citizens (Passel & Cohn, 2009). In 2009, the rate of immigrants without insurance (documented and undocumented) increased to two and one-half times that of native-born citizens (ANA, 2010a).
- Due to a lack of insurance, both documented and undocumented immigrants are much less likely to have had a regular source of health care, a recent visit to a health provider, or preventive care than U.S. citizens (Kaiser, 2008).
- There was a decline in the provision of uncompensated care for both U.S. citizens and documented/undocumented immigrants after 1999. Documented/undocumented immigrants, however, were more likely to have a health care visit classified as “uncompensated care” than U.S. citizens (Stimpson, Wilson, & Eschbach, 2010).
- Both documented and undocumented immigrants are significantly less likely to use the emergency room, and communities with lower rates of emergency room rates tend to have higher concentrations of non-U.S. citizen immigrants. In 2007, approximately 20 percent of adult U.S. citizens reported going to the emergency room, but 13 percent of adult non-U.S. citizen immigrants reported going to the emergency room (Kaiser, 2008).

Other factors need to be taken into account when considering immigrants’ access to health services.

- Health professionals working with migrant farm-workers affirm that farm-workers suffer discrimination in the workplace, and are often threatened with cut in pay, loss of work, and deportation if they miss work or object to

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working in unhealthy work conditions (Health Outreach Partners, 2010).

- Due to the lack of health insurance, immigrants working in occupations with high fatality rates (transportation, material moving, construction) and a higher rate of workplace injury (construction, painters, roofers) are particularly vulnerable to health and financial crises should they have an accident or acute onset of disease and need extended medical care (Leite, Castaneda & Wallace, 2008).
- Undocumented immigrants and their U.S.-born children account for 11 percent of people with incomes below poverty level—twice their representation in the total population (5.5 percent). Among U.S.-born children of undocumented parents who are eligible for benefits such as CHIP, 25 percent remain uninsured (Passel & Cohn, 2009).
- Serious parasitic and bacterial infections affect this population. Cysticercosis (tapeworm), dengue, and Chagas disease have been identified within impoverished Latino populations, with cysticercosis emerging as a leading cause of epilepsy among Latinos (Hotez, 2007; Hotez, 2009).

ANA Policy

The 2010 ANA House of Delegates held the position that health care is a basic human right, and stated that all individuals who reside in the US should have access to health care, including documented and undocumented immigrants (ANA, 2010a). This resolution reaffirms ANA's half-century-old position that health care is a basic human right and should be available to all people in the US regardless of ability to pay (ANA, 1958) - a position also shared by international groups (Hunt, 2006), and the International Council of Nurses position on the provision of health services for migrant people (ICN, 2006).

The resolution is rooted in nursing's professional ethics to:

- Advocate for the care of individuals, families, communities, and populations (ANA, 2010b);
- Accord moral respect to all, recognizing the moral worth and dignity of all people regardless of their personal attributes or life situation (ANA, 2001); and
- Labor for equitable distribution and availability of health care services on the national level as well as the global level (ANA, 2010b).

The resolution reflects ANA's responsibility as a professional organization to:

- Speak for nurses collectively in shaping health care within the US (ANA, 2001), and

"Affordable health services for all immigrants is essential to ensure a basic human right, as well as promote cost-effective, preventive health care for the whole U.S. population. "

- Address health policies that affect accessibility, quality, cost, and the violation of human rights (ANA, 2010b).

Summary

The enactment of PPACA makes health care more affordable—and consequently more available—to many people. The legislation, however, does not increase access to Medicaid or CHIP for documented immigrants, and it only allows emergency care for undocumented immigrants. Affordable health services for all immigrants is not just a right, but provides cost-effective, preventive health care for the whole U.S. population. Further more:

- There are 7.8 million undocumented immigrants in the workforce who can contribute to making health insurance affordable in the US. Allowing them to participate in the various options to purchase health insurance outlined by PPACA distributes the cost-sharing of health care across a broader population of consumers (Immigration Policy Center, 2009).
- As of 2009, only 17 states offered Medicaid/CHIP coverage to documented immigrants without a five-year waiting period, and only 15 states offered prenatal care to women regardless of immigration status through the unborn child option of CHIP (Kaiser, 2009). Increasing immigrants' access to comprehensive perinatal care makes better use of public health funding by improving health outcomes for mothers and children and by reducing the demand for costly emergency care (DuBard & Massing, 2007).
- The number of uninsured people with chronic diseases who were unable to access regular health care or prescription drugs continued to increase between 1997 and 2006. Continuity of care for chronic conditions is essential for managing symptoms, preventing complications and comorbidities, and saving health dollars by avoiding hospitalizations (as well as the indirect costs of work-loss days and disability) (Hoffman & Schwartz, 2008). Latino populations—who will increasingly account for the middle-aged and elderly—are more likely to be overweight, have a higher prevalence of diabetes, and are at a higher risk for developing other health conditions (Livingston, Minushkin & Cohn, 2008). Incorporating immigrants, therefore, into community-wide programs for health promotion and chronic disease management promotes the health of the whole population while stemming health care costs in the future.
- Addressing the health needs of immigrants means addressing the larger public health issues that disproportionately affect people of color and people living in poverty. Serious parasitic and bacterial infections affect the poorest populations in U.S. urban centers, Appalachia, the American south, the U.S.-Mexico border, and the Native American tribal lands (Hotez, 2008). Within



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the Latino population, the common denominator among these infections is not immigration status, but poverty (Hotez, 2009). Accessible health services limit the deleterious effects of disease while disrupting the cycle of poverty that disease can perpetuate; quality health care also promotes better control of infectious diseases which can adversely affect the larger U.S. population.

There is concern among many regarding the financial burden that undocumented immigrants pose to U.S. taxpayers, undocumented immigrants do not pay income taxes (Martin & Ruark, 2010; Camarota, 2006). Research shows that undocumented immigrants do generate tax revenues through sales and payroll taxes, and many undocumented immigrants file federal and state tax returns as well. Their overall share of tax revenue is low, however, due to low-paying jobs (Camarota, 2006; Hill, Lofstrum & Hayes, 2010).

While the costs to the federal government imposed by undocumented immigrant households is less than half of other U.S. households, their tax payments are only about one quarter of what other U.S. households contribute. Many of the government-sponsored program costs are not associated with undocumented immigrant adults themselves but with their U.S.-born children who are eligible for food stamps and WIC, and who receive public education as well as free school lunches (Camarota, 2006).

What is often missing is an analysis of the overall consequences of not providing basic care to the whole population living in the US. Again, the fiscal and public health risks of not ensuring adequate levels of well-being to all living in the US can result in greater health care costs to taxpayers over time (Livingston, Minushkin, & Cohn, 2008; Hoffman & Schwartz, 2008).

Therefore, ANA advocates that all immigrants have access to affordable healthcare without burdensome restrictions and the threat of deportation. The ANA also urges nurses and other nursing organizations to:

- Advocate as well for affordable health care for both documented and undocumented immigrant families,
- Be creative in reaching out to immigrant communities to assess their health needs,
- Assist all immigrant families to access available resources within the community for health care,
- Ensure that health facilities are providing culturally competent care so that health care is more accessible to all immigrants, and
- Work together and speak with one voice for the “equitable distribution and availability of healthcare services throughout the nation and the

Table 1
Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act of 2010 as Applies to Immigrants

	Documented immigrants	Undocumented immigrants	U.S.-Born Children of undocumented immigrants
Eligibility for insurance	<p>Must comply with individual mandate;</p> <p>May purchase from state insurance exchanges</p> <p>Eligible for premium tax credits and cost-sharing reductions</p> <p>Eligible for temporary “high-risk” pools and “basic health plans” offered by a state</p> <p>No waiting periods for enrolling in state insurance exchanges or premium tax credits</p>	<p>Exempt from individual mandate</p> <p>Not allowed to purchase private health insurance at full cost in state insurance exchanges</p> <p>Not eligible for premium tax credits or cost-sharing reductions</p> <p>May seek emergency care (EMTALA)</p> <p>May seek nonemergency care at community health centers or safety-net hospitals</p>	<p>Eligible to purchase from the state insurance exchanges (child-only coverage)</p> <p>Eligible for premium tax credits and reduced cost-sharing</p>
Eligibility for Medicaid/CHIP	<p>Maintains current federal immigrant eligibility restrictions including five-year-or-more waiting period</p> <p>States have option to provide benefits to children and pregnant women regardless of date of entry</p> <p>Citizens of Compact Free of Association states (Federated States of Micronesia) residing in the US remain ineligible for federal Medicaid</p>	<p>Ineligible for Medicare, Medicaid, or CHIP</p>	<p>Eligible for Medicaid or CHIP</p>

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